FINDINGS OF PERMANENT SUBCOMMITTEE ON INVESTIGATIONS ON HEALTH MAINTENANCE ORGANIZATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

MAY 18, 1978

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FINDINGS OF PERMANENT SUBCOMMITTEE ON INVESTIGATIONS ON HEALTH MAINTENANCE ORGANIZATIONS

THURSDAY, MAY 18, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:35 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Curtis, and Dole.

[The committee press release announcing this hearing and the opening statement of Senator Dole follows:]

[Press Release, Committee on Finance, Subcommittee on Health, U.S. Senate]

FINANCE COMMITTEE ANNOUNCES HEARING ON FINDINGS OF THE SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS ON HEALTH MAINTENANCE ORGANIZATIONS

Senator Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Senate Finance Committee, announced today that the Subcommittee will hold a hearing on a report of the Committee on Governmental Affairs prepared by its Permanent Subcommittee on Investigations. The report is a result of several years of investigation and review of HMO's which identifies patterns of fraud and abuse.

The hearing will include testimony concerning illegal and criminal activity found during investigation of certain HMO's and other health care organizations, as well as discussion of preliminary findings of continuing criminal activity.

The hearing will be held at 9:30 A.M., Thursday, May 18, 1978 in Room 2221, Dirksen Senate Office Building.

Witnesses for this hearing will be:

Hon. Sam Nunn, Vice Chairman, Permanent Subcommittee on Investigations; Val Halamandaris, special counsel, Select Committee on Aging, House of Representatives.

OPENING STATEMENT OF SENATOR BOB DOLE

Thank you Mr. Chairman, I am pleased to join with you this morning in welcoming our distinguished colleague Senator Sam Nunn and the other witnesses scheduled to appear before this subcommittee.

I would like to commend Senator Nunn, and you Mr. Chairman for your ongoing interest and concern for the recipients of health care in this country. The work of the permanent subcommittee on investigations is well known as are your efforts to combat fraud and abuse in the medicare and medicaid programs.

In 1976, Americans spent $139 billion for health care and health care costs continue to rise. The enactment of medicare and medicaid have had an enormous impact on health services in America. More people are receiving health care than ever before. There have been considerable increases in outlays which have increased from 5.9 percent of the gross national product to almost 8.6 percent of

the GNP today. The burden of health care costs has also shifted from the private to the public sector. About 42 percent of all health care costs are paid today by the government as opposed to only 25 percent 10 years ago. In an attempt to address the problem of escalating health care costs alternative systems of health care were sought out.

The pre-paid health plan and the health maintenance organization were two such alternatives. I believe many of these programs have a great deal to offer and should be encouraged. Many well meaning health providers and others have sought to offer to medicare and medicaid recipients and to others, good, comprehensive health care. But alas there are those who would take advantage of these individuals and of the government and it is those people that we have come together today to discuss.

Mr. Chairman, you know that as a co-sponsor of your medicare and medicaid anti-fraud and abuse bill, I share your deep concerns over misuse and abuse of program monies. I share your deep concern for those individuals who depend on the government for their health care. But Mr. Chairman, they depend on us for much more. They depend on us to insure that the care they are receiving is good care. That the care is in fact really provided. We must make every effort to see that this takes place.

Senator Nunn I am anxious to hear from you new information on the present status of your investigations into prepaid health plans and HMO's. Your activities and that of your staff are vitally important to our efforts to provide safe, quality, care at a reasonable price.

Thank you Mr. Chairman.

Senator TALMADGE. This hearing will be in order.

This morning, the Subcommittee on Health will hear testimony concerning the findings and recommendations of the Senate Permanent Subcommittee on Investigations with respect to Health Maintenance Organizations—HMO's. It is my understanding that Senator Nunn will also discuss alleged irregularities and administrative inadequacy beyond those included in his formal report to the Senate.

Mr. Thomas Moore, a well-known health care consultant and expert on Health Maintenance Organizations, will testify concerning his experiences and findings.

Mr. Val Halamandaris, who has a distinguished career as a Senate investigator, and who is now employed by the House of Representatives, will testify concerning alleged criminal and fraudulent activities in health care institutions and organizations.

Much of the fraudulent and exploitative activity in HMO's has been at the expense of the medicaid program. Thus far, through effective statutory safeguards, we have prevented similar exploitation of medicare. There are well-meaning people who suggest easing medicare and medicaid HMO requirements and further liberalization of reimbursement. I believe this hearing may, in fact, indicate a clear need for tightening up on HMO eligibility requirements and reimbursement rather than relaxing them.

The Senate will shortly consider renewal and expansion of the overall Health Maintenance Organization authorization. Information developed at this hearing should also aid Senate consideration of that legislation.

Now, as always, it is a distinct pleasure to welcome my colleague from Georgia, Sam Nunn, who is Vice Chairman of the Permanent Subcommittee on Investigation. He has done a lot of work in this field and he has worked very closely with this subcommittee in that capacity.

It is a pleasure, indeed, to welcome you to the hearing, Senator Nunn. You may proceed as you see fit.

Senator NUNN. Thank you very much, Mr. Chairman. First of all, I would like to introduce David Vienna who is staff expert on the PSI

subcommittee in regard to health matters. He has done an enormous amount of work in this area. Without him, we could not be here with the thorough report we have today.

STATEMENT OF HON. SAM NUNN, A U.S. SENATOR FROM THE STATE OF GEORGIA, ACCOMPANIED BY DAVID VIENNA, STAFF, PERMANENT SENATE INVESTIGATIONS SUBCOMMITTEE

Senator NUNN. I am grateful for this opportunity to appear before before you today to present to you the report by the PSI subcommittee on its inquiry into the prepaid health plans and health maintenance organizations.

I also wish to discuss certain other information that the Investigations Subcommittee staff has obtained and raise a number of questions suggested by this information.

This information relates to alleged current abuses in the Federal HMO program. Most of the new information we have developed has not been given the scrutiny of a public hearing with witnesses under oath and subject to questions. Nonetheless, I will discuss a number of examples that give rise to the very serious questions about the current Federal HMO effort.

First, I would like to express my appreciation to you, Mr. Chairman, and to Senator Dole and the other members of your subcommittee. Likewise, the Permanent Subcommittee on Investigations has helped on this HMO inquiry, has been helped in this inquiry by your competent staff. Specifically I would like to thank Mr. Jay Constantine, Mr. John Kern, and Mr. Bob Hoyer for their continuing help in our overall inquiry.

Mr. Chairman, I would like to offer the report that we have recently made as an exhibit at this point in the record.

Senator TALMADGE. Without objection, it will be inserted into the record at this point.

[The material referred to follows:]

95th Congress }
2d Session }
SENATE
{ Report
{ No. 95-749

PREPAID HEALTH PLANS

AND

HEALTH MAINTENANCE ORGANIZATIONS

REPORT

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

MADE BY ITS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

April 20 (legislative day, February 6), 1978.—Ordered to be printed

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95TH CONGRESS } SENATE { REPORT
2d Session } { No. 95-749

PREPAID HEALTH PLANS AND HEALTH MAINTENANCE ORGANIZATIONS

APRIL 20 (legislative day, FEBRUARY 6), 1978.—Ordered to be printed

Mr. JACKSON, from the Committee on Governmental Affairs, submitted the following

REPORT

I. INTRODUCTION

The State of California implemented in 1972 an alternative form of delivering, organizing and financing health care services to beneficiaries of Medi-Cal, the State's Medicaid program. Program costs in California had risen rapidly and continuously under the old system of paying physicians, hospitals and other providers fees for their services.

For example, in March 1966, Medi-Cal programs operations began spending at the rate of $600 million a year. By 1970, program costs had doubled to $1.2 billion. The upward spiraling cost and a suspicion that at least some of the inflation was caused by the unnecessary provision of health care services to the poor led the State Administration to sponsor, and, in 1971 the legislature to adopt, the Medi-Cal Reform Act. This law enabled the California Health Department to contract with prepaid health plans (PHP) for the delivery of health care to Medicaid beneficiaries.

PHP's are comparable to health maintenance organizations (HMO). Both are private entities—primarily corporations—which agree to provide a broad range of health care services to groups of individuals for a fixed monthly rate per individual or family. This is known as a capitation payment. These enterprises either employ or contract with physicians and other providers of health services. Similarly, they either own or contract with health care facilities. The PHP/HMO approach envisions that by grouping physicians together, often in one medical center, comprehensive health care can be made available at reasonable cost and that the quality of care to patients can be enhanced through physician peer group pressure.

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In theory, the HMO's aim is to provide enrollees with preventive medical services, thereby reducing hospitalization and the resulting high costs. In a properly administered HMO, persons who need treatment receive full care. The incentive exists to keep patients healthy and to detect and treat illnesses in their early stages so they will not need more expensive care. The HMO's fixed monthly income forms a ceiling under which administrators agree through contracts to provide for the health care needs of the people they serve.

In short, there is no financial incentive to provide unnecessary medical services, whereas in the fee-for-service system, there is a financial incentive to provide patients with more services than they need, because medical providers are paid for each service.

Prepayment by consumers for health care services from groups of physicians began in the late 1920's in Southern California and in Oklahoma. In Los Angeles in 1929 two physicians, named Ross and Loos, organized a group of physicians and began providing health care services through a number of clinics to employees of the city water department. At Elk City, Oklahoma, another physician encouraged farmers and others living in the area to form a cooperative for health care services similar to co-ops they organized for the sale of their crops.

The Kaiser Foundation Health Plan, the largest prepaid group practice with more than 3 million enrollees, began in the 1930's. This health plan developed out of the need to provide health care services to employees of Kaiser Industries building a canal from the Colorado River, across the Southern California desert, to agricultural areas as well as the city of Los Angeles. Physicians providing health care services to the workers found that reimbursement from workmen's compensation insurance and from receiving fees for their services caused difficult collection problems.

Kaiser employees and their families there, as well as in the World War II shipbuilding plants of the company in Northern California, were offered a company-supported prepaid health program. In 1945, Kaiser Health Plan membership was made available to persons who were not employed by Kaiser Industries.

Through the years the concept grew. Prepaid group practices were formed to serve public employee groups in industrial States with large stable work forces. The decision in 1972 by California to provide health care services to its Medicaid beneficiaries through prepaid plans was followed by passage by the Congress of the HMO Development Act of 1973 to stimulate the growth of prepaid systems.

Pursuant to authority delegated to it by the Senate Committee on Governmental Affairs, which was then known as the Committee on Government Operations, the Senate Permanent Subcommittee on Investigations in October 1974 began an inquiry into fraud and abuse in the Medi-Cal prepaid health plans. Half of the funds for Medi-Cal are provided by the Department of Health, Education, and Welfare under Title 19 of the Social Security Act, known as the Medicaid program.

The inquiry was conducted under a Senate resolution authorizing the Permanent Subcommittee on Investigations to study or investigate:

> The efficiency and economy of operations of all branches of the Government including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement, incompetence, corruption, or unethical practices, waste, extravagance, conflicts of interest, and the improper expenditure of Government funds in transactions, contracts, and activities of the Government or of Government officials and employees and any and all such improper practices between Government personnel and corporations, individuals, companies, or persons affiliated therewith, doing business with the Government; and the compliance or noncompliance of such corporations, companies or individuals or other entities with the rules, regulations, and laws governing the various governmental agencies and its relationships with the public.

Public hearings on Medi-Cal prepaid health plans were held by the Subcommittee on March 13 and 14, 1975, and on December 14 and 15, 1976. Senator Henry M. Jackson, Chairman of the Subcommittee, and Charles H. Percy, the Ranking Minority Member, said at the opening of the March, 1975 hearings that the Subcommittee hoped to learn from the mistakes of California's PHP program so that the same errors would not be made in other State Medicaid programs and in the new Federal HMO development program. Senator Jackson called the HMO concept a "good idea that should not be abandoned because men without conscience, profiteers and scam artists took the initiative in California from those with good intentions."

Senator Percy noted that the intention of Congress in passing the HMO Development Act in 1973 was "to test this health care delivery system nationwide. Our thinking was and is that such a one-step complete health delivery system based on preventive care might be ready for implementation when national health insurance becomes law."

This report is based upon a record developed during the March 1975 and December 1976 hearings and an investigation of program reform efforts. The report summarizes information obtained by the Subcommittee evidencing: fraud and abuse of the California Prepaid Health Plan program; failures by the State government in program management; inadequacies in Federal oversight of the California program; and questions concerning the adequacy of the present Federal program to encourage the development of health maintenance organizations across the nation.

The Subcommittee inquiry found that almost all of the 54 California prepaid health plans reviewed by the Subcommittee were non-profit, tax-exempt organizations that subcontracted with for-profit corporations and partnerships owned or controlled by officers or directors of the non-profit organizations. The inquiry showed that this type of corporate structure and contracting practice opened the way for the diversion of Medicaid funds away from the program's purposes.

Consultants served as brokers, promoting State contracts for interested entrepreneurs in return for a percentage of Medicaid program payments made under State contracts. The money to finance these contracts came from the poor who were enrolled in prepaid health plans by door-to-door salesmen employed by the plans, some of whom threatened, coerced and forced the signatures of Medicaid beneficiaries on their plan enrollment forms.

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The quality of much of the health care—sometimes provided through non-accredited and substandard hospitals—was judged to be poor and even dangerous by State medical auditors. State program managers ignored these reports as well as findings of the State's own fraud investigators, legislative hearings, audits and exposes in the press. The State's failure to respond to compelling evidence of fraud and abuse was part of the extraordinary government mismanagement of the Medi-Cal program.

II. Fraud and Abuse of Prepaid Health Plans

The Subcommittee inquiry identified a pattern of improprieties and practices.

From the very outset of the California program, consulting companies were formed to assist individuals desirous of forming prepaid health plans. These companies obtained contracts for their clients from the State Medicaid agency and then offered to manage the plans for physicians inexperienced in administration.

Complicated PHP corporate structures were created. In general, the corporate entities contracting with the State Medicaid agency were non-profit, tax-exempt corporations. In many cases however, the directors and officers of these non-profit corporations created for-profit partnerships and corporations, which then subcontracted with the tax-exempt organizations to provide the services and facilities needed to fulfill the obligations under the master State contracts. These corporate structures enabled Medicaid funds to be diverted from their intended beneficiaries and into the pockets of plan operators.

The method almost exclusively used by the prepaid health plans to enroll patients was to send door-to-door salesmen through the ghettos and barrios of California enrolling Medicaid beneficiaries. For each person enrolled, the State paid a monthly capitation payment, which varied according to the aid category of each beneficiary. For example, at the inception of the program about $18 per month was paid for each individual receiving aid to families with dependent children. The payment was higher for persons receiving aid to the blind, aged and totally disabled because these beneficiaries usually require more services. The door-to-door sales effort led to substantial abuses.

Finally, the Subcommittee obtained information from experts who evaluated the quality of care provided in the plans and who found many cases of substandard patient care.

A. Consultants

The Subcommittee developed evidence and took testimony on the rapid growth of consulting companies that dealt with the PHP program. There were computer consultants, management consultants, consultants to assist plans in their relations with minority groups, with health department employees and officials and even with State legislators. The primary focus was on those consultants who offered assistance in obtaining contracts from the State Health Department and who offered management services in exchange for a fixed percentage of Medi-Cal payments to the plans.

One of the consulting firms whose activities figured in the Subcommittee's inquiry was known as Health Management Systems, Inc. (HMS), a computer service firm. HMS was organized by Allen J. Manzano in February 1972 shortly after Mr. Manzano had left his position as Chief Deputy Director of the California Department of

Health Care Services.[1] Six other department employees also left their State jobs to take positions with Mr. Manzano's firm. Several of the six had participated in developing the State's computerized eligibility system for the PHP program.[2] Based on their expertise, HMS developed and offered prospective PHP program contractors a computerized system for obtaining certification of welfare recipients as eligible for enrollment in the PHP program.[3] Because of HMS's familiarity with the State's eligibility system, Mr. Manzano's company was presumably in a position to provide this service more readily than the contractors themselves or other consulting firms less familiar with the State program.

By March 1972, very shortly after the firm was established, HMS had obtained the first in a series of contracts with prepaid health plans, some of which had had dealings with the Department of Health Care Services during Mr. Manzano's tenure as Chief Deputy Director. In 1973 and 1974, HMS provided services to at least 10 organizations that already had or subsequently obtained contracts with the Department of Health Care Services[4] with HMS's assistance.

During the fiscal year ending January 31, 1974, approximately 85 percent of HMS's $1.4 million in sales came from four customers: Consolidated Medical Systems, the Foundation Community Health Plan of Sacramento, the Orange County Health Foundation and Paid Prescriptions. Consolidated, the Sacramento Foundation and Paid Prescriptions had had dealings with Mr. Manzano relating to their business with the State when he was a health agency official.[5]

In exchange for the services provided PHP contractors by HMS and its staff of former State employees, HMS received a percentage of the gross Medi-Cal payments to the plans. Mr. Angus Scott, President of Consolidated Medical Systems, told the Subcommittee that over a 20-month period beginning in 1973, his plan, the largest PHP, paid HMS about $1.2 million at the rate of approximately $60,000 per month (p. 356).[6] Mr. Scott said Consolidated is now paying $4,000 per month for the same services with a different firm (p. 358). With regard to payment for computer services based on a percentage of gross Medicaid receipts, Mr. Scott said "anything having to do with the fee structure based on total enrollment would automatically be prohibitive."

To help ensure the integrity of Federal contractual and other actions and to guard against conflicts of interest, undue influence and favoritism in Federal Government transactions, section 207 of Title 18 of the United States Code contains postemployment prohibitions applicable to former officers and employees of Federal Departments and agencies. Such persons may not act as an agent or attorney for anyone other than the United States in connection with certain matters in which the former officer or employee participated personally and substantially while in Federal services. The law also sets forth a one-year post-employment prohibition respecting matters which were within the area of official responsibility of a former employee

[1] Exhibit 17, December 14, 1976 hearing record.
[2] Ibid.
[3] Ibid.
[4] Exhibit 18, December 14, 1976 hearing record.
[5] Ibid.
[6] Page numbers cited in this report refer to pages in the printed hearing entitled "Prepaid Health Plans" of March 13 and 14, 1975 and December 14 and 15, 1976.

at any time during the last year of his or her service. These statutory prohibitions do not apply to State government personnel even though decisions made at the State level often involve the expenditure of large amounts of Federal funds.

While the Subcommittee's inquiry produced no information evidencing any violations of law by anyone associated with HMS, it is clear that the firm did substantial business with contractors who had had dealings with the Department of Health Care Services while Mr. Manzano and his associates were employed by the State government, some of which may have fallen within the area of their official responsibility. HMS's success in attracting PHP's and prospective plans as clients so shortly after Mr. Manzano had left State service created at least the appearance that HMS was the consultant to do business with in order to obtain favorable attention by the Department of Health Care Services.

[In a hearing on matters unrelated to prepaid health plans, the Subcommittee received testimony which also raised questions relating to the administration of Federal funds by State officials. In that situation, a computer design firm had received a contract from the State of West Virginia to develop an improved Medicaid program management and claims processing system for the State of West Virginia. Some 90 percent of the firm's contract costs were paid by the Federal Government. The president of the firm testified before the Subcommittee that he sold stock in his firm to the medical director of the West Virginia Medicaid program at the same time the official was responsible for overseeing the firm's performance under the contract. In addition, the company president testified that the West Virginia official entered into a contract with his firm to perform consulting services in the State of Arizona. This consulting contract was also entered into at the time the State official was responsible for overseeing the contractor's performance in West Virginia.] [7]

In view of the very substantial Federal contribution to the Medicaid and other State-administered programs, consideration should be given to bringing State employees who administer such programs, and whose actions bring about the expenditure of Federal funds, within the conflict of interest restrictions applicable to Federal officers and employees.

California Medical Management, Inc. (CMM), was another PHP consulting firm. Dr. Bernard Aran, President of Rose Medical Group, a small Southern California PHP, told the Subcommittee on March 13. 1975:

> . . . The firm (CMM) provided assistance in obtaining PHP contracts with the State and also handled all administrative chores, including marketing and bookkeeping.
>
> Eventually, I agreed to sign a contract with CMM for it to obtain a contract for Rose Medical Group to be a PHP and for CMM to handle administrative and marketing details of the plan. As a doctor, the idea sounded like a good one, since I did not enjoy the administrative details of running a business. I simply wanted to practice medicine.

[7] Pp. 52–56, Medicaid Management Information Systems hearings, September 29, 1976.

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> I was told my contract was more favorable to me than others CMM had negotiated with other PHP applicants, since it required no cash down. Other plans signed up by CMM, I was told, paid $11,500 on signing and another $11,500 when the State approved the contract. CMM then took 10 percent of the monthly gross of the plans they assisted for marketing and administrative functions it performed. In the contract with Rose, CMM was to be paid 50 percent of the net income and no pre-contract cash was required (p. 123).

Dr. Aran testified that CMM did not perform on its contract with him and that he was left to manage his plan on his own. He told the Subcommittee how he began to be involved with a number of others offering various services. By the Fall of 1973, Rose Medical Group was in financial trouble. To illustrate the attractiveness of the PHP program to unscrupulous promoters. Dr. Aran testified that he

> met a man who said he would give me $50,000 if I agreed to give 25 cents per enrollee per month forever. It was not a loan. He said he would pay $50,000 if he could have 25 cents per month for the duration. I turned the offer down (p. 124).

Another plan encountered problems with a consultant. Dr. Bruce Frome, President of a PHP known as Marvin Health Services, became involved with a consulting firm called People's Industrial Consultants. Dr. Frome told the Subcommittee that his plan was not going to survive with Medicaid beneficiaries alone. In addition, he said that State and Federal regulations and laws required that prepaid health plans could have not more than 50 percent of their enrollment population on Medicaid after a 3-year period.

So Dr. Frome sought to enroll members of union locals. He entered into an agreement with People's Industrial Consultants of Beverly Hills. He paid the group an advance fee for $35,000 against monthly commissions of 10 percent of the gross union payments to the plan that People's could develop.[8]

A few months after Dr. Frome entered into the agreement, he said:

> The FBI met me outside of my office and indicated to me that people that were working for and that owned People's Industrial Consultants had spent half their lives in jail, that they were connected with organized crime and that they were doing me the biggest favor of my life by telling me this. In which case I immediately told my accountant to go to another office and disassociate us from them, which we did (p. 95).

Mr. Scott testified that such percentage fee arrangements are "wrong." The Subcommittee developed evidence that percentage fees for legal, accounting and other services were charged to PHP's. In other businesses, charges for such services are not based upon the percentage of gross sales volume of the companies receiving the service. Moreover, such arrangements in prepaid health plans and health maintenance organizations may defeat the need for these entities to

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[8] Exhibit 18, March 13, 1975 hearing record, "Agreement" between People's Industrial Consultants and Western Health Management Services, Inc. (Marvin Health Services Inc.)

develop capital reserves. In short, payment for non-medical services on the basis of a percentage of gross income to prepaid plans runs the risk of unnecessarily depleting the entities of funds through a reimbursement system that could become excessive as the plans grow.

B. CORPORATE STRUCTURES

Most of the prepaid health plans reviewed by the Subcommittee were non-profit corporations that contracted with existing for-profit corporations to provide services needed by the non-profit corporations to fulfill their Medi-Cal contractual obligations. The for-profit corporations were created by or involved ownership interests on the part of directors and/or officers of the non-profit entities.

Non-profit PHP's contracted with these related entities for services including medical care, management and computer services, rental of clinic buildings, pharmacy and transportation services, and malpractice insurance. The president of a prepaid health plan known as Family Health Program established a for-profit corporation which charged the non-profit corporation for the use of a cabin and a boat by his plan's physicians and employees (p. 428).

The primary issue raised by the corporate structures of the prepaid health plans is the potential for the diversion of funds from their intended purpose—health care. In addition, a serious question is raised as to whether such arrangements breach the letter and intent of the tax laws under which non-profit organizations are accorded tax-exempt status.

In April 1974, the California Auditor General reported that a survey [9] of 15 prepaid health plan contractors revealed that of $56.5 million in Medi-Cal funds going to these plans in a specified period, only an estimated $27.1 million or 48 percent was actually spent on health care services.[10] The balance, $29.4 million, went for administrative costs and profits. The Auditor General said that net profits ranged from 6 to 33 percent of gross Medi-Cal fund payments to the plans.[11]

Subcommittee staff identified one plan where the return on invested capital amounted to 3,000 percent (p. 48).

Angus Scott, President of HMO International (HMOI), the for-profit management company for Consolidated Medical Systems (the non-profit PHP contractor of which Mr. Scott was also president) told the Subcommittee in the December 14, 1976 hearing that his plan resembled a "pretzel palace." He said HMOI's "organizational structure [comprised of different corporations and partnerships] is almost incomprehensible, onerous to manage, duplicative of expense, and in a word, it is wrong" (p. 343). He said he was in the process of reorganizing his corporations into a more simple structure following his recent appointment as chief executive officer of the firms.

Mr. Scott and other witnesses testified that the State Health Department's preference was to contract with non-profit corporations. Review of State laws and regulations shows that the health department could contract with either non-profit or for-profit corporations. The

[9] This report was highly controversial because PHP's criticized the auditor general for developing the numbers without the benefit of an audit.
[10] Exhibit 4, March 13, 1975 hearing record, "Report of the Auditor General on 15 Prepaid Health Plans, April 22, 1974."
[11] Ibid.

preference for contracting with non-profit entities was a matter of policy.

While Mr. Scott argued for a straightforward for-profit corporation with perhaps three wholly-owned subsidiaries, Dr. Robert Gumbiner, the chief executive officer of another prepaid plan, argued for a corporate structure involving a non-profit corporation doing business with related for-profit entities.

Dr. Gumbiner is president of Family Health Programs, Inc., a non-profit health maintenance organization. According to a November 1, 1976 General Accounting Office Staff Study entitled "Relationships Between Non-Profit Prepaid Health Plans with California Medicaid Contracts and For-Profit Entities Affiliated with Them," done at the request of the Subcommittee, the directors, officers and employees of Family Health Programs, Inc. formed nine for-profit partnerships and corporations that in some cases borrowed money from the non-profit entity to build buildings which were, in turn, leased back to the non-profit-corporations.

Dr. Gumbiner emphasized the difficulties health maintenance organizations have in raising capital:

> If the organization was a for-profit company, each year its net profits would be taxed up to 50 percent and it could never accumulate the necessary reserves. Reserves are used to cover adverse utilization, actuarial miscalculations or inflation in order to protect the HMO and its consumers (p. 435).

He noted that HMO's must have reserves just as insurance companies and "that there are no insurance-type protective statutory counter-regulations to protect the HMO reserve from taxation."

Andrew Campbell, Vice President for Finance of Family Health Program, said:

> The significance of these reserves and the question of for-profit versus not-for-profit is that these reserves are not deductible as expenses under generally accepted accounting principles and, therefore, would not be deductible under the Internal Revenue Code without specific legislation such as the insurance industry has (p. 435).

Dr. Gumbiner explained that the relationships between non-profit Family Health Program and a number of related partnerships and corporations serve two purposes. The for-profit entities enable the total organization to raise capital as well as offer management and physician staff members investment opportunities to attract and keep competent personnel.

In summary, Dr. Gumbiner said:

> I agree that the non-profit organization combined with a for-profit support system, if there are regulations to regulate fair dealing, no conflict of interest, arms' length agreements would be what I consider to be probably a good arrangement for both entities and to give the consumers the security they need (p. 434).

Subsequent to the Subcommittee December 1976 hearings, the California Health Department declined to renew its contract under which

Family Health Program provided prepaid health care services to 17,000 Medicaid beneficiaries. The California Attorney General filed a suit against Dr. Gumbiner, and other directors of the non-profit Family Health Program and all of its related for-profit entities. In the suit filed in Los Angeles Superior Court on February 18, 1977, the Attorney General alleged that Dr. Gumbiner and others "wrongfully and without legal justification authorized, appropriated, paid and disbursed to themselves" assets of the non-profit corporation through the for-profit entities. According to the Attorney General more than $2,265,000 had been diverted from the non-profit firm.[12]

Dr. Gumbiner denied the State's allegations, and on April 15, 1977, the Attorney General and Dr. Gumbiner and the other defendants settled the suit by signing an "Agreement and Stipulation." Dr. Gumbiner agreed to recompute the interest rates paid on certain loans from Family to the related for-profit entities and to sell most of the assets held by the for-profit entities to the non-profit corporation at a fair market value to be concurred in by the Attorney General.[13]

Family Health Program contended that the Attorney General had no jurisdiction to file such an action. In a letter provided to the Subcommittee explaining why the litigation was settled out of court, attorneys for Family Health Program said that:

> After the litigation commenced, in order to avoid great expenditure of management, time and expense and public relations problems it was agreed for settlement purposes that the Attorney General have jurisdiction. Under the Attorney General's jurisdiction, the Attorney General requested certain adjustments on past interest payments and divestiture of certain properties by some of the directors. If you would examine the Agreement, the Stipulation and the Judgment you will find that the Attorney General wanted to have FHP own as much property as possible but not deny the present owners a reasonable return on investment. On each proposed sale the sellers were allowed to make a reasonable return. Furthermore, the Attorney General continued to allow FHP to lease its main buildings from the present owners even though they were related parties (p. 448).

Raymond Johnson, a partner in Price Waterhouse & Co., told the Subcommittee at its December 14, 1976 hearing that the Government should require prepaid health plans and health maintenance organizations to file consolidated financial statements. He said such a requirement is the only way to obtain a true picture without obscuring the facts of what is happening to the money:

> It [a consolidated statement] is the only method because you have the same people on both sides of all the transactions. There is no objective way to evaluate or measure the inter-entity arrangement and agreements (p. 347).

[12] *People of the State of California vs. Robert Gumbiner, et al.* Complaint for Restitution, Damages, Surcharge and Removal of Trustees, Enforcement of a Charitable Trust and for Injunctive and other Equitable Relief.

[13] "Agreement and Stipulation," April 15, 1977, between the People of the State of California and Robert Gumbiner, et al.

Edward Densmore, Associate Director of the General Accounting Office's Human Resources Division, told the Subcommittee on December 15, 1976, that the GAO had never done a financial audit of a prepaid health plan. He noted that one plan commissioned a comprehensive audit of its own records; that the audit cost $910,000; and took more than a year to complete (p. 484). "My guess is," said Mr. Densmore, "that if we were to do this type of thing, it would cost us several hundred thousand dollars, and it would also take probably several months to a year to do, also" because of the complexity of the intercompany relationships in these complicated corporate structures (pp. 484–485).

He said, "I think if we had consolidated statements or some requirement along these lines—something along the lines of a uniform chart of accounts or some definition as to what the different line items would be—[it] would be very helpful."

Witnesses representing the Internal Revenue Service testified that there are no IRS restrictions against self-dealing by the directors and officers of tax-exempt corporations. "As long as the organization pays no more than fair market value for the goods or services it obtains in these self-dealing transactions, they provide no basis for the Service to question the organization's exemption," said Joseph Tedesco, Director of the IRS's Exempt Organizations Division (p. 517).

Mr. Tedesco explained that under the tax and case law, organizations are granted tax exempt status if they are "not organized for profit but [are] operated exclusively for the promotion of social welfare" (p. 516).

From the record developed by the Subcommittee, it appears that tax avoidance may be the primary motivation for the creation of the complicated array of non-profit and for-profit entities found among PHP's. The assets of the non-profit PHP plans themselves are not taxable by reason of the plan's tax exempt status. In the hands of the non-profit entity, assets such as physical plants and equipment offer no tax avoidance opportunities to the owners of the non-profit plan. Consequently, some PHP plans have elected to contract with for-profit entities owned or controlled by their own shareholders, officers or directors for the use of properties needed in PHP plan operations. In the hands of separate for-profit corporations and partnerships, such assets do provide opportunities for tax avoidance by way of depreciation deductions, for example.

According to Mr. Howard Schoenfeld, Technical Advisor to the Assistant IRS Commissioner for Employee Plans and Exempt Organizations, the "only way you could possibly explain" the complicated corporate structures found among PHP plans is in terms of the tax advantages they offer (pp. 519–520).

C. MARKETING AND ENROLLMENT PRACTICES

The State of California did not prescribe or recommend any manner through which prepaid health plans could enroll Medicaid beneficiaries. Moreover, because contracts were granted to more than one plan in the same geographic area, plans were forced to compete for enrollees, not only with the fee-for-service sector, but also with other plans.

In addition, the State Health Department, shortly after the program began, required that no more than 50 percent of a plan's enrollees could be Medicaid beneficiaries.

Generally the method by which plans enrolled beneficiaries was by sending salesmen door-to-door through poverty neighborhoods. In an effort to respond to the limitation on the allowable percentage of Medicaid enrollees the president of one PHP unknowingly entered into a contract with a group of alleged organized crime figures who promised to enroll labor union locals in exchange for a percentage of gross billing from the union members (p. 93).

Perhaps the greatest number of abuses found by the Subcommittee involved marketing and enrollment practices. Medicaid enrollers were paid a commission or per-person fee for each individual enrolled or on the basis of family enrollments. It appears that at times PHP marketing practices became nothing more than a street hustle.

According to a sworn statement obtained by the Subcommittee and made a part of the hearing record, a husband and wife team had developed an ingenious way of enrolling PHP clients.

> The husband would canvass an area, going door to door, asking if there were any Medi-Cal clients at the homes. If a householder declined to give such information, the man would tell them that he was a member of the local police department—the El Monte, California police department—and that they were required to give him the information . . . The man was, indeed, employed by the City of El Monte and he worked at the police department. He was a janitor.
>
> Once this man determined if a home contained Medi-Cal beneficiaries, his wife would go to the home and attempt to enroll the family members into the . . . PHP. Sometimes the husband would accompany the wife. If they could not obtain admittance to the home, or, if once inside, the welfare clients objected to signing up with the PHP, the man would again throw his weight around as a policeman.[14]

Larry Pipes, President of South Los Angeles Community Health Plan, told the Subcommittee that "I am familiar with cases where a physician who controlled a prepaid health plan actually used [gave] dangerous drugs and narcotics to influence patients to enroll" (p. 66).

One witness offered an explanation for these practices. Dr. Aran, medical director of the Rose Medical Group, Inc. told the Subcommittee that:

> There are so many plans that the PHP business is more competitive than the very competitive supermarket industry in Los Angeles where there are supermarkets every couple of blocks.
>
> In Venice alone, the area in which I have my plan, there are four other plans competing for patient-enrollees. This sort of competition for enrollees places the PHP program on a collision course with the people of the ghettos who are now very skeptical of the plans themselves . . . None of this

[14] Exhibit 15, March 18, 1975 hearing record, "Affidavit of Earl Stanley DeNayer."

is conducive to the practice of medicine nor is it appropriate for the delivery of health care (p. 125).

To insure that only healthy persons, who would make few demands on the PHP, were enrolled some plans "selectively enrolled" the poor. In one plan, a woman would collect the signed enrollment forms and call the signators. She would ask a series of questions aimed at determining whether the prospective enrollee was healthy or not. If the PHP employee found an enrollee had a condition that might be a financial burden on the plan, the employee would "lose" the enrollment form. If the person indicated that it had been some time since he had visited a doctor or a dentist, the woman would direct him to the plan's clinic for a physical or dental examination, which would be charged to the Medi-Cal program on a fee-for-service basis. Once again, if the patient was found to have severe problems, the enrollment form would be lost.[15] This screening practice violated State regulations and resulted in charging off to the fee-for-service Medi-Cal program the cost of ascertaining whether the prospective enrollee had a health condition that would be a financial burden to the PHP.

Refugio M. Garcia, a California State medical auditor, told the Subcommittee that frequently persons were enrolled in plans after physical examinations were conducted, the cost of which was charged to the Medicaid program on a fee-for-service basis. During an audit he conducted for one plan he said he discovered that "complete medical workups of Medi-Cal recipients were carried out under fee-for-service arrangements . . . following that, [the fee-for-service physicals] I was told by the RN [registered nurse] at one of the PHP clinics these persons would be enrolled in the PHP" (p. 211).

Sometimes sick persons slipped through the selection process. California Health Department investigators obtained sworn statements from persons who said that once they became ill, they were disenrolled from a plan, which processed disenrollment forms with the State. Some of the forms contained the forged signatures of those persons being disenrolled.[16]

One patient was disenrolled through forgery of her signature after she was taken to a hospital with a serious respiratory disease. Two days after her admittance, the patient's daughter received a telephone call from the plan asking her to disenroll her mother. The daughter refused. Nevertheless, the State Health Department received a signed disenrollment form for the patient. State investigators later confirmed the signature had been forged.[17]

While there were those who were forced out of plans against their will, there were others who couldn't get out of them no matter how hard they tried. Following their enrollment in PHP's, some beneficiaries sought to be disenrolled. "The people were told that either they couldn't disenroll or that disenrollment forms had been processed," according to Mrs. Vera McClendon, a welfare rights worker in Los Angeles.[18]

Mrs. McClendon and other neighborhood workers in Los Angeles formed the Los Angeles Health Rights Organization "just to deal

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[15] Ibid.
[16] Exhibit 14, March 13, 1975 hearing record, "Affidavit of Leonard Hayes."
[17] Ibid.
[18] Exhibit 1, March 13, 1975 hearing record, "Affidavit of Vera McClendon."

with the problems faced by poor people who joined prepaid health plans." [19]

The organization started a program to help people disenroll from the plans.[20] There were negotiations with the State Health Department, which agreed to allow plan enrollees to file their disenrollment forms with these health rights organizations rather than with the plans, which were "losing" them.[21]

After about two months, State officials complained to Mrs. McClendon that there were so many disenrollments that the State couldn't process them all and the plans were complaining. The Health Department stopped accepting disenrollment forms filed through the health rights group and began accepting only those forms filed through the plans. "Once again," Mrs. McClendon said, "people filed their disenrollment forms with the plans and disenrollments were delayed or never filed." [22]

Problems relating to enrollment, disenrollment and grievance procedures were identified by the General Accounting Office in its September 10, 1974 report on "Better Controls Needed for Health Maintenance Organizations under Medicaid in California." In that report, the GAO

> noted many cases in which recipients submitted complaints or disenrolled from PHP's because they believed the plan was misrepresented when they enrolled. . . . Because of the heavy investment in obtaining facilities and staff to begin operations, new PHP's are interested in enrolling members as rapidly as possible. The PHP's contracted with marketing firms or employed door-to-door solicitors and reimbursed them on an incentive basis. . . . GAO believes these circumstances have contributed to enrollment irregularities. . . . Improvement is needed in the State monitoring system to insure that PHP's . . . promptly process recipients requests for disenrollment.

Earl Stanley DeNayer, a Senior Special Investigator for the California Department of Health, told the Subcommittee that during the 1974–75 period at Family Health Program, then the third largest PHP with 17,000 Medicaid enrollees, "some persons who signed enrollment forms were given physical examinations by plan physicians before the enrollment form was sent to Sacramento," the State capital (p. 374).

Mr. DeNayer testified that the forms of those who did not pass the physicals were not sent to Sacramento but that commissions were nonetheless paid to the enrollers "so that no suspicions would be aroused." Moreover, he said "the names of those persons who flunked these screening physicals were placed on a 'blacklist,' against which the names of subsequent new enrollees could be checked," so previously rejected persons would not be enrolled in subsequent marketing efforts (p. 374).

Dr. Gumbiner, President of Family Health Program, denied engaging in these selective enrollment practices (p. 418).

[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

Mr. DeNayer, however, placed into the record of the hearing an internal Family Health Program memorandum setting forth an "Incentive Pay Program" for door-to-door salesmen. The memo read:

> The reason for this suggested change is to, number one, change the direction of the type of people enrolled, i.e., from OAS [Old Age Security] and ATD [Aid to the Totally Disabled] to AFDC [Aid to Families with Dependent Children] because of the high cost and utilization of the OAS and ATD type individuals. Number two, by changing the pay from contracts to persons enrolled, you will give the enroller the incentive to enroll more people as opposed to more contracts, (AFDC as opposed to OAS and ATD).[23]

Aside from the impact of door-to-door sales on Medicaid beneficiaries, the technique also took its toll on the plans themselves. Mr. Scott, President of both Health Maintenance Organization International and its affiliate, Consolidated, said that his PHP spent more than $900,000 in 1975 to market his plan door-to-door (p. 341).

D. QUALITY OF CARE

During its inquiry the Subcommittee staff identified one PHP operator who became known as the "Phantom" to physicians in the emergency room of a hospital in the Santa Monica Bay area of Los Angeles. This physician was called the "Phantom" because he would close his clinics on nights and weekends and disappear, forcing his patients to go to a hospital emergency room for care (p. 16). The hospital staff found that after they had provided care to these patients, the hospital could not get reimbursed.

Under California law, once a Medicaid beneficiary is enrolled in a plan, that plan is financially liable for all health care services provided the enrollee. Many plans took the position that if hospitals provided health care services to PHP enrollees without the prior authorization of the plan, then the plan was not financially liable for those services. The "Phantom" was the only person authorized to admit his plan's enrollees to hospitals for treatment (p. 16).

Through the practice of closing clinic doors to enrollees, the "Phantom's" plan and others could reduce costs and, perhaps increase profits.

But "who has profited how much through what conniving scheme is not the main issue in the PHP program," Dr. Lester Breslow, Dean of the UCLA School of Public Health, told the Subcommittee (p. 59). "The fact that people [for] whose health care Government has declared itself responsible are not getting care—that is the main issue," he said.

The Subcommittee received information relating to specific instances of poor quality of patient care:

> Enrollees of one plan were placed in clinic holding rooms for observation, prior to hospitalization, without any nurses or physicians present to observe them (p. 211).
>
> Medical records keeping was so poor that the chart of a five year old boy showed that he had an ovarian cyst removed (p. 205).
>
> A woman diagnosed as having gonorrhea was not treated for two months following the diagnosis (p. 205).

[23] Exhibit 17, December 14, 1976, hearing record.

A physician prescribed barbiturates to a patient who was a known heroin user (p. 66).

A surgeon operated on two patients at the same time (p. 66).

A hospital administrator was found to be prescribing and administering drugs (p. 66).

A plan physician continued to ignore requests from a nursing home to transfer one of the plan enrollees to a hospital. After repeated requests, the patient was taken to a plan clinic where he was examined and returned to the nursing home. A lawyer was retained by the enrollee's sister; the patient was hospitalized; and died. The attending physician said he should have been placed in the hospital sooner.[24]

In addition to these and other examples, the Subcommittee received testimony from a physician who surveyed East Los Angeles Doctors Hospital for the California Medical Association. The facility, which provided hospital services for six prepaid health plans, was denied certification, on the basis of poor quality of care, by the Medical Association which had conducted a voluntary quality review evaluation. This review was in addition to one performed by the Joint Commission on the Accreditation of Hospitals whose approval is required by the government programs.[25]

The physician-surveyor, Dr. Robert Shlens, a Los Angeles orthopedic surgeon and member of the Medical Associations' Medical Staff Survey, said that in the 7 years preceding his testimony, he participated in 81 hospital surveys in the State of California. He said:

> In my experience, I have observed that some of the worst hospitals have been in the forefront of those obtaining lucrative prepaid health plan contracts. These substandard hospitals are usually small and privately operated, frequently located in low income areas where the greatest number of welfare program beneficiaries reside (p. 144).

The Subcommittee also obtained evidence that one plan used more than nine unlicensed physicians.[26] Some of these unlicensed physicians were placed into the plan by an official of the criminal justice system in Los Angeles County, who also operated a health consulting firm.[27]

Some plans didn't have enough physicians to take care of the patients enrolled. In one large plan, there were no obstetricians though there were a large number of pregnant women enrolled in the plan, and only two pediatricians for the 110,000 persons enrolled, many of whom were children (p. 59).

Subcommittee testimony, exhibits and sworn statements also indicate a lower than expected number of surgeries on enrollees of prepaid health plans. Dr. Breslow said that a plan he had reviewed "provided less than half the amount of hospital care used in well-organized group practice prepayment plans . . ." (p. 60). And Refugio Garcia, a State Medical Quality reviewer, said he found one small plan in which all of the 13 surgeries done in a three month period in 1974 were for thera-

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[24] Exhibit 1, December 14, 1976 hearing record. "Report to the Governor" by Heistand, et al.

[25] Exhibit 26, March 14, 1975 hearing record, "California Medical Staff Survey of East Los Angeles Doctors' Hospital."

[26] Exhibit 34, March 14, 1975 hearing record, "Report of Investigation, California Health Department."

[27] Ibid.

peutic abortions (p. 211). This is an indication that the plan may have selectively enrolled young women whose care would be less costly to the PHP than an enrollment population more reflective of the age and sex characteristics of the community.

In September 1974, General Research Corporation of Santa Barbara, California, published a report it had prepared for the Department of Health, Education, and Welfare on the quality of care provided in the California PHP's. General Research found fault with the quality of care provided in the plans it surveyed and concluded that "the PHP program to date needs improvement from a quality-of-care viewpoint" (p. 61).

Dr. Breslow said:

> The State of California has been relying to a considerable extent on medical audits of the several components of care in its prepaid health plans (medical, dental, pharmaceutical, X-ray, etc.) for the purpose of assessing quality. The report of audits, however, have been quite uneven. Several different State staff physicians and other State personnel participate in these audits without much uniformity. One gets the impression of a casual approach to the matter (p. 61).

He recommended that a monitoring system for quality of care be established to include a number of specific reviews, including deaths of enrollees, hospital charts, physician turnover in plans, periodic surveys of enrollees and reviews of enrollee grievances.

The GAO, likewise, recommended in its September 10, 1974 report that Federal regulations should be promulgated to "identify management data . . . which can be advantageously used by the States to monitor HMO quality of care and devise procedures to insure that accurate, standardized data is available to HMO audit teams."

This GAO recommendation followed the agency's findings that California's evaluations of quality of care in PHP's "have not been performed in sufficient depth to insure that the law's intent (relative to quality) is being met."

Steven Passin, Special Deputy Director of the California Health Department, called the State Medical Auditing System of PHP's "capricious" and said that it "utilized no guidelines, no chart uniformity, [and] no criteria . . ." (p. 121). Mr. Passin said the State would need the assistance of the Federal Government in reforming the PHP program. He said that over a period of two years, at a cost of several million dollars, the State could develop systems to monitor the plans. "The area of most importance is the development, the testing, [and] the implementation of the quality assurance and assessment system for the medical program," he said (p. 121).

III. Government Program Management and Oversight

The California Health Department, formerly known as the Health Care Services Department, is the State Medicaid Agency responsible for the letting of contracts and management of the State's Prepaid Health Plan Program. Fifty percent of the program administrative costs and the program funds are provided to the State from the Department of Health, Education, and Welfare (DHEW).

In January 1975, the California Health Department began to reform the PHP program. DHEW joined in the reform effort following the Subcommittee's March 1975 hearings. The State's effort to clean up the PHP program faltered in 1976 but was reinstituted by the Federal Government following passage by the Congress of the Health Maintenance Organization Act Amendments in the fall of 1976. These amendments require that in order for a prepaid health plan to receive Medicaid funds, it must be qualified and certified by the Department of Health, Education, and Welfare. States were allowed under the amendments to continue contracting for Medicaid services on a provisional basis with those plans which had submitted applications to the Public Health Service and upon which no action had been taken within 90 days of submission. California, however, opted to contract only with organizations which had been qualified or whose applications had successfully passed initial screening procedures which were part of the qualification process.

A. State Management: 1971 Through 1974

From the program's very beginning, there were clear indications and later solid evidence of fraud and abuse that the State of California Medicaid Agency failed to acknowledge in its management of the program.

The State Health Department did not respond to consumer complaints; covered up investigative reports; ignored negative quality of health care reports; failed to respond to legislative oversight hearings; and ignored the findings and recommendations of analysts and auditors.

There was great pressure on the staff of the health management systems section of the California Department of Health Care Services in 1972 to develop PHP contracts. The Governor, the Health Director and the legislature all supported the prepaid health plan program as a popular prescription to cure the continually escalating costs of the States' nearly $2 billion Medicaid program (p. 6). All saw it as the way to cut Medicaid program costs by 10 percent.

By November 1972 there were seven contracts granted to prepaid health plans. A State PHP newsletter proclaimed, "we are committed to aggressive implementation and expansion of the PHP program" (p. 6). The seven PHP contractors at the time were authorized to

enroll 40,000 Medi-Cal beneficiaries and the newsletter predicted that 40 new contract proposals would cover an additional 680,000 welfare recipients in 1973. This would have resulted in the enrollment in prepaid plans of half of California's two million Medi-Cal beneficiaries which became the State Health Department's official goal in 1973 (p. 6).

Through 1973, 40 new contracts were awarded bringing to 47 the total number of plans which enrolled a total of 202,000 persons at the cost of $45.7 million (p. 6). By the end of 1974, there were a total of 54 plans with 252,000 enrollees (p. 6). The State paid these plans $81.6 million, half of which came from the Federal Government (p. 6).

The peak year, in terms of numbers of plans and enrollees, was 1974. The goals had not been met. Instead of enrolling half of the State's welfare population, the PHP's enrolled only 10 percent (p. 6). Instead of improving the health care services for the poor, evidence presented before the Subcommittee indicates the poor may have actually suffered from the program. And instead of saving the State money, the program may have actually cost the Medicaid program more than would have been spent had the program never even begun.

Beginning in November 1972, 6 months after the first PHP contract was in force, a pattern of abuses was already identified. Newspapers reported:

> PHP emergency clinics, required to be open 24 hours a day by contractual agreement, were closed during the evening hours (pp. 9–13).
>
> PHP investors were turning huge profits on their investments.
>
> Federal law enforcement authorities were probing the involvement of organized crime in prepaid health plans (pp. 9–13).
>
> A Los Angeles Grand Jury indicted a PHP door-to-door salesman for forging the signatures of Medi-Cal recipients on enrollment forms (pp. 9–13).

1. Legislative oversight

In 1973, there began a series of legislative hearings, pinpointing the problems. There were hearings on fraudulent and abusive enrollment practices and the quality of care provided in prepaid health plans. At a hearing in Los Angeles, the California Assembly Health Committee learned that PHP's were using unaccredited hospitals; that a physician in one plan was accused of keeping a patient addicted to codeine rather than giving him proper treatment; and a patient with a curable eye problem in another plan was allowed to go blind while under the care of a physician.

On November 15, 1973, the State Legislative Analyst H. Alan Post released a 50-page report [28] revealing widespread abuse, deception, and illegal practices in PHP's serving welfare beneficiaries and charged the State Administration with failure to properly monitor the then, $65-million-a-year program. Program flaws reported by Mr. Post included: (1) failure of the State Health Department to make adequate background checks on principals involved in PHP contracts; (2) failure of the State to adequately audit financial records of plans; (3) fre-

[28] "A review of The Regulation of Prepaid Health Plans," by H. Alan Post, Legislative Analyst of California, November 15, 1973.

quent rotation of State contract managers so that they were unable to acquire knowledge of the operation of the plans; (4) inability of the State to provide cost data on plan operations; and (5) lack of State review of quality and necessity of patient care.

While the news reports and legislative criticism could be read by State Health Department management and staff in the public media, there was other information available to program managers that was even more compelling.

2. Handling of complaints

In November 1972, John Blaul, a California Health Department investigator, was assigned by the California Health Department to conduct field investigations of welfare recipients' complaints against PHP's in Los Angeles. Blaul was able to handle only six cases a day, 10 percent of the number received daily. In a sworn statement to the Subcommittee Blaul said that he was told by his superiors that professional Health Department investigators were not to be involved in his inquires because the Health Department "didn't want to rub the doctors the wrong way." [29]

Blaul looked into many allegations and found numerous legitimate complaints. The allegations included forged enrollment forms, and misrepresentations by enrollers claiming they were State or County welfare workers, wearing nursing uniforms or physician smocks.[30]

Each Friday, Blaul would travel to Sacramento for a weekly meeting of the PHP contract managers. Though he repeatedly asked that sanctions be applied against the plans, nothing was done. When he asked that something be done about the forged enrollments, he said his supervisor "told me to forget about it." [31]

During the period Blaul was in charge of reviewing consumer complaints, boxes containing 2,500 complaints were removed from his office in Sacramento while he was on a trip to Los Angeles. He sought the boxes because he needed them to follow up on complaints, but he was told they had been sent to State archives. Blaul's superior told him not to worry about the 2,500 complaints because there were more important things to work on.[32]

3. Background checks

James Latham, also a member of the Health Department's investigations section, testified before the Subcommittee. He was assigned initially to do background checks on PHP applicants and physicians. He contrasted his previous experience running background checks on applicants for State liquor licenses, and he said the State procedures for obtaining such licenses were more stringent than obtaining a PHP contract (p. 133).

Mr. Latham testified that he was the only man assigned to review the backgrounds of applicants for PHP contracts. He said:

> . . . [In] 1972 and 1973, applications were coming in faster than I could handle them. I was the only one, for most of that time, assigned to do these investigations. It proved impossible to do a very complete check on an applicant and each

[29] Exhibit 11A, March 13, 1975, hearing record, "Affidavit of John Blaul."
[30] Ibid.
[31] Ibid.
[32] Ibid.

of its medical providers who were to deliver specialized medical, marketing and billing services. I was assigned to investigate 10–12 plans a month, each of which could have as many as 660 medical, marketing and billing service providers.

As a result, the background checks were too often but necessarily, cursory. I did not regard this as satisfactory since these plans effectively controlled the health of thousands of people.

Occasionally, I was able to identify serious problems with applicants and communicate my doubts to superiors. Sometimes my recommendations were ignored (p. 133).

Latham said he first committed his objections to writing, but that he stopped doing this when he found department officials shared his findings with the subjects of his background checks. "I found this out because several applicants called me to complain about my opinions on them," he said (p. 133).

Latham also noted that several consulting companies began promoting contracts. Among these consulting firms was California Medical Management, Inc. (CMM), which had submitted eight contract proposals at the same time. Latham said he learned of cash outlays by plan applicants to CMM and of post-contract administrative service and management arrangements each plan had with CMM whereby CMM would receive a percentage of gross welfare fund receipts. "I regarded this as an unacceptable arrangement, since CMM was skimming off excessive management fees, in my mind," Latham said (p. 133).

When he expressed opposition to all of the eight plans because he felt—"the plans would not be financially capable of providing high quality medical care since so much of their funds were committed to the management firm"—his recommendations were ignored (p. 133).

In May 1973, Latham said, he told the Director of the PHP program about connections between one plan and a group of alleged organized crime figures. The PHP program director told Latham to give his information to a Health Department attorney, who told him the contract should not be renewed.

Latham said that while writing the report on his findings regarding this plan, he was directed to destroy the report by the PHP program director's secretary (p. 133). He did not destroy the report, which he gave to the Subcommittee. The memorandum was placed in the record of March 14, 1975, hearing as a sealed exhibit (Exhibit No. 20). The memorandum alleged that organized crime figures had obtained a contract with Marvin Health Services, a prepaid health plan. Information relating to this situation was presented to the Subcommittee in the testimony of Dr. Bruce Frome (pp. 93–95 of the March 13, 1975, hearing record), and appears in Chapter II of this report.

4. Investigations

The California Health Department maintains an investigations unit, which employed during the early period of the PHP program about 50 experienced investigators. In addition to the testimony of James Latham, who was assigned to do background checks, the Subcommittee obtained sworn statements from other investigators including Chester

C. Jones, who was the head of three investigative field offices in Southern California.

Originally assigned to conduct background checks on would-be physician providers for the plans, Jones and his subordinates were directed in November 1971 to cease further inquiries following their development of damaging information on a number of physicians (p. 41).

Throughout 1972, Jones and other investigators routinely forwarded growing numbers of complaints to Sacramento and repeatedly asked for authority to investigate.

In May 1973 Jones was relieved of his position in charge of the San Diego and San Bernardino field offices. But the volume of complaints grew and investigations were finally authorized in July 1973. But by the end of the month, the authorizations were rescinded. Jones was relieved of his Los Angeles field office command and was directed in August 1973 to investigate alleged kickbacks in State mental hospitals (p. 88).

Leonard E. Haynes, a former Los Angeles policeman and one of Jones' investigators, gave a sworn statement to the Subcommittee in which he gave detailed examples of what his inquiries had developed.[33] In summary, he said:

> I had confirmed serious allegations of violations of law, administrative regulations and medical ethics. These violations included forged enrollments, selective enrollments of healthy persons only and forged disenrollments of sick persons who were costing the plans monies, long waiting periods before medical treatment, poor and non-existent care, misrepresentations by enrollers who were paid a capitation rate for each enrollee and false advertising.
>
> I have forwarded literally hundreds of allegations by complainants against PHP's to my superiors in Sacramento that appeared to me to be worthy of corrective action, where no such action has been ordered.
>
> In addition, I have recommended to Sacramento that criminal and/or administrative action be brought against four large PHP's in the Los Angeles area. And in each case, no initiatives were forthcoming. Detailed investigations of these four plans turned up confirmed examples of false advertising, as well as numerous examples of bad or no care, forged enrollments, and in one case, a PHP contractor signed an agreement with the State pledging the services of a hospital which did not, in fact, offer services to that plan's enrollees. In none of those cases did the Health Department seek legal or administrative action against the plans.[34]

In August 1973, the Los Angeles District Attorney sought Haynes' assistance in investigating criminal fraud charges against a PHP door-to-door salesman, who was subsequently convicted. The District Attorney asked Haynes' superiors in Sacramento for the investigator's help. The Health Department authorized Haynes to serve "in an

[33] Exhibit 8, March 13, 1975, hearing record "Affidavit of Leonard E. Haynes."
[34] Ibid.

advisory or liaison capacity," with the District Attorney's Office, according to a letter to the prosecutor.[35]

The Subcommittee obtained an internal Health Department memorandum written by Haynes' superior relating to the District Attorney's request for his assistance. The memo says, in part:

> I have attempted . . . to limit the involvement of Lennie Haynes and still give the impression that we intend to cooperate fully. I'm afraid if we are too standoffish we will cause the DA to suspect we are trying to suppress his investigation and this may cause an exaggerated intensification of the DA's interest and suspicion of the Departments' culpability in the award . . . of PHP contracts.[36]

5. Quality of care review

State Medical quality reviewers suffered the same experience as Latham and the other investigators. Dr. Joseph Mells, a medical consultant to the State Health Department, testified before the Subcommittee about the inferior quality of care found in the PHP clinics he reviewed. With regard to State management he said:

> . . . It is my belief that none of the medical shortcuts that occur at these PHP clinics could continue if my superiors in the Health Department took a more aggressive role on behalf of the Medi-Cal recipients whom they are supposed to protect (p. 206).

Dr. Mells cited in his testimony four clinics that needed re-evaluation within 30 days of an audit that found deficiencies. But a State official who controlled the auditors' schedule "directed us to audit other clinics, and did not allow us any time to re-audit the clinics with the most serious problems" (p. 206).

At one point Dr. Mells asked his superior to join him on an audit. His testimony was as follows:

> I tried to show him how we review the individual medical charts. He appeared somewhat impatient and asked if we had to go into such great detail. I informed him that careful review is necessary to ensure that the PHP patients were receiving adequate care (p. 206).

During the early years of the PHP program, no contract was ever cancelled or failed to be renewed based upon quality evaluations despite the belief by State quality reviewers that there was cause for such action on grounds of poor quality.

For example, the record before the Subcommittee shows that a physician found that 11 of 27 charts reviewed at one PHP clinic "were unsatisfactory based on diagnosis and treatment." [37] This clinic, which cared for 214 PHP enrollees, was found by the physician-reviewer to provide treatment to patients "below the norm of acceptable care." The reviewer recommended that the clinic be dropped from participation in the program. No action was taken.[38]

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[35] Exhibit 34, August 16, 1973, Letter to Joseph B. Busch, District Attorney, County of Los Angeles, from James A. Walker, Deputy Director, Health Department.

[36] Exhibit 34, August 15, 1973, memorandum to Jim Walker from Gerry Rohlfes, regarding "PHP Investigations."

[37] Exhibit 29, March 13, 1975, hearing record, "Affidavit of Keith W. Baumgardner."

[38] Ibid.

While some physician-reviewers found faults in certain plans and clinics, others avoided the obvious. For example, one audit team member notified a physician, who was a team leader, that "unlicensed personnel were presenting themselves as doctors and providing care to the patient. . . . [but] he [the physician] did not include any reference to this situation in that report to the State Health Department in Sacramento" resulting from the on site medical audit of the plan in question.[39]

Keith Baumgardner, a medical reviewer for the State, in a sworn statement to the Subcommittee, said that "thousands of poor white, Spanish speaking and black children whose parents have enrolled them in prepaid health plans, are not immunized against diptheria, smallpox, polio and tetanus. Nor are these children given physical examinations and evaluations as required by the State in its contracts with the plans. I have been told by doctors and administrators that these examinations and immunizations are not given because they cost the plan too much to provide." [40]

"Economics, not good professional judgment, decides the level of care at these PHP's," Refugio Garcia told the Subcommittee. "As a result, in far too many cases, care provided to PHP patients is either inadequate or non-existent. . . . One of the most disturbing facts about the PHP's is that most of them have an extremely healthy enrollment, for the most part. This may be attributed to the method of enrollment," Garcia said (p. 211).

While State regulations did set forth a number of services—such as immunizations—that had to be provided to beneficiaries (p. 225), the overall standard was that quality of care provided in prepaid health plans had to be equal to or better than that provided in the fee-for-service sector (p. 213). Witnesses told the Subcommittee that since there is no standard for measuring quality in the fee-for-service sector, it was difficult to impose any standard of quality in the prepaid plans. However, in the face of reports of obvious quality problems from its own staff, the State Health Department did not respond.

6. Rates

Just as there was no objective method by which quality of care could be judged, there likewise was no method by which rates could be arrived at in a manner both fair to the plans as well as the taxpayer.

Until July 1974, the State negotiated rates with plans after first arriving at a base, which was determined by simply taking the estimated per capita cost of the Medicaid program by county in each of the four aid categories [41] and paying the PHP's 90 percent of these figures.[42] Under State regulations, the capitation payments to the plans could not exceed the per capita cost of care in the fee-for-service Medi-Cal program.[43] In some cases, however, the negotiations resulted in rates that exceeded the actual per capita fee-for-service costs. As a result, after July 1974, the State no longer negotiated rates, but simply paid

[39] Ibid.
[40] Ibid.
[41] Persons qualified to receive Medicaid program benefits if they fell into one of the following aid categories: aid to families with dependent children, aid to the blind, to the aged, and to the totally disabled.
[42] Exhibit 31, March 13, 1975, "Program White Paper," p. 250. Hearing record.
[43] Exhibit 31, p. 257.

the amount arrived at through the arithmetical method based on estimated program costs, by county, by aid category.[44]

The question of the appropriateness of rates was one of three primary concerns, along with enrollment practices and quality assurance evaluations, addressed by the General Accounting Office review of prepaid health plans done at the request of the Senate Committee on Finance and released on September 10, 1974. In its report, the GAO said that "California's anticipated cost savings for fiscal year 1973 may not have been realized because (1) the State's estimated fee-for-service per capita costs used to negotiate PHP rates were overstated because the State under-estimated reductions in medical costs due to legislative changes in Medi-Cal and (2) one PHP was awarded rates higher than the State's per capita fee-for-service estimate." [45]

As a result of these and other findings, the GAO said it "believes that there is no assurance that the PHP program is achieving its objective of reducing Medicaid costs." [46]

Furthermore, the record before the Subcommittee shows that most large plans some of which were found by State investigators to have been engaged, at one time or another, in selective enrollment practices, had a disproportionate number of welfare clients receiving Aid to Family with Dependent Children (AFDC). Most large plans had more than 80 percent of their enrollment population on AFDC, as contrasted to the entire Medi-Cal population, in which 70 percent of the beneficiaries were on AFDC (p. 453). One plan had 97 percent of its enrollees on AFDC (p. 453). AFDC clients are the youngest and least demanding of health care services in contrast to beneficiaries of the other three aid categories, including aid to the blind, aged and totally disabled.

Because of the selective enrollment and pre-screening practices known to have been employed by many of the PHP's, the State of California may have made monthly payments for health care services for Medi-Cal beneficiaries who never used or only occasionally used the Medi-Cal fee-for-service program.

The GAO report of September 10, 1974, said that "the program may not be saving money as projected by DH (California Department of Health) and might be more costly than the fee-for-service program." The GAO said it studied two large PHP's and compared actual program costs to fee-for-service costs. In one case, the State expected to save about $1.2 million from its prepaid contract, but the GAO found that only $255,000 was saved. In the other case, the State expected to save about $351,000 through a PHP contract, but actually exceeded fee-for-service costs by about $151,000.

The GAO also produced a report on August 8, 1975, entitled, "Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program." In that report, the GAO said that the State had negotiated rates with the Medical Care Foundation of Sacramento for fiscal years 1973 and 1974 which exceeded actual per capita fee-for-service costs by $4.3 million. The GAO recommended that DHEW recover the Federal share of this overpayment, because the overpayment violated State and Federal regulations, which require

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[44] Ibid.
[45] "Better Controls Needed for Health Maintenance Organization Under Medicaid in California," General Accounting Office, September 10, 1974.
[46] Ibid.

that HMO rates not exceed the cost of fee-for-service. In a March 6, 1978, letter to Senator Jackson, Chairman of the Subcommittee, the GAO reported that as of December 1977 DHEW had not recovered these funds, and they remain unrecovered to this day. The letter appears as an appendix to this report.

Though the Health Department was required by Section 14302 of the State Welfare and Institutions Code to "determine by actuarial methods" the capitation rates to be paid to the plans, it did not.[47] Rather, the Department simply attempted to hold payments to the plans to levels that would not exceed the cost of fee-for-service. But as the GAO found, even the fee-for-service cost ceiling was exceeded.

In short, by not establishing an actuarial method to determine capitation payments as required by Section 14302 and by relying on an imprecise estimate of fee-for-service costs as a base, the State provided program administrators little guidance for their rate setting decisions.

As discussed in the section of this report entitled Corporate Structures, many of California's plans organized themselves into complicated corporate structures and opened the way for possible diversion of funds. In April 1974, as previously noted, the California Auditor General disclosed in a controversial report, that more than 50 percent of the Medicaid funds going to 15 plans studied were accounted for as administrative costs and profits.

7. Subcontracts

The General Accounting Office review for the Subcommittee of the corporate structures of five prepaid health plans revealed that the officers and directors of the non-profit corporations under contract to the State Health Department created for-profit corporations and other entities which provided services to the non-profit plans through subcontracts. In some cases, buildings were leased to the non-profit corporations by partnerships created by the non-profit corporate directors and officers.

State of California regulations required that the subcontracts be reviewed and approved. The GAO reported that:

> The State requires:
> 1. All PHP subcontracts shall be entered into pursuant to regulations established by the State agency.
> 2. All PHP subcontracts shall be in writing and shall be transmitted by the PHP to the State agency for approval.
> 3. The PHP subcontracts must demonstrate to the satisfaction of the State agency the legal sufficiency of the subcontractor's commitment and ability to perform.
> 4. The PHP subcontracts shall state the amount of compensation or other consideration which the subcontractor or provider will receive under the terms of the subcontract with the PHP. . . .

But, the GAO found that:

> The State agency has not established criteria or regulations outlining the elements required to be included in a PHP's subcontracts. A "for discussion only" draft of such elements was issued in April 1976. As of September 1, 1976, the draft had not been finalized.

[47] Exhibit 31, p. 257, March 13, 1975, hearing record.

A State official in charge of PHP operations stated that no guidelines or criteria have been established for review and approval of subcontracts by State contracting officers. Consequently, the State approval process basically consists of a cursory review of the subcontract submitted for approval.

This official further stated that the State generally does not give written approval to a PHP for subcontracts; rather, the common practice is to give tacit approval by not objecting to the subcontract. For the PHP's studied, the State had not approved their subcontracts, but had given preliminary approval for subcontracts in the case of Omni-Rx Health Care. Also, the State is only aware of those subcontracts which are submitted by the PHP and not those that a PHP has failed to submit. Another State official stated that many PHP's entered into subcontracts prior to the approval requirement.

In summary, the State has not provided the PHP's with regulations regarding subcontract format, nor has it prepared criteria for subcontract approval for use by its contract managers. The State has not formally approved PHP subcontracts as required by State law (pp. 584–585).

8. Program "philosophical setting"

Richard H. Lohmeyer, Chief of the California Health Department's Health Plans Administration Unit, prepared an analysis of the PHP program called "Program White Paper" and dated January 16, 1975.[48] In that paper, he discussed the "philosophical setting" of PHP program management:

> The implementation and management of the PHP program was closely watched by Department management with certain philosophical positions being adopted to expedite the development of the concept. The specific positive impact of these philosophical positions is difficult to assess; the negative impact has created numerous problems which have been visible to program critics. The principal positions adopted are as follows:
>
> 1. No attempt by the Department of Health staff at standardizing the operation of PHP's.
>
> This position was adopted to prevent the State from stifling the creativity of contractors in developing mechanisms to best operate their business. This strategy was successful to the degree that the plans under contract present a vast array of organizational and operational methods of dealing with a similar problem—the delivery of health services for which the contractor is at risk.
>
> The negative effect of the policy has been:
>
> *a.* Workload items which should be routine have become significant problems because each plan has a different system of dealing with its program operations (enrollment forms, disenrollment forms, peer review, grievance mechanisms, etc.).

[48] Exhibit 31, March 15, 1975, hearing record.

b. State staff directed to disregard financial resources in evaluating proposed PHP's.

This position was based upon the concept that if an individual was willing to assume the risks inherent in a PHP and was able to arrange for the delivery of services then his immediate resources would be inconsequential as far as the Department was concerned. This position enabled many persons to qualify for and obtain a PHP contract.

As a consequence, many existing contractors currently lack adequate resources to effectively launch their plans. Consequently, enrollment levels have remained low, and adverse risk has resulted in restricted delivery of health services and in some cases even financial collapse.

c. Data reporting systems should be on a summary basis for both financial and service elements of plans operations.

This policy was designed to (1) keep the administrative costs of a plan at a minimum and (2) keep government intervention in their operations at a minimum.

This policy has severely handicapped the Department in attempting to monitor performance of contractors in meeting his contractual commitments in delivering quality health care. It has equally affected efforts to evaluate plans as health service providers in that the utilization data reported is not comparable to fee-for-service data nor to data submitted by other plans.

B. DHEW OVERSIGHT: 1971 THROUGH 1974

The public record and internal files of the Department of Health, Education, and Welfare's central and regional offices are replete with evidence of problems in the California Prepaid Health Plan program. Between 1971 and 1974—from the time the program began through the period of greatest abuse—DHEW officials did little to protect the Federal interest in the plans.

The PHP's funded half through Federal Medicaid funds and half by the State, grew as a cost item for the Federal Government from nothing in 1971 to more than $7 million in 1973 and to more than $50 million by the end of 1974. DHEW, the source of 50 percent of the PHP program funding, was responsible for overseeing the Federal investment.

In a September 2, 1971, memorandum to all DHEW regional offices, Howard N. Newman, Commissioner of the Medical Services Administration, the Federal Medicaid agency, established a network of agency personnel to monitor the nationwide progress of health maintenance organizations. Mr. Newman's memorandum noted "the national implications of these activities and the need to coordinate the activities and policy development throughout the department . . ." [49] A national project manager was also appointed. The purpose was to prepare the 10 DHEW regional offices to monitor the progress of HMO's in State Medicaid programs across the country.

[49] Memorandum of September 2, 1971, to Social and Rehabilitation Service Regional Commissioners from the Commissioner of the Medical Services Administration regarding "Follow-up of August 3 Memorandum on Administration of HMO Projects."

Principal attention was focused on the department's regional office in San Francisco. Unlike California, other States were slow to implement prepaid plans in their Medicaid programs. Michigan and Maryland each had developed three such organizations by 1974. California, by contrast, had 54 in operation by the end of 1974.

By the fall of 1972, only a few plans had received contracts from the California Department of Health Care Services. On October 5, 1972, HEW Undersecretary John Veneman, a former California Assemblyman, wrote the California Health Director as follows:

> The development of HMO's in California has advanced beyond the experimental stage and the Department of Health Care Services is to be congratulated on the sophistication of its HMO law and regulations. Its elaborate and well thought out contracts for the inclusion of Medicaid eligibles in these comprehensive health delivery systems can be a model which other States can follow. Particularly gratifying to HEW because they add to our capacity for evaluating the quality, equity of access and cost effectiveness of this form of health care delivery, are the monthly reporting requirements specified in the Medi-Cal contracts. This is the type of data other States are seeking when they are considering implementing HMO's as a priority program.[50]

However, at about the same time a report was being prepared suggesting problems in California. Prepared by Kathleen L. Peterson, a Medical Services Specialist in DHEW's San Francisco regional office, the report was sent to Mr. Newman January 2, 1973.[51] Although Miss Peterson's report was more a description than an evaluation of the system, it was filled with danger signals. For one thing the report showed a 34 percent annual disenrollment rate, with about 75 percent of those disenrolling complaining that they could no longer go to their own physicians. Thus, almost a third of the persons enrolling in California PHP's appeared to be dissatisfied.[52] At the same time and despite the high disenrollment rate, the report also found that the rate of satisfaction among beneficiaries in PHP's was higher than among those in fee-for-service.[53]

One of the items included in Miss Peterson's report was a "message from the Director" of the California Health Department in the "Prepaid Health Plan Newsletter." This "message" dealt with "allegations that in order to secure a prepaid health plan contract with the State's Medi-Cal program . . . it is necessary to: (a) pay consultant fees to highly placed officials of the State or legislature, and/or (b) employ consultants or management firms who can supposedly get priority and preferential treatment for their clients." [54]

The director's "message" declared that "no individual or firm receives priority or preferential treatment on PHP proposals," but acknowledged that "in some cases, the knowledge and experience of

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[50] Letter of October 5, 1973, from John G. Veneman, HEW Undersecretary, to Dwight Geduldig, California Health Care Services Department Director.

[51] Memorandum to Gene Beach, Associate Regional Commissioner for Medical Services, from Kathleen Peterson, Medical Services Specialist, regarding prepaid health plans in California, January 2, 1973.

[52] Ibid.

[53] Ibid.

[54] Ibid.

individuals or consulting firms could be of value in developing a PHP proposal." [55]

Among the data sent to Mr. Newman by Miss Peterson was a negative report on HMO International, a firm which provided management services to a non-profit PHP that held a State contract.

The report was prepared by the California Council for Health Plan Alternatives (CCHPA) which was under HEW contract to develop a system for rating health care plans so that persons considering various health insurance offerings would be able to judge the value of each.

CCHPA had been asked by the Teamsters Joint Council #42 in Los Angeles to evaluate for its Health and Welfare Committee a program offered by the California Medical Group Health Plan, Inc. (CMGHP). CMGHP was managed by HMO International, the management firm for Consolidated Medical Systems (CMS), a PHP with several clinics in the Los Angeles area. These clinics were the same as those serving CMGHP.

The analysis of CMGHP's operation essentially focused on HMO International's health services. CCHPA concluded that the firm "represents a new and rapidly growing form of profiteering medical care organization designed to exploit our (union) members, the poor, and anybody else who becomes a member." [56]

A team of doctors, reviewing CMG-CMS facilities, found:

> Nearly a third of the doctors listed as providing service full time were merely "moonlighting part time as they prepared for careers in medical specialties."
>
> Two-fifths of the doctors were graduates of foreign medical schools "generally far below the standard of U.S. medical education."
>
> As a general rule, the plan utilizes small for-profit hospitals which, for the most part, do not provide the scope and quality of service available to and used by the majority of Californians, including those enrolled in other large prepayment plans. . . . Moreover, there was an identifiable reluctance to hospitalize CMG-CMS enrollees, since the service provides less than half the amount of hospital care provided by other health care plans in California, including group practice prepayment plans.
>
> At the same time, CMG-CMS stripped from more than 100 of its physicians the power to hospitalize patients except in life-or-death emergencies. One general practitioner and two physicians under him were entrusted with authority to hospitalize. Such a procedure limits seriously the exercise of professional judgment . . . one must question whether this is in the best interest of the persons served.[57]

Following this review and report, a second analysis of HMO International was done. This review, directed by Kerr White, M.D., a noted public health specialist from Johns Hopkins University, uncovered some problems in the plan, but in general gave HMO International a clean bill of health.

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[55] Ibid.
[56] Ibid.
[57] Ibid.

Another item available for Mr. Newman's study, included in Miss Peterson's January 1973 report, was a letter of complaint against one of the CMG-CMS facilities, North Valley Medical Group of Pacoima, California. It was a letter to the Health Department from Dr. Harold M. Cohen, Chief of Staff of Pacoima Memorial Lutheran Hospital, outlining abuses by the plan in marketing health care.[58] Dr. Cohen warned: "if this group is not censured immediately countless people will be deprived of adequate care and suffer morbidity and mortality." [59]

Dr. Cohen reported numerous instances in which North Valley Medical Group enrollees were pressured into joining that PHP by the plan's employees who represented it to be a mandatory replacement for Medi-Cal; who omitted telling Medicaid eligibles that they would lose their free choice of doctor; and who claimed the facility offered 24-hour service, when it did not.[60]

Dr. Cohen also asserted that the PHP implied it had a formalized relationship with Pacoima Memorial Lutheran, when, in fact, it did not. In addition, Cohen cited case after case in which the PHP attempted to deny hospitalization of its enrollees or withdraw them from Pacoima Memorial Lutheran for non-medical reasons.[61]

In one case, a one-year old suffering from staph pneumonia was admitted by Cohen, who feared for the baby's life. Cohen said he "was called daily by the North Valley Medical Group to discharge the patient since hospitalization was too expensive; in spite of the attending physician's explanation that the prognosis was grave." [62]

Also, and as noted earlier in this report, the General Research Corporation of Santa Barbara, California, performed an evaluation of the quality of care provided by the prepaid health plans of California under a contract awarded by DHEW. The work began July 1, 1973.

In the same month, the PHP problems had become so widespread that Ms. Gene Beach, Associate Medical Commissioner in DHEW's San Francisco office, sent a staff memo to Mr. Newman in Washington which detailed the issues.[63] The memo was written by James W. Kee, a DHEW medical services specialist. Noting that the 47 PHP's then operating had 178,372 enrollees and a potential enrollment of more than 795,000 the memo by Mr. Kee reported that critics of the plan included "disenchanted enrollees, welfare rights groups, provider organizations, the press, and representatives of organized labor." [64]

Mr. Kee's memo described the complaints as dealing in large measure with marketing abuses, quality and availability of service and questionable disenrollment practices.

Mr. Kee reported that the General Accounting Office was auditing six PHP's and that a research firm had been directed by HEW to evaluate the PHP program. He warned that "there is no indication that the worst is over," since the San Diego District Attorney had only recently filed a civil fraud action against a PHP in that city.[65]

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[58] Letter to Tom Herrhartz, Chief, California PHP, Development Bureau, from Harold M. Cohen, M.D., Chief of Staff, Pacoima Memorial Luthern Hospital, November 6, 1972.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Ibid.
[63] Memorandum to Gene Beach from James W. Kee, Medical Services Specialist, regarding "Summary of Recent Prepaid Health Plan Highlights, July 30, 1973."
[64] Ibid.
[65] Ibid.

These and other developments led Mr. Kee to conjecture that "the adverse publicity received by PHP's will make it increasingly difficult to attract new enrollees. It is also conceivable that most MediCal eligibles with a propensity to join a PHP may have already done so. Thus, the 47 plans may find that their enrollment will [reach a] plateau far short of the maximum allotment, which in turn could jeopardize their fiscal soundness, as well as encourage cut-throat marketing techniques." [66]

In summary, Mr. Kee's memo declared:

> It is no exaggeration to say that the California PHP program is a potential powder keg, and that any explosion here will have repercussions that go far beyond the State boundaries.[67]

In September 1973, Mr. Newman received from Ms. Beach a highly critical report on the fiscal management of PHP's prepared by the California Joint Legislative Audit Committee. The report declared that more than half the incoming revenue for the plans was used for administrative rather than medical care purposes.[68]

In December 1973, Mr. Newman received from the San Francisco DHEW office another report quite critical of the PHP program, this one prepared by the California Legislative Analyst, an official of the State Legislature.[69]

By January 1974, the problem in the PHP's had become known to HEW officials far senior to Mr. Newman, including John D. Young, Assistant Secretary Comptroller at the department. A January 7 DHEW Audit Agency memo to Mr. Young, which eventually found its way to the San Francisco regional office, reported on the GAO investigation, which had not been made public.

Mr. Young was told:

> GAO found that contrary to health plan claims the prepaid health plans *are not* costing less than fee for service.
>
> HEW should become more involved in the establishment of rate structures and the monitoring of the program.
>
> HEW has not issued guidelines for the program. This is a major problem which has caused many of the difficulties experienced by the Health programs.[70]

Six months later, in June 1974, nearly a year after Mr. Kee's warning had been hand-carried to Mr. Newman, Charles M. Sylvester, acting regional DHEW commissioner in San Francisco, called directly on Washington for assistance to deal with the PHP problems. Mr. Sylvester's memo went to the Assistant to the HEW Administrator for Field Operations, and to Mr. Newman.[71] He included a copy of the latest critical newspaper article on PHP's—a 3,000 word account of "Favoritism and Shoddy Services" being delivered by the plans.[72]

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[66] Ibid.
[67] Ibid.
[68] Memorandum to Howard Newman from Gene Beach, Sept. 28, 1973.
[69] Memorandum to Howard Newman from Gene Beach, Dec. 7, 1973.
[70] Memorandum from F. J. Majka, Assistant Director, HEW Audit Agency to John D. Young, Assistant Secretary, Comptroller, Regarding "GAO Review of HMO Operations."
[71] Memorandum from Charles M. Sylvester, Acting Regional Commissioner, to Carolyn Betts, Assistant to the Administrator, Regarding "Prepared Health Plans Problems in California, June 5, 1974."
[72] Ibid.

Mr. Sylvester stated the regional office lacked the manpower to perform a "serious monitoring effort in this controversial, highly visible portion of the Medicaid program." [73]

He asked for help, as had Ms. Beach many months before that. Mr. Sylvester also included another copy of the Kee memo of July 1973, a reminder to Washington that nothing had been done.

In August 1974, the new DHEW commissioner of the Medical Services Administration, Keith Weikel, began to receive the same kind of PHP information his predecessor had been studying for 2½ years. In August 1974, a California Auditor General's report showing that about $4.2 million in double payments had gone to PHP's was sent to Mr. Weikel by the San Francisco regional office.[74] About half of that money was Federal funding. Charles A. Woffinden, Acting Associate Regional Commissioner for Medical Services, informed Weikel that the audit report blamed the duplicate payments on "inadequate controls in the Department of Health over the payments for Medi-Cal recipients to PHP's." [75]

In addition to receiving the report from the State Auditor General, Dr. Weikel also received in September 1974 the report by General Research Corporation on its evaluation of the quality of care provided to beneficiaries.

General Research found:

> 1. Most plans are, in fact, for-profit, with nonprofit corporations performing the actual contracting functions and in turn subcontracting for services. Given the present PHP payment system, with the State paying the plans in flat capitation fees and not for services rendered, the possibility of profit maximization at the expense of quality of care exists. It is this possibility that makes the financial structures of the plans relevant. . . .[76]
>
> . . . The peer review systems for most of the PHP's studied amounted to a system in name only. . . .[77]
>
> . . . The existing State monitoring and control system . . . is not adequate for effectively uncovering PHP's that are delivering inadequate medical care. . . .[78]

General Research's principal recommendation was that the "State develop, implement, and enforce a monitoring and control system sufficiently robust to identify the plans that are not providing adequate care and to correct the deficiencies." [79]

C. STATE AND FEDERAL MANAGEMENT AFTER JANUARY 1, 1975

In January 1975, the Governor of California directed a panel of private citizens to review the California PHP program. Their report is included in the Subcommittee's December 15, 1976, hearings as Exhibit 1.

This report corroborated allegations of:

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[73] Ibid.

[74] Memorandum from Charles A. Woffinden, Acting Associate Regional Commissioner, to Keith Weikel, Regarding California State Audit of Prepaid Health Plans, August 21, 1974.

[75] Ibid.

[76] *Evaluation of California's Prepaid Health Plans, Final Report*, by Daniel Z. Louis and John J. McCord, September 1974, General Research Corporation.

[77] Ibid.

[78] Ibid.

[79] Ibid.

A cover-up of investigations;
The inappropriate involvement of consulting companies;
Inadequate quality of care disclosures to the Department; and
The loss of 2,500 complaints.

The report also contained numerous recommendations.

The Subcommittee hearings of March 1975 took place shortly after the completion of the above report. During his appearance before the Subcommittee, Mr. Steve Passin, Special Deputy Director of the Health Department and PHP program director, testified that the 80 health professionals, lawyers, investigators, and auditors on the review panel had confirmed the criticisms of newspapers, analysts, legislative oversight committees and auditors (p. 121).

Mr. Passin said the review team found:

> The existence of high-level mismanagement which was manifested by—
>
> (1) A capricious medical audit system that utilized no guidelines, no chart uniformity, no criteria, and untimely transmission of reports back to PHP's;
>
> (2) Lack of effective intermediate sanctions against PHP's (the only sanction was the extreme—cancellation); and
>
> (3) A lack of planning which has led to problems such as gross enrollment and marketing abuses (p. 111).

Mr. Passin also said that preventive health measures, which are central to long-run savings in prepaid health care, were ignored by the Department. No enforcement mechanism existed to ensure that PHP's took these steps. He said that no consistent direction was adhered to in any aspect of the program.

Mr. Passin told the Subcommittee that the State would need assistance from the Federal Government in reforming the program and making it a "model" for the nation. Specifically, he cited the need for the development, testing, and implementation of a quality monitoring system.

Subsequent to the hearings, the Department of Health, Education and Welfare began working with Mr. Passin and others in the California Health Department. Together, they prepared a grant proposal to develop systems for monitoring the quality of patient care and ascertaining the costs of health care delivery for rate setting purposes.

Through the balance of 1975 and into early 1976, the California Health Department took action against PHP's by enforcing existing regulations. The State refused to renew or cancelled 27 of the State's 54 plan contracts (p. 333).

The State Health Department received from DHEW in February 1976 initial funding for a $5.2 million demonstration project to develop methods to monitor quality and set appropriate rates (p. 333).

Specifically, the study seeks to develop adequate administrative tools for public agencies contracting on a prepaid basis with medical care providers on behalf of public beneficiaries. The primary goals of the project are to develop a system to determine reasonable rates for government to pay. This system would be based on a sophisticated analysis of prepaid plan costs with adjustments for the age, sex and basic health conditions of plan enrollees.

In addition, the project seeks to develop methods of evaluating and correcting quality of care issues that are peculiar to patients in a prepaid system, where specific patient encounters are not regularly reported to the reimbursement agency. This element of the project seeks to respond to the problem, identified in the Subcommittee hearings, involving the financial disincentive in prepaid health plans to provide the necessary care to those who need it.

The project is seeking to develop methods of enrolling and stabilizing membership of low income persons many of whom are transient. This transiency is detrimental to the economic stability of prepaid plans because it results in sometimes extensive turnover in the enrollment population. In addition to the question of enrollment stability, the project seeks to develop methods of educating the enrollees in self care through new health education techniques. The aim of this element of the project is to reduce the non-medical demands on prepaid organizations by low income enrollees who often bring a wide range of social problems to health agencies in the absence of other sources of advice and support.

The project, which was intended to take 3 years to complete, is concluding its second year. It started slowly because shortly after DHEW awarded the grant to the California Health Department in early 1976, the State's efforts to reform the PHP program—of which the grant was an integral part—suffered a serious setback.

Shortly after he proposed a series of substantial changes in the PHP program regulations, Mr. Passin, the program director, was assigned to a new job in the Health Department. Thomas G. Moore, Jr., Mr. Passin's deputy, replaced him.

Though the effort to tighten the regulations was postponed, Mr. Moore responded to reports of the State Auditor General, the Governor's task force, the General Accounting Office and the Subcommittee's 1975 hearing record. In February 1976, he proposed to audit five of the largest prepaid health plans to see just what were their actual health care delivery costs (p. 334).

Omni-Rx Health Care Inc. of Los Angeles, the first plan selected for this series of audits, objected. The officials of the plan argued that if the Health Department verifies the appropriateness and the quality of care provided by a plan, then the State has no business auditing plan distribution of funds within its corporate structure (p. 334). State regulations in force then and through the early part of 1977 provided that while PHP's were required to submit their subcontracts for approval, "such subcontracts may have payment amounts or reimbursement rates deleted from them before submission" to the Health Department (p. 334).

Omni-Rx declined to voluntarily submit financial records of its related for-profit companies to State auditors. Plan officials also refused to honor Health Department administrative subpenas for these records (p. 334).

In the midst of this, the State in April 1976 declined to renew the personal services contract of Mr. Moore, the PHP program director.

Moore's successor decided not to enforce the rejected subpenas. More than 50 stories in the Sacramento press followed on the mishandling by the State of the Omni-Rx audit. The California Assembly Health Subcommittee on Investigations began hearings in July on

the Health Department's conduct of the inquiry and audit and, in doing so, reviewed the plan's corporate structure.

In August 1976, a preliminary report was issued by the California legislative Subcommittee:

> The relationships between these individuals [officers and directors of the non-profit corporate contractor] and companies [providing services to the non-profit] are so entangled that they obstruct public scrutiny and confuse efforts to trace passage of public funds from one entity to another.[80]

But the California Subcommittee reserved most of its criticism for the Health Department. The Subcommittee said that from the beginning of the PHP program, the two main weaknesses of the PHP program were the State's "inability to trace taxpayers' funds . . . to assure that they were indeed used for the provision of health care services and [the State's] failure to monitor the quality of care so that government could counteract the private incentive to minimize services in order to maximize profits." [81]

DHEW Undersecretary Marjorie Lynch, in an October 5, 1976, letter to the Governor of California, noted that despite efforts to reform the PHP program, "flagrant abuses . . . still persist." [82] She said:

> The continued failure of the State to correct the serious deficiencies of the PHP program, documented in a multitude of investigations, makes it necessary for me to ask you to take certain minimum actions so that the State of California can continue to receive Federal matching funds for its program.[83]

Ms. Lynch asked that contracts with plans be brought into compliance with Federal regulations by February 15, 1977. At the same time, she required that an "action plan" to correct program deficiencies be presented to the Federal Medicaid agency by the State Health Department.[84]

An investigator from the Permanent Subcommittee on Investigations testified at its hearing on December 14, 1976, that the period from November 1975 to November 1976 was one in which a:

> . . . game of musical chairs was played with the director of the alternative health systems division. There were four directors in that period. The staff was completely off balance. There were investigations. There were, I think, 50 newspaper reports in the "Sacramento Bee," alone, during this period on the problems within the program. It was in turmoil, chaos.

The investigator went on to say that the period was characterized by very little leadership from the Governor's office, the Department of HEW, and the California Department of Health.

In October 1976, President Ford signed into law amendments to the Health Maintenance Organization Act (90 Stat. 1945), in large part a response to the PHP troubles in California.

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[80] August 2, 1976, letter to Governor Edmund G. Brown from Mr. Barry Keene, Chairman, Assembly Health Care Investigations Subcommittee.
[81] Ibid.
[82] Exhibit 1, December 14, 1976, hearing record. Letter from Marjorie Lynch, Undersecretary of HEW, to Governor Edmund G. Brown, October 5, 1976.
[83] Ibid.
[84] Ibid.

These amendments gave DHEW the ultimate authority over which plans would be allowed to participate in the State Medicaid programs. The amendments require that in order to receive Medicaid funds, a prepayment health plan must be qualified and certified by DHEW.

While the California Health Department's efforts to reform its PHP program collapsed when one plan rejected the State's right to audit, there were also other signs of failure. Promised new regulations were not even proposed until late in 1976. Objective standards for medical audits were not prepared (p. 334).

The DHEW Audit Agency reviewed the PHP program from July 1, 1975, until March 25, 1977. In a report issued on December 16, 1977, the agency acknowledged that the State of California had taken some steps in response to deficiencies which had been identified. However, it was sharply critical of: (1) State payment for health care services under the fee-for-service program for beneficiaries who were, at the same time, enrolled in prepaid health plans; (2) inadequate health care quality standards and monitoring; (3) the absence of a satisfactory system to investigate complaints and allegations concerning fraud and abuse; (4) the failure to develop a rate-setting method; (5) the failure to adequately determine financial stability of contract applicants; and (6) the failure to review self-dealing relationships and establish guidelines against which to judge administrative charges within the plans.[85]

The hearings held by the Permanent Subcommittee on Investigations on December 14 and 15, 1976, focused primarily on the corporate structures of the plans. At the request of the Subcommittee, the General Accounting Office had conducted a staff study of the corporate structures of five plans. In addition, the Subcommittee had asked the GAO to review State and Federal regulations and their enforcement relating to plan contracts and subcontracts. GAO's report was issued November 1, 1976, and figured prominently in the Subcommittee's hearings.

The GAO found that although the State regulations require that all subcontracts be in writing and approved by the Health Department, the Department had not issued regulations establishing criteria or standards applicable to such contracts. "Consequently," the GAO study said, "the State approval process basically consists of a cursory review of the subcontract submitted for approval." [86]

In addition, the report said that of the five plans studied, "The State had not approved their subcontracts but had given preliminary approval in the case of only one plan." [87]

The GAO reported that although HEW regulations require regional office approval of all PHP subcontracts in excess of $100,000 "the contracts with the five PHP's studied had not been approved by the HEW regional office." [88]

On the second day of the Subcommittee's hearings, the Governor of California announced that the State would not renew its Medicaid contract with Omni-Rx Health Care Inc., the non-profit plan that had

[85] Report on Audit of California's Administration of Prepaid Health Plans' Participation in the Medi-Cal Program during the period July 1, 1975, through March 25, 1977, DHEW Audit Agency, December 16, 1977.
[86] Exhibit 36, GAO Staff Study, pp. 96–97.
[87] Ibid.
[88] Ibid.

rejected the State's audit efforts earlier in 1976. In addition, the Governor announced that the State would ask the courts to appoint a special master to oversee the operations of Omni-Rx Health Systems, Inc., the for-profit firm that provided management services to the non-profit firm.

By January 1977, with DHEW and State officials working closely together, a full review of the remaining 27 plans was well underway. All of the plans, with the exception of one, were seeking renewal of their contracts which expired on the last day of March 1977.

While the October 1976 HMO Act Amendments required Federal qualification of an HMO as a condition of receiving a State Medicaid contract, the amendments allowed the State to continue contracting for medical services on a provisional basis with those HMO's which had submitted applications to the Public Health Service and upon which no action had been taken within 90 days of submission. California, however, opted to contract only with plans which had been Federally qualified or whose applications had successfully passed the initial procedures which were part of the qualification process.

By March 1, 1978, California had contracts with 12 plans. Of the 12, three are exempt from the provisions of the HMO Act and its amendments, six have been qualified by DHEW and three have successfully passed the DHEW screening procedures which are part of the qualification process. As of March 1, 1978, there were 125,000 Medicaid beneficiaries enrolled in these 12 organizations.[89]

Enactment of the HMO Act amendments in October 1976 required the State to contract only with Federally qualified organizations. This meant writing new contracts between the California Medicaid agency and those prepaid health plans that obtained qualification. The amendments effectively brought about an environment for reform and California took advantage of the situation.

In September 1976 Mr. Bruce Yarwood was appointed to head the prepaid health plan program and concurrently with the reform required by the October 1976 amendments, he directed a number of other changes.

New regulations, paralleling the Federal HMO legislation and strengthening the State's existing regulations, were promulgated.

A new standard contract was developed, better improved performance standards were adopted and a State staff team approach to contract management was instituted.

Standards for the evaluation of quality of care began to be prepared.

The process by which contracts were renewed was totally revamped.

These efforts and the 1976 HMO Act Amendments had the effect of reducing the number of PHP's with State Medicaid contracts from 26 to 12.

In addition, the California legislature passed and the Governor signed on September 22, 1977, a new law aimed at responding to the problems identified by the Subcommittee and others. For example, the new law prohibits certain types of marketing practices. Respond-

[89] Personal interview with John Larrea, Chief of Alternative Health, California System Branch, California Health Department, February 28, 1978.

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ing to the problem of complicated corporate structures, the new law requires the prime PHP contractors to manage themselves and prohibits subcontracting for management. The statute prohibits interentity conflicts of interest on the part of plan officials and forbids percentage fee arrangements. In addition there are broad requirements for disclosure by plan officials of ownerships' interest and reimbursement.

On the matter of conflicts of interest of State employees, the law forbids such employees from obtaining employment for one year with prepaid health plans with which they had dealings as government representatives.

Mr. Yarwood, in an October 12, 1977, letter to the Subcommittee, said:

> As a summary of where we are and where we are going in California, we think the HMO concept is a viable one. We think it has important contributions to make to provide quality care to the people of California and will be an effective medium to help control the skyrocketing costs of health care. At the same time, we believe the experience of California has got to be carefully looked at in terms of where the HMO program is going both in the State and nationally. The HMO approach to health care must be subject to careful review. A "laissez faire" approach to promote the unrestrained growth of the program would only ignore the California experience when that approach was used, and in my opinion be a sad mistake.

IV. Federal HMO Program

While the Federal Government had to be called upon to complete the reform of the California PHP program, the Subcommittee's hearings show that many of the problems found in the California PHP program also exist in the Federal HMO program.

The testimony of HEW officials and GAO data previously developed on the Federal HMO program raises serious questions about the ability of the Federal program to accomplish needed reforms.

The HMO Act of 1973 (87 Stat. 914) approved December 29, 1973, amended the Public Health Service Act to establish a Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMO's.

The act spells out in considerable detail, the definition and the requirements of an HMO. Among other things, the act specifies the basic and supplemental health services to be provided the HMO membership, the basis for fixing the rate of prepayment, and the organizational structure of an HMO.

The act authorizes a "demonstration program" designed to promote the development of new, and expansion of existing, HMO's by:

Providing financial assistance through grants, contracts and loans;

Providing a market for HMO's by requiring certain employers to include in any health benefits plan offered to employees the option of membership in an HMO that the Secretary of HEW has "qualified" to be in compliance with the requirements of the HMO Act; and,

Removing restrictive State laws and practices which could serve to hinder the development and operation of a qualified HMO.

The Act did more than set up a series of incentives for HMO's. It also provided for the Federal regulation of HMO's that have been assisted or qualified under the Act. The 1976 amendments to the Act require Federal qualification, and thus Federal regulation, for Medicaid and Medicare prepaid health plans.

The problem with the Federal program appears to be twofold:

(1) The HMO Act, as amended, does not permit the Federal Government to fully respond to some of the marketing, enrollment, and corporate structure abuses and problems the Subcommittee has identified.

(2) The Federal program has not, and is not, adequately organized and staffed to regulate HMO's so as to assure the public of the quality medical service and fiscal integrity expected of Federally certified HMO's.

For example, Federal HMO law and regulations do not respond to the problems of marketing and enrollment. DHEW is powerless under present law and regulations to monitor door-to-door sales or to take action against selective enrollment or disenrollment.

DHEW has no quality standards against which to review the performance of Federally qualified HMO's, though it is supposed to maintain a compliance program.

GAO, which is required to evaluate HMO's and monitor DHEW's HMO program under Section 1314 of the HMO Act, reported to Congress in July 1975, November 1975, and again in September 1976,[90] that the Federal HMO program had not been efficiently organized by DHEW and that there are inadequate numbers and types of Federal staff to implement Federal activities for HMO technical assistance, financial management, legal review, qualification and compliance, and field monitoring.

Thus it appears that the problem of abuses in the delivery of Medicaid services through prepaid health plans, which seemed beyond the control of the California authorities, have not been solved by shifting responsibility to the Federal program.

Dr. William Munier, Director of the DHEW Office of Quality Standards, told the Subcommittee that there are no provisions in the law and regulations applicable to Federal HMO's prohibiting the kind of self-dealing arrangements found in the California PHP's.

Furthermore, William McLeod, director of the HMO Qualification and Compliance Office, said there is nothing in present law or regulations to prevent an HMO from establishing self-dealing relationships after it is Federally qualified (p. 512).

Dr. Munier testified that he and his staff have found other HMO's with "interlocking, interrelated corporate entities" similar to those found in California. He said:

The relationships fall into three general categories:

> The first is the real estate tax shelter and expensive pyramiding operation. This type of relationship can involve both conversion of already owned real estate and/or use of public securities to purchase real estate.
>
> The second category is the management services contract operation similar to those explored in the GAO study.
>
> The third category entailed use of a "paper" organization, or one which delegates all decision-making authority and operations to other organizations (pp. 496–497).

Dr. Munier said DHEW could not deny Federal qualification solely because of self-dealing arrangements, but if self-dealing precludes adequate assurance of financial soundness, then it can be denied.

Mr. McLeod said that of 25 qualified HMO's, "24 are non-profit organizations and most of those have self-dealing relationships to one extent or another" (p. 498).

DHEW officials explained that under the Health Maintenance Organization Act, the Federal Government can only give loan guarantees

[90] Statement of Gregory Ahart, Director, Human Resources Division, GAO, before the Subcommittee on Health and the Environment, House Committee on Interstate & Insular Affairs: November 21, 1975, Statement of James Martin, Deputy Director, Human Resources Division, before the Subcommittee on Health, Senate Labor & Public Welfare Committee: September 3, 1976, GAO report "Factors that Impede Progress in Implementing the Health Maintenance Organization Act of 1973 (HRD 76–128).

to for-profit HMO's. Assistance to not-for-profit HMO's includes direct loans, loan guarantees and grants.

Dr. Munier said that the present Federal grant and direct loan program for non-profit HMO's does not provide the necessary capital to build facilities and develop management services required for an HMO to be cost effective.

During the testimony of these HEW officials, the subject of the granting of $1.2 million to Metromed Health Plan, Inc., of New York was discussed. Dr. Donald Kelly, the project director of Metromed, had invoked his Fifth Amendment right against testifying before the Subcommittee concerning his activities in California where he developed the largest prepaid health plan in the State, HMO International, and its related non-profit PHP, Consolidated Health Systems.

The Subcommittee sought to determine whether any background check had been made on Dr. Kelly and whether HEW had looked into his previous activities in California which had been the subject of sharp criticism. The Subcommittee was told that "we do look at the individual, but from the standpoint of the assurances that he provides us in the explicit details of how he would intend to move forward" (p. 505). Dr. Frank Seubold, who is responsible for the grant and loan element of the HMO program, said that Federal law and regulations do not give him authority to look behind the forms and proposals of individuals (p. 505).

Questioned by Senator Sam Nunn concerning the report developed by the Subcommittee with regard to California and whether DHEW's HMO staff is capable of administering the program, Dr. Munier indicated he didn't think the present staff could do the job.

GAO has persistently reported and DHEW has acknowledged the need for improved performance in the Federal program. The GAO September 1976 report specifically stated GAO's concern over the lack of ". . . the expertise needed to efficiently monitor the loan and loan guarantee program." According to GAO ". . . the lack of a uniform loan guarantee policy for departmental programs could theoretically lead to commitments to potential loan recipients which contradict the enabling legislation or are otherwise contrary to the financial interest of the United States." [91]

The General Accounting Office has recently reported to DHEW that loans totaling more than $2 million to two Federally qualified HMO's in Florida and Oregon are in trouble and that the Federal Government may not get its money back.[92]

In his testimony before the Subcommittee, Mr. McLeod said that he did not believe there is adequate protection for the Government and taxpayers in the grant, loan, and loan guarantee program for HMO's.

> . . . I do think the relationship [of] not-for-profit corporations that are recipients of Federal loans where the bulk of the corpus of the loan funds are expended by contracting with for-profit organizations invite opportunities for collapsing the not-for-profit once they have exhausted the draw-

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[91] Factors that Impede Progress in Implementing the Health Maintenance Organization Act of 1973, General Accounting Office, September 3, 1976, p. 22.

[92] Letter Report from General Accounting Office to DHEW Health Services Administration, May 2, 1977, and February 11, 1977 and DHEW Replies to GAO March 25, 1977 and August 16, 1977.

down phase of the loan, thereby leaving the Government with an empty shell . . . (p. 514).

At the time of the Subcommittee hearing, there were 25 qualified HMO's with 160,000 members. It was estimated that by the end of 1977, there could be as many as 60 qualified organizations enrolling 4 million persons. Actually, by the end of 1977 there were 51 qualified HMO's with 4,142,414 enrollees. Most of the increase in enrollee numbers among the qualified HMO's was accounted for by the qualification of the Kaiser Health Plan in California and Hawaii where there are 2.9 million enrollees. An additional 500,000 enrollees were added to the program when six existing HMO's were qualified.

Dr. Munier noted that the law requires DHEW to maintain a quality assurance program, but he testified that "we have not been terribly active in this arena." Indeed, Dr. Munier said that he was the only person working on quality assurance, and he said he was only giving a small percentage of his time to it (p. 510).

Dr. Munier testified that DHEW may be able to rely on Professional Standards Review Organizations (PSRO) and even some State governments for quality assurance monitoring of HMO's. But Dr. Munier testified that "a problem that exists is that the review of ambulatory services is still optional [under PSRO's] and that comprises the bulk of the HMO transactions" (p. 511). The GAO and DHEW have subsequently reported to Congress that implementation of the Federal PSRO program is faced with the same type of management deficiencies evidenced by the Federal HMO program.[93]

The DHEW officials were asked whether in light of what they knew about the problems besetting HMO's, the California prepaid health plans, and the law and regulations they administer, there might be a need for a moratorium so that the law can be redrafted to make it responsive to abuses.

Mr. McLeod said he felt a "moratorium was in order so that we could get our house in order to address many of these [problems], plus give us a chance to revise our application review process and work off the existing backlog" (p. 514).

Subsequent to his testimony before the Subcommittee, Dr. Munier on May 17, 1977 sent a memorandum to the Office of the Assistant Secretary for Health regarding the status of the HMO qualification and compliance program. This memorandum is an important and candid disclosure of HEW's inability to manage the HMO program. It speaks of "weaknesses in the statute, delays in issuing implementing regulations, low levels of appropriations, the Department's lack of 'commitment,' and the ineptitude of the bureaucracy."

Dr. Munier noted that the HMO program is comprised of two separate functional units—the component that approves the loans and grants and a unit that is required to qualify HMO's and see that they comply with the laws and regulations. His memorandum states that lack of coordination between these two units "has thrown the program significantly out of balance," and adds that:

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[93] Testimony of Greg Ahart, Director of GAO Human Resources Division, before House Ways and Means Oversight Subcommittee, April 4, 1977.

> The grant and loan program funded developing HMO's without knowledge of how they were to be judged, because the HMOQ&C (the Office of Qualification and Compliance) activity had insufficient resources to both develop adequate guidelines and process the large number of applications received. Some guarantees probably should never have been funded had qualification guidelines been known. On the other hand, some viable grantees have nearly gone out of business because of the long wait for qualifications.[94]

According to Dr. Munier, the HMO program still [May 17, 1977] has no formal compliance program despite the fact that there were 31 qualified HMO's across the country and 51 applications pending. [As of December 31, 1977, 51 organizations had been qualified and 33 applications were pending.]

Any applicants denied qualification can seek redress in an administrative process or the courts. The 19 permanent staff members assigned to the work must not only review the applications, but they also must be prepared to defend their qualification denials in time-consuming adjudication proceedings. At the same time, they are supposed to maintain a program of compliance for existing HMO's. In short, the unit is severely understaffed. An important factor in this understaffing is the failure to utilize on a permanent basis the available staff in the HEW regional offices. HMO qualification and compliance operations are centralized at the agency's offices in Rockville, Maryland. There has apparently been an unwillingness or inability to share the workload with the regions.

Dr. Munier summarized his report, saying:

> The present situation can best be summarized as an imminent disaster. The qualification application backlog that existed in October 1976 has increased. The creation of a separate Compliance Branch has served to document the compliance deficit developed over the prior two and one-half years. This deficit is the logical product of devoting nearly all resources on the immediate problems of qualification and neglecting the qualified HMO's. In addition, Administrative Hearings will consume enormous portions of staff time, while new implementing regulations and associated guidelines are urgently needed for the amendments of 1976. In short, the years of understaffing the critical functions of HMOQ&C are now about to surface as a major embarrassment for the Department.[95]

The Senate Health Appropriations Subcommittee on February 27, 1978, approved the creation of 37 new positions for the HMO program. DHEW officials testifying before the Subcommittee said that of the 37 positions, 13 would be added to the 12 persons now responsible for the qualifications aspect of the HMO program. Some 23 positions would be added to the group of 9 persons responsible for the compliance aspect of the program.

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[94] Memorandum from William Munier, M.D., to the Office of the Assistant Secretary for Health, May 17, 1977.
[95] Ibid.

By the end of 1977, a total of 172 organizations had received a total of $131.3 million in loans and grants from the HMO program. Of the 172, some 92 organizations remain active. Eighty have either abandoned plans to begin business operations or have been determined not to be feasible organizations. Such groups received $8.5 million in grant funds.

Included in the 172 organizations which have received funds, 39 organizations, which received $97 million in loans and grants from the program, were qualified. An additional 12 organizations were qualified, but did not receive funds from the program. Only two HMO's received loan guarantees. The guarantees totaled $2,182,000.

V. Findings and Recommendations

A. Summary

The State of California implemented in 1972 an alternative form of health care organization, financing and delivery in its Medicaid program when it began contracting with prepaid health plans. It was a bona fide effort to reduce spiraling Medicaid program costs, and at the same time, to improve the quality of care for the poor. The State attempted to duplicate in its Medicaid program the history of a generation of success and consumer satisfaction with prepaid group practice organizations. The enthusiasm for the program and the hope that it would succeed resulted in a belief on the part of the State officials that the prepaid health program would be a panacea.

Subsequent to the implementation of the PHP program in California, the Federal Government enacted in 1973 the HMO Act to provide funds for the development of HMO's across the nation. However, the PHP program resulted in the development of more prepaid health systems in California than in any other State. As Senators Jackson and Percy said at the opening of the Subcommittee's March 1975 hearings, the inquiry was aimed at learning from the mistakes of the California PHP program so that the same errors would not be made in other States and in the new Federal HMO development program.

The California PHP program was plagued by a medical commercialism that was often nothing more than profiteering. The program very seriously needed to be regulated—to be managed—not only to achieve the original policy ideal, but more importantly, for the protection of the public purse and the poor.

The hearing record of the Permanent Subcommittee on Investigations shows that the California Health Department contracted with non-profit, tax exempt prepaid health plan corporations whose officers and directors created or contracted with for-profit entities they owned or controlled to provide the services required by the PHP to fulfill its State Medicaid contract responsibilities. Through these often complex corporate structures, State and Federal Medicaid program funds were diverted from their intended beneficiaries. The State auditor general in April 1974 reported that as much as 52 percent of the Medicaid funds were accounted for in administrative costs and profits.

In an effort to obtain enrollees in their plans, numerous PHP operators used deceptive and fraudulent enrollment techniques in their door-to-door sales operations. Enrollees who sought to disenroll from plans were trapped in them by the failure of some plans to process these disenrollment forms with the State health department. Other enrollees, who needed treatment, were involuntarily disenrolled from the plans by the operators when the cost of their care became expensive.

The quality of care provided in some plans was below reasonable standards, as judged by the State's own medical auditors. Some of the plans contracted with substandard and non-accredited hospitals. Consulting firms exacted exorbitant fees for providing management and computer services.

While both DHEW and the California Health Department were aware of all of these problems, they did little from the program's inception in 1972 to January 1975 to reform the program. At the Federal level, responsible officials ignored warnings about the program's deficiencies for three years. Investigative reports on abuses and fraud were ignored as were medical quality audit findings. Program contract managers were rotated so frequently, according to the State's legislative analyst, that none of them spent enough time working with specific plans to learn enough about each to manage them properly.

The State failed to scrutinize the role of consultants. The State's failure to act on its own investigative reports was tantamount to condoning program improprieties.

Congress responded to the situation with the Health Maintenance Organization Act Amendments, late in 1976, which required that all PHP's receiving Medicaid funds be Federally qualified HMO's. This forced the California PHP's to be approved by HEW as a condition of continuing in the California Medicaid program.

Some plans did not seek Federal qualification and dropped out of the program. Six plans have been qualified. There are presently 11 California PHP's seeking Federal HMO qualification from DHEW.

One of the root causes of the excessive administrative costs and profits of the plans was the State's failure to develop, in violation of its own regulations, an actuarially based, reimbursement rate. To this day, the State has no method to objectively monitor quality of patient care. DHEW provided the State a $5.2 million grant to develop a method to determine appropriate rates and monitor patient treatment. A rate setting method is expected to be tested this year as is a quality monitoring system.

Prepaid group practice can be a successful alternative to fee-for-service medicine. As Senator Jackson said at the opening of the Subcommittee hearings, the concept of prepayment of health care services "is a good idea that should not be abandoned because men without consciences, profiteers and scam artists took the initiative in California from those with good intentions." Indeed, no witness at the hearings was critical of the HMO concept.

However, the record of the California program should alert other State health program administrators, Federal program managers and the Congress to the kinds of fraud and abuse possible in prepayment systems. It should be a clear warning that effective regulatory and management safeguards are essential in these and other State and Federal health care programs.

The Subcommittee's hearing record shows that existing laws and regulations are inadequate to cope with marketing abuses and problems related to corporate structure and contractor management. Indeed, Federal officials have made clear their concern that the Federal investment in some HMO's is in jeopardy, and that they are powerless under present law to effectively safeguard Federal funds. It is clear that

DHEW now lacks the resources to properly monitor the quality of care provided in Federally qualified HMO's and to assure compliance with existing Federal regulations.

In short, unless remedial action is taken, the Federal Government, through its program of financing the development of HMO's, faces the prospect of encountering nationwide the same kinds of scandal and abuse that have plagued the California Medicaid program.

B. MAJOR FINDINGS AND RECOMMENDATIONS

1. Consulting companies often charged excessive fees to prepaid health plans particularly when fees were based on a percentage of gross income

There is, without question, an important role for qualified consulting firms in the prepaid health plan area. The Subcommittee finds, however, that the compensation arrangements between certain of the plans studied and their outside consultants bare little or no relation to the reasonable value of the services contracted for. For example, two consulting companies entered into contracts with groups seeking PHP contracts with the State of California. These contracts provided that if the State contract were to be awarded, the consultant would provide management, marketing and/or computer services and would be reimbursed on the basis of a percentage of gross Medicaid receipts from the State, without regard to the actual or reasonable cost of the services. In another case, a consulting company entered into a contract with a plan which agreed to pay the consultants 10 percent of the gross receipts it would receive from any labor union business the consultants could direct to the plan, again without regard to reasonable costs.

One witness noted that his plan formerly had been paying $60,000 per month to a consulting company for computer services. That payment was based on a percentage of the gross Medicaid payments to his plan. At the time of the Subcommittee's hearings, he was paying only $4,000 per month based on reasonable charges.

The regulations promulgated by DHEW provided that the regional offices were responsible for review and approval of all PHP subcontracts in excess of $100,000. However, the GAO found that DHEW neither reviewed nor approved any such subcontracts of the five PHP's examined at the request of the Subcommittee. Likewise, the GAO found that the California Health Department failed to review and approve subcontracts as provided for in State regulations.

In a December 16, 1977 report on the California PHP program, the DHEW audit agency recommended that California Department of Health secure "written subcontracts for each PHP" and "require prior approval of all subcontracts including individual providers (physicians, hospitals and others)."

> *The subcommittee recommends* that the Medicare, Medicaid and HMO Acts be amended to require that DHEW promulgate regulations to assure that compensation under any contracts for services to an HMO shall not exceed the reasonable cost of such services. Such regulations should eliminate unwarranted payments by HMO's on the basis of a percentage fee for any goods or services rendered.

2. There is a serious potential for conflict of interest involving the acts of State officials and employees who handle Federal health care funds

In two separate inquiries the Subcommittee has found State officials engaged in activities that raised serious questions of conflict of interest. In California, a State official left his position as deputy director of the State medicaid agency and established a consulting company. The company obtained contracts for and with a number of PHP contractors and prospective contractors, some of which dealt with the State medicaid agency when he was a State official.

In another situation, the Subcommittee found that a West Virginia official, responsible for overseeing the performance of a medicaid program contractor, purchased stock in the contractor's corporation and accepted consulting business from the firm in another State.

To guard against such conflicts of interest on the part of Federal officers and employees, Section 207 of Title 18 of the U.S. Code disqualifies former officers and employees from dealing with certain matters connected with their former duties and official responsibilities. Section 207(b) of Title 18 imposes a one-year post-employment restriction respecting matters which were within the area of official responsibility of a former officer or employee at any time during the last year of his Federal service. Section 208 of Title 18 prohibits certain actions by Federal employees affecting their personal financial interests.

Under the Medicaid program many State and local employees are called upon to administer hundreds of millions of dollars of Federal funds.

> *The subcommittee recommends* that the restrictions imposed on Federal officers and employees under Sections 207 and 208 of Title 18 of the U.S. Code be made applicable to officers and employees of State and local governments who are responsible for the expenditure of substantial amounts of Medicaid program funds.

3. Prepaid health plans in almost every instance, involved complicated corporate structures consisting of non-profit corporations whose directors and officers contracted with for-profit entities they owned or controlled. This created a strong appearance of improper self-dealing. In certain instances it resulted in unnecessary and improper depletions of funds and the diversion of funds from health care services

Special attention should be focused on situations where the Federal Government contracts with corporations, whether they are non-profit or for-profit, which then subcontract with entities owned by officers or directors of the prime contractor or parties related to the prime contractor through interlocking directorate or officer relationships. Such structures lend themselves to self-dealing. They can and do lead to unnecessary administrative costs and excessive profits. There is no question that non-profit prepaid health plans will require the services of outside entities. But when these outside entities involve common directors, shareholders and officers, special vigilance is needed to guard against improper diversions of funds.

> *The subcommittee recommends* that the Medicare, Medicaid and HMO Acts be amended to require:

(*a*) That HMO's file with the DHEW Secretary a consolidated financial statement on an annual basis.

(*b*) That the DHEW Secretary issue regulations establishing and requiring the use of a uniform system of accounts and reporting by HMO's. Such regulations should define each account so that financial information reported by HMO's will be consistent among the HMO's.

(*c*) That Federally-supported programs be prohibited from reimbursing HMO's for costs that exceed the amounts that a reasonably prudent businessman would have paid. The so-called "prudent buyer" principle, adopted by Medicare authorities, should be made explicit in the Medicare and Medicaid law.

(*d*) That, as a condition of qualification and continued Federal support, each HMO applicant and each qualified HMO be required to provide documentary evidence satisfactory to the Secretary of DHEW of its legal status as a sole-proprietorship, partnership, corporation, joint stock company, trust, or other entity. Such evidence shall include:

Certified copies of articles of incorporation, partnership agreements, by-laws, and the names and addresses of all owners, partners, officers, directors, and shareholders owning 5 percent or more of outstanding stock, and the owners of 5 percent or more of any bonds or other obligations issued by the HMO or applicant.

(*e*) That each HMO fully disclose to the DHEW Secretary, in writing, all leases and contracts for goods and services with any entity in which any of its owners, partners, shareholders (of 5 percent or more), officers or directors or members of the immediate families of any of the above has any ownership or financial interest.

(*f*) That the Secretary of DHEW shall, upon notice to the parties, and a determination that any HMO is engaged in any self-dealing relationships that unnecessarily increase the cost of the HMO doing business, require the HMO to correct the situation within 60 days. Furthermore, the beneficiaries of such self-dealing shall be required to make restitution of such funds to the HMO. Should the HMO fail to comply the Secretary shall withdraw qualification.

4. *Self-dealing relationships between the directors and officers of non-profit corporations that contract with the Federal Government and for-profit entities appear to violate the intent of the Internal Revenue Code*

The interrelationships between non-profit and for-profit entities makes possible the diversion of health care funds from their intended beneficiaries. Furthermore, those practices appear to violate the Federal Government's intent in granting tax-exempt status to non-profit corporations that propose to provide a socially beneficial service. The HMO Act allows Federal grants—gifts of taxpayer funds—to only non-profit corporations. The HMO Act presumes the beneficence of the non-profit corporation and its directors and officers. Yet many of the HMO's that have already qualified have apparent self-dealing relationships with for-profit entities substantially tied to, owned, or controlled by non-profit corporate trustees.

The subcommittee recommends that this report and the hearing record be referred to the Commissioner of Internal Revenue. The Commissioner should examine whether the non-profit/for-profit corporate arrangement of prepaid health plans and HMO's described in this report are compatible, as a matter of policy, with those provisions of the Internal Revenue Code granting tax-exempt status to non-profit health service organizations, and transmit his conclusions to the Subcommittee. It is also recommended that this report be referred to the Joint Congressional Committee on Internal Revenue Taxation for its review of the same matter.

5. *Door-to-door selling of health care services lends itself to fraud and abuse. In addition this method of enrolling beneficiaries in prepaid health plans is expensive to the plans and diverts funds from health care services*

Door-to-door sales of the services of prepaid health plans was marked by patent abuse and fraud. The poor were induced and threatened into signing enrollment forms by techniques ranging from gifts to coercion. This marketing technique proved to be inordinately expensive. It opened the way for the plans to selectively enroll only healthy patients. The scheme tended to reduce the financial risks of such plans and take unfair advantage of the State's method of reimbursement. One plan operator testified that the cost of his marketing program was $900,000 a year—an expense which added substantially to overall program costs. Door-to-door selling is an inappropriate way to obtain enrollments in prepaid health systems.

The subcommittee recommends that door-to-door solicitation of enrollees for HMO's be prohibited.

6. *California PHP program managers and Federal overseers of that program have no reliable or systematic method by which to judge the quality of care provided to enrollees of prepaid health plans. Likewise, the Federal Government has no program to monitor quality of care in the national HMO program*

Other than the subjective review of PHP clinics by California medical auditors, there was no orderly, objective and efficient means by which PHP program managers or Federal overseers could evaluate the quality of care rendered by prepaid health plans. State reports showed that plans frequently sent patients to substandard and non-accredited hospitals, and State auditors turned up clear cases of patient abuse. There continues to be no reliable, systematic program for identifying quality of care problems in the delivery of health services in an HMO. As the hearing record shows, there exists a heavy financial incentive to enroll the healthy and to avoid providing health care services to persons who need care.

Although required by the Health Maintenance Organization Act, there is presently no effective system for monitoring the quality of health care provided by HMO's. Such monitoring is particularly important in view of the California experience where many enrollees were not provided needed medical services. This experience is the result of the financial disincentive to provide needed health care services to enrollees of prepaid plans and the failure by the State to effectively monitor the provision of health care services to patients.

HMO's offer the promise of improved health quality for patients through programs of preventive medical care—detecting and treating illnesses and conditions before they become catastrophic and expensive to treat. Without an effective measure of whether necessary services are being provided, that promise will be unfulfilled.

DHEW, partially in response to this situation in California awarded the State of California a $5.2 million grant to study health care monitoring and evaluation systems. The State, under the grant, is developing a system for the computerized tracking of patient encounters with HMO's. Government already monitors every service provided to patients whose care is financed through the Medicare and Medicaid programs reimbursing physicians and other providers on a fee-for-service basis. The California experience with prepaid health plans demonstrates the need for such a monitoring system for enrollees in prepaid health systems.

> *The subcommittee recommends* that the Secretary of the Department of Health, Education and Welfare report to the Subcommittee by January 1, 1979, setting forth a specific program to carefully monitor the number of enrollees and nature of the health care services provided to them in Federally qualified HMO's. Furthermore, the Secretary should report to the Subcommittee on the same date a specific program to evaluate the quality of care provided to enrollees of HMO's.

7. There is no effective rate-setting method by which the State of California can determine fair rates to pay prepaid health plans for the care of Medicaid beneficiaries. However, such a method will be tested this year under a grant to the State of California from DHEW

California law required the Medicaid agency to reimburse prepaid health plans on the basis of actuarially-determined rates. The record before the Subcommittee shows that the State failed to implement its own law in this regard.

PHP rates were arrived at by simply taking the per capita cost of the Medicaid program by county in each of the four categories of Federal-State program aid—aid to families with dependent children, to the aged, and to the totally disabled—and paying 90 percent of these figures.

The General Accounting Office in its September 1974 report said that there is "no assurance that the PHP program is achieving its objective of reducing Medicaid costs." In fact, the GAO said, the program may be "more costly than the fee-for services program." This statement remains true to this day.

The Subcommittee found instances where HMO's (1) unreasonably limited the provision of health care services to those who needed such services, (2) utilized marginal facilities and manpower, and (3) diverted funds away from health care purposes. Clearly, a method is needed for determining what is a fair and reasonable rate of reimbursement for contract goods and services. That method must not reward systems that deny needed health care services and divert funds from their intended beneficiaries.

The Secretary should take into account the results of the study being funded by the DHEW grant. Under the grant the State of

California is currently seeking to determine rate-setting methods. Ultimately, the Congress should consider legislation standardizing rate reimbursement programs for both Medicare and Medicaid programs.

The subcommittee recommends that the Secretary of Health, Education, and Welfare report to the Subcommittee by January 1, 1979, a uniform method of establishing actual costs of an HMO in providing health care services along with a method of determining an appropriate rate of reimbursement.

8. The State of California overpaid a prepaid health plan by $4.3 million for fiscal years 1973 and 1974 in violation of its own regulations and those of the Federal Government. DHEW has not recovered the Federal share of the overpayment as recommended by the General Accounting Office

The GAO found that the State had overpaid the Medical Care Foundation of Sacramento in fiscal years 1973 and 1974. The overpayment totalled $4.3 million—the amount by which reimbursement to the Foundation exceeded the per capita of fee-for-service costs in the plan's marketing area. State and Federal regulations provide that reimbursement to PHP's and HMO's cannot exceed fee-for-service levels. The overpayment is a direct result of the State's failure to develop a rate setting method as required by its own law.

The GAO recommended that DHEW recover the Federal share of the overpayment, which would amount to approximately $2.2 million.

The subcommittee recommends that the Secretary of the Department of Health, Education, and Welfare report to the Subcommittee by June 1, 1978, either a plan for the recovery of these funds from the State of California or the reason why such recovery cannot be made.

9. Federal HMO program officials lack adequate statutory authority and manpower to cope with the kind of problems that beset the California program, to administer the Federal HMO program and to monitor the performance of Federally-qualified HMO's

Chapter IV of this report makes it clear that Federal HMO program administrators believe that existing statutes and regulations are inadequate to cope with the troublesome problems that beset the California PHP program. According to a series of reports by the General Accounting Office the Federal HMO program has not been efficiently organized and DHEW has committed inadequate staff resources to assure proper program management. Concern was expressed that the financial interests of the Government may not be adequately protected in the HMO grant, loan, and loan guarantee programs. The record before the Subcommittee evidences a serious lack of coordination of DHEW's HMO qualification, funding and compliance activities.

The subcommittee recommends that the problems identified in Chapter IV of this report be given careful consideration by the responsible legislative committees and appropriations subcommittees of the Congress in connection with their oversight and actions relative to the Federal HMO program.

10. Federal law and regulations are not adequate to prevent the willful diversion of funds for HMO development

Federal HMO program administrators testified before the Subcommittee concerning the inadequacy of current law and regulations to deal with problems of corporate structure, marketing, and financial abuse. They also noted the law and regulations do not provide adequate protection for the Federal expenditure of HMO grants, loans and loan guarantees. As some witnesses testified, a new HMO may have problems developing capital. What the law and program regulations do not effectively cope with is the ability of HMO's to divert and misallocate Federal funds for private gain.

The General Accounting Office has recently reported to DHEW that loans totalling more than $2 million to two Federally qualified HMO's in Florida and Oregon are in trouble and that the Federal Government may not get its money back.

In his testimony before the Subcommittee, the director of the Federal HMO qualifications office said that he did not believe there is adequate protection for the Government and taxpayers in the grant, loan, and loan guarantee program for HMO's. He warned of the situation in which not-for-profit corporations expend the bulk of the Federal funds in contracts with for-profit organizations. This invites opportunities for collapsing the not-for-profit corporations once the drawdown of Federal funds has been exhausted, leaving the Government with an empty shell.

> *The subcommittee recommends* that the Health Maintenance Organization Act be amended to make the principal owners, officers and directors and HMO's personally liable for the return to the Federal Government of any funds determined to have been willfully diverted or misallocated in a fraudulent manner or for personal gain.

C. ADDITIONAL FINDINGS

1-A. The PHP program in the State of California was grossly mismanaged over a period of years. Awareness of the California experience should help Federal, State and local authorities to avoid a repetition of California's problems in PHP and HMO programs elsewhere

The California PHP program was seriously mismanaged and grossly abused. Reform efforts did not begin to take lasting effect until following the enactment of amendments to the Federal HMO Act in October 1976. The record shows that the State of California failed to enforce its own program regulations and failed repeatedly to respond to evidence of fraud and abuse reported by the press, by its own investigators and auditors, by State legislative committees, and by the General Accounting Office. The State failed to act effectively against highly questionable enrollment and marketing practices. It developed no objective standards and criteria for quality of care reviews, or for determining fair rates of payment to the plans. Program officials ignored their own staff investigative and quality of care audit reports. As a result, an atmosphere was created that invited mismanagement and abuse.

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The use of prepaid health plans to deliver health care services to Medicaid beneficiaries in California began as an innovative and highly promising alternative to the costly fee-for-service system of financing such health care programs. The value of this kind of health care delivery system had been demonstrated by successful prepaid group health plans, and has been recognized at the Federal level in the Health Maintenance Organization Act of 1973, as amended. Prepaid health plans and HMO's continue to be a promising alternative to the traditional fee-for-service health financing mechanism.

The Subcommittee recognizes the value of prepaid health plans and HMO's as vehicles for the organization, financing and delivery of health care services. However, the record developed during the Subcommittee's hearings and discussed in this report should alert responsible Federal, State and local officials and help them to avoid the many problems that beset the California PHP program.

1–B. The Department of Health, Education and Welfare was lax in its oversight of Federal Medicaid funds used in California in the PHP program. DHEW failed to respond in a timely way to information it received evidencing fraud and abuse and failed to act effectively to curb abuses

The record before the Subcommittee makes it clear that the Department of Health, Education and Welfare was apprised of serious problems affecting California's prepaid health program by numerous sources including the media and the Department's San Francisco regional office. Yet the Department remained immobile in the face of this information until the situation was addressed by the Subcommittee in its hearings.

Only then did DHEW begin to respond with active support of California's belated efforts to reform the program. When California's reform efforts faltered, DHEW did threaten to cut off funding for the program. However, the record shows that throughout much of the period, DHEW failed to enforce its own PHP regulations.

DHEW was lax in its oversight over Federal Medicaid funds spent in the California program over a period of years. In effect, the Department abdicated its responsibility to insure that millions of dollars in Federal grant funds were properly spent.

The record developed by the Subcommittee and summarized in this report is clearly pertinent to the Congress' continuing interest in prepaid health plans and HMO's as vehicles for the delivery of Federally financed health care services. This record of the serious mismanagement, fraud and abuse that beset the California program, demonstrates the need for greater Congressional, State and local oversight over such programs, and the need for effective management and monitoring by DHEW and State authorities to obviate program abuse.

The subcommittee recommends that the Chairman transmit copies of this report to the Senate Committee on Finance, the Senate Committee on Human Resources, the House Committee on Ways and Means, the House Committee on Interstate and Foreign Commerce, and the Senate and House Committees on Appropriations for their review in connection with legislation and appropriations involving the Federal health maintenance organization programs and other Federal programs involving the delivery of health care services through prepaid group health plans.

The following Senators, who were Members of the Permanent Subcommittee on Investigations at the time of the hearings, have approved this report:

Henry M. Jackson	Charles H. Percy
Sam Nunn	Jacob K. Javits
Lawton Chiles	William V. Roth, Jr.

Because I was not present at the hearings of the Permanent Subcommittee on Investigations covered by this report, I reserve judgment at this time respecting the findings and recommendations contained therein. However, I authorize the filing with the Senate of the proposed report prepared by the Subcommittee entitled, "Prepaid Health Plans and Health Maintenance Organizations."

April 5, 1978.

JOHN GLENN,
U.S. Senator.

The Members of the Committee on Governmental Affairs, except those who were members of the Senate Permanent Subcommittee on Investigations at the time of the hearings, did not sit in on the hearings on which the above report was prepared. Under these circumstances, they have taken no part in the preparation and submission of the report except to authorize its filing as a report made by the subcommittee.

VI. Appendix

Comptroller General of the United States,
Washington, D.C., March 6, 1978.

B-164031(3)
Hon. Henry M. Jackson,
Chairman, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate.

Dear Mr. Chairman: This letter responds to your request for information relating to the Foundation Community Health Plan of the Medical Care Foundation of Sacramento (Foundation). Specifically, we were asked to determine if the Federal Government has recovered Medicaid funds paid to the Foundation as recommended in our previous reports and if the State of California should refund Federal Government grant funds to the Foundation as part of a prepaid health plan rate-setting demonstration study.

We made our review at the Department of Health, Education, and Welfare (HEW), HEW's San Francisco Regional Office, the California Department of Health, and the Foundation. We reviewed program records and interviewed HEW, State, and Foundation officials.

As requested by your office, we did not obtain written comments on this report. However, we discussed our observations with HEW, State, and Foundation officials.

HEW HAS NOT RECOVERED FUNDS AS WE RECOMMENDED

We have issued two reports dealing, in part, with the Foundation:

"Better Controls Needed for Health Maintenance Organizations Under Medicaid in California," B-164031(3), September 10, 1974, and

"Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program," MWD-76-15, August 8, 1975.

Our 1974 report evaluated California's use of prepaid health plans. The report contained many findings and recommendations relating to various aspects of the prepaid plan program, including weak procedures for determining reimbursements to prepaid plans. The report noted that the Foundation was paid per capita rates which exceeded those normally paid to a prepaid plan.

In our 1975 report we explained in more detail the deficiencies in California's prepaid health plan rate-setting mechanism and also discussed the rates paid to the Foundation. We reported that California had negotiated monthly per capita rates with the Foundation for fiscal years 1973 and 1974 which exceeded actual per capita fee-for-service costs in the same counties by $4.3 million. Both Federal and State regulations prohibit paying prepaid plans more than the same services would cost under the fee-for-service system.

According to the State, the Foundation was paid rates exceeding fee-for-service costs because it had suffered adverse selection. That is, Medicaid recipients, who had chosen to enroll in the Foundation's Plan, were sicker, and thus more costly to care for, than Medicaid recipients who remained in the fee-for-service system. If this contention had been true, paying the Foundation at higher rates would have been appropriate under both Federal and State regulations. However, when we examined the data the State used to determine adverse selection, we concluded that the data did not justify that conclusion. Therefore, we recommended that HEW recoup from California the Federal share of excessive payments to the Foundation.

State and Foundation officials agreed that the higher rates had not been justified. However, Foundation officials believed their data did indicate that adverse selection had occurred. They said that an additional actuarial study, including State data on the fee-for-service system, was needed to prove that adverse selection had taken place.

As of December 1977, HEW had not attempted to recoup funds from California based on our 1975 recommendation on fiscal year 1973 and 1974 Foundation activities. However, HEW did inform the State that it was going to recoup the Federal share of overpayments to the Foundation as reported by the California Auditor General. The Auditor General had reported in June 1975 that the State had paid the Foundation capitation rates exceeding the per capita average fee-for-service cost upper limit without the actuarial support required by State law. The Auditor General estimated that during calendar year 1974, the Foundation had received excessive payments of $1.6 million. As of December 1977, HEW had not recovered the Federal share of the $1.6 million, and the issue was still unresolved.

CALIFORNIA'S PREPAID HEALTH PLAN DEMONSTRATION PROJECT

In February 1976, HEW awarded a demonstration project grant to California to develop a rate-setting methodology for prepaid health plans and a model quality assessment and cost control system for use by State Medicaid agencies. A purpose of the grant was to determine if the Foundation had suffered adverse selection. HEW said that this grant would fulfill the intent of many of the recommendations in our 1974 and 1975 reports on California's prepaid health plan program. Background on the Foundation's involvement in this grant follows.

During negotiations for a prepaid plan contract for July 1975 to June 1976, the Foundation told the State it would need a monthly per capita rate of $30.31 for Medicaid recipients in the Aid to Families with Dependent Children (AFDC) category. The State countered that, because of the State and Federal fee-for-service upper limit on prepaid plan payments, it could pay the Foundation no more than $25.62 per AFDC recipient. The Foundation asserted that it had no intention of contracting with the State at rates below those computed by its actuary and would cease doing business with the State if it could not obtain a satisfactory rate.

Since the State would not pay the Foundation at rates exceeding the fee-for-service upper limit, a contract was negotiated which provided for State payments of $25.62 to the Foundation for AFDC eligibles plus a provision for Federal payment for an additional $4.69, contingent on the award of a grant by HEW to the State. Failure of the Federal Government to award the grant to the State for payment of the supplemental capitation rates and development of a rate-setting methodology would result in cancellation of the State's contract with the Foundation. Payments under the additional capitation rate provision were to be applied retroactively to July 1, 1975, and were to continue until June 30, 1976, when the State's rate of $25.62 could be adjusted to reflect the capitation rate which would result from the rate-setting study segment of the grant.

The State anticipated that the HEW grant would be awarded under authority of section 222 of the Social Security amendments of 1972 (Public Law 92–603) which provide for Medicaid demonstration grants. However, section 222 did not permit HEW to include, as part of the grant, funds for retroactive payments.

On December 31, 1975, an amendment to section 222 became law (section 107 of Public Law 94–182) and allowed retroactive payments under section 222 if certain requirements were met. Senate Report 94–549, in explaining the amendment, states that it

"Would remove a technical barrier to the Secretary's approval of a grant to the Sacramento Medical Care Foundation which is aimed at obtaining data to assist [HEW] in developing appropriate reimbursement mechanisms for health maintenance organizations."

On February 9, 1976, HEW approved a $5.2 million grant to California. The grant had four major objectives, including developing an actuarially sound rate-setting mechanism for prepaid health plans. The grant period runs until November 1979, and as of January 23, 1978, $3.4 million of the grant had been paid to the State.

Of the $3.4 million given the State, $1,107,426.25 was paid to the Foundation on April 16, 1976, and represented retroactive capitation payments above the State capitation rate. Additional payments to the Foundation, totaling $180,776.05, were made for May and June 1976. From July 1975 to June 1976, capitation payments from grant funds totaled about $1.3 million. Effective July 1, 1976, the Foundation canceled its contract with the State because the maximum ($28.48) the State was willing to pay the Foundation for the year beginning July 1, 1976, was $9.33 per eligible person a month less than the Foundation would accept ($37.81). Under the grant provisions, grant funds could not be used for extra capitation payments after June 30, 1976.

RESULTS OF THE FOUNDATION'S PORTION OF DEMONSTRATION GRANT

On July 27, 1977, the State submitted to HEW a study of alleged adverse selection in the Medicaid population covered by the Foundation.

The State concluded that payments to the Foundation for Medicaid eligibles during 1974 were not higher than Medicaid costs would have been under the fee-for-service system. This conclusion was based on the fact that the Foundation experienced higher use of some types of services than their use under the fee-for-service system. Therefore,

the State determined that it did not have to repay the Federal share of per capital payments to the Foundation which exceeded average per capital fee-for-service costs.

We have analyzed the State's study and, in our opinion, the report does not substantiate a determination that the Foundation suffered adverse selection. We believe that the methodology used by the State could not reasonably support such a conclusion. Greater use of medical services does not necessarily imply greater need for such services because use is affected, in part, by the utilization control and reimbursement practices of the payer. It is not surprising that, when the State works backward from actual cost and utilization data, it finds support for the adverse selection theory because the whole premise of its study becomes self-fulfilling. The State assumed that Foundation utilization controls were as effective as those for the fee-for-service program, and therefore, the Foundation was no more susceptible to overuse than was the fee-for-service program. However, utilization differences can be due to subtle differences in utilization control and the reimbursement methods for health practitioners.

We also noted several other problems in the study:

The study results are sensitive to the correlation of the paid claims and number of eligibles data, and the study admits to flaws in this data.

For hospital use, the primary unit studied should have been total days of hospitalization rather than number of admissions.

The analysis of utilization by age and sex should have been presented in the report. A preliminary report on the study which was provided to us stated that adverse selection could not be supported by age and sex analysis.

As previously discussed, our 1975 report pointed out that the State's 1973 study justifying higher payments because the Foundation had experienced adverse selection could not be substantiated. In view of the State's failure to justify payment rates higher than those customarily used for prepaid plans, we recommended that HEW recoup Federal sharing payments to the Foundation which exceed the limit established by Federal regulations.

In our view, when a State deviates from its established procedures and negotiates higher per capita rates for one plan than those that would customarily be used for other plans, the burden for justifying the higher rates rests with the State. In our opinion, California's July 1977 study fails this test.

As of February 1, 1978, HEW had not formally evaluated the State's report or taken a position on it.

CALIFORNIA'S PAYMENT OF GRANT FUNDS TO THE FOUNDATION

The law allowing retroactive demonstration grant payments to the Foundation requires that such payments only be made in connection with a rate-setting methodology study but does not define the extent of participation in the study necessary to qualify for the funds.

HEW's grant to the State only requires the Foundation to give data to the State for the rate-setting study to qualify for the extra Federal capitation payments. Also, the State's contract with the Foundation contains only one requirement relating to the rate-setting

study—that the Foundation give data to the State. The Foundation did provide the required data to the State. Therefore, the Foundation met the conditions of the grant and thereby met the conditions of the law.

CONCLUSION

The State has, in our opinion, failed to justify paying rates to the Foundation exceeding those that would normally have been paid to a prepaid health plan. We believe the burden of justification rests with the State when it decides to deviate from regular procedures and regulations, and the State has failed to meet this burden. Accordingly, we believe HEW should implement our prior recommendation and recoup the Federal share of all excess payments made to the Foundation through fiscal year 1975.

The law is not specific on how extensively the Foundation had to participate in the rate-setting study, and HEW's grant to the State and the State's contract with the Foundation only required the Foundation to give data to the State. Because the Foundation did give data to the State, we see no grounds on which to demand repayment from California for its payment of demonstration grant funds to the Foundation.

We trust this information satisfactorily answers your request. As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

Senator NUNN. The subcommittee's report on its investigation is full of examples of fraud and abuse of patients as well as shortcomings in the present law and program administration with regard to HMO's. I would like to make it clear that, in my view, this does not mean that all HMO's are bad or that the program should be scrapped.

Indeed, bona fide, prepaid group practice is a viable method of organizing, financing, and delivering health care which should be encouraged. To label all HMO's as bad or to suggest that the concept is doomed on the basis of the subcommittee report would be erroneous and irresponsible. Likewise, simply because we find some fee for service physicians and hospitals overcharging, providing more services to patients than they need or being convicted of fraud does not mean that fee for service health care is bad.

I hope the Finance Health Subcommittee will perceive our report in this overall context.

I come before you today to urge you to protect medicare and medicaid program funds from the kinds of fraud and abuse identified by all the subcommittee's investigations. Your committee is to be commended for placing strong safeguards against HMO abuses of the medicare program as early as 1972.

I am also aware that similar safeguards were voted by the Senate for the medicaid program in 1973, but that the House of Representatives did not take action on the Senate bill. I think that is unfortunate.

House passage in 1973 of your committee proposal to protect medicaid programs from HMO fraud and abuse would have prevented many problems with regard to title XIX that we address today. Our report discusses the subcommittee's investigation of the prepaid health plans receiving medicaid funds in California. At the peak of the program there, some 54 plans provided health care services to more than 250,000 medicaid beneficiaries.

As you will recall, I have testified here on other issues involved in our inquiry. I will not repeat those this morning, but they are part of my prepared testimony, the complete text of which I hope would be a part of the record.

The cornerstone of the program was the State of California's belief that it would save money by contracting with these HMO's. The General Accounting Office said in 1974 that the program might have cost more than paying doctors' fees for the services. Almost all of the HMO's were nonprofit corporations, but the officers and directors of those organizations contracted with for profit companies they owned or controlled for services needed to fulfill State contract obligations.

We found that more than half of the medicaid funds going to many of these HMO's were diverted from health care services through these for-profit firms and were accounted for as administrative costs and profits. We found in one case that the return on invested capital in one California plan was something like 3,000 percent. These facts are quite significant, for they show that HMO's can be manipulated to defeat the very purpose of such organizations. HMO's offer the promise of health care services at fixed monthly costs to the persons enrolled. By selling its services to large numbers of people, the HMO is assured of large amounts of cash flow.

From this pool of funds, the HMO can finance health care for patients who need it. There is a financial disincentive to provide more services than the patient needs.

This is in contrast to the financial incentive in fee for service financial systems which pays health providers for each service rendered.

While there may be a financial disincentive for HMO's to overutilize, there was evidence in California of the financial incentive to provide less service than patients required. Some California HMO's closed clinics on nights and week-ends which were required to remain open under the State contracts.

One plan with nearly 100,000 enrollees, most of whom were women and children, had only one obstetrician and no pediatrician. We found several additional examples of poor medical services.

Instead of performing surgeries, pain-killing drugs were given to patients. In some cases, children were not immunized. Sick patients were placed in clinic holding rooms instead of in hospitals where they belonged.

Hospitalized patients were discharged too early. Some were the subjects of efforts to disenroll them when their hospital stays grew long and expensive.

In summary, the financial disincentive to provide necessary services combined with corporate structures enabling the easy diversion of funds can potentially turn HMO's into havens of financial and patient abuse.

One of the subcommittee's goals in its investigation of prepayment systems in California was to learn from the mistakes of that program so that the lessons could be applied to Federal HMO efforts. According to their testimony before our subcommittee, HMO officials have no mechanisms under the law to respond to marketing and enrollment abuses.

They have no regulations preventing or controlling self-dealing by HMO principals. They cannot safeguard the Federal investment in HMO's from abusive financial practices. They have neither a financial auditing program nor a method to evaluate the quality of care provided in HMO's, though HEW is required under the act to have such compliance programs.

Mr. Chairman, building upon this foundation would be building on quicksand. The administration, in its HMO bill, would liberalize medicare and medicaid reimbursement to HMO's and increase from $1 to $2 million the amount of grant funds and from $2.5 to $5 million the amount of Federal loan funds an HMO can receive.

Based upon experience to date, it seems as though HEW is rewriting the old saying, double or nothing—to double and nothing, for there is nothing, not a word—in the administration's HMO bill that effectively responds to the evidence of HMO fraud and abuse.

I would like to ask the Chairman to place in the record of this hearing Senate bill 2676, the administration's HMO proposal.

Senator TALMADGE. Without objection, so ordered.

[The material referred to follows:]

95TH CONGRESS
2D SESSION

S. 2676

IN THE SENATE OF THE UNITED STATES

MARCH 6 (legislative day, FEBRUARY 6), 1978

Mr. KENNEDY (for himself, Mr. SCHWEIKER and Mr. RIBICOFF) (by request) introduced the following bill; which was read twice and referred to the Committees on Finance and Human Resources jointly by unanimous consent

A BILL

To amend provisions of law concerned with health maintenance organizations.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 SECTION 1. This Act may be cited as the "Health Main-
4 tenance Organization Amendments of 1978".
5 TITLE I—AMENDMENTS TO THE PUBLIC HEALTH
6 SERVICE ACT
7 APPROPRIATION, LOAN, AND LOAN GUARANTEE
8 AUTHORIZATIONS
9 SEC. 101. (a) Section 1304(j) of the Public Health
10 Service Act is amended (1) by striking out "1978" and

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1 inserting instead "1981", and (2) by striking out "1979"
2 and inserting instead "1981".
3 (b) Section 1305 (d) of that Act is amended by striking
4 out "1980" and inserting instead "1981".
5 (c) Section 1309 (a) of that Act is amended (1) by
6 striking out "and" after "1977,", and (2) by striking out
7 everything after "1978" and inserting instead ", $23,910,-
8 000 for the fiscal year ending September 30, 1979, and
9 such sums as may be necessary for the fiscal years ending
10 September 30, 1980, and September 30, 1981.".
11 LIMITATIONS ON, AND EXCLUSIONS FROM, BASIC HEALTH
12 SERVICES
13 SEC. 102. (a) The material in section 1301 (b) of
14 that Act preceding paragraph (1) is amended by striking
15 out "other than those prescribed by or under this title"
16 and inserting instead "(other than a limitation authorized
17 by the Secretary that he finds will assist in the develop-
18 ment of health maintenance organizations; and other than
19 a limitation otherwise prescribed by or under this title)".
20 (b) Section 1302 (1) of that Act is amended by in-
21 serting after the second sentence the following: "A health
22 maintenance organization may, in specific circumstances,
23 exclude from basic health services those services for which
24 the Secretary authorizes an exclusion, if the Secretary finds
25 that not including those services in those circumstances will

1 assist in the development of health maintenance organi-
2 zations.".

3 (c) The first sentence of section 1302(2) of that Act
4 is amended (1) by striking out "and" at the end of clause
5 (F), (2) by redesignating clause (G) as (H), and (3)
6 by inserting after clause (F) the following:

7 "(G) services that the Secretary, under the mate-
8 rial in section 1301(b) preceding paragraph (1), or
9 under the third sentence in paragraph (1) of this sec-
10 tion, has authorized to be excluded from basic health
11 services; and".

12 LIMIT ON DIRECT CONTRACTING FOR SERVICES

13 SEC. 103. The antepenultimate sentence of section 1301
14 (b)(3) of that Act is amended—

15 (1) by striking out everything before the third
16 comma and inserting instead "A health maintenance
17 organization may not, in any of its fiscal years, enter
18 into contracts with physicians or entities other than
19 medical groups or individual practice associations if the
20 amounts paid under such contracts for basic and supple-
21 mental health services provided by physicians exceed
22 15 per centum of the estimated total amount to be paid
23 in such fiscal year by the health maintenance organiza-
24 tion for basic and supplemental health services provided
25 by physicians", and

1 (2) by inserting before the period ", and does not
2 apply to a health maintenance organization during the
3 forty-eight-month period beginning with the month fol-
4 lowing the month in which the organization becomes a
5 qualified health maintenance organization (within the
6 meaning of section 1310(d))".

7 ADDITIONAL REQUIREMENTS FOR HEALTH MAINTENANCE
8 ORGANIZATIONS

9 SEC. 104. (a) Section 1301(c)(11) of that Act is
10 amended—
11 (1) by striking out the subclause designation;
12 (2) by inserting "(E) major financial and other
13 transactions among the health maintenance organization
14 and related organizations (as defined by the Secre-
15 tary)," after "members," in subclause (D).
16 (b) Section 1301(c) of that Act is amended—
17 (1) by striking out "and" at the end of clause
18 (10),
19 (2) by striking out the period at the end of clause
20 (11) and inserting instead "; and", and
21 (3) by adding after clause (11) the following:
22 "(12) provide the Secretary (A) in any case in
23 which the health maintenance organization is related to
24 another organization by common ownership or control,
25 an annual consolidated financial statement, and, in all

1 other cases, an annual financial statement, and (B) with
2 respect to any major financial or other transaction be-
3 tween the health maintenance organization and a related
4 organization (as defined by the Secretary), a certifi-
5 cation that the terms of the transaction are at least as
6 favorable to the health maintenance organization as they
7 would have been if the transaction had occurred between
8 the health maintenance organization and an entity not
9 related to the health maintenance organization.".
10 (c) This section is effective one hundred and eighty days
11 after the enactment of this Act.

12 REPEAL OF CERTAIN RESTRICTIONS

13 SEC. 105. (a) (1) Section 1303 (c) of that Act is
14 repealed.
15 (2) Section 1303 (d) of that Act is amended—
16 (A) in paragraph (1), by striking out "paragraph
17 (2)" and inserting instead "subsection (d)",
18 (B) by striking out "(d) (1)" and inserting instead
19 "(c)",
20 (C) by striking out "(2)" and inserting instead
21 "(d)", and
22 (D) by redesignating subparagraphs (A) and (B)
23 as paragraphs (1) and (2), respectively.
24 (b) (1) Section 1304 (d) of that Act is repealed.
25 (2) Section 1304 (c) of that Act is amended—

1 (A) in paragraphs (1) and (2), by redesignating
2 clauses (A) and (B) as clauses (1) and (2), re-
3 spectively,
4 (B) by repealing the paragraph designation "(1)",
5 and
6 (C) by redesignating paragraph (2) as subsec-
7 tion (d).
8 (c) Sections 1303(i) and 1304(k) of that Act are
9 repealed, but any funds available for obligation under section
10 1303(i) or 1304(k) at the time of enactment of this Act
11 shall remain available for obligation until the end of the fiscal
12 year in which enactment of this Act occurs.
13 (d) Subsections (e) and (f) of section 1305 of that
14 Act are repealed.
15 (e) (1) Section 1306(b) of that Act is amended (A)
16 by repealing clause (2), (B) by renumbering clauses, (3)
17 through (8) as (2) through (7), and (C) by striking out
18 "paragraph (3)" in the last sentence and inserting instead
19 "paragraph (2)".
20 (2) The second sentence of section 1307(b) of that
21 Act is amended by striking out "section 1306(b) (3)" and
22 inserting instead "section 1306(b) (2)".
23 INCREASED SCOPE AND AMOUNT OF GRANTS, CONTRACTS,
24 AND LOAN GUARANTEES FOR INITIAL DEVELOPMENT
25 COSTS

1 Sec. 106. (a) Section 1304(b)(1) of that Act is
2 amended by inserting "(including health maintenance orga-
3 nizations)" after "entities" each place it occurs,
4 (b) The first sentence of section 1304(b)(3) of that
5 Act is amended by striking out "one-year" and inserting
6 instead "three-year".
7 (c) Section 1304(f)(2)(A) of that Act is amended
8 to read as follows:
9 "(A) $2,000,000, and".
10 INCREASE IN LIMITS FOR LOANS AND LOAN GUARANTEES
11 FOR INITIAL OPERATION COSTS
12 Sec. 107. Section 1305(b)(1) of that Act is amended
13 (1) by striking out "$2,500,000" and inserting instead
14 "$5,000,000", and (2) by striking out "$1,000,000" and
15 inserting instead "$2,000,000".
16 LOANS AND LOAN GUARANTEES FOR THE CONSTRUCTION
17 OF AMBULATORY HEALTH CARE FACILITIES
18 Sec. 108. (a)(1) Section 1305(b)(1) of that Act
19 is amended by striking out "this section" each place it occurs
20 and inserting instead "subsection (a)".
21 (2) Section 1305(b)(2) of that Act is amended by
22 inserting "or subsection (b)" after "subsection (a)".
23 (b) Subsections (b) through (d) of section 1305 of
24 that Act are redesignated subsections (c) through (e).

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1 (c) Section 1305 of that Act is amended by adding
2 after subsection (a) the following:
3 "(b) The Secretary may—
4 "(1) make loans to public or private entities (in-
5 cluding health maintenance organizations) to assist them
6 in the acquisition, construction, or renovation of, or the
7 purchase of equipment for, ambulatory health care facil-
8 ities for health maintenance organizations, and
9 "(2) guarantee to non-Federal lenders payment of
10 the principal of and the interest on loans made to private
11 entities (including health maintenance organizations) to
12 assist them in the acquisition, construction, or renova-
13 tion of, or the purchase of equipment for, ambulatory
14 health care facilities for health maintenance organiza-
15 tions.".
16 ADMINISTRATIVE LOCATION OF QUALIFICATION
17 AND COMPLIANCE ACTIVITIES
18 SEC. 109. (a) Section 1310(h) of that Act is amended
19 to read as follows:
20 "(h) The administration of the duties and functions of
21 the Secretary, insofar as they involve making determinations
22 as to whether an organization is a qualified health mainte-
23 nance organization within the meaning of subsection (d),
24 shall be integrated with the administration of section 1312.".
25 (b) Section 1312(c) of that Act is repealed.

1 REPEAL OF LIMITATION ON SOURCE OF FUNDING FOR
2 HEALTH MAINTENANCE ORGANIZATIONS

3 SEC. 110. Section 1313 of that Act is repealed.

4 HEALTH MAINTENANCE ORGANIZATIONS UNDER A
5 STATE CERTIFICATE OF NEED PROGRAM

6 SEC. 111. (a) The second sentence of section 1523 (a)
7 (4) of the Act is amended by striking out "services, facili-
8 ties, and organizations" each place it occurs and inserting
9 instead "services and facilities".

10 (b) Section 1531 (5) of that Act is amended by strik-
11 ing out "and health maintenance organizations" and "and
12 organizations".

13 REVIEW OF FACILITIES, EQUIPMENT, AND SERVICES
14 OF HEALTH MAINTENANCE ORGANIZATIONS

15 SEC. 112. (a) Section 1532 (c) of that Act is
16 amended—

17 (1) in the material preceding paragraph (1), by
18 striking out "Criteria" and inserting instead "Except as
19 provided in subsection (d), criteria",

20 (2) by striking out paragraph (8),

21 (3) by renumbering paragraph (9) as (8), and

22 (4) by striking out the last sentence.

23 (b) Section 1532 of that Act is amended by adding
24 at the end the following:

25 "(d) Criteria required by subsection (a) for health

1 systems agency and State agency review, in relation to the
2 facilities, equipment, or services of health maintenance
3 organizations (as defined in section 1301), shall include
4 only those criteria specified by the Secretary, and shall be
5 consistent with the standards and procedures established by
6 the Secretary under section 1306 (c).".
7 (c) This section is effective one hundred and eighty
8 days after the enactment of this Act.

9 TITLE II—AMENDMENTS TO TITLES XI AND
10 XVIII OF THE SOCIAL SECURITY ACT

11 CAPITAL EXPENDITURES LIMITATION AS APPLIED TO
12 HEALTH MAINTENANCE ORGANIZATIONS

13 SEC. 201. Section 1122 of the Social Security Act is
14 amended—
15 (1) by striking out "or health maintenance orga-
16 nizations" each place it occurs,
17 (2) by striking out "or health maintenance orga-
18 nization" each place it occurs, and
19 (3) in subsection (d) (2), by striking out "or
20 organization, or of any facility of such organization,".

21 ADMINISTRATIVE LOCATION OF MEDICARE HEALTH MAIN-
22 TENANCE ORGANIZATION ACTIVITIES

23 SEC. 202. (a) Section 1876 (b) (2) (A) of that Act is
24 amended by striking out "and in the Office of the Assistant
25 Secretary for Health".

1 (b) Section 1876(b)(2)(B) of that Act is amended
2 by striking out "Commissioner of Social Security" and insert-
3 ing instead "Administrator, Health Care Financing Adminis-
4 tration".

5 REQUIREMENT UNDER MEDICARE FOR ENROLLMENT BY
6 HEALTH MAINTENANCE ORGANIZATIONS OF INDIVID-
7 UALS UNDER SIXTY-FIVE

8 SEC. 203. Section 1876(h)(2) of that Act is amended
9 to read as follows:
10 "(2) Paragraph (1) shall not apply to a health main-
11 tenance organization—
12 "(A) that is a public health maintenance
13 organization,
14 "(B) that has received a grant under section 330
15 of the Public Health Service Act in the current or pre-
16 ceding calendar year, or
17 "(C) to which the Secretary, for good cause shown,
18 has granted a waiver from the application of paragraph
19 (1).".

20 PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS
21 UNDER MEDICARE

22 SEC. 204. (a) Section 1876(a)(1) of that Act is
23 amended—
24 (1) by striking out "and" at the end of clause
25 (A),

1 (2) by striking out the period at the end of clause
2 (B) and inserting instead ", and", and
3 (3) by adding at the end the following new clause:
4 "(C) for services provided under part A for indi-
5 viduals enrolled with such organization pursuant to sub-
6 section (e) who are entitled to hospital insurance bene-
7 fits under part A but who are not enrolled for medical
8 insurance benefits under part B.".
9 (b) Section 1876(a)(2) of that Act is amended to
10 read as follows:
11 "(2) The Secretary shall annually determine a per
12 capita rate of payment for each health maintenance organi-
13 zation. The rate shall be equal to 95 percent of the adjusted
14 average per capita cost. Each month the Secretary shall pay
15 each such organization its rate, in advance, for each individ-
16 ual enrolled with it pursuant to subsection (e).".
17 (c) Section 1876(a)(3) of that Act is amended to
18 read as follows:
19 "(3) The term 'adjusted average per capita cost' means
20 the average per capita amount that the Secretary estimates
21 (on the basis of actual experience, or retrospective actuarial
22 equivalent based upon an adequate sample and other infor-
23 mation and data, in the geographic area served by a health
24 maintenance organization or in a similar area, with appro-
25 priate adjustments to assure actuarial equivalence) would be

1 payable in any contract year for services covered under this
2 title and types of expenses otherwise reimbursable under this
3 title (including administrative costs incurred by organizations
4 described in sections 1816 and 1842) if such services were
5 to be furnished by other than a health maintenance
6 organization.".

7 (d) The first sentence of section 1876 (a) (4) of that
8 Act is amended by striking out "subparagraph" and insert-
9 ing instead "subsection".

10 (e) Section 1876 (b) (1) of that Act is amended—

11 (1) in clause (A), by (A) inserting "part A
12 or" before "part B", and (B) by striking out "sub-
13 paragraph (A) or (B)" and inserting instead "sub-
14 paragraph (A), (B), or (C)", and

15 (2) in clause (C), by (A) inserting "and" at
16 the end of subclause (i), (B) striking out subclause
17 (ii), and (C) redesignating subclause (iii) as (ii).

18 (f) Section 1876 (c) of that Act is amended—

19 (1) in the material preceding clause (1), by (A)
20 striking out "risk sharing", and (B) striking out "sub-
21 section (i) (2) (A)" and inserting instead "subsection
22 (i)", and

23 (2) in clause (2), by—

24 (A) inserting "and in the case of an individual
25 who is entitled to hospital insurance benefits under

1 part A but who is not enrolled for medical insur-
2 ance benefits under part B," after "part B,", and
3 (B) inserting "or section 1812, respectively"
4 before the period.
5 (g) Section 1876(e) of that Act is amended to read
6 as follows:
7 "(e) An individual may enroll with a health mainte-
8 nance organization under this section as may be prescribed
9 in regulations, and may terminate his enrollment with a
10 health maintenance organization as of the beginning of the
11 first calendar month following a full calendar month after
12 he has requested termination.".
13 (h) Section 1876(g)(1) of that Act is amended by
14 inserting "the applicable clause of" before "subsection (c)".
15 (i) Section 1876(g)(2) of that Act is amended to
16 read as follows:
17 "(2) If the health maintenance organization provides
18 to its enrollees under this section services in addition to
19 those described in the applicable clause of subsection (c),
20 the portion of its premium rate or other charges for the
21 services described in the applicable clause of subsection (c)
22 shall not exceed the actuarial value of the deductible and
23 coinsurance which would otherwise be applicable to such
24 enrollees under part A and part B if they were not enrolled
25 under this section, the portion of its rate or other charges

1 for other services described in subsection (c) shall not ex-
2 ceed the adjusted community rate (as defined in subsection
3 (i) (2) (B), but without adjustment for any deductible or
4 coinsurance) for those services, and the remaining portion
5 of its premium rate or other charges shall not exceed what
6 that portion of the rate or other charges would be if the
7 enrollees were not entitled to hospital insurance benefits
8 under part A or enrolled for medical insurance benefits
9 under part B.".
10 (j) Section 1876 (i) (1) of that Act is amended to
11 read as follows:
12 "(i) (1) The Secretary is authorized to enter into a
13 contract with any health maintenance organization which
14 undertakes to provide the benefits described in subsection
15 (c) to individuals enrolled with such organization pursuant
16 to subsection (e).".
17 (k) Section 1876 (i) (2) of that Act is amended to
18 read as follows:
19 "(2) (A) The contract shall provide that, if the ad-
20 justed community rate for an individual enrolled with the
21 organization pursuant to subsection (e) is less than 95 per-
22 cent of the adjusted average per capita cost (as defined in
23 subsection (a) (3)), further adjusted to reflect the indi-
24 vidual's enrollment under part A, part B, or both parts A
25 and B, the health maintenance organization shall provide

1 to the individual reduced charges, additional services, or some
2 combination of reduced charges and additional services,
3 that the Secretary finds are at least equal in value to the
4 difference between 95 percent of the adjusted average per
5 capita cost, as so further adjusted, and the adjusted com-
6 munity rate.

7 "(B) The term 'adjusted community rate' means the
8 rate of payment which the Secretary estimates would apply
9 to an individual enrolled with a health maintenance organiza-
10 tion pursuant to subsection (e) for the benefits described in
11 the applicable clause of subsection (c) if the rate of payment
12 were determined under a 'community rating system' (as de-
13 fined in section 1302 (8) of the Public Health Service Act,
14 other than subparagraph (C)), but adjusted for the ap-
15 plicable deductible and coinsurance under parts A and B
16 and for characteristics of the population eligible for benefits
17 under those parts.".

18 (l) Section 1876 (i) (6) is amended (1) by inserting
19 "and" at the end of clause (A), (2) by striking out clause
20 (B), and (3) by redesignating clause (C) as (B).

21 (m) Paragraph (3) of section 1876 (i) of that Act is
22 repealed, and clauses (4) through (6) are renumbered as
23 clauses (3) through (5).

24 (n) Section 1876 of that Act is amended by adding at
25 the end the following new subsection:

1 "(l) If an individual is enrolled pursuant to subsection
2 (e) with a health maintenance organization with which the
3 Secretary has entered into a contract under this section,
4 neither the individual nor any other person or entity (except
5 for the health maintenance organization) shall be entitled
6 to receive payments from the Secretary under this title for
7 services furnished to the individual.".

8 (o) Section 1833 (a) (1) (A) of that Act is amended
9 by inserting "(other than a health maintenance organiza-
10 tion as defined in section 1301 of the Public Health Service
11 Act)" after "organization" the first place it occurs.

12 (p) The amendments made by this section shall apply
13 with respect to services furnished on or after the first day
14 of the twenty-fifth calendar month which begins after the
15 date of enactment of this Act, or earlier with respect to any
16 health maintenance organization if the Secretary and the
17 organization so request, but shall not apply, with respect to
18 services furnished by a health maintenance organization to
19 any individual who is enrolled pursuant to section 1876 (e)
20 of the Social Security Act with that organization and at
21 the time the organization first enters into a contract subject
22 to the amendments made by this section, unless the individ-
23 ual requests determines at any time that the amendments
24 should apply to all members of the health maintenance
25 organization because of administrative costs or other admin-

1 istrative burdens involved and so informs in advance each
2 affected member of the health maintenance organization.

3 HEALTH MAINTENANCE ORGANIZATION PARTICIPATION
4 IN MEDICAID

5 SEC. 303. (a) Section 1902(a) of that Act is
6 amended—
7 (1) by striking out "and" at the end of paragraph
8 (39),
9 (2) by striking out the period at the end of para-
10 graph (40) and inserting instead "; and", and
11 (3) by adding after paragraph (40) the follow-
12 ing new paragraph:
13 "(41) provide that the State will enter into a
14 provider agreement with any health maintenance orga-
15 nization which requests such an agreement under which
16 the State will make payments to the health mainte-
17 nance organization for services and benefits covered
18 under the State plan and provided by the health main-
19 tenance organization to any individual eligible for bene-
20 fits under the State plan who chooses to enroll with,
21 and is accepted for enrollment by, the health mainte-
22 nance organization.".
23 (b) Section 1903(m) of that Act is amended by strik-
24 ing out the first word and inserting instead "For purposes
25 of this title, the".

1 (c) (1) The amendments made by this section shall
2 (except as otherwise provided in paragraph (2)) apply
3 to medical assistance provided, under a State plan approved
4 under title XIX of that Act, on and after the first day of
5 the first calendar quarter that begins more than six months
6 after the date of enactment of this Act.

7 (2) In the case of a State plan for medical assistance
8 under title XIX of that Act which the Secretary determines
9 requires State legislation in order for the plan to meet the
10 additional requirements imposed by the amendments made
11 by this section, the State plan shall not be regarded as failing
12 to comply with the requirements of such title solely on the
13 basis of its failure to meet these additional requirements be-
14 fore the first day of the first calendar quarter beginning after
15 the close of the first regular session of the State legislature
16 that begins after the date of enactment of this Act.

17 PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS
18 UNDER MEDICAID

19 SEC. 304. (a) Section 1903(m) of that Act is amended
20 by adding at the end the following new paragraph:

21 "(4) (A) No payment may be made under this title
22 to a State with respect to expenditures incurred by it for
23 payment for services provided by a health maintenance
24 organization, unless payment by the State for services was
25 made pursuant to a provider agreement between the State

1 and the health maintenance organization that meets the re-
2 quirement of subparagraph (B).
3 "(B) The agreement referred to in subparagraph (A)
4 shall contain the following terms:
5 "(i) The Secretary shall annually determine a per
6 capita rate of payment for each health maintenance or-
7 ganization with which a State has contracted. The rate
8 shall be equal to 95 percent of the adjusted average per
9 capita cost. Each month the State shall pay each such
10 organization its rate, in advance, for each individual
11 enrolled with the organization who is eligible for bene-
12 fits under the State plan. The term 'adjusted average
13 per capita cost' means the average per capita amount
14 that the Secretary estimates (on the basis of actual ex-
15 perience, or retrospective actuarial equivalent based
16 upon an adequate sample and other information and
17 data, in the geographic area served by a health mainte-
18 nance organization or in a similar area, with appropriate
19 adjustments to assure actuarial equivalence) would be
20 payable in any agreement year for services and benefits
21 covered under the State plan and types of expenses
22 otherwise reimbursable under the State plan if such
23 services and benefits were to be provided by other than
24 a health maintenance organization.
25 "(ii) The health maintenance organization shall

1 provide to, or arrange to have provided to, each in-
2 dividual enrolled with the organization who is eligible
3 for benefits under the State plan the services and bene-
4 fits covered under the State plan.

5 "(iii) An individual may terminate enrollment with
6 a health maintenance organization as of the beginning
7 of the first calendar month following a full calendar
8 month after he has requested termination.

9 "(iv) If the adjusted community rate for an indi-
10 vidual enrolled with the organization who is eligible for
11 benefits under the State plan is less than 95 percent of
12 the adjusted average per capita cost (as defined in
13 clause (i)), the health maintenance organization shall
14 provide to the individual additional services or benefits
15 that the State and the organization have agreed upon
16 and that the Secretary finds are at least equal in value
17 to the difference between 95 percent of the adjusted
18 average per capita cost and the adjusted community
19 rate. The term 'adjusted community rate' means the rate
20 of payment which the Secretary estimates would apply
21 to an individual enrolled with a health maintenance
22 organization who is eligible for benefits under the State
23 plan if the rate of payment were determined under a
24 'community rating system' (as defined in section 1302
25 (8) of the Public Health Service Act, other than sub-

1 paragraph (C)), but adjusted for characteristics of the
2 population eligible for benefits under the State plan.
3 "(v) Such additional terms as the State and the
4 health maintenance organization may agree upon,
5 except such terms the Secretary finds will impede the
6 development of health maintenance organizations.".
7 (b) The amendments made by this section shall apply
8 to medical assistance provided, under a State plan approved
9 under title XIX of that Act, on or after the first day of the
10 first calendar quarter that begins more than twenty-four
11 months after the date of enactment of this Act.

Senator NUNN. In the face of overwhelming evidence, HEW presented Congress legislation which does not respond to HMO fraud and abuse. Instead, HEW would increase funding to HMO's and repeal the present method of reimbursing HMO's for the care of medicare beneficiaries.

In its place, HEW would pay HMO's 95 percent of the average per capita fee-for-service costs of medicare. The same reimbursement would apply to medicaid under the proposal.

In arriving at the proposed reimbursement rate, the areawide costs of the fee-for-service program, including the Government's cost of program administration, for example, carrier and intermediary costs, would be determined. Ninety-five percent of this sum would be computed on a per capita basis and paid to the HMO.

This calculation would amount to approximately 100 percent of the fee-for-service costs for medical services. The only savings to the Government would be the administrative costs of fee for service.

This overall administration reimbursement proposal raises a rather interesting question. Why should the Federal Government give organizations $2 million in grants and $5 million in loans to set up Health Maintenance Organizations and then pay them an amount equal to fee for service for providing care to medicare and medicaid beneficiaries?

Mr. Chairman, as you well know, your subcommittee considered in 1972 a proposal to pay HMO's 95 percent of the medicare fee for service levels and you wisely rejected that proposal. It was resurrected in the administration's proposal which has its root in an HEW conference to review legislation and regulations governing HMO contracting with medicare and medicaid on September 23, 1977.

One of the advocates of the proposal is James Lane, counsel to the Kaiser Foundation Health Plan. I offer Mr. Lane's paper for inclusion in the record.

Senator TALMADGE. Without objection, it will be included in the record at this point.

[The material referred to follows:]

ENCOURAGING HMO PARTICIPATION IN MEDICARE AND MEDICAID

(Presentation to Conference to Review Legislation and Regulations Governing HMO Contracting for Medicare and Medicaid.)

(By James A. Lane, Counsel, Kaiser Foundation Health Plan, Inc.)

The purpose of this paper is to discuss the issues which should be addressed in developing provisions to encourage a substantial increase in participation by health maintenance organizations (HMOs) in the Medicare and Medicaid programs as part of the basic policy of the Administration to encourage the development and growth of HMOs because they are a cost-effective alternative to the predominant fee-for-service health care delivery system.

The discussion is based largely upon the direct, extensive experience of the Kaiser-Permanente Medical Care Program in operating group-practice HMOs; in serving as a provider of care to Medicare and Medicaid beneficiaries and participating in the development of federal and state statutes, regulations and policies concerning HMOs.

The Kaiser-Permanente Program had over 140,000 Medicare members in its six Regions as of December, 1976. It had four Medicaid contracts with the states of California, Oregon, Washington and Hawaii covering over 28,000 Medicaid recipients as of December, 1976.

The Program receives payment for Part A services provided to its Medicare members on the basis of the cost of such services determined retrospectively using standard Medicare rules. Part B payments are based on retrospective cost determination in accordance with the group practice prepayment plan provision of the Medicare Act. Medicare members are enrolled in a supplemental plan which covers the deductible and coinsurance amounts not covered by Medicare and provides services such as preventive health services and outpatient drugs, which Medicare does not cover. Thus, Medicare does not pay the Program a prospectively determined rate, which is the usual way in which the Program receives payment; nor does the Program have any contracts under Section 1876 of the Act (the Medicare HMO provision).

The Program's Medicaid contracts provide for determination of the amount of payment on a prospective basis and to that extent are consistent with the Program's basic method of operation. In addition, the Program provides services to Medicaid recipients on a fee-for-service basis. For example, the revenue from providing services to Medicaid recipients on a fee-for-service basis in the Northern California Region where there is no prepaid contract was approximately $2.7 million in 1976.

Although the Program's total Medicare and Medicaid membership is substantial compared to the total size of most HMOs, it is less than six percent of the Program's total membership and most of the Medicare members were members of Kaiser Foundation Health Plan before they entitled to Medicare.

The Program has not made substantial efforts to enroll Medicare members who are not already members, or to enroll Medicaid members for the following reasons:

MEDICARE

1. There are inadequate or uncertain benefit or rate incentives for non-Program members to join the Health Plan;
2. The existing payment provisions (§§ 1815, 1833 and 1876) are inconsistent with the Program's basic method of operation because they involve retroactive determination of the amount of payment, an irrational method for Program planning and operation, instead of paying on a periodic rate basis;
3. The "lock-in" requirements of § 1876 would be difficult, if not impossible to impose upon the Program's existing Medicare members.

MEDICAID

1. There are inadequate benefit incentives for non-Program members to join the Health Plan;
2. The Medicaid program, and especially the prepaid health plan (PHP) program in California has a history of administrative and payment instability and it is not in the best interests of the Program to have significant numbers of members enrolled as members of a group that is subject to uncertain administration. This problem can be equally troublesome to Medicaid beneficiaries;
3. The PHP program in California has imposed special, different and often unrealistic and irrelevant requirements on participating HMOs and continues to propose new requirements of similar character.

The interest of group practice HMOs in substantially increasing their participation in Medicare and Medicaid will depend upon the extent to which those programs are changed to have HMO provisions which are consistent with the mode of operation of organized systems of care which have been successful.[1] This means that Medicare and Medicaid must have provisions which allow arrangements that are comparable to those of the major group purchasers which offer group practice HMO coverage to their employees or beneficiaries.

Those group purchasers pay for HMO benefit packages on a periodic rate basis, not on a cost basis subject to retrospective adjustments. In addition, the amount of payment by the group is such that the differences in cost among the choices available is evident to the group members so they are aware of and may choose cost-effective alternatives. For example, the Federal Employees Health Benefits Program offers a wide choice of plans to federal employees, but makes the same contribution toward the rate of each plan. The employee must pay the difference between the federal contribution and a plan's rate, and the employee's payment may vary substantially from plan to plan.

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[1] Both Part A and Part B of Medicare and Medicaid were designed to mesh with the traditional fee-for-service and cost reimbursement methods of payment.

A major reason for members joining the Kaiser-Permanente Program is that it is able to provide a more comprehensive benefit package for comparable payments than other health benefits carriers. This difference is apparent to persons making choices because the Program offers a more comprehensive benefit package, lower out-of-pocket costs or a lower contribution rate for comparable benefits, or some combination of these economic advantages.

The Kaiser-Permanente Program is able to provide more benefits for the same rate because it assures appropriate utilization of services, especially hospital services (See Attachment A). Thus, the members of the Program use substantially fewer hospital days per thousand persons than comparable fee-for-service populations, so they do not have to pay for unnecessary hospital days. The savings accrue to the members in the form of increased benefits or lower rates.

A similar difference in utilization exists in the Medicare program. Health Plan Medicare members use substantially fewer days than Medicare beneficiaries who obtain services from fee-for-service providers (See Attachment B). However, under existing Medicare reimbursement provisions, all savings accrue to Medicare and not to the Medicare members of the Health Plan.

The critical factor in increasing the number of Medicare and Medicaid beneficiaries enrolled in HMOs is to provide sufficient incentive for them to enroll in an HMO when to do so means that they will have to accept less freedom of choice of physicians and hospitals than they may now have. This can be accomplished by paying HMOs the savings resulting from their efficiency which they may pass on to their Medicare and Medicaid members in the form of added benefits or lower rates or both. However, this requires paying HMOs more than "cost" for providing Medicare or Medicaid covered services and will result in HMO members receiving greater benefits than other Medicare beneficiaries. Although this is contrary to the basic manner in which Medicare and Medicaid operate, it is essential if HMO participation in those programs is to be increased. Incentives for enrollment in cost-effective systems are a basic requirement for significant delivery system reform.

There are a number of methods and formulas for paying HMOs, but there are two principles that are essential for the active participation of HMOs on a risk basis. They are:

1. The rate should be determined prospectively and should be on a per capita basis. Both the HMO and the Medicare or Medicaid programs should know what the rate will be in advance. This will allow each to plan and budget accordingly.
2. The rate should include the savings which an HMO creates through its operational efficiencies when compared to non-HMO costs in the area. The savings should be used to provide added benefits or lower rates to encourage persons to join the HMO.

The setting of the rate will involve a trade off between maximum expansion of Medicare and Medicaid membership in HMOs and minimum short-term costs to the Medicare and Medicaid programs. If the rate includes little or none of the savings of an HMO, there will be little or no way for an HMO to provide added benefits or lower rates and little incentive for persons to join the HMO. There will appear to be the potential for substantial cost reduction in the Medicare and Medicaid programs, but unfortunately such reduction will not materialize because of limited membership expansion. If the rate includes all, or most of the savings of an HMO, the HMO may provide greater benefits or lower rates which will result in greater incentives for beneficiaries to join the HMO. Cost reduction in Medicare and Medicaid is not the only reason for HMO expansion. In addition, there will be immediate savings to new HMO members and to the total health care economy.

To determine the amount of HMO savings, the adjusted community rate of the HMO should be subtracted from the adjusted average per capita cost in the same area (AAPCC). The adjusted community rate should be the HMO's community rate for non-Medicare and non-Medicaid members with appropriate actuarial, benefit, time and complexity adjustments. Under current law, only qualified HMOs may participate on a prepaid basis in Medicare and Medicaid; they must have over 50 percent non-Medicare and non-Medicaid members; the rates for such members must be developed through a community rating system. Using this system as one of the bases for rates will assure that they are reasonable because they will be based upon the rates an HMO develops in order to meet its financial requirements and to attract non-Medicare and non-Medicaid members. It also will eliminate any need for the costly audits which are involved in retrospective cost payment methods.

The AAPCC should be similar to the one set forth in § 1876. It should be modified to be based on the per capita costs to Medicare or Medicaid of obtaining the covered services from non-HMO providers in the area, including administrative costs, with appropriate adjustments for age, sex and disability status differences.

The following are other important issues which need to be addressed.

Development of service capability.—The HMOs which have demonstrated the greatest cost containment capability are prepaid group practice plans such as the Kaiser-Permanente Program. They are organized systems of health care delivery which assume the responsibility for organizing the health care resources their members need. The resources necessary to provide services to Medicare beneficiaries and adult category Medicaid recipients are substantially greater than those needed for the average HMO member. Therefore, any significant expansion of HMO membership for such individuals will require a substantial expansion of an HMO's service capability.

However, this will be occurring at the same time that federal and state governments are embarking on programs to severely limit or halt the expansion of health care service capability. The major hospital cost containment proposals before Congress exempt HMO hospitals from their provisions, and it is imperative that these exemptions be retained. However, this is not true of P.L. 93–641, § 1122 of the Social Security Act and numerous existing or proposed state certificate of need and hospital rate regulation programs. There is a real danger that HMO's expansion projects will be caught in the web of capital expenditure controls and will be either halted or seriously delayed so that even with adequate payment provisions, Medicare and Medicaid membership growth will be limited.

It is essential that this issue be addressed at the same time that the payment provisions are modified. It requires major revision in the HMO provisions of the certificate of need requirement of P.L. 93–641 and § 1122 and any state hospital cost containment programs which request delegation under a federal program should be required to exempt HMO hospitals.

Medicaid rate setting system.—If a satisfactory method of determining Medicare rates is designed, it should be applied to Medicaid to the extent appropriate. § 1876 in its present form should not be applied to Medicaid. In any event, Medicaid programs should be required to develop rate setting methods which are binding upon them and result in the determination of the payment level sufficiently in advance of the HMO contract date for the HMO to plan accordingly.

Medicare lock-in.—§ 1876 requires members of risk basis HMOs to receive all Medicare services or payments from or through the HMO, not from the Medicare program. This is different from the existing Medicare program under which Medicare reimburses beneficiaries for out-of-plan services.

The change in coverage will create substantial administrative and communication problems for HMOs and their existing members. These can be resolved by allowing HMOs to have a risk-basis contract for new members and a cost contract for those members who are covered at the time the first risk-basis contract is entered into, but do not choose to be locked in.

This also would minimize the increased cost to Medicare which would result if all existing Medicare members of an HMO entering into a risk-basis contract were required to be locked in. Because most existing members would not choose to become locked in, at least initially, the "savings" due to their membership would continue to accrue to Medicare. Thus, the initial cost to Medicare of an existing mature HMO entering into a risk-basis contract would be reasonably small and would be offset by increased Medicare membership in the HMO.

HMO offering.—In order for Medicare and Medicaid beneficiaries to enroll in HMOs, they must know that such an option is available to them, and its advantages and disadvantages. To date, the mechanisms for accomplishing this are poor.

The method used by HMOs in enrolling employed groups is worth consideration. In the group setting, an employee is offered options including an HMO option based on an informed choice, when he or she becomes eligible for health benefits. This would appear to be a sound approach for the Medicare and Medicaid programs provided that enrollment does not exceed an HMO's capacity. In addition, it would eliminate the need for door-to-door solicitation which has led to abuses in California's prepaid health plan program.

Additional requirements.—HMOs participating in the Medicare and Medicaid programs on a prepaid basis will have to be federally qualified and will have to meet the requirements of state licensing statutes such as the Knox-Keene Health Care Service Plan Act in California. Nevertheless, there is a tendency, especially in Medicaid in California, to place additional requirements upon HMOs. Too

often this occurs without adequate justification for the added costs. Serious consideration should be given to limiting the added requirements which a state may impose to those which are approved by the Secretary.

The above dicussion indicates that significant changes are needed in order to attract active HMO participation in Medicare and Medicaid and may lead to the conclusion that the Kaiser-Permanente experience with government agencies has been largely unsatisfactory. The opposite is true. We have over 15 years experience with federal, state and local government employee health benefits programs. Over 350,000 of the Program's members are enrolled through the Federal Employee Health Benefits Program and over 750,000 of the Program's members in California are enrolled through state and local government employee programs. The contrast with Medicare and Medicaid should lead to the conclusion that HMO participation will be increased to the extent the Medicare and Medicaid HMO provisions are modified to more closely resemble group health benefits programs, including those for government employees.

This requires that:

(1) HMO rates be determined prospectively;

(2) HMO rates include the savings from their operational efficiencies so that they may be used to provide incentive for new members to join HMOs;

(3) Medicare and Medicaid beneficiaries be offered the option of joining HMOs in their area; and

(4) Requirements beyond those in the HMO Act and state licensing statutes be kept to a minimum.

ATTACHMENT A

APPENDIX TABLE 14.—KAISER FOUNDATION HEALTH PLAN, NORTHERN CALIFORNIA REGION, 1974 HOSPITAL UTILIZATION DATA, AGE AND SEX ADJUSTED TO SELECTED POPULATION DISTRIBUTIONS

Age group	KFHP Northern California Region [1]			Percentage distribution		
	Hospital days per 1,000 per year	Discharges per 1,000 per year	Percent distribution membership (n=1,188,621)	Northern California region resident population (n=5,815,000) [2]	California resident population (n=20,684,000) [2]	Total U.S. population (n=212,163,000) [3]
0 to 4	201	51	7.4	7.4	8.0	8.0
5 to 9	101	28	9.2	7.9	8.0	8.3
10 to 14	102	22	11.0	9.6	9.6	9.7
15 to 19	194	42	10.1	9.0	9.3	9.8
20 to 24	354	89	8.0	8.8	8.7	9.0
25 to 29	386	98	9.7	8.4	8.3	7.7
30 to 34	324	72	8.4	7.3	7.1	6.3
35 to 39	331	60	6.5	5.9	5.6	5.4
40 to 44	374	59	5.9	5.7	5.5	5.3
45 to 49	477	68	5.8	5.9	5.7	5.6
50 to 54	639	83	5.7	6.0	5.8	5.6
55 to 59	782	98	4.5	4.9	4.8	4.9
60 to 64	1,128	128	3.4	4.1	4.1	4.3
65 to 69	1,360	151	2.1	3.2	3.3	3.5
70 to 74	1,883	193	1.3	2.4	2.6	2.7
75 to 79	2,331	232	.7	1.7	1.8	1.9
80 to 84	2,758	290	.3	1.1	1.1	1.2
85 plus	3,278	341	.1	.8	.8	.8
All ages	410	69	100.0	100.0	100.0	100.0

	Kaiser Foundation Health Plan utilization data adjusted to selected population distributions		
	Northern California region resident population	California resident population	Total U.S. population
A. Age adjustment only:			
Hospital days per 1,000 per year	517	517	524
Discharges per 1,000 per year	78	79	79
B. Age and sex adjustment: [4]			
Hospital days per 1,000 per year	509	513	524
Discharges per 1,000 per year	78	78	78

[1] Calendar year 1974 data.
[2] Estimated distribution at July 1, 1974, per California Department of Finance data.
[3] Estimated distribution for 1974, per U.S. Department of Commerce, Bureau of the Census, Current Population Reports, series P-25, No. 493, table 2.
[4] See Appendix Table 15.

ATTACHMENT A

HOSPITAL UTILIZATION IN THE KAISER-PERMANENTE MEDICAL CARE PROGRAM COMPARED TO THAT OF THE GENERAL POPULATION OF THE UNITED STATES, 1970-75

Year	Civilian resident population (thousands)[1]	Non-federal, short-term general and special hospitals: Admissions per 1,000[2]	Patient days per 1,000[2]	Average length of stay (days)[2]
United States:				
1970	201,722	145	1,189	8.2
1971	204,250	148	1,181	8.0
1972	206,457	149	1,178	7.9
1973	208,087	153	1,191	7.8
1974	209,689	157	1,225	7.8
1975	211,445	159	1,221	7.7
1976		(3)	(3)	(3)

Year	Average membership (thousands)	Discharges per 1,000	Hospital days per 1,000	Average length of stay (days)
Kaiser-Permanente program:				
1970	2,096	79	477	6.1
1971	2,244	78	465	6.0
1972	2,452	76	456	6.0
1973	2,593	76	452	6.0
1974	2,720	75	432	5.8
1975	2,852	75	423	5.7
1976	3,016	74	416	5.6

[1] "Social Security Bulletin," December 1976, table M-40.
[2] Utilization rates were computed based on data contained in table 1, "Hospital Statistics, 1976 Edition, Data from the American Hospital Association Annual Survey," A.H.A., Chicago, Ill.
[3] Not available.

ATTACHMENT B

HOSPITAL DAYS PER 1,000 PERSONS AGE 65 AND OVER BEFORE AND AFTER MEDICARE, KFHP, NORTHERN CALIFORNIA REGION AND U.S. GENERAL POPULATION

	Hospital days per 1,000 persons age 65 and over: KFHP, NCR	United States	Age/sex adjusted KFHP, NCR rates[1]
Premedicare[2]	2,322	3,449	2,453
After medicare:[3]			
1967	2,189	3,698	[4] 2,912
1968	2,269	3,990	2,552
1969	2,154	4,048	2,336
1970	2,019	3,904	2,193
1971	1,989	3,835	2,190
1972	1,989	3,835	2,226
1973	1,990	3,853	2,171
1974	1,797	3,963	1,918
1975	1,858	4,003	2,030
1976	1,791	4,121	1,945

[1] Assuming U.S. age/sex population distribution.
[2] Data are for the 2 latest premedicare periods for which such information is available; the year ended June 30, 1963, for KFHP, northern California, and calendar year 1965 for the United States. (Source: P.H.S. Publication No. 1000, Series 13, No. 3.)
[3] (a) Utilization data for the U.S. general population age 65 and over are from midmonthly "Hospital Indicators" sections of "Hospitals." (b) Average population figures used to convert total hospital days to rates per 1,000 were estimates of the resident civilian population as of July 1 of each year. Source: Selected issues of U.S. Department of Commerce, "Current Population Reports."
[4] The 1967 hospital day rate is age-adjusted only. Hospital days by male-female distributions are not available.

DISCUSSION

Question. If the Medicare HMO payment provision is changed to satisfy the principles set forth in the presentation, how many new Medicare members will Kaiser Foundation Health Plan enroll?

Answer. That can not be determined at this time. Growth will vary by Region and will depend upon several factors. It is unlikely that there would be a large growth in Medicare members because much of the capacity to grow in the near future in the Program's large Region will be needed to provide services to new HMO groups and membership growth in existing groups.

However, changes in the Medicare HMO payment provision should not be contingent upon Kaiser Foundation Health Plan being able to enroll a large number of new members. Many new HMOs have ben started throughout the country in the past decade. More than forty of them are now qualified. They have considerable capacity and need new enrollment. There is no satisfactory way for them to participate in Medicare, but with a good provision they can increase total Medicare HMO enrollment much more rapidly than large, established HMOs and their prospects for successful operation will be enhanced.

Question. Why is Kaiser Foundation Health Plan willing to go to the trouble of having both a risk basis and cost reimbursement contract when a cost reimbursement contract violates the principles set forth in the presentation?

Answer. First, under a risk basis contract our existing Medicare members would lose their present advantage of having claims for non-Program, non-emergency services covered by Medicare. We believe this may be difficult for some of our Medicare members to understand and accept and may disrupt our relationships with them. We do not want this to occur, so retention of a cost basis alternative is essential. In addition, our existing members do not need any incentive to join our Program, they are already members.

Second, if our more than 140,000 Medicare members were all covered under a risk sharing contract, the payment of the "savings" to Health Plan would probably cost Medicare millions of dollars. This cost may be a major obstacle to adopting and implementing an effective HMO provision. With a two contract approach, it is anticipated that many of our existing members would probably not choose to be covered under the risk sharing contract in the near future so the initial cost implications for Medicare would be reduced.

Question. How can "ripoffs" of Medicaid programs by HMOs be prevented?

Answer. The abuses which occurred in the prepaid health plan (PHP) program in California were a result of irresponsible promotion of PHPs by the state administration concerned primarily with saving money quickly and not with the calibre or long-term commitment of many of the PHPs with which it contracted. Significant changes have since occurred which make it highly unlikely that the California PHP experience will be repeated. They are:

(1) State governments (including California's) have become more cautious in dealing with HMOs in their Medicaid programs and more realistic in their expectations of savings.

(2) The federal Medicaid program has issued regulations covering participation by HMOs.

(3) Many states have adopted comprehensive HMO licensing statutes which provide for substantial regulation of HMOs.

(4) In order to participate, HMOs must be federally qualified (with certain limited exceptions) which involves meeting detailed requirements and being subject to continuing compliance review.

(5) More than 50 percent of an HMO's members must be non-Medicare and non-Medicaid members (unless this requirement is waived by HEW) and Medicaid members must be treated the same as other members. This assures that Medicaid members will receive the same services as other members and not receive second-class care.

The question also may be directed to the possibility that an HMO which meets all relevant standards may receive payment in excess of its "costs" for its Medicaid members, especially when payment is based upon the average per capita cost of purchasing covered services for Medicaid recipients in the area on a fee-for-service basis. This has lead to proposals that HMOs account for the services provided to Medicaid members and their costs. These proposals would impose a cost reimbursement system upon HMOs which is inconsistent with their method of operation. It also is inconsistent with the principle of community rating. Community rating means that members of an HMO pay (or have paid on their behalf) the same amounts for the same benefits as all other members with the

same family size regardless of their need for, or utilization of, services, the nature of their group, or the utilization of the group's members. Thus, under a community rating system, there is no direct relationship between the amount paid by a group (such as Medicaid) and the services provided members of the group.

There are two provisions that can assure that an HMO is not being unjustly enriched from Medicaid payments. First the per capita payment should be adjusted to reflect actuarially significant differences between the composition of the HMO's Medicaid membership and the Medicaid recipients being served by non-HMO providers in the area. Second, the HMO should be required to pass on to its Medicaid members the difference between the payment and its adjusted community rate. However, if states are allowed to establish HMO payments using their own methods, the payment levels may fluctuate from year to year because of budget pressures and other factors, including low estimates of inflation rates. Therefore, an HMO should be allowed the option of placing some or all of the difference between the state's payment and its adjusted community rate in a reserve fund to be drawn upon when the state payment is less than the HMO's adjusted community rate.

Senator NUNN. The conference was attended only by a few, other than Mr. Lane, including Bruce Yarwood, the chief deputy director for programs of the California Health Department. Mr. Yarwood sent, on December 16, 1977, a memorandum prepared by his staff to HEW. This memorandum was prepared in response to an issue paper which included a proposal to pay HMO's 95 percent of fee for service levels. I will read from a part of that memorandum.

"If the primary interest of the issue paper was to produce a proposal pleasing to the HMO industry, it undoubtedly succeeded." I would submit the rest of his statement for the record. I think that is an interesting analysis of this proposal.

I think, to get right down to the point without getting into a lot of details about this particular issue, Mr. Chairman, the California Health Department says that under the administration's reimbursement formula, the medicaid prepayment program costs could rise from $60 million to $71 million a year. Aggregate HMO profits from the State medicaid program would increase 250 percent from $7.5 million to $18.8 million.

In summary, the State is already paying HMO's at a reasonable level for the services they provide. Any increase in the payment would be an absolute increase in HMO profits. The California Health Department said, and I quote: "The 95 percent rate would undoubtedly be higher than the premiums that most HMO's charge private members, an exception to the usual principle that Government should pay no more for goods and services than private purchasers. It is difficult to believe that legislators would accept such an arrangement."

This information was prepared by Rigby Leighton, the director of the prepaid health research, evaluation, and demonstration project which is committed to receive $5.2 million in HEW funds. I offer this memo as an exhibit.

Senator TALMADGE. Without objection, it will appear in the record at this point.

[The material referred to follows:]

STATE OF CALIFORNIA—MEMORANDUM

Date: December 16, 1977.
Subject: Comments on HEW issue paper on HMO reimbursement options.
To: Bruce Yarwood, Division of Medical Assistance OB 8, Room 1540.
From: Rigby Leighton, PHRED Project, 455 Capitol Mall, 250.

This is in response to your request that we analyze the unofficial issue paper sent to you by Cliff Gauss with his letter of 30 November 1977, titled "Medicare

and Medicaid Payment to Health Maintenance Organizations (HMOs)." The paper discusses five issues, which I will use as section headings for my first group of comments.

Question. Issue 1: How should Medicare pay HMOs that elect to be at risk?

Answer. The paper presents four options, all of which are discussed in terms of *Medicare* reimbursement. The options can be summarized as follows:

1. Pay a percentage of adjusted average per capita cost (AAPCC). The AAPCC would be the per capita cost of Medicare patients under fee-for-service in the HMO's service area, adjusted as necessary to correspond with the age and sex distribution of those Medicare beneficiaries who become enrollees of the HMO. This is the quantity that we usually refer to as the fee-for-service maximum, since by law it is a maximum rate at which Medicaid capitation can be set. Conceptually, this is the closest of the four options to the manner in which California PHP rates have been set up until the most recent rate-setting cycle, when we began the shift to an actuarial method.

2. Pay a percentage of AAPCC, but require the HMO to use the margin between the paid rate and the "adjusted community rate" either to reduce enrollee premiums or increase benefits. The adjusted community rate is the HMO's usual premium (for non-Medicaid and non-Medicare individuals), adjusted to (1) the scope of benefits and (2) the expected utilization patterns of Medicare enrollees. In other words, this is the HMO's asking price in the private marketplace, adjusted to the Medicare enrollee population's needs and coverage. The implicit assumption of this option is that the percentage of AAPCC would be higher than the adjusted community rate.

3. Pay a percentage of AAPCC, but require that the margin between the rate paid and actual costs (plus a retention factor) be used either to reduce enrollee premiums or increase benefits.

4. Pay the adjusted community rate.

The recommended option was number 2, although option 1 was also considered acceptable.

The concept common to both of these recommended options is that the rate should be keyed to the AAPCC, the per capita costs that Medicare realizes under fee-for-service. The weakness of this concept is that the utilization patterns under the HMO mode of health care delivery differ significantly from fee-for-service utilization. It appears from the definition of AAPCC given in the paper, that the fee-for-service utilization patterns are assumed when the AAPCC is calculated. Taking a percentage of the AAPCC (less than 100%) is a crude way of recognizing that HMOs can operate at lower cost than fee-for-service, primarily because of the altered utilization pattern. It can be useful as a general benchmark, but there are certainly more refined actuarial techniques for establishing an appropriate capitation rate.

The HMO's community rate, on the other hand, is based on expected utilization patterns under the HMO mode of health care delivery. Moreover, it is likely to a percentage of AAPCC would be, and it wil reflect the cost-relevant attributes be more relevant to the localized medical economics in the HMO service area than a percentage of AAPCC would be, and it will reflect the cost-relevant attributes of the structure of the HMO (whether it is an IPA or closed panel, whether it owns its own hospitals, etc.). The adjusted community rate, then, would produce a more reasonable capitation rate than percentage of AAPCC.

Option 2 implicitly assumes that the percentage of AAPCC would be set high enough to exceed the adjusted community rate, which appears to be recommended in order to induce HMOs to take Medicare business. In other words, the government would be paying the HMO a higher rate than private enrollees are paying. For Medicaid this is presently prohibited by Federal regulations and, in California, by State law. It seems improbable that legislators will ever be comfortable with the government paying more than the private sector for comparable services.

The paper argues against option 4, the adjusted community rate, on the grounds that (1) it will not be sufficiently attractive to HMOs, and (2) it would not permit HMOs to grow because it would not allow HMOs to plow excess income back into additional enrollee benefits. These arguments seem weak, since the community rate presumably is the HMO's asking price—the price at which it is willing and able to do business. Moreover, if we assume that it is a reasonably-administered HMO, the price will include costs of expansion, among them the cost of attracting more enrollees by improving the benefit package.

The manner in which the community rate is adjusted to represent the Medicare population is critical, of course. In particular, the utilization rates assumed in those adjustments should be based on prepayment experience rather than fee-for-

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service experience. I should think that by now there has been enough experience data obtained from Medicare beneficiaries in a prepaid setting to enable this type of adjustment to be done reasonably well.

None of the four options is what we would call actuarial in the strictest sense of the word. By "actuarial" we mean taking into consideration, in the form of explicit quantitative assumptions, the demographic nature of the target population, the utilization rates that as best we can determine represent the health care needs of such a population, and the expected cost per unit of service under that particular delivery system (with suitable allowance for administration, marketing, reserves for growth, etc.). The adjusted community rate should come close to the results of an actuarial analysis done specifically for the Medicare population, particularly if the HMO is in a competitive situation. But we are convinced that government agency contracting with an HMO should be able to use an actuarial approach to at least check the validity of the adjusted community rate, and should have the authority to establish a capitation rate lower than the adjusted community rate, whenever supported by such actuarial analysis.

Finally, our attempts to deal with rate-setting issues in California's PHP program have led us to the conclusion that there should be the option for risk-sharing reimbursement arrangements with HMOs. There are two reasons for this:

1. An HMO properly can assume risk only for the health care costs over which it has some measure of control. Depending on the structure of the HMO, there may be types of cost over which this organization has relatively little control. For example, Kaiser can be held accountable for the cost per unit of service for hospital care, because that organization owns its own hospitals. California Medical Group Health Plan, on the other hand, must use community hospitals; CMGHP can control hospital utilization, but it has relatively little control over hospital per diem charges. It is unlikely that we will see a rapid replication of Kaisers, so if we want to encourage the expansion of HMOs we should be prepared to exempt them from all or part of the risk associated with factors over which, by their organizational nature, they have relatively little control.

2. Risk-sharing would also be a way to handle the problem of the new, growing HMO, which has not reached a large enough enrollment to be protected from actuarial vagaries. A capitation rate that would suffice on a total risk basis for a mature HMO would, with the right kind of risk-sharing, also be appropriate for the immature one. The advantage of this over other approaches to special treatment of new HMOs is that the government would have costs in excess of the capitation rate only if those costs are realized by the HMO.

In summary, our recommendation would be quite different from that of the HEW paper. We would consider the AAPCC not to be a justifiable basis for a capitation rate. The adjusted community rate is more appropriate, but it should be considered a maximum; it should be checked for reasonableness by using actuarial analyses specific to the target population, and when indicated the contracting government agency should be enabled to set a rate lower than the adjusted community rate. The option of risk-sharing arrangements should also be kept open.

Question. What percent of the AAPCC should be adopted under Medicare?

Answer. As we have just noted, we don't believe that "percent of AAPCC" is the proper way to set rates, which in effect disqualifies us from substantive comments on this question. For information purposes we will note a few facts from the California PHP program.

In the first two years of the PHP program (fiscal year 1972–73 and fiscal year 1973–74), the State negotiated rates with each individual contractor. The benchmark used by the State negotiators was to have rates that were no more than 90 percent of fee-for-service. In general, the negotiators were successful. A retrospective analysis done in 1974 indicated that for the first year of the program the capitation rates averaged 83 percent of fee-for-service per capita costs, and for the second year it was 85 percent. (There were one or two notable exceptions, in which rates were set considerably higher than these percentages.)

These percentages were based on a simple comparison of capitation rates and per capita costs within each aid category, with no attempt to measure the possible effects of biased selection on the part of the PHPs or under-service by the PHPs. After the first two years of the program the practice of negotiating rates with individual contractors was stopped, and the State began establishing standard rates for each county. In fiscal year 1974–75, this was done by simply averaging together the existing PHP rates (plus adding an inflation factor),

thus preserving the relationship between the rates and fee-for-service per capita costs. In the succeeding three years other refinements were entered into the rate-setting process, but the already-established relationship between the rates and per capita costs remained the most important reference point.

For the fiscal year 1977–78 rates, we attempted for the first time to take an actuarial approach. Because of limitations on the data available this was possible only for the AFDC aid category and even for this category many of the actuarial assumptions were more subjective than we would like. The bottom line, however, was interesting: The rate derived by our actuarial method turned out to be 83 percent of projected fee-for-service costs.

Trying to establish the "right" relationship between a prepaid capitation rate and fee-for-service costs involves a variety of complex issues, still largely unresolved. For example: To what extent has the California PHP program been susceptible to favorable selection? To what extent are the PHPs able to live with rates at 83 percent of fee-for-service because they do not provide sufficient service to their Medi-Cal enrollees? To what extent is 83 percent a reasonable figure because there is extensive over-utilization in fee-for-service? Recognizing the uncertainty introduced by unanswered questions such as these, we would still have to believe that the 95 percent of AAPCC recommended in the HEW paper would represent a rate considerably in excess of what HMOs actually need to provide good quality care to a Medicare population.

Question. Should Medicaid reimbursement conform with Medicare?

Answer. The following three options are discussed in the paper:

1. Permit states to set Medicaid rates independently of Medicare rates, as they now do.
2. Require states to use the same rate-setting method as Medicare.
3. Require states to pay at a minimum the adjusted community rate (this time meaning adjusted to the Medicaid population).

The HEW paper is split on its recommendation for which of these options should be followed. HCFA, sensitive to "states rights" issues and the technical differences between Medicaid and Medicare programs, favors option 3. The planning and evaluation staff recommends option 2, under the rationale that Medicaid should conform to Medicare where feasible.

Obviously, we would agree that the two programs should have the same reimbursement method if and only if the rate-setting technique we think is appropriate (described above) is used for Medicare. The rate-setting options favored in the issue paper would raise the rates in California's PHP program by about 14 percent (the difference between 95 percent of AAPCC and 83 percent of AAPCC). (It is easy to see why these options were favored by the industry, as noted in the issue paper.) Also, these options would take us back to square one in terms of the hard-won progress we have been making toward something that could be decently called an actuarial rate.

It would be more sensible to think in terms of bringing the Medicare rate-setting method into conformance with the Medicaid method. After all, current regulation provides that HMO capitation rates paid under Medicaid shall have an actuarial basis, shall be reasonable, and shall be not more than either the adjusted community rate or the AAPCC. Also, HEW must review and approve all Medicaid contracts in excess of $100,000, which would cover virtually all HMO contracts, so there already exists a mechanism for Federal approval of the rate-setting method. If Medicare HMO contracts were subject to these same constraints and were put through the same review mechanism, the objective of conformity could be realized.

A major concern in discussion of this issue in the paper is the HEW staff belief that states don't really want to contract with qualified HMOs. If this is indeed the case, it is remarkably shortsighted on the part of the states, since HMOs can save them a considerable amount of money. But even if this is a real issue, there is no need to entangle it with the other issues inevitably associated with rate-setting. The most direct way of encouraging states to contract with HMOs for Medicaid is through the usual process of manipulating FFP. For example, set FFP at 75 percent for the first contract year with an HMO, 60 percent for the second, then 50 percent thereafter.

Question. Should qualified HMOs be required to contract with Medicare and Medicaid?

Answer. In general, we agree with the issue paper's position that the leverage of Federal qualification should be used to encourage mature HMOs to deal with Med'care and Medicaid agencies. As the paper notes, the qualification requirements for a period of open enrollment and a marketing plan that will produce

an enrolled population representative of the population service area, together imply that the HMO could not avoid enrolling Medicaid or Medicare beneficiaries.

The key issue, as always with health care providers, will be the rate of payment. In theory, the "adjusted community rate" represents the HMO's asking price, and one might consider requiring the HMO to accept any government-funded beneficiary at such a rate. In practice, there will be considerable room for dispute on how a community rate, based on planning related to a non-Medicaid and non-Medicare population, is properly adjusted to match the scope of benefits of those two programs, and the health care needs of those two populations. This brings us once again to our point that the government agency which would contract with HMOs must be prepared to deal with actuarial issues.

Question. Should existing Medicare reimbursement methods be maintained?

Answer. The issue paper favors allowing a three-year overlap period, during which current Medicare enrollees would be maintained on the existing reimbursement system while new enrollees were added under the new reimbursement method. From an administrative standpoint, this is a forbidding prospect. Fortunately, it would not have direct impact on Medicaid enrollees.[1]

GENERAL COMMENTS

If the primary intent of this issue paper was to produce a proposal pleasing to the HMO industry, it undoubtedly succeeded. The concept of paying 95% of per capita costs should have almost universal appeal to HMOs, since (to quote the issue paper itself) " . . . actual HMO costs can be expected to run tyically about 15–20 percent below that of the fee-for-service system." The notion that the HMOs would be required to plow back the difference between the adjusted community rate and this percentage of AAPCC in the form of reduced premiums and/or increased benefits is a gesture in the direction of proper use of public funds, but would be virtually unenforceable. What we have here is the equivalent of the "reasonable cost" requirement that the hospital industry managed to get into Federal Medicaid and Medicare regulation.

In my judgment, this paper represents a superficial treatment of reimbursement of HMOs under a government-funded health program. It seems to represent that school of economic though that government can get the "marketplace" to behave properly by careful definition of the goods and services to be purchased, and clever construction of the reimbursement method. My own conviction is that the marketplace image, which centers on the vendor/purchaser relationship, is no longer apt. Instead of a simple purchaser, government is becoming a steward over scarce resources. Instead of simply setting a price, the price must be justified to a considerable extent.

In terms of HMO rates (or, for that matter, any other form of provider reimbursement) this means that the amount of dollars paid must be justified in health care terms. This is what we mean by the actuarial approach to rate-setting—we begin with an understanding of the health care needs of the target population, we define the mix of health care services we believe are necessary and sufficient to meet those needs, we estimate the costs of each of those services and thereby the aggregate cost, and finally through this process we arrive at rate of payment. We do recognize that may not be the final step, since the "actuarial" rate may have to be modified downward in recognition of budget constraints or upward to induce vendors to deal with us (the primary theme of the issue paper), but these should be only adjustments for such pragmatic reasons, not the fundamental methods by which rates are set.

As a final comment, I would strongly resist the notion that there can be any simple rate-setting formula which is appropriate for all, or even most, local situations. What we need are a set of broadly-defined priciples that constitute a framework in which a variety of rate-setting methods may be used, in order to have the flexibility to respond intelligently to local conditions. The fee-for-service per capita cost as an absolute maximum (with allowance for "actuarial equivalence" of fee-for-service and HMO populations) is an example of a principle to which most reasonable people can agree, and which ought not to constrain development of HMO contracts. Once we get beyond simple principles such as this into the details of actuarial methodology, we certainly do not want to have statements engraven in law—such as 95 of AAPCC—which would stultify progress for years to come.

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[1] Except for those who are also Medicare beneficiaries. This is presently about 7 percent of the Medi-Cal enrollees in PHPs.

Senator NUNN. The Finance Committee passed legislation specifically authorizing this project in 1975 following the first round of prepaid health hearings in the permanent subcommittee and the receipt by your subcommittee of a number of reports on prepaid systems by the General Accounting Office.

Mr. Chairman, the standards and methods being developed by the California project can be important and useful to Government program administrators. I know that the staff of your subcommittee and my subcommittee over the past many months have continually recommended to the HMO staff at HEW to discuss with the California demonstration project staff what their findings are.

As of yesterday there has neither been a visit, nor even a telephone call, from HMO program staff to the California project, as far as I know. It is as if the HEW staff does not want to know.

I strongly suggest that our subcommittee continue to monitor. as we have, the work of the California demonstration project and when its work is concluded, you may well want to consider the possible inclusion of the HMO cost determining, rate-setting and quality evaluation methods as part of the medicare and medicaid programs.

Perhaps HEW is ignoring the California project for the same reason the report by the Permanent Subcommittee on Investigations is apparently not taken too seriously at HEW.

Our subcommittee contends in its report that the California prepaid health experience portends what can be expected in the Federal HMO effort. Our report concludes, and I quote from that report: "Unless remedial action is taken, the Federal Government, through its program of developing HMO's faces the prospect of encountering, nationwide, the same kind of scandal and abuse that have plagued the California medicaid program."

Mr. Chairman, during the course of our continuing interest in HMO's, the subcommittee staff has received unsolicited telephone calls from credible sources offering examples of problems in the Federal HMO program similar to those identified in the subcommittee report. In addition, the staff obtained information on its own. I would like to discuss some of this information.

Because most of the individuals and organizations involved have not been interviewed or otherwise offered the opportunity to respond to the information and allegations we have obtained, I will not mention names. However, each of the examples I will give is supported by materials obtained from the files of HEW, the General Accounting Office, interviews with employees of HMO programs, and/or from interviews of Government auditors and HMO employees.

With that understanding, I would like to offer the information we have obtained as a sealed exhibit and to discuss these issues.

Of course, we would be delighted for your staff to take a look at this, but I believe that in light of the fact we have not completed the record in these cases—we have not interviewed the people who are charged with abuses—I think it would be better if we did not make it public.

Senator TALMADGE. Do you feel it would be appropriate to hand this over to the Department of Justice?

Senator NUNN. I think in some cases it may be appropriate. I am not saying that all of these are criminal matters. Some of them are

matters of abuse that would be civil in nature. Some of them are matters of abuse that are not even governed by law, so it would depend on each individual circumstance. Some of them could involve criminal allegations.

Senator TALMADGE. Without objection, the information will be received at this point.

Senator NUNN. Mr. Chairman, the case I would like to discuss involves the certification of a former California prepaid health plan as a federally qualified HMO. I bring this up because there is no clearer example of how the Federal HMO program may not be learning from California's mistake.

This particular HMO is a nonprofit corporation which has received $437,000 in HMO loans. The medical director is the president and sole owner of a for-profit management company and a company that leases a clinic building to the HMO.

The medical director's wife owns corporations which provide lab and pharmacy services to the HMO. This organization has a history of negative medical quality and financial audits by California agents. As late as March 8, 1978, 1 week before Federal qualification, the HMO was put on notice by the State that it had not been responsive to problems which had been identified.

The HMO has reported that its administrative costs are running $14 for every $39.57 per month the State medicaid program pays for each of the 5,500 medicaid members enrolled in the plan. This amounts to 40 percent of the medicaid program payments to the plan.

The subcommittee's concern in its inquiry and report is that through complicated corporate structures which can artificially increase HMO costs, moneys can and are, in many cases, diverted from health care.

The utilization records of this newly qualified HMO either bear out the subcommittee's concern for diversion of funds or they indicate that this organization has enrolled some of the healthiest poor people in the State—indeed, in the Nation.

For example, the medicaid beneficiaries in the 13 qualified HMO's in the State of California are hospitalized at a rate of 319 days per 1,000 enrollees per year. This average in itself is below the 400 to 500 day average in most HMO's. But for the newly qualified HMO the rate is 95 days, less than a third the statewide rate.

The statewide rate for hospital outpatient visits is 133 per 1,000 enrollees per year. The rate of this newly qualified HMO is one-seventh that, at 20 visits.

Dental visits statewide are running at a rate of 747 visits per 1,000 enrollees per year, but the newly qualified HMO's rate is 204 visits.

The qualification of this HMO raises a number of questions.

First, to what extent does the Federal HMO qualification process take into account the possible diversion of funds through complicated corporate structure?

Second, what weight is given during the qualification process to patient utilization rates of the HMO's.

And third, now that this HMO is qualified, what can HEW do to insure a reasonable standard of care for the enrollee?

Frankly, Mr. Chairman, I do not believe that there are answers to those questions, but I believe that they should be asked of HEW.

I have other examples I am going to skip in the interests of time. I know that you have other witnesses here, so I will move on to page 13.

Mr. Chairman, there are some examples I will list briefly. Each is indicative of HMO program problems.

Our investigative subcommittee and the General Accounting Office recently referred to the HEW-Inspector General allegations that the executive director of a western HMO received a kickback from a firm providing services to his plan. In addition, the plan paid for the executive director's round-trip, first-class airfare to St. Louis. Likewise, the HMO paid for "emergency out of area service."

The man allegedly flew to St. Louis where surgeons reversed his vasectomy.

In an east coast HMO which had received more than $3 million in grants and loans, the $65,000 a year executive director told my staff that his plan provides him with a $300 a month car allowance and all maintenance costs of the car. This car is a new Mercedes-Benz which the executive director said is used exclusively to drive to the administrative office of the plan and its two clinics. He lives a block away from his office and has a car for his own personal use.

Now, I am not saying that this is scandalous, but it raises a broad question about how grant and loan recipients are spending their funds.

Mr. Chairman, my staff has obtained internal HEW documents indicating that five HMO's are in serious financial trouble. These five plans have borrowed over $12 million which the Government may lose if the plans fail. These kinds of examples and those investigated and documented in the subcommittee's report raise some fundamental questions that must be addresse, in my view, prior to any enactment of the administration's proposed legislation or even extension of the present program.

One, once surfaced, does the internal HMO management mechanism have the capability to take decisive action to stop the abuses?

Two, will adequate safeguards be developed to minimize the frequency of these kinds of problems?

Finally, is Congress discharging its oversight responsibilities adequately? Are we going to insure that this megabuck program can be controlled? Can we assure that it will not become just another giveaway program?

I am also skipping page 14, Mr. Chairman. I think a lot of this information that I am skipping is relevant, and I would ask you give your attention to it, but I know that you have a time problem, so I will——

Senator TALMADGE. The full statement will be inserted in the record.

Senator NUNN. Going to page 15, Mr. Chairman, despite the facts I have presented and the concerns I have raised, I do not believe we should overreact or harshly criticize the officials at HEW and the Director of the HMO program. There are very few people in the Nation who understand thoroughly prepayment systems and only a handful who have broad enough backgrounds to appreciate the benefits of HMO's and, at the same time, recognize their potentials for abuse.

When the Government announces that it will finance the development of anything, it creates instantly a new industry, a financial

constituency, and a host of problems because some of the people inevitably attracted to the Federal trough are those interested in a fast buck.

Their success is directly relative to the quality of program administration. The poorer the program management, the greater the potential for actual rip-off.

HEW should be given a chance to advance its policy initiative and expand the development of HMO's. However, HEW should temper its fervor with an understanding of what can happen to taxpayer funds and patients when a program is not managed properly.

Indeed, it is the very problems with medicare and medicaid that provide us with reasons that such systems as HMO's should be given an opportunity to succeed. But let us not build another uncontrollable, unmanageable, inflationary program in the process. It would be the height of irresponsibility to do so, given what we already know. Let's not legislate on the basis of the promises of those offering easy answers to complex problems. Let's try new methods, but let's try them cautiously and carefully before we open the gates of the Federal Treasury.

Therefore, we ask that HEW listen. Listen to the facts. Take an historical view of not only HMO's, but also what can happen when a major Government initiative is begun without serious regard for good law, effective regulations and proper management.

Mr. Chairman, in closing, I would like to invite your attention to what may be a growing problem. As you may know, our subcommittee is taking a fresh look at Federal law-enforcement efforts to deal with what many perceive to be a growing organized crime problem in this country.

One thing is clear: Organized crime is becoming very sophisticated in its financial activities and, of course, it is always attracted the vast dollars without much regard to whether they are tax dollars or gambling dollars.

There are preliminary implications that there may be a move on the part of organized crime figures into the health care services industry. This makes efficient Government program administration all the more important.

Just to give you an example, the subcommittee staff a few years ago received information that a west coast prepaid health plan operator was the subject of a contract to kill him. The reason was that he had failed to withdraw a lawsuit that he had filed against a chain of hospitals and clinics allegedly owned by Chicago crime figures.

Staff informally developed information that tended to confirm the threat, which was allegedly never carried out because the man who was to pull the trigger died of a heart attack the day before the planned execution. I am not certain whether he was enrolled in a prepaid health plan or not.

As for the HMO operator, he has recently been convicted of bribing union officials to contract with his plan.

The Permanent Subcommittee on Investigations has been watching another corporation which plans to franchise HMO's. The franchise plan raises a question as to whether it is good public policy to provide health care through outlets similar to the way McDonald's sells hamburgers.

This particular corporation has been the recipient of HEW funds related to, but not provided directly by, the HMO program. I would

prefer not to name this firm because of our ongoing interest in it, but I have a sealed exhibit on materials of this particular corporation.

Senator TALMADGE. Without objection, this information will be received at this point.

Senator NUNN. The subcommittee staff, through the cooperation of Midwestern law-enforcement officials has established a relationship between one director of this corporation and organized crime figures in Detroit.

I am not, in any way, suggesting that the HMO industry has been, or is about to be, taken over by organized crime. However, I do not believe we can mix the Mafia and medicine and expect to have good health care for the people. Any identification of organized crime figures in the health care services industry should be a lesson to us all that there is a need for more vigilant, effective and efficient Government and private sector health program administration.

I am sure you will agree with me that the large majority of health professionals and those who operate and work in health facilities are decent, conscientious and dedicated men and women. Our concern should be those who make a mockery of that dedication and decency by taking advantage of them with schemes, various scams and other kinds of methods that we have identified.

I think that we should be especially concerned with sloppy and careless Government program administration which are easy marks and Government officials who refuse to respond to compelling records of fraud and abuse.

In summary, Mr. Chairman, I am saying we ought to slow down. We seem to be doing more and more in Government and we seem to be doing it poorer and poorer. We had our HMO hearings about 1½ years ago. We had developed a tremendous amount of information at that time. We had HEW officials come up. These were people who are not at the very top, but they were responsible officials in the HMO program. What they basically said was that they cannot manage the HMO program properly.

These were the people who were really in the trenches. These were the people who managed the program. Basically, they said "slow down" to us. Of course, that is not the official policy of HEW now. HEW is saying "speed up." Based upon what the people who manage the program told us, I am saying this morning that I think we ought to slow down.

I think HMO's have a real place in the overall delivery of health care services, but we are going to see a fantastic mess if we do not correct the problems which are all too obvious already.

Senator TALMADGE. I want to thank you for an excellent and most alarming statement.

Has this information been submitted to the Department of Justice, to Secretary Califano and also the Inspector General of HEW, and to the General Accounting Office for further verification?

Senator NUNN. No, sir. We are in ongoing investigations on most of these new items I came out with today. The reason I did not name names is that investigations have not been completed. Our staff is working with the General Accounting Office.

But I felt that because of the timing involved here, that unless we made this information known to your committee, at least in terms of

some of the potential abuses we have seen, that by the time we have completed our investigation, which will be later on this year, and in some cases early next year, we may have already committed Federal resources in a way we may later regret.

We are working on these cases. They are in all sorts of different stages right now. We will be working with GAO to complete them.

Senator TALMADGE. I agree that it is an ongoing investigation and I commend you for it. It seems to me some of the facts that you have recited today are clear violations of the law, and reflect lax administration. It seems to me that your findings ought to be turned over to the Department of Justice for prosecution where that is indicated and to the Inspector General of HEW for further investigation; to Secretary Califano for his information in administering this program; and also to the General Accounting Office to assist and further develop the investigation that your committee has started.

Would you agree with that?

Senator NUNN. I agree with you in general, but there will be various stages at which we think we ought to do that. We think, for instance, we ought to go to a certain point in terms of our investigation before we turn it over to the Justice Department. What we always do when we feel we have strong evidence of a criminal violation is turn it over to the Justice Department. That will be followed in this case.

Senator TALMADGE. Have any indictments been made to date?

Senator NUNN. Well, there have been several indictments and convictions.

Senator TALMADGE. I can appreciate your concern about inappropriate or premature disclosure of the names of HMO's where possible fraud or abuse has occurred, but what assurance do we have that timely and proper action will be taken to confirm and correct these problems?

Senator NUNN. Well, I cannot be very optimistic on that. There are grand juries looking into some of the criminal aspects but the preponderance of the problems we have identified are not criminal in nature. They are administrative in nature. They relate to abuses and inefficiencies, many of which do not even violate a law.

For instance, there is the whole system of what we call the pretzel-palace corporate structures, we seem to have given the name "nonprofit" some kind of sanctity. If something is nonprofit, we think it must be Simon Pure.

But what we have seen in case after case is that the nonprofits are set up and then the same people on the boards of the nonprofits control the profitmaking corporations. The nonprofits become a conduit for Government funds. The money flows right into these for profit organizations which the nonprofit officials control.

Now, that is really not a violation of the law. But that is what we are pointing out in our report. A good many of these things are gross inefficiencies, or gross abuses, that do not even violate existing law and regulation.

Senator TALMADGE. Now, as you know, we passed the Anti-Fraud and Anti-Abuse bill, so if it is related to medicaid or medicare, it would probably violate some of those laws. Would you not concur?

Senator NUNN. I believe your fraud and abuse bill, which is now law, is a drastic improvement. I think it is responsive to some of these problems.

Senator TALMADGE. I understood from your previous response that you would be willing to ask the General Accounting Office to follow up and report back on each of the cases that you have cited?

Senator NUNN. We will be glad to do that.

Senator TALMADGE. Based upon the evidence, would it not be reasonable for us to at least put the brakes on the whole HMO program?

Senator NUNN. Mr. Chairman, I would like to think carefully before answering that question but, after thinking carefully about it, my answer is yes.

Senator TALMADGE. Why would it not make sense to hold up new HMO's until the Inspector General of HEW, after evaluation and audit, certified to Congress that the Department can properly administer and audit the program?

Of course, HMO's presently in the pipeline could continue while the Inspector General investigated each one.

Senator NUNN. I would agree with that completely. I do emphasize that I think HMO's have a place in the health care delivery system. I think that there are some of them that have demonstrated that they have done a good job. But I think we are at a juncture. Most of the HMO's that are doing a good job really do not involve substantial amounts of Government funds and did not use Government funds to gets started. They were developed on a private basis. When you inject the Government, it is a different ball game altogether. That is what we are about to do.

Senator TALMADGE. When you spread honey around, it will attract flies. Is that what you are saying?

Senator NUNN. That is right.

Senator TALMADGE. Policing HMO's can be a massive job, requiring hundreds of staff members and great expense. How would you propose that we gear up for this monitoring effort?

Senator NUNN. I do not have all of the answers. We have set forth a number of recommendations that I could share with you. I think it might be worthwhile to summarize some of the things that we have recommended.

First of all, we found consulting companies who exacted exorbitant fees based on a percentage of gross plan income. We recommended HEW promulgate regulations responding to this problem.

We also recommended on the corporate structures that there be a consolidated financial statement and we said that the Secretary should have the power to direct payment back to the HMO's of money improperly diverted. We also asked the IRS to get involved in this, because there is some real misuse, we think, of nonprofit corporations. That is another legal remedy.

We found extraordinary problems with door-to-door marketing, marketing the plans door to door. This gets into the cases I have cited previously before your subcommittee. In one case, people thought they were signing a petition to impeach Gov. Ronald Regan and they were actually entering into an HMO contract. We found others that they were giving away Kentucky fried chicken dinners for people to sign up.

So we recommended strongly they do away with the door-to-door marketing. California has placed some controls on marketing and has taken a good many other steps to correct the abuses that we have pointed out and that their own people have pointed out.

So I think if the Federal Government now were to slow down and to take a look at what is happening to California and look at some of the ways they have corrected those plans out there—and I do not say they are perfect; they have probably got a long way to go—then we could avoid many of these problems.

Senator CURTIS. May I ask a question at that point?

Senator TALMADGE. Senator Curtis?

Senator CURTIS. Do these abuses in the HMO's get a Federal subsidy?

Senator NUNN. Yes, sir. But the ones we have looked at are the ones in California. We now see, as HMO's are spreading across the Nation, that some of the very same abuses that we have found in California we find in other HMO's too.

Senator CURTIS. My question is this: Have you found these abuses in the non-Federal subsidized HMO's?

Senator NUNN. I do not think we could make a comparison of that, Senator Curtis. A great many of these have excellent reputations, but we have not directed our investigations toward them.

Senator CURTIS. I think the answer is to take the Federal subsidy and sponsorship away from them. If this is a good thing, it will grow by itself. Some of them have done an outstanding job, but once we start a Federal program to hand out money, why of course people are going to figure out ways to get it.

Senator NUNN. Well, you know, it really does not make much sense to require that the recipients of Federal funds be nonprofit corporations unless those nonprofits are not affiliated with for profits. Otherwise, the word nonprofit has no meaning whatsoever——

Senator CURTIS. That is what I mean. There were a number of HMO's that were operating before this Federal program came along.

Senator NUNN. Right.

Senator CURTIS. What I want to know is: Have you found any abuses there? I think the way to end the abuses is to end the Federal program.

Senator NUNN. Well, I just have to say, Senator Curtis, that we really have not investigated those kinds of plans enough to give you a good answer.

Senator CURTIS. Thank you.

Senator TALMADGE. Senator Dole?

Senator DOLE. I think it is an excellent statement. In addition to the California area, you have investigated other areas too?

Senator NUNN. Of course, California was in the forefront of developing prepaid health plans, particularly in terms of Federal funds with the medicaid programs, so I would have to say that our primary focus has been there. We are spreading out now because the HMO concept is spreading out, and we are looking in other areas. We are finding some of the same pattern of abuses in other areas that we found in California.

Senator DOLE. Are you finding some of the same people involved in other areas that were involved in California?

Mr. VIENNA. Senator, yes, we did. In one case a witness before our subcommittee invoked his constitutional rights. He had developed the largest plan in California and he was setting up an HMO in New York.

Senator NUNN. We have found some of this. I do not think we could say that there was any kind of network.

Senator DOLE. Now, is it your purpose to, by this hearing, recommend changes in law? You say some things are only abuses, they are not covered by law, and you are not covered by the new fraud and abuse law. Hopefully then we will have some recommendations or we will put those together at this committee level. The problem should probably be addressed by the law is the point that I make.

Senator NUNN. Senator Dole, we have discussed that with your staff and Senator Talmadge's staff. We have a whole series of recommendations beginning on page 49 of our report which we have filed with you this morning. Some of them are rather complex. I have mentioned a good number of them in passing, but they are in detail here.

So we have recommended new law. We recommended it to HEW and one of the disappointing things is HEW wanted to go full speed ahead on this without coming back and addressing some of these problems.

Senator DOLE. Well, I agree with you that maybe it is time to slow down rather than speed up. It is pretty difficult to get that message through to HEW.

Senator TALMADGE. Senator Curtis?

Senator CURTIS. I have no further questions.

Senator TALMADGE. Thank you very much, Senator Nunn. We appreciate your contribution to the committee's deliberations.

[The prepared statement of Senator Nunn follows:]

STATEMENT OF SENATOR SAM NUNN (D-GA.), VICE CHAIRMAN OF THE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. Chairman and members of the Subcommittee, I am grateful for this opportunity to appear before you today to present to you the report by the Permanent Subcommittee on Investigations on its inquiry into prepaid health plans and health maintenance organizations.

I also wish to discuss certain other information the Investigations Subcommittee staff has obtained and raise a number of questions suggested by this information. This information relates to alleged current abuses in the Federal HMO program.

Most of the new information we have developed has not been given the scrutiny of a public hearing with witnesses under oath and subject to questions. Nonetheless, I will discuss a number of examples that give rise to very serious questions about the current Federal HMO effort.

First, I would like to express my appreciation for the personal interest and support of Senator Talmadge and Senator Dole in the work of our Subcommittee. Likewise, the Permanent Subcommittee on Investigations has been helped in this HMO inquiry and others by your most competent staff. Specifically, I would like to thank Jay Constantine, John Kern, and Bob Hoyer for their continuing help in our health inquiries.

The report on HMO's is timely. Both the Senate and the House are about to consider renewal of the Health Maintenance Organization Act with a half billion dollar authorization. This is a law that authorizes the Department of Health, Education, and Welfare to give grants, loans and loan guarantees for the development and operation of HMO's.

The study of health maintenance organizations by the Investigation Subcommittee offers the Congress the opportunity to further improve the HMO Act and the Medicare and Medicaid programs to assure not only a more effective expenditure of public funds, but also to ensure the health and safety of patients entrusting themselves to HMO's.

Mr. Chairman, I would like to offer the report as an exhibit to this hearing record.

The Subcommittee's report on its investigation is full of examples of fraud and abuse of patients as well as shortcomings in present law and program administration with regard to HMO's. That does not mean that all HMO's are bad or that the program should be scrapped.

Indeed, bona fide prepaid group practice is a viable method of organizing, financing and delivering health care which should be encouraged. To label all HMO's as bad or to suggest that the concept is doomed on the basis of the Subcommittee report would be irresponsible. Likewise, simply because we find some fee-for-service physicians and hospitals overcharging, providing more services to patients than they need or being convicted of fraud does not mean that fee-for-service health care is bad.

I hope the Finance Health Subcommittee will perceive our report in this context. I come before you today to urge you to protect Medicare and Medicaid program funds from the kinds of fraud and abuse identified by the Subcommittee investigation.

Your Committee is to be commended for placing strong safeguards against HMO abuses of the Medicare program as early as 1972. I am also aware that similar safeguards were voted by the Senate for the Medicaid program in 1973 but that the House of Representatives did not take action on the Senate bill. It's too bad. House passage in 1973 of your Committee proposal to protect Medicaid programs from HMO fraud and abuse would have prevented many problems with regard to Title XIX.

Our report discusses the Subcommittee's investigation of the prepared health plans receiving Medicaid funds in California. At the peak of the program there, some 54 plans provided health care services to more than 250,000 Medicaid beneficiaries. As you will recall, I have testified here before on issues involved in our inquiry.

There were several times more Medicaid prepaid health plans in California than in all the other States combined. The 1972 implementation on a large scale of prepaid health system contracting in California preceded by almost two full years the enactment of the Federal HMO Act at the end of 1973.

Our investigation found that most of the California HMO's sent door-to-door salesmen through the poverty neighborhoods. These salesmen offered Kentucky fried chicken dinners, free tickets to the Los Angeles Rams football games and stereo head sets to people who agreed to enroll in these HMO's.

Of course, the people didn't have to pay anything to join; the State Medicaid program was picking up the tab.

One blind lady signed an enrollment form after she was told someone would read the Bible to her every week. And a number of people signed their names to enrollment forms after they were told they were signing petitions to impeach Governor Ronald Reagan.

Once in the plans, the people ran into some very serious problems. Our investigation found a doctor who operated on two patients at the same time. One plan employed eight unlicensed foreign medical graduates who practiced medicine. Sick people were denied hospitalization. Narcotics were given to drug addicts. Medical records were a mess.

The cornerstone of the program was the State's belief that it would save money by contracting with these HMO's. The General Accounting Office said in 1974 that the program may have cost more than paying doctors' fees for their services. Almost all of the HMO's were non-profit corporations, but the officers and directors of these organizations contracted with for-profit companies they owned or controlled for services needed to fulfill State contract obligations.

We found that more than half of the Medicaid funds going to some HMO's were diverted from health care services through these for-profit firms and were accounted for as administrative costs and profits. We found that the return on invested capital in one California plan was 3,000 percent.

These facts are quite significant for they show how HMO's can be manipulated to defeat the very purpose of such organizations. HMO's offer the promise of health care services at fixed monthly costs to the persons enrolled. By selling its services to large numbers of people, the HMO is assured of a large amount of money. From this pool of funds, the HMO can finance health care to patients who need it. There is a financial disincentive to provide more services than the patients need. This is in contrast to the financial incentive in the fee-for-service financial system which pays health providers for each service rendered.

While there may be a financial disincentive in HMO's to overutilize, there was evidence in California of the financial incentive to provide less services than patients required.

Some California HMO's closed clinics on nights and weekends which were required to be open under their State contracts. One plan with nearly 100,000 enrollees, most of whom were women and children, had only one obstetrician and no pediatricians.

We found several additional examples of poor medical services. Instead of performing surgeries, pain killing drugs were given to patients. Children were not immunized. Sick patients were placed in clinic holding rooms instead of in hospitals where they belonged. Hospitalized patients were discharged too early. Some were the subjects of efforts to disenroll them when their hosptial stays grew too long and expensive.

In summary, the financial disincentive to provide necessary services, combined with corporate structures enabling the easy diversion of funds, can turn the HMO's into havens of financial and patient abuse.

One of the Subcommittee's goals in its investigation of prepayment systems in California was to learn from the mistakes of that program so that the lessons could be applied to Federal HMO efforts.

According to their testimony before our Subcommittee HMO officials have no mechanisms under the law to respond to marketing and enrollment abuses. They have no regulations preventing or controlling self dealing by HMO principals. They cannot safeguard the Federal investment in HMO's from abusive financial practices. They have neither a financial auditing program nor a method to evaluate the quality of care provided in HMO's though HEW is required under the Act to have such compliance programs.

Mr. Chairman, building upon this foundation would be building on quicksand. The Administration in its HMO bill would liberalize Medicare and Medicaid reimbursement to HMO's and increase from $1 million to $2 million the amount of grant funds and from $2.5 million to $5 million the amount of Federal loan funds an HMO can receive. Based upon experience to date it seems as though HEW is rewriting that old saying, "double or nothing" to "double and nothing!" For there is nothing—not a word—in the Administration's HMO bill that effectively responds to the evidence of HMO fraud and abuse. I would like placed into the record of this hearing Senate Bill 2676, the Administration's HMO proposal.

HEW has made the development of HMO's across the nation a major initiative. On March 10 of this year, the HEW Secretary convened a conference of labor and business leaders to encourage their participation in the development of HMO's and the enrollment of union populations in them.

Likewise in April, the Secretary sent to the White House a number of options for national health insurance. Included is a highly visible and prominent role for health maintenance organizations.

The HEW officials have made a number of speeches and have given testimony before the Congress advocating HMO's and stressing their importance as a major means toward containing health care costs.

There is little question that the development of HMO's is a major policy initiative of the HEW Administration.

I would like to place in the record, reports by the General Accounting Office and internal HEW documents evidencing problems in the HMO program. These can be made a single exhibit to include all of these reports which deal with problems ranging from self dealing in Federally qualified HMO's to problems of inferior qualify of patient care. There are reports of misallocation of Federal funds by HMO's and fraud against the Government.

In the face of this overwhelming evidence, HEW presented to the Congress legislation that does not respond to HMO fraud and abuse. Instead HEW would increase funding to HMO's and repeal the present method of reimbursing HMO's for the care of Medicare beneficiaries. In its place HEW would pay HMO's 95 percent of the average per capita fee-for-service costs to Medicare. The same reimbursement would apply to Medicaid under the proposal.

The present Medicare reimbursement formula provides that the HMO's costs of provided services to Medicare beneficiaries be subtracted from the program's fee-for-service costs in the geographic area. As a reward for its efficiency and as a benefit to Government, the difference between the HMO's costs and fee-for-service costs are split between the organization and Government.

The Administration contends that increased reimbursement to HMO's is necessary to encourage the development of more organizations. James Lane, Counsel to the Kaiser Foundation Health Plan, explained the position at an HMO conference held by HEW in September of last year.

"The critical factor in increasing the number of Medicare and Medicaid beneficiaries enrolled in HMO's is to provide sufficient incentive for them to enroll in an HMO when to do so would mean that they will have to accept less freedom of choice of physicians and hospitals than they have now.

"This can be accomplished by paying the HMO's the savings resulting from their efficiency which they may pass on to their Medicare and Medicaid members in the form of added benefits or lower rates or both."

In arriving at the proposed reimbursement rate, the areawide cost of the fee-for-service program, including the Government's costs of program administration, for example, carrier and intermediary costs, would be determined. Ninety-five percent of this sum would be computed on a per-capita basis and paid to the HMO. This calculation would amount to approximately 100 percent of the fee-for-service costs for medical services. The only savings to the Government would be the administrative costs of fee-for-service.

The Administration's bill presumes that accurate fee-for-service figures for small regional areas can be identified in order to compute the percentage. HEW's experience, however, is to the contrary. Likewise, States can't precisely quantify Medicaid costs on even a county-wide basis.

This overall Administration reimbursement proposal raises a rather interesting question. Why should the Federal Government give organizations $2 million in grants and $5 million in loans to set up health maintenance organizations and then pay them an amount equal to fee-for-service for providing care to Medicare and Medicaid beneficiaries?

The DHEW proposal for HMO reimbursement belies all of the arguments that HMO's are financial alternatives to fee for service. Indeed, attaching HMO reimbursement to the fee-for-service inflationary spiral should raise the question as to whether we need HMO's at all from a simply financial standpoint.

Mr. Chairman. As you well know, your Subcommittee considered in 1972 a proposal to pay HMO's 95 percent of Medicare fee-for-service levels and you rejected it, wisely. It was resurrected in the Administration proposal which has its roots in a HEW "Conference to Review Legislation and Regulations Governing HMO Contracting with Medicare and Medicaid" on September 23. 1977. One of the advocates of the proposal is Kaiser's Mr. Lane. I offer Mr. Lane's paper for inclusion in the record.

The conference was attended by only a few, other than Mr. Lane, including Bruce Yarwood, the Chief Deputy Director for Programs of the California Health Department. Mr. Yarwood sent on December 16, 1977, a memorandum prepared by his staff to DHEW. The memorandum was prepared in response to an issue paper which included a proposal to pay HMO's 95 percent of fee-for-service levels. I'll read from a part of that memorandum:

"If the primary interest of the issue paper was to produce a proposal pleasing to the HMO industry, it undoubtedly succeeded. The concept of paying 95 percent of per capita costs should have almost universal appeal to HMO's. Since (to quote the issue paper itself), 'actual HMO costs can be expected to run typically 15 to 20 percent below that of the fee-for-service system.' The notion that the HMO's would be required to plow back the difference between the adjusted community rate and this (95) percentage . . . in the form of reduced premiums and/or increased benefits is a gesture in the direction of proper use of public funds, but would be virtually unenforceable."

Mr. Chairman, I offer for the record of the hearing, Mr. Yarwood's complete memorandum to HEW.

The Subcommittee staff recently asked the California Health Department to project the cost impact on the State Medicaid program if the Administration's proposal is adopted.

In a letter to me, California explained it is presently paying $60 million a year to 13 HMO's for health care services to 125,000 Medicaid beneficiaries. This represents a spending level equal to about 80 percent of fee-for-service costs in the State.

The California Health Department says that under the Administration's reimbursement formula, the Medicaid prepaid program costs could rise from $60 million to $71 million a year. Aggregate HMO profits from the State Medicaid program would increase 250 percent from $7.5 million to $18.8 million. In short, the State is already paying HMO's at a reasonable level for the services they provide. Any increase in the payment would be an absolute increase in HMO profits.

The California Health Department said "95 percent rates would undoubtedly be higher than the premiums most HMO's charge private members, in exception to the usual principle that Government should pay no more for goods or services than private purchasers. It is difficult to believe that legislators would accept such an arrangement."

This information was prepared by Rigby Leighton, the director of the Prepaid Health Research Evaluation and Demonstration Project, which is committed to

receive $5.2 million in HEW funds. I offer his letter to me as an exhibit. The Finance Committee passed legislation specifically authorizing this project in 1975, following the first round of prepaid health hearings in the Permanent Subcommittee and the receipt by your Subcommittee of a number of reports on prepaid systems by the General Accounting Office.

Both your Subcommittee and ours were concerned that Government develop methods to determine the actual costs of delivering specific health care services in HMO's where there is a financial disincentive to provide the necessary level of care. In addition, we were concerned that Government have an appropriate and uniform method of determining rates to pay and whether care being provided to enrollees is appropriate.

Mr. Chairman, the standards and methods being developed by the California project can be important and useful to Government program administrators. I know that the staff of your Subcommittee and my Subcommittee over the past many months have continually recommended to the HMO staff at HEW to discuss with the California Demonstration project staff what they are finding.

As of yesterday, there has neither been a visit nor even a telephone call from HMO program staff to the California project. It is as if the HEW staff does not want to know. I strongly suggest that our Subcommittees continue to monitor, as we have, the work of the California Demonstration project. And when its work is concluded, you may well want to consider the possible inclusion of the HMO cost determining, rate-setting and quality evaluation methods as part of the Medicare and Medicaid programs. Perhaps HEW is ignoring the California project for the same reason the report by the Permanent Subcommittee on Investigations is apparently not taken too seriously.

Mr. Chairman, we have been told by HEW officials and staff that our report deals with California prepaid health plans, not Federally qualified HMO's. HEW regards the California experience as an aberration that has been resolved.

Our Subcommittee contends in its report that the California prepaid health experience portends what can be expected in the Federal HMO effort. The report concludes that "unless remedial action is taken, the Federal Government, through its program of financing the development of HMO's faces the prospect of encountering nationwide, the same kinds of scandal and abuse that have plagued the California Medicaid program."

Mr. Chairman, during the course of our continuing interest in HMO's, the Subcommittee staff has received unsolicited telephone calls from credible sources offering examples of problems in the Federal HMO program similar to those identified in the Subcommittee report.

In addition, the staff obtained information on its own. I would like to discuss some of this information. Because most of the individuals and organizations involved have not been interviewed or otherwise offered the opportunity to respond to the information and allegations we have obtained, I will not mention any names. However, each of the examples I will give is supported by materials obtained from the files of the Department of Health, Education and Welfare, the General Accounting Office, from interviews with employees of the HMO program and/or from interviews of Government auditors and HMO employees.

With that understanding, I would like to offer the information we have obtained as a sealed exhibit and discuss these issues.

Mr. Chairman, the first case I would like to discuss involves the certification of a former California prepaid health plan as a Federally qualified HMO. I bring this up because there is no clearer example of how the Federal HMO program may not be learning from California's mistake.

This particular HMO is a non-profit corporation which has received $437,000 in HMO loans. The medical director is the president and sole owner of a for-profit management company and a company that leases a clinic building to the HMO. The medical director's wife owns corporations which provide lab and pharmacy services to the HMO.

The organization has a history of negative medical quality and financial audits by California agencies. As late as March 8, 1978, one week before Federal qualification, the HMO was put on notice by the State that it had not been responsive to problems which had been identified.

The HMO has reported that its administrative costs are running $14 for every $39.57 per month the State Medicaid program pays for each of the 5,500 Medicaid members enrolled in the plan. This amounts to 40 percent of Medicaid program payments to the plan.

The Subcommittee's concern in its inquiry and report is that through complicated corporate structures which can artificially increase HMO costs, monies can be diverted from health care.

The utilization records of this newly qualified HMO either bear out the Subcommittee's concern for diversion of funds or they indicate that this organization has enrolled some of the healthiest poor people in the State.

For example, the Medicaid beneficiaries in the 13 qualified HMO's in California are hospitalized at a rate of 319 days per thousand enrollees per year. This average, in itself, is below the 400 to 500 a day average in most HMO's. But for the newly qualified HMO the rate is 95 days, less than a third the statewide rate.

The statewide rate for hospital outpatient visits is 143 per thousand enrollees per year. But the rate of this newly qualified HMO is one-seventh that, at 20 visits. Dental visits statewide are running at a rate of 747 visits per thousand enrollees per year. But the newly qualified HMO's rate is 204 such visits.

The qualification of this HMO raises a number of questions.

First, to what extent does the Federal HMO qualification process take into account the possibility of diversion of funds through complicated corporate structures?

Second, what weight is given during the qualification process to patient utilization rates in HMO's? and

Third, now that this HMO is qualified, what can HEW do to assure a reasonable standard of care for the enrollees?

Mr. Chairman, another matter of concern to the Investigations Subcommittee was the slippage of Federal grant and loan funds from the non-profit HMO to related for-profit entities.

In a mid-Atlantic State, a non-profit corporation was created to take over a for-profit HMO, which had been created by a nursing home chain. The purpose according to sources was to take advantage of Federal grants and loans.

Immediately prior to qualification, the non-profit board created by resolution a $500,000 indebtedness to the nursing home chain. According to reliable sources interviewed, satisfactory documentation was not provided to support the contention that such a debt was owed. At first, HEW staff won an agreement from the nursing home chain that it would subordinate its interest in the indebtedness to the Government's $2.5 million loan. But in December, 1977, the staff allowed the non-profit HMO to use Federal loan funds to pay off the debt.

This incident raises a question about whether HMO loans should be used in such a way. The primary purpose of the loan program is to assist developing HMO's make it through the difficult first years. Should Federal loan funds be used to buy out proprietary interests?

Mr. Chairman, there are other examples of possible diversion of funds. For some time, HEW has known first hand of a problem with an HMO now in financial trouble in a southeastern State. In this case, the GAO reported that Federal grant and loan funds were being diverted through the non-profit corporation to a for-profit entity, which in turn used part of he funds to purchase equipment. Once again, in turn, the equipment was leased back to the non-profit HMO. The GAO found that among the items leased were disposable test tubes and syringes.

The HMO office was recently advised by the HEW regional office that a Federally qualified HMO in the Pacific Northwest is using part of its $2.5 million loan to build a building in direct violation of the terms of the loan and HEW regulations.

In addition to diversion of funds, there are examples of questionable HEW management decisions. The GAO will soon make public a report on how the Denver regional HEW office allowed, contrary to law, Federal health care funds to be used to build an HMO clinic. Title to that building is now vested in an HMO.

Mr. Chairman, there are other examples that I will list briefly. Each is indicative of HMO program problems. The Investigations Subcommittee and the General Accounting Office recently referred to the HEW Inspector General allegations that the executive director of a western HMO received a kickback from a firm providing services to his plan. In addition, the plan paid for the executive director's round trip first class air fare to St. Louis. Likewise, the HMO paid for an "emergency out of area service." The man allegedly flew to St. Louis where surgeons reversed his vasectomy.

In an east coast HMO which has received more than $3 million in grants and loans, the $65,000 a year executive director told the staff that his plan provides him with a $300 a month car allowance and all maintenance costs for the car.

The car is a new Mercedes Benz, which the executive director said is used exclusively to drive between the administrative office of the plan and its two clinics. He said he lives a block away from his office and has a car of his own for his personal use.

While this is not scandalous, it raises a broad question about how grant and loan recipients are spending their funds.

Mr. Chairman, my staff has obtained internal HEW documents indicating 5 HMO's are in serious financial trouble. These 5 plans have borrowed over $12 million which the Government may lose if these plans fail.

Mr. Chairman, these kinds of examples, and those investigated and documented in the Subcommittee's report raise some fundamental questions that must be addressed prior to any enactment of the Administration's proposed legislation or even the extension of the present program:

1. Once surfaced, does the internal HMO management mechanism have the capability to take decisive action to stop the abuses?
2. Will adequate safeguards be developed to minimize the frequency of these kinds of problems; and
3. Finally, is Congress discharging its oversight responsibilities adequately? Are we going to be able to ensure that this megabuck program can be controlled? Can we ensure it will not become just another giveaway program?

The information staff has obtained on abuses suggests that there is a need for an expanded number of competent staff involved in the HMO qualification and compliance elements of the programs.

The Administration acknowledged the need for more staff. In February, HEW asked for and received from the Appropriations Committee an increase in 37 positions for the programs. HEW officials promised the Appropriations Committee that of the new positions, 13 would be added to the 12 persons now responsible for qualification. Some 23 persons would be added to the group of 9 persons responsible for compliance.

The Director-Designate of the HMO program now intends to have 10 persons in qualifications, 15 short of the number promised to the Appropriations Committee and 25 persons in compliance, 7 less than what the Appropriations Committee expects.

When I learned of this plan last week, I directed the staff of the Permanent Subcommittee to bring it to the attention of the Appropriations Committee staff and suggested that Senator Warren Magnuson, the Chairman, be advised.

The Appropriations staff told us that they had not been advised of this planned cutback by HEW. Senator Magnuson provided us with an exchange of letters between his Committee and HEW on the 37 new positions and the planned use of them. With Senator Magnuson's consent, I offer this correspondence for the record of this hearing.

In addition, I offer as an exhibit, a May 9, 1978, memorandum of the HMO program Director-Designate on re-organization of the program staff. Attached is a chart showing the planned cutback in qualification and compliance staff. There is also a memorandum discussing the commitment to Senator Magnuson and the intended reversal.

Subcommittee staff discussed this matter with the HMO Program Director. He said that the commitment was made prior to his taking over the job. Based on his review, too many slots had been allocated to the compliance and qualification functions.

Following approval of his reorganiaztion plan by superiors, he said he intends to discuss it with Appropriations staff. He insisted that there are appropriate numbers of staff to maintain their responsibilities at this time.

Nevertheless, the question remains: Does this cutback in compliance and qualification staff reflect a change in HEW's announced commitment to improve program management?

Mr. Chairman, in spite of the facts I have presented and the concerns I have raised, I don't believe we should overreact or react harshly to the officials of HEW and the director of the HMO program. There are very, very few people in the nation who understand prepayment systems and only a handful who have a broad enough background to appreciate the benefits of HMO's, and at the same time recognize their potentials for abuse.

The Department of Health, Education and Welfare has selected HMO development as its major cost containment and health delivery system reform effort. The Administration made this choice because there is evidence of financial and quality of care benefits resulting from some prepaid health organizations of long standing around the country.

But the organizations that form the basis of this policy initiative were founded, and developed for the most part, on their own, without Federal or State Government support. They were the creations, frequently, of consumer groups, as is the case with the Group Health Cooperative of Puget Sound, an HMO with an excellent reputation.

When the Government announces that it will finance the development of anything, it creates instantly a new industry, a financial constituency and a host of problems, because some of the people inevitably attracted to the Federal trough are those interested in a fast buck. Their success is directly relative to the quality of program administration. The poorer the program management, the greater the potential for actual ripoff.

HEW should be given a chance to advance its policy initiative and expand the development of health maintenance organizations. However, HEW should temper its fervor with an understanding of what can happen to taxpayer funds and patients and manage the program accordingly.

We have only to look at what happened to us when we got into the Medicare and Medicaid programs. When Government dollars were placed into the medical marketplace, we created instantly a political and financial constituency, clothed in human needs and standing in a medical-commercial complex that includes huge professional and trade associations and million of elderly and poor. The older the programs become, the more difficult and complex become our efforts at reform.

Indeed, it is the very problems with Medicare and Medicaid that provide us with reasons that such systems as health maintenance organizations should be given an opportunity to succeed.

But let us not build another uncontrollable, unmanageable, inflationary program in the process. It would be the height of irresponsibility to do so, given what we know now.

Let's not legislate on the basis of the promises of those offering easy answers to complex problems. Let's try new methods—but let's try them cautiously and carefully before we open the gates of the Federal Treasury.

Therefore, we ask that HEW listen. Listen to facts. Take a historical view, not only of HMO's, but also of what can happen when a major Government initiative is begun without serious regard for good law, and effective regulations, and proper management.

Mr. Chairman, in closing, I would like to invite your attention to what may be a growing problem. As you may know, the Subcommittee is taking a fresh look at the Federal law enforcement efforts to deal with what many perceive to be a growing organized crime problem in this country. One thing is clear, organized crime is becoming very sophisticated in its financial activities—and, of course, it is always attracted to vast dollars without much regard to whether they are tax dollars or gambling dollars.

There are preliminary indications that there may be a move on the part of organized crime figures into the health care services industry. This makes efficient Government program administration all the more important.

Just to give you an example, the Subcommittee staff a few years ago received information that a west coast prepaid health plan operator was the subject of a contract to kill him. The reason was that he had failed to withdraw a lawsuit he had filed against a chain of hospitals and clinics allegedly owned by Chicago organized crime figures.

Staff informally developed information that tended to confirm the threat, which was allegedly never carried out because the man who was to pull the trigger died of a heart attack the day before the planned execution. As for the HMO operator, he has recently been convicted of bribing union officials to contract with his plan.

The Permanent Subcommittee on Investigations has been watching another corporation which plans to franchise HMO's. The franchise plan raises a question as to whether it is good public policy to provide health care through outlets similar to that way McDonald's sells hamburgers.

This particular corporation has been the recipient of HEW funds related to, but not provided directly by the HMO program. I would prefer not to name this firm because of our ongoing interest in it, but I have a sealed exhibit of materials on this corporation.

The Subcommittee staff, through the cooperation of midwestern law enforcement officials, has established a relationship between one director of this corporation and organized crime figures in Detroit.

I am by no means suggesting that the HMO industry has been or is about to be taken over by organized crime. However, I don't believe we can mix the mafia and medicine and expect to provide good health care to the people. Any identification of organized crime figures in the health care services industry should be a lesson to us all that there is a need for more vigilant and efficient government and private sector health program administration.

I am sure you will agree with me that the large majority of health professionals and those who operate and work in health facilities are decent, conscientious and dedicated men and women.

Our concern should be those who make a mockery of that dedication and decency by taking advantage of them with schemes and scams. We should be especially concerned with sloppy and careless government program administration which are easy marks and government officials who refuse to respond to compelling records of fraud and abuse.

Senator TALMADGE. Senator Nunn, if you would care to stay, we would be delighted for you to come up and listen to the other witnesses.

Senator NUNN. I will. I would like to hear the other witnesses.

Senator TALMADGE. The next witness is Mr. Thomas S. Moore, Jr., health care consultant.

Mr. Moore, you may, if you see fit, insert your full statement into the record and summarize it and proceed in any manner that you see fit.

STATEMENT OF THOMAS S. MOORE, JR., HEALTH CARE CONSULTANT

Mr. MOORE. Senator, I am sorry that I do not have a prepared statement to offer you this morning. I am here merely to respond to questions that have been generated by the previous testimony.

Senator TALMADGE. For the record, would you please describe your background and experience in the health care field?

Mr. MOORE. Yes, sir.

I have been involved with the public administration of health and welfare programs since 1962 when I first joined the——

Senator TALMADGE. Please hold the mike a little closer to your voice so we can hear you.

Mr. MOORE. I was saying I first became involved in government administration of health and welfare programs in 1962 in the second term of Gov. Pat Brown's administration. Following that, I was Director of the Office of Legislation for the Public Health Service here in Washington when Dr. William Stewart was Surgeon General. You may recall that period.

Following that, I returned to California where I worked for and represented an organization put together by the California unions, a consortium of unions to develop prepaid group practices—this was prior to the HMO legislation—because the unions were seeking more stable and predictable financing of health care.

For several years, we have both advocated the development of what are now called HMO's and, at the same time, developed in a self-defensive posture a battery of standards and qualifications because the programs were beginning to solicit union business.

Following that, I was self-employed as a consultant for a time, then I later joined the California Department of Health in 1975 first to direct an experiment and demonstration unit and then later as deputy director responsible for what is called alternative health systems which is that branch of the State department of health which oversees HMO prepaid health plans.

In April of 1976, I was separated with some dispute over policy and program management.

Since then I have been self-employed, again as a consultant, now with Contra Costa County which is just northeast of San Francisco, the only example in the country of a publicly sponsored developing HMO, and as a consultant with the senior health program in Chinatown, San Francisco, named On Lok, which is attempting to develop an experimental comprehensive program for very frail and elderly persons as an alternative to nursing home care.

Senator TALMADGE. I understand that you have information concerning the use of medicaid payments by prepaid health plan for the purpose of making political contributions. Would you describe that situation as fully as you can?

Mr. MOORE. Yes, sir.

The history of the development of the program in California was marked by political involvement from the very beginning. In 1969 and 1970 prior to the time that the program became a permanent one, while it was still in the experimental stage, the contracts that were let by the State for so-called experimental or demonstration plans, seemed to be largely developed on a pattern based on the political relationships with the contractors—and I say that because the State had never developed adequate standards, never developed even a procedure, an objective procedure, for reviewing the applications that came in.

By 1971 when the policy of promoting the programs became set in the law, a number of legislators created corporations or companies or management services within their law firms or in organizations affiliated with them which processed applications to the State for contracts.

The result of this was—which has been submitted to the Subcommittee on Investigations in previous testimony—was enormous pressure on the State officials to award contracts because to fail to do so was to face retaliation from the legislature.

In the case that you mentioned, however, a contractor with about 10,000 enrollees named Omni-Rx—which was the subject of an earlier congressional investigation—was found in the fall of 1976 to have illegally contributed about $120,000 in a 2-year period in political campaign contributions of various kinds in California.

Senator TALMADGE. And that was Government money you are talking about?

Mr. MOORE. Nearly all of it was Government money, almost the exclusive source of their revenue. They did have some private business, but most of their income, as determined by a GAO audit of the program, came from medicaid sources. They were set up to be a medicaid contractor.

This was a classic case of the nonprofit corporation backed by a series of for-profit subcontracting units owned almost exclusively, or mainly by the officers who had incorporated the nonprofit shell.

Senator TALMADGE. Is that the detailed information in the sealed envelopes to which Senator Nunn referred to?

Mr. MOORE. Actually this information, excluding the campaign contributions, has been previously submittted to the Congress. It was a part of the General Accounting Office review of the organization and

financing of California prepaid plans, reported, I believe, last spring or last winter. I am not certain about the date.

It is already a matter of record.

The campaign contributions were discovered by the department of corporations which, in California, has recently acquired responsibility for licensing and overseeing the program. The interesting thing, and to me the point that touches most of the issues this morning, is that in spite of several thousand man-hours of audit effort in the program, the campaign contributions were not discovered that way. They were discovered only, finally, by a tip from someone inside the organization to the master that had been appointed by the court because the organization was already in trouble.

If it had not been for that tip, they probably never would have been located.

Senator TALMADGE. These campaign contributions were discovered by tips from people administering the organization?

Mr. MOORE. That is right. Someone within their organization.

Senator TALMADGE. Who got the money?

Mr. MOORE. Well, a great many people got the money. The largest collected contributions fell out this way. A variety of Democratic finance and campaign committees going by a number of names, received about $13,000 to $14,000.

Lieutenant Governor Mervin Dimaly received a total of $14,250 including one $10,000 contribution made on September 15, 1976, which was not an election year.

Governor Brown received through various committees—the current Governor Brown—$8,600. The rest were scattered among legislators, local office holders, local candidates throughout the State.

There were some national contributions made. Senator Tunney received some money for his campaign. It was very widely distributed through the leadership of the legislature.

Senator TALMADGE. Was the timing of the contributions of any significance?

Mr. MOORE. Well, it may have been and it may not have been. The thing that I found significant about it was that the rate of contributions began to increase as the pressure came on from the Department.

If I may take a moment, Senator, that program had never been audited. Not in the history of the State's expenditure of medicaid funds, and by the time I became deputy director we were spending $100 million a year on the 52 contractors. No serious audit had been made of any of the programs. There had never been any track developed to learn where the tax dollars were going.

We had clear evidence that enormous profiteering was taking place, and the evidence consisted, in part, of some financial records that were supplied that showed large profits in the subcontractors, high salaries being paid, and a willingness on the part of some of the contractors to get a contract at any price. That offer was made frequently to me as a State official and, in the earlier days when I worked for the unions. A contractor would come to the union and say, "I do not care what the amount of money is, just give me the prepaid contract and I will make out."

Well, there is clear evidence that under those circumstances they know something that we did not know about the use and the cost of

services. We felt that an audit was in order. We were beginning to allow contracts to lapse and cancel others because of poor quality of care, but the financial issue was hanging over all of our heads.

We began to press the audit of this program. That is when we began to really bear down on them, the level of—the flow of money into the political arena increased.

Senator TALMADGE. Who were the key principals in the Omni-Rx and what was their background?

Mr. MOORE. The principal figures in the operation and ownership of the program were two men, one named—a physician named Ed Dickstein and his associate, whom I believe had been previously involved with him in a series of real estate ventures named Merv Newell. They were owners, or coowners, in virtually every one of the subsidiary corporations except the medical partnerships, which Mr. Newell would not have been allowed to be a member.

There was a third person who became significant as the controversy over this program arose. They hired him to come to Washington to lobby against the PHRED project that was mentioned by Senator Nunn, the prepaid health research evaluation and demonstration project which you approved for about $5 million in research and demonstration money.

They hired the husband of Congresswoman Yvonne Braithwaite Burke, William Burke, to represent them in efforts to solicit the support of the Black Caucus here and other, I think, well-intended but largely at too great a distance, Members of Congress in an effort to shut down that demonstration project or to stop its approval.

Burke's hiring was kept from us until we discovered it by accident in the spring of 1976 and that is important because the law in California, and the regulations, require that all subcontracts of any significant nature be reported and approved in advance. That was in the law.

However, in this case they simply withheld the notice until, again, we were told by someone inside the organization.

Senator TALMADGE. Was Mr. Burke involved in the campaign contribution?

Mr. MOORE. He was not a recipient of any. Mrs. Burke received $2,000.

Senator TALMADGE. Did he distribute any of the funds?

Mr. MOORE. Not to my knowledge. I do not know firsthand that he did.

Senator TALMADGE. Was the money in his account?

Mr. MOORE. His account?

Senator TALMADGE. Yes. Did his account contain the money?

Mr. MOORE. He received payments in a series of accounts from Omni-Rx, some for marketing services—at least that is the way it was identified on the disbursement records, although they had a full-time marketing director——

Senator TALMADGE. Were those campaign contributions or payments of personal services?

Mr. MOORE. One assumes that they were a combination, but I cannot honestly say that I know, Senator. The track of this money, of the campaign contributions, was not provided by the Department of Corporations at the time they released the figures. They did not tell us through what processes the funds were distributed.

Senator TALMADGE. Are there any indications that the Omni-Rx people got anything in return for their political contributions?

Mr. MOORE. Well, I can tell you from personal experience that they got access to the administration of the program in California and to the legislature. They were able, on one occasion, to compel a hearing by an Assembly Committee into the administration of the program and on several other occasions, in effect, our efforts to carry out the law—which had not been carried out for several years—were put on trial at their request.

They had—I was told repeatedly by members of the legislature staff—I was warned repeatedly by members of the legislature staff—that they had access throughout the Capitol and that I should never underestimate their political influence.

Senator TALMADGE. Were there any indications or evidence of strange payments or contributions in other California HMO's?

Mr. MOORE. Well, the history of the program had been characterized by payments. There were cases in which consultant fees were paid to, or offered to, legislative staff and members of the legislature. The payments were connected to the rate of growth of the program.

There were cases in which there were payments made up front by contractors seeking a contract to the legislature or members of the legislature for professional services.

All of this, ultimately, of course was coming out of public funds. Since, for most of these programs their exclusive membership, their exclusive enrollment, was from the public sector. They were Medi-Cal recipients.

Senator TALMADGE. What do you know about a federally qualified HMO named HMO Concepts?

Mr. MOORE. HMO Concepts was previously called Health Care Associates, I believe, in Orange County. It has reorganized and changed its name.

It is an organization which represents the kinds of surveillance problems that this entire program faces all of the time. It has a series of subcontracting-for-profit organizations backing its nonprofit primary contracting front. The most interesting thing about it, and the things that are alarming from a management standpoint, at least in the public programs, are the low rates of utilization. The program has a very low rate of hospitalization, very low rates of use of outpatient services; so far as we can tell, a very low rate of preventive services.

It has, over the years, been consistently what I would characterize as an underutilizer. We know so little about the appropriate distribution of medical services to low income families that it is impossible to say what the standards ought to be. The problem is that from my own experience, both in Government and with the unions, whenever we saw very, very low utilization in a prepaid program we considered that cause for alarm and serious inquiry into either the stability of their patient population because it could mean a kind of a turnover leading to selectivity of enrollment, or stability in physician staff. Instable, high turnover in physician staff would frequently encourage low use frequently among populations.

The program has been federally qualified but it was qualified at a time when the State was raising very serious questions about the quality of its care. More to the point, the State was asking repeatedly for

them to respond to previous complaints. It had a history of not being responsive to medical and and management audit findings.

It is a very troublesome, uncertain program with a history of strained relations with the State program managers, but it is qualified.

Senator TALMADGE. What were the conditions in California which contributed to these medicaid abuses?

Mr. MOORE. The program began with a deliberate plan on the part of the administration to encourage as rapid a growth as possible with the hope that either competition in the marketplace would be self-correcting—that is, that low-income people would be able to disenroll and that their disenrollment would discipline the programs or that the stronger ones would eat up the little ones and there would be a period of consolidation and merger. At that time, I was working for the unions in California and most of these programs would try to get a State contract and then come to the unions and say, we are good enough for Medi-Cal, we must be good enough for your membership.

Knowing that the State had no standards, no real standards, and was not conducting anything like an objective evenhanded review of the contractors, we set up our own review and screening process and over a 4-year period we never approved a single California PHP for union enrollment.

That does not mean that some of the unions did not contract with them, but they did so over our objections and over our warnings.

The State notion that you can clean up the program afterward was a serious mistake. It is extremely difficult to cancel contracts. It is extremely difficult, even with substantial evidence, to shut down a going organization that has several thousand people enrolled in it.

If you are a program manager, you find it very hard, even when you know that the program is riddled with abuses, to close up a shop that is employing several hundred people who are completely innocent of the frailties of the administration.

It was out of that experience, watching that development during that period and my later, direct, experience directing the State program that has led me to the conclusion that it is important to have a very tight screening for entering the program because it is extremely difficult to close it down later.

Senator TALMADGE. Is there any reason to believe that the problems of the programs are unique to California and would not occur elsewhere?

Mr. MOORE. No, Senator. Californians are accustomed to being regarded as peculiar and we may deserve some of that, but any time—Senator Nunn's statement concerned a very telling comment. You create a benefit, you create a new industry.

And California investor physicians, and others are no different from those in any other State. If there is not adequate regulation, the conditions will exist.

I will say this. I certainly saw, in my labor years, the same problems with the unions and private health contractors in other parts of the country that I was invited to visit, so I can assure you that the conditions are widely spread.

Senator TALMADGE. Based upon your extensive experience with HMO policy and operations to date, what do you believe would be an appropriate Federal position toward HMO's at this time?

Mr. MOORE. Well, first, let me say something about my own role in this. I have long been an advocate of HMO development. I would take a much harsher view of fee for service, perhaps, as a reimbursement mechanism than Senator Nunn. I am a member of an HMO, as a matter of fact.

It is our best hope for the stabilization of the health industry, which is essential. But, having said that, I think that the program desperately needs to have in place, or at least in the field testing stages, the kind of monitoring and surveillance instruments that are being developed by the PHRED project in California, so that you get very early warning signals, both on the applicants before they are qualified, and on their operations in the troubling first years of qualification or even first months, when they are just going into business, as much to help them—those which are having management problems—as much to help those as to discipline the ones which are clearly taking advantage of the program.

The gap that is growing between fee-for-service costs of the average family and the rates being charged by HMO's and prepayment, and what that gap represents as out-of-pocket costs to families, is leading to a tremendous surge of enrollment.

In California, the growth is astronomical. The programs can barely hire people and build facilities fast enough to take care of it. That kind of situation needs very careful scrutiny.

There was no methodology for reporting or surveillance in the early 1970's and it was because of the lack of that that Congress supported the PHRED grant and we worked so hard to get it, to start developing those tools. The tools are still not in place. And while I think that it would be unwise to punish those who have applied and are in the pipeline for qualification because they have done so in good faith under the law that invited them to do so, I believe that the program needs the management instruments in hand, or else we will have California across the country.

Senator TALMADGE. What is your evaluation of the administration of the HMO program by the Department of Health, Education, and Welfare?

Mr. MOORE. First, I must say that I have not conducted a formal evaluation. I was invited by the Under Secretary to participate in some staff seminars over the question of rate reimbursement. Yet it would be absurd to suggest that this administration, certainly the Under Secretary—who, by the way, coincidentally was largely responsible for my entering government in the first place in 1962. It was because of him that I was given a chance to work in State administration.

It would be absurd to suggest that there is anything but the highest standards prevailing in their operation and in the greatest public interest. The problem is, as you well know, that HEW is like a series of tribal camps and this program inspires more ideological conflict and more controversy, I believe, than any other medical program that I have ever seen. It is difficult to communicate to you the intense feelings that were generated by people who agree on common objectives. It has been true in HEW staff—there are great conflicts there—it is true outside between the welfare rights organizations with whom I work, the union consumers and the public proponents of HMO in the State.

In an atmosphere of great tension and controversy and arguments over how we are going to take the experience of the large and successful programs like HIP, Group Health Co-op and Kaiser and translate that into a new public program, there is a great deal of turmoil.

I would say that they have not settled down on objectives, and I would say further that there is a terrible shortage of legislative history, or legislative memory, at the staff level.

Senator TALMADGE. Are you familiar with the present statutory safeguards on HMO participation in medicare?

Mr. MOORE. Yes, sir.

Senator TALMADGE. Is there anything inappropriate or unreasonable about those requirements in the present law?

Mr. MOORE. The county where I am a consultant, Contra Costa, has one of, I believe, only two contracts with the medicare administration for services to medicare eligibles at risk. We found the negotiation of the contract time-consuming, but not difficult. It is certainly no burden on us, but as a public program, we do not have the same economic interests as a private one.

But the requests are reasonable. We did not find anything unreasonable about it.

I would like to suggest something that has been said before here and before the other committee, but it requires emphasis, I think, and that is that we are burdened—program operators are burdened with far too many agencies involved in this business. There was testimony given by one of the PHD contractors that he had to submit a review to something like 11 agencies in the course of doing business with Federal employees, State employees, medicare, medicaid and the State agencies.

That is not only inefficient, but what happens is that the regulatory agencies get put one against the other. Over the years, the programs that we considered totally unfit to serve union families would get a contract with somebody, with the State medicaid agency, and then come in and use that as an excuse to try to get union business.

If we do not have a common standard for reimbursement, if we do not have a common standard for surveillance and reporting, it is not only unfair to the operators who must submit to an endless round of audits and reporting, but it is not necessarily better management because you get the agencies played off against the other.

Senator TALMADGE. Senator Dole?

Senator DOLE. With reference to the campaign contributions, is the contribution information a matter of public record?

Mr. MOORE. Yes. It was contained in a March 3 press release by the Corporation's Commissioner in California announcing that they were amending a previous complaint against the company to include these illegal contributions.

Senator DOLE. That, essentially, covered all that type of information?

Mr. MOORE. It covered only that information on that particular plan, Senator. My intention was to audit six organizations in the State with Omni-Rx being the first. None of the others have ever been audited. And they are all similar corporate structures with similar political relationships within the State legislature and administration.

Senator CURTIS. What administration are you talking about?

Mr. MOORE. The last two. The Reagan administration from about 1969 through 1974 and then the Brown administration, the Jerry Brown administration.

Senator DOLE. Are you in the process of doing that now?

Mr. MOORE. I am sorry, doing what?

Senator DOLE. Well, you said your intention was to look at six?

Mr. MOORE. Oh, no, I am out of the administration. I was released. In a dispute over audit practices, and what was characterized by my superiors as an abrasive personality and inability to get along with the legislature, I was fired.

Senator DOLE. Would you be classed as what we called a whistle blower?

Mr. MOORE. Well, that is flattering. I tell you, I was scared most of the time, because you were damned if you did and you were sure damned if you didn't in terms of monitoring the law.

Senator NUNN. Senator Dole, may I interject something at that point?

Senator TALMADGE. Would you yield at that point, Senator Dole? Senator Nunn?

Senator NUNN. Yes. During the course of this investigation, Mr. Moore was working very closely, in many cases, with our staff, and they have a very high regard for his ability and integrity. During the course of the investigation, there was some real rough play. Our staff was involved and he was involved and there were a good many allegations made against Mr. Moore and David Vienna of our staff.

The allegations were made by those who were being investigated, including allegations of payoffs and bribes and so forth. As soon as I heard about it, I got in touch with the Justice Department—this was a couple of years ago—and demanded that they have an immediate investigation of our own staff, and I told our staff that I was doing that. I did not want anybody to believe they could call off our investigation by making counterallegations against our staff.

The Justice Department investigated our staff as well as Mr. Moore, and I also insisted that they give us the results of that investigation, and both of them were found to be innocent of any kind of wrongdoing in connection with this.

But I just interject that to say that is what happens when you get close to the targets. They would start throwing around all sorts of allegations.

I do not know all the background of Mr. Moore's dismissal. I do know that he is credited by a lot of people with doing an excellent job while he was there.

Senator TALMADGE. Senator Dole?

Senator DOLE. Apparently, the other investigation will never be pursued then, right?

Mr. MOORE. Most of those plans were put out of business by the 1976 amendments which required that continuing contracting could only take place with qualified HMO's. I regret that they—perhaps I am too close to it to be sufficiently objective—I regret that the audits were not conducted because, just as California is frequently pointed to as an exception, so Omni-Rx is pointed to in California as an exception, and I must say, without hard evidence to document it, that that is nonsense. They were not the exception. They characterized the program.

Now, it is much harder to get a Federal HMO contract, or to get qualified, than it was to get those contracts. They sent in form applications, just changed the name and the date, and in many cases, they got contracts.

I am not suggesting that Federal procedures are anywhere near as poor as the State procedures were. The trouble is that we do not have the compliance apparatus in place. Once qualification is granted, they are cut loose and running, and that has inherent problems.

Senator NUNN. Would Senator Dole yield to me for just one other thing?

You were talking about investigations and whether they were being pursued. It is my information that there is a grand jury in Sacramento looking into some of these matters right now, including some of the political contributions that have been alluded to this morning. Our subcommittee has been in touch with the FBI. We have been cooperating with them. They have a rule 30 where they are going to ask us to turn over some information we have to them.

So I do not think we have heard the last of this political contribution thing, and it is being investigated by the Justice Department.

Senator TALMADGE. Any further questions?

Senator DOLE. I have none.

Senator TALMADGE. Senator Curtis?

Senator CURTIS. You mentioned some HMO's that existed prior to the Federal program.

Mr. MOORE. Yes, sir.

Senator CURTIS. Who are they?

Mr. MOORE. Most of the contractors with the State of California—and at one time we had as many as 54—were all entities created prior to the Federal HMO program. They began, some of them began, in the 1930's.

Senator CURTIS. They did have contracts with the State?

Mr. MOORE. Yes; they did, and they were privately financed. They were not financed with public funds. The only public funds they received were payments for services for their enrollees.

Senator CURTIS. Who were some of those?

Mr. MOORE. Well, the list included Omni-Rx; American Health Care in San Francisco; Health Alliance in Northern California, which is now a qualified HMO; Maxi-care in Los Angeles, which is now a qualified HMO.

The Family Health Plan in Long Beach; Family Health Care of Pomona; Kaiser——

Senator CURTIS. Well, just a few moments ago you mentioned Kaiser and somebody else?

Mr. MOORE. Yes.

Kaiser has had a small contract for prepayment in the southern California region for several years. I am not sure exactly when it began, and that was prior to the Federal HMO program.

Senator CURTIS. Now, in your direct investigation and in your observation, these HMO's that existed before the Federal legislation, has any corruption shown up among them?

Mr. MOORE. Yes.

Senator CURTIS. Which ones?

Mr. MOORE. Omni-Rx was created before the Federal program. It was a——

Senator CURTIS. Was it in operation before the Federal program?

Mr. MOORE. Yes, sir. It was in operation, I believe, as early as 1973 when the legislation was first passed. It was making campaign contributions by the spring of 1974, so it was certainly in operation by then.

Senator CURTIS. When did the Federal Act go into effect?

Mr. MOORE. Well, it became effective in the winter of 1974. The legislation was passed in 1973.

Senator CURTIS. I will rephrase my question.

The corruption, wrongdoing that you have directly investigated and has come to your knowledge, has that involved in every case activities that were financed in part by Federal funds?

Mr. MOORE. If by financed you mean were they being paid with public funds, yes.

Senator CURTIS. Got any support?

Mr. MOORE. They were being paid by public funds, but none of the programs that were in the early California development ever received—none of those that we investigated and found fault with had received any public subsidies for startup. There were a few grants made in the pre-1973 period out of old Public Health section 314 money, but those programs generally were outside of the difficulties that we saw with the others.

Senator CURTIS. What I am trying to find out is the corruption and wrongdoing existent in all HMO's or those that are primarily funded and helped by the Federal program?

Mr. MOORE. I would not say either case, from my experience, Senator. The climate that creates the abuse is not Federal subsidy or Federal payment, it is the tremendous flow of money with very low accountability and virtually no disclosure of internal operations.

I saw, in the case of a union sponsored program in Long Beach, which never got a Federal contract and never sought a State contract, the most outrageous failures, either to provide care or to manage money. They did not pay hospital bills. They finally went bankrupt because the hospital sued them.

That was a completely private operation. It never had any public dollars in it and it was designed solely to exploit the goodwill of a few of its officers and their relationship with organized labor.

Senator CURTIS. Give me a typical case of an HMO that did get Federal funds. What did they get for startup money and how much did they get?

Mr. MOORE. I would have to provide the average figures for the record. The typical programs that I have been familiar with in California have received somewhere in the neighborhood of $300,000 to $500,000 in grants prior to their ability to qualify for operational loans, for startup.

Senator CURTIS. $300,000 to $500,000 for startup?

Mr. MOORE. That is right.

Now, the average nationwide may be considerably less than that.

Senator CURTIS. What were they supposed to do with that?

Mr. MOORE. They were supposed to develop management systems—to develop their relations with the providers, to develop marketing

materials qualified under various State licensing laws and, in general, pull together the professional staff that is necessary for the operation of a complex program.

Senator CURTIS. Did they get any help after that?

Mr. MOORE. Well, then some of them go on and have qualified for loans, and I cannot tell you the average amount of——

Senator CURTIS. Do they get any more grants after that?

Mr. MOORE. No. Usually they do not get grants once they have gotten into the operational stage. They get a grant to cover their losses during an operational period, but once they become qualified they are no longer eligible for a grant.

Senator CURTIS. They get a grant to cover losses?

Mr. MOORE. Yes, sir.

Senator CURTIS. Over how long a period of time?

Mr. MOORE. It depends upon a marketing plan that has been approved. The assumption here is, you see, that they are going to have to enroll membership starting from zero, but there is a basic overhead that goes with the program whether you have one patient, one enrollee, or 100,000, and the Federal strategy was to provide financial support during that period in which they meet a marketing objective and become solvent and are then self-sufficient.

Senator CURTIS. Cite me a case of where they got a grant to pay operating costs?

Mr. MOORE. To be specific about amounts would take some research, but I know that the health alliance program in northern California received grants.

Senator CURTIS. About how much?

Mr. MOORE. I do not know, sir. I really do not know.

Senator CURTIS. You do not even have an estimate of what the nature was, whether it was $10,000 or $100,000?

Mr. MOORE. Well, it would be more in the $100,000 range. The Foundation Community Health Plan in Sacramento received grants for the development of monitoring technology. That was, again, several——

Senator CURTIS. That was after they were operating?

Mr. MOORE. Well, yes, sir. They were operating as a foundation, but they were not fully qualified as an HMO.

Senator CURTIS. Some of them did get grants to take care of their losses?

Mr. MOORE. Operating losses during a period up to the point where they were expected to become solvent are covered—can be subsidized—by Federal funds; yes, sir.

Senator CURTIS. How long is that period?

Mr. MOORE. It varies with the marketing plan and it varies with marketing circumstances.

Senator CURTIS. From how long to about how long?

Mr. MOORE. I believe the rule of thumb used by HEW is that they should make their turnaround at the end of 3 years.

Senator CURTIS. So there is a possibility that they might receive a grant for losses during the first 3 years?

Mr. MOORE. Yes.

Senator CURTIS. Now, about their loans. What kinds of loans are made? Are they fully secured? Are they joint loans where part of the money comes from some private lender?

Mr. MOORE. The loans are guaranteed by the Government itself.

Senator CURTIS. Fully guaranteed?

Mr. MOORE. I believe so. You see, rarely are there any assets to offer in these programs.

Senator CURTIS. So they are not secured?

Mr. MOORE. Not in that sense. They are simply federally guaranteed.

Senator CURTIS. Do a number of them get loans?

Mr. MOORE. There is an extensive loan program. I do not know the number nationwide.

Senator CURTIS. But I mean the ones that you are familiar with, did some of them get loans?

Mr. MOORE. Yes. Several of them have received loans. Again, HANC, as we call it, did. I am trying to think whether maxicare did or not. I am not sure.

The loan program is designed for slightly different purposes. It is a way of assuring that they will not fail because of the lack of adequate cash to meet emergencies, the acquisition of property and that sort of thing.

Senator CURTIS. It seems like the Congress set out quite an invitation for people to get in the act. They would give them sizable sums of money to start up with, make them eligible for a grant to cover their losses, and then loan them money, fully federally guaranteed, even if they have no assets. Looks like there ought to be a little bit of investigation on the Potomac. That is not your responsibility, but really, if that is not an invitation, at least to maladministration, to say nothing about corruption, I do not know how you would make one.

Now, the next thing I am going to ask for is, as much as anything else, to protect the innocent. You have referred to political contributions and named some names.

Would you, at your convenience, submit for the record the names and what office they held or were running for of the contributions that have come to your attention?

Mr. MOORE. Yes, sir. I will prepare that when I return to California.

[The following was subsequently supplied for the record:]

[State of California, Department of Corporations—News Release]

CORRECTION OF TYPOGRAPHICAL ERROR

MARCH 4, 1977.

Attached to the Department of Corporations' News Release dated March 3, 1977, issued for immediate release, there was a list of political contributions to state officials. On the eighth page (the last entry) of said listing, the contribution listed for Leo McCarthy on "9/19/76" should be deleted.

On the Federal Contributions list on page 10, the contribution of $1,000 dated 2/25/76 to McCarthy Dinner Committee should be deleted and that contribution should be listed on the State and Local Contributions list.

[State of California, Department of Corporations—News Release]

MARCH 3, 1977.

Commissioner of Corporations Willie R. Barnes announced today, Thursday, March 3, 1977, the filing of a motion to amend the existing complaint in the lawsuit of the People of the State of California against Omni-Rx Health Systems (Omni-Rx), Omni-Rx Health Care, Inc. (Care), Edward R. Dickstein (Dickstein), Merv Newell (Newell), et al. This would be the second amended complaint filed in this matter. Commissioner Barnes indicated that today's filing is part of the continuing investigation into charges against Omni-Rx Health Systems, Inc. and affiliated entities ordered by Governor Edmund G. Brown, Jr. on August 9, 1976, for which supplemental funds have been made

available to the Department of Corporations by AB 4038 which was passed during the last session of the Legislature and signed by Governor Brown on September 15, 1976.

The complaint attached to the motion filed today alleges additional violations of the California Corporate Securities Laws of Section 25401 (offer and sale of securities by communications omitting material facts), Section 25541 (scheme, device, practice or course of business to defraud in connection with offer of securities) and Section 25166 (false statements to the Commissioner) involving more than $120,000 of funds expended by Omni-Rx, Dickstein and Newell for political purposes. The complaint also alleges two additional violations of Section 25400 of the Corporations Code involving acts and transactions being effected for the purpose of manipulating the price of Omni-Rx stock.

The complaint alleges that between July 21, 1974 and December 15, 1976 Omni-Rx, Dickstein and Newell expended more than $120,000 for political purposes. Many of the payments were campaign contributions to candidates for various state and federal offices; many of which, according to the complaint, were made by Omni-Rx, Dickstein and Newell in violation of state or federal laws regulating the making of such contributions and the reporting of such contributions. No allegations in the complaint are directed toward any improper conduct by the recipients of such political contributions. Moreover, Commissioner Barnes has cautioned that no implications regarding improper conduct by recipients should be drawn from the filing of the amended complaint.

The complaint alleges that Omni-Rx, Dickstein and Newell engaged in a systematic and continuous program of making illegal payments for political purposes, all of which, under the circumstances, should have been disclosed to the company shareholders and prospective purchasers of the company's stock because the nature of such conduct and the quantification of such sums of money were material facts relating to the company's operations and financial condition. Attached to this news release is a list of political contributions to state officials for which the required disclosure filings have been made with the California Secretary of State in Sacramento. In addition, there is attached a list of political contributions made to federal officials. The complaint alleges that the contributions by Omni-Rx, Dickstein and Newell were made through the instrumentality of Imperial West Medical Group (IWMG). IWMG is a partnership controlled by officers and directors of Omni-Rx and engaged in the practice of medicine in Los Angeles. Defendant Dickstein was a principal partner in this partnership.

The new counts allege that IWMG purchased 10,000 shares of Omni-Rx stock in an open market transaction at the original offering price for the purpose of creating a misleading appearance of active trading in the sales of Omni-Rx. Further, a separate count alleges that Defendants Dickstein and Newell induced an individual to purchase 5,000 shares of Omni-Rx stock guarantying the purchase of the 5,000 shares over a period of time at a price equal to that individual's original purchase price plus 7% for the purpose of creating a false and misleading appearance as to the value of Omni-Rx stock.

This action arises out of a lawsuit filed on December 15, 1976 in Los Angeles Superior Court by Commissioner Barnes against Omni-Rx, a publicly-held corporation, Care, a non-profit prepaid health plan, five defendants who are officers and directors of the public corporation, Farmers & Merchants Bank of Long Beach, and two accounting firms, Seidman & Seidman and Gold, Kipnis and Kohn. In the lawsuit the Commissioner alleged various violations of the California Corporate Securities Law and the Knox-Mills Health Plan Act.

An amended complaint was filed on January 28, 1977 alleging additional violations of Section 25110 of the Corporate Securities Law dealing with the unqualified sale of securities by Omni-Rx, Dickstein and Newell. The amendments also alleged that Care used misleading representations and deceptive contracts in the solicitation of memberships in its Jurupa Valley Plan in Riverside County, and that Care failed to enter into written agreements with medical providers servicing the Jurupa Valley Plan.

On December 16, 1976, Judge Norman R. Dowds, Los Angeles Superior Court, ordered that a Temporary Restraining Order be issued prohibiting Omni-Rx, Dickstein, Newell and others from violating certain provisions of the Corporate Securities Law and from further advertising and violation of the Knox-Mills Health Plan Act and further prohibited among other things, the disposing, transferring or concealing any of the books or records of Defendants Omni-Rx, Care, Dickstein, Markovitz, Koch, Standers or Newell or relating to any transaction involving any of said Defendants; or from disposing, encumbering, transferring

or concealing any funds, securities, or other assets of Defendants Omni-Rx, Care, Dickstein, Markovitz, Koch, Standers or Howell.

On January 7, 1977, Judge Phillips appointed Monte A. Krissman as the Special Master of all assets and other property directly or indirectly owned, beneficially or otherwise by, or in possession, custody or control of Omni-Rx, all assets and other property to which Omni-Rx has any right of possession, custody or control in order to obtain an adequate accounting of the Defendant's assets and liabilities and to operate the business as he deems practicable.

The Special Master has the power to institute, defend, compromise and intervene in lawsuits, and to undertake such independent inquiries and investigation to the extent he deems necessary and prudent into the affairs and liabilities of all Defendants in connection with this action and related matters. He is also to cooperate fully with the Commissioner and other law enforcement and regulatory agencies, as well as, within his discretion, undertake independent inquiries and investigations.

On January 28, 1977, after a complaint had been filed by the Commissioner, Judge Phillips appointed Herbert Wolas of Los Angeles as Receiver for Care, the non-profit prepaid health plan. Wolas is appointed during the pendency of this action or until further order of the Court. He took possession of all assets and other property directly or indirectly owned beneficially or otherwise by, or in the possession, custody or control of Care.

Mr. Wolas has indicated that he will be terminating the agreement between Care to provide health care services to members of the Jurupa Valley Health Association in Riverside County.

On February 3, 1977 Judge Charles S. Vogel of the Los Angeles County Superior Court granted a preliminary injunction against Dickstein and Newell. This injunction restrains Dickstein and Newell from various violations of the California Corporate Securities Law of 1968 and from disposing, encumbering, transferring, or concealing any of the books, records, funds, securities or other assets of Defendants Omni-Rx, Care, Dickstein and Newell.

By the terms of the preliminary injunction Defendants are restrained from offering or selling any security unless they have secured from the Commissioner of Corporations a qualification authorizing the offer and sale of such securities. Further, they are restrained from offering or selling securities other than in conformity with the terms and conditions of the qualification obtained from the Commissioner and from using any written or oral communication which includes any untrue statement of any material fact or omits to state material facts in connection with the offer or sale of any security. The injunction contains further provisions concerning restraining the use of any device, scheme or artifice to defraud in connection with the offer, purchase or sale of any security. Finally, Defendants Dickstein and Newell are restrained from the filing of reports or applications with the Commissioner which contain untrue statements of material facts or material omissions.

STATE AND LOCAL CONTRIBUTIONS

Recipient	Date	Amount
Californians for Brown	May 14, 1974	$1,500
Committee to elect Marlin McKeever	May 30, 1974	100
Citizens for Brown	Sept. 18, 1974	5,000
Siegler for assembly	Oct. 7, 1974	500
Wilson for assembly	do	500
Mayesh for assembly	do	500
Wornum for assembly	do	500
Dymally Dinner Committee	Oct. 11, 1974	1,250
Brown for '74	Oct. 29, 1974	2,100
Triphon for Senator	Dec. 2, 1974	1,000
Bradley dinner committee	do	600
Dymally dinner committee	Dec. 16, 1974	1,500
Friends for Manatt	Jan. 6, 1975	1,000
Greene for Senate committee	Jan. 30, 1975	1,250
Hughes for assembly	May 1, 1975	400
Klein for council	May 15, 1975	500
Unruh dinner committee	July 1, 1975	200
Moscone for mayor	do	200
Bill Greene dinner committee	July 24, 1975	750
Burt Pines dinner committee	Aug. 4, 1975	750
Moretti dinner	Sept. 10, 1975	1,500
Otto Lacayo	do	500
Westside Democratic committee	do	200

STATE AND LOCAL CONTRIBUTIONS—Continued

Recipient	Date	Amount
Californians for an effective legislature	Sept. 16, 1975[1]	$1,250
Dymally dinner committee	Nov. 3, 1975	1,500
Moscone for major	do	100
Berman dinner committee	Nov. 12, 1975	600
Hughes' testimonial dinner	Dec. 1, 1975	750
Do	Mar. 15, 1976	1,000
Curtis Tucker campaign	Mar. 25, 1976	1,000
Mayor Doris A. Davis dinner dance committee	Mar. 30, 1976	300
Greene dinner committee	Apr. 7, 1976	1,250
Friends of Assemblyman Dixon	Apr. 22, 1976	1,500
Citizens for Waters	Apr. 23, 1976	500
Pasadena urban coalition	Apr. 26, 1976	50
Johnny Collins committee	May 3, 1976	500
Bill Greene	May 20, 1976	200
Johnny Collins committee	June 2, 1976	500
Cindy Wear election committee	do	500
Assemblyman John Knox	June 4, 1976	750
California Democratic Party	July 1, 1976	1,250
Curtis Tucker committee	Aug. 26, 1976	2,000
Lieutenant Governor Dymally election committee	Sept. 15, 1976	10,000
Leo McCarthy	Sept. 19, 1975	1,250
Friends of Paul Priolo	Sept. 30, 1976	500
Bill Greene for Senate	Oct. 7, 1976	3,750
Theresa P. Hughes dinner	do	2,000
Cindy Wear for assembly	do	500
Theresa P. Hughes Birthday Committee	Oct. 20, 1976	700
Curtis Tucker Campaign Committee	Oct. 22, 1976	2,000
Citizens for Waters	Nov. 24, 1976	1,250

[1] McCarthy.

FEDERAL CONTRIBUTIONS

Recipient	Date	Amount
United Democratic campaign committee	Sept. 12, 1974	$2,000
Tunney for Senate committee	Dec. 16, 1974	1,000
United Democratic finance committee	Feb. 18, 1975	1,000
Citizens for Tunney	May 22, 1975	1,000
Phillip Burton for Congress	do	500
Democratic victory 1976	Nov. 3, 1975	1,250
Committee to reelect Senator Humphrey	Jan. 9, 1976	2,000
McCarthy dinner committee (State and local)	Feb. 25, 1976	1,000
Tunney for Senate	do	1,000
United Democratic finance committee	Mar. 15, 1976	1,000
Committee for Dellums' congressional fund	Apr. 13, 1976	600
Carter for President committee	Apr. 26, 1976	1,000
Do	do	1,000
Do	do	1,000
Do	do	1,000
Do	do	1,000
Democratic congressional dinner committee	May 11, 1976	2,500
Horner election committee	May 12, 1976	500
Carter for President committee	May 20, 1976	1,000
Do	do	1,000
Citizens for Senator John Tunney	May 28, 1976	2,000
Democratic conv. housing	June 15, 1976	100
Do	do	100
Carter for President committee	July 7, 1976	2,500
The Andrew Young campaign	July 29, 1976	50
Paul Sarbanes	Aug. 19, 1976	1,000
Congressional Black Caucus dinner	Sept. 10, 1976	1,000
Committee to reelect Yvonne B. Burke	Oct. 7, 9176	2,000
United Democratic campaign committee	Oct. 15, 1976	1,500

Senator CURTIS. Thank you.

Senator TALMADGE. Any questions, Senator Nunn?

Senator NUNN. I just have one question.

Mr. Moore, why were you dismissed?

Mr. MOORE. The official reason was that I had become ineffective in my job because of criticisms of members of the legislature and was damaging to the program.

My own view is that I had provided some excuse because of some controversy with a couple members of the legislature but that the real reason was that they thought that by dismissing me the audit would stop, the investigation would stop, and, in fact, it did stop until newspapers in California, principally the Sacramento Bee, dwelt on the subject at such length that the administration was embarrassed into resuming the audit.

Senator NUNN. Well, when you say "they" thought that the investigation would stop, who was "they"?

Mr. MOORE. Omni-Rx and the legislators who were supporting them in their criticism of my administration of the program.

Senator NUNN. Who actually did the firing?

Mr. MOORE. I was fired by the director of the department of health, Dr. Jerome Lachner, the previous director, and I was an appointee of such a type in California which did not entitle me to any hearing or redress. I was a consultant awaiting permanent appointment, so I did not have any rights to a hearing or anything else.

Senator NUNN. Well, was that decision taken by the director of the health program himself, or was that a higher decision passed down to him, or do you know?

Mr. MOORE. He was instructed. He took responsibility for it, but clearly he was instructed by the secretary of the human resources agency to fire me.

Senator NUNN. Was that his decision? At what point do you think the decision was made, at what place?

Mr. MOORE. I think the decision was made on the day that the secretary discovered that I had sent a memorandum to the regional office in San Francisco about our findings of an illegal contract within the Omni-Rx organization and my recommendation that they withhold approval of an HMO loan application which Omni-Rx had filed until we cleared up the matter with an audit.

When they found that memorandum, I detected a noticeable change in the climate in Sacramento. I found myself hourly on trial before the people that I worked for in explaining what I was doing. I had to re-justify audits that had already been approved and the allocation of manpower which had been previously approved.

The memorandum was, I suppose—I am sure I intended it to be—extremly damaging, because they had every reason to believe that they were going to get their HMO loan.

Senator NUNN. Well, does this mean that political pressure was put on your superiors to fire you, or what kind of——

Mr. MOORE. There is no question in my mind that I was fired as a result of a combination of legislative pressure and pressure from the industry outside which had considerable leverage both within the administration and the legislature at the time.

Senator NUNN. What official in the State government made the decision to fire you in your opinion?

Mr. MOORE. Mario Obledo, who is the secretary of the human resources agency. That is the State counterpart of HEW. The reporting relationships were that I reported through a chief deputy to the director, Dr. Lackner, and it was Dr. Lackner who took responsibility for the decision because, under the statutes, he had the responsibility.

Senator TALMADGE. Thank you very much, Mr. Moore, for your contribution to our deliberations.

Our next witness is Mr. Val Halamandaris, special counsel to the Select Committee on Aging of the House of Representatives.

Mr. Halamandaris, we are delighted to have you back before our committee again. You may insert your full statement in the record and summarize it as you see fit.

Mr. HALAMANDARIS. Thank you, Mr. Chairman. I will be glad to do that.

STATEMENT OF VAL HALAMANDARIS, SPECIAL COUNSEL, SELECT COMMITTEE ON AGING, HOUSE OF REPRESENTATIVES

Mr. HALAMANDARIS. I must say it is a pleasure to be here today. I would like to say that I have the highest regard for both of the Senators from Georgia. I credit the two of you, along with Senator Moss, for the progress that we have made with respect to the fight against fraud and abuse.

Senator Nunn is personally responsible for the bill which created the Office of Inspector General within the Department of Health, Education, and Welfare.

I would like to make note of how far we have come. Five years ago when I started my digging into fraud and abuse, HEW had 10 investigators monitoring fraud and abuse for the whole country. There were 23 or 24 States that had not referred a single case of medicaid fraud for prosecution.

Thankfully all of that has changed, largely because of Senator Nunn's bill which created the Inspector General's Office and similarly Senator Talmadge's bill which created the fraud and abuse units at the State level. We are beginning to get some action. But I am still concerned that our hearings for the last 4 or 5 years have still exposed only the tip of the iceberg.

I think that most people in this room would be familiar with me and my credentials and what I have done with respect to investigating medicare and medicaid fraud in the past. I will say this, that I am here today in my capacity as a private citizens. I am not here speaking on behalf of the Senate Committee on Aging, or the House Committee, or any of its members. I am speaking privately.

I would like to summarize just briefly three of our activities. The first was to establish a phony clinic in Chicago and pretend that we were a group of physicians opening for business. We put a sign in the window and a telephone number where people could reach us.

As a result of that, vendors of all descriptions began to come in and offer us money under the table.

The second aspect of our investigation was posing as medicaid patients, which we did in five States. All of us took a physical exam, and were certified as healthy. We then began to present ourselves for treatment in various medicaid clinics.

The third aspect of our investigation was to set up a dummy corporation in Chicago and we had printed some business cards, saying "Health Care Industries." I had my name listed as Lester J. Gillis. I think I was vice president for development.

Lester J. Gillis, of course, is the real name of Babyface Nelson, the famous hoodlum. With only the business card and a physician along

for cover, we answered an ad from the New York Times, and with that small amount of color, the people who offered medicaid mills for sale made the most incredible admissions.

They would say things like, "Harry, bring the real books." And we would see glaring evidence of the kickbacks and rebates and the schemes that were going on. They seemed to be very much the norm. People discussed openly with us their involvement in payoffs to officials in the State and city health departments who were described as being "connected." They described organized crime contacts; they described a protection racket which the Mafia was running in the Bronx and pointed out to us that if we were to buy a certain medicare mill that no one could open within 20 blocks of us, and the reason for that, of course, was that the "unions won't let them."

We asked, "Well, do you have to pay the unions anything?" "Yes you have to pay them a little something." We were given the name of an individual to see and a rough idea of how much money we had to pay.

All of that information, of course, was turned over to the U.S. attorneys in the appropriate districts, particularly in the southern district of New York. As I understand it, the matters are still under investigation.

As I say in my statement, I want everyone to understand that I feel that medicare and medicaid are vitally important programs. They are something that we not only should do, but must do, if we call ourselves civilized.

If you feel the way I do, and you are subjected to what I have learned about medicare and medicaid fraud, it is very much like having to watch while someone corrupts your daughter. That is a harsh statement, but that is how I feel.

I was asked to come here today and talk about my experience with health maintenance organizations. I do not want to mislead anyone. The subject of health maintenance organizations was given the least priority of any area that we investigated. The reason for that was that Senator Nunn and his committee were giving them such great emphasis and we thought we would concentrate our efforts on other aspects of the system.

Nevertheless, we did have many complaints relating to HMO's, particularly from the State of Illinois, and that is what I am bringing here to you today, experience from a completely different State.

Our experience with HMO's started with a letter that I have supplied for the record that was received by Senator Moss. It was dated December 16, 1975. It said:

> Sir. I have to report that I have been approached by a caseworker for the Illinois Department of Public Aid to join an HMO. The worker said that if I did not join, I would lose my welfare card. I asked some of my friends in different parts of the city if this had ever happened to them and it did.
>
> I thought I would still have freedom of choice as to what doctor and what hospital I would go to.

The letter goes on to say that the man found out differently and he wanted our committee to do something about it.

Now, it was a rather staggering statement for someone to suggest that an official with the welfare department in Illinois was enlisting individuals for a private, nonprofit HMO. Nevertheless, we began an investigation and confirmed that that was exactly what was happening.

We encountered two black attorneys who were bringing a suit on behalf of a number of welfare recipients. Let's talk about Dorothy Keys for a minute.

Dorothy Keys was a young black mother in her early forties and she had two children to support. She suffered from multiple sclerosis, which left her legally blind.

The HMO salesman came to her home and promised her that she would have the benefit of the "greatest medical care in the world." Unfortunately, it did not turn out that way. Mrs. Keys found out only too soon that there was no medical care available and that she had enrolled in an HMO. The only way that she could get her medicaid card back was to go down and disenroll.

Well, she made several efforts to disenroll—and imagine this blind woman with MS making repeated trips to the HMO, signing forms, going to the callous welfare department and back and forth—all to no avail.

Her needs soon became intensified because, as happens with MS from time to time, the sight was restored in one of her eyes. But she needed glasses in order to see. Her vision was quite blurred. Nevertheless, care was unavailable and for a period of 9 months or more she went without any sort of health care services whatsoever.

I provided a number of other examples. Take Gertrude Henry who was a 69-year-old black lady who was responsible for two minor children. One day in November Mrs. Henry found out that she did not receive a medicaid card in the mail and called up the welfare department caseworker. The caseworker said, "Well, of course you do not have a medicaid card. You are enrolled in the HMO."

And the woman could not understand how she got enrolled for the HMO. She certainly did not give her consent, sign any papers.

An inquiry was made and the HMO officials swore up and down that two salesmen had been present when she had signed papers agreeing to sign up with the HMO. This woman was then presented with the option of going downtown to the HMO and back to the welfare department five or six times signing disenrollment forms. She, too, was not able to disenroll.

Imagine this woman that was told that she has to sign forms to disenroll in order to be able to get her medicaid card back when she did not sign forms to enroll in the first place.

Now, Henrietta Lee, similar experience. Henrietta Lee had a kidney stone opeartion. She needed care. Her daughter was suffering from double vision. Both went untreated for exactly the same reasons.

Gloria Lenisey is another person in Chicago who was signed up by an official of the welfare department and given repeated promises. The story repeats itself over and over again.

Now, the natural question is what do these people do for care. The answer is given by Carrie Montgomery. She too was enrolled in an HMO but couldn't get care. After her child was involved in a car accident she became desperate. She went into the hospital emergency room and gave them the medicaid number which she had been given several months before.

In other words, she subjected herself to criminal and financial liability in order to get care.

A final example is Miss Joyce Gradley. Joyce was told that she was going to be eligible for a new consumer buying club. They were going

to teach Joyce how she could save 25 to 50 percent on purchases over retail, and this program was supposed to be only available to welfare mothers. In order to prove that she was a welfare mother, Joyce had to show her medicaid card.

Well, of course, what the officials did is took the number off the medicaid card and then enrolled Joyce in the HMO without her consent.

As you can see, I have encountered many of the same problems with HMO's that Senator Nunn articulated so well in his statement. I think that there are severe problems.

In my statement I point out the financial difficulties that this particular HMO encountered. An audit was ultimately conducted because of disclosures of financial mismanagement in the Chicago Sun Times. An audit revealed that literally hundreds of thousands of medicaid funds were used to buy questionable trips to Las Vegas, Nev.; Florida; California.

There were purchases for liquor, flowers, art, clothing, support of the directors of the HMO in a very opulent style of life. They left a trail of fine restaurants from one end of the country to another, all charged to the program.

There was evidence of a double billing practice in which the HMO physicians who were already receiving one fee through capitation were also billing patients privately.

There were some $200,000 in legal fees which, interestingly enough, were paid to lawyers who were involved and affiliated with the HMO. One was a founder of the HMO as a matter of fact. The appropriateness of these legal fees were questioned by the auditors.

Then there were questionable loans which were made to so-called agents who did their best to enlist patients in the HMO.

Now, the interesting thing to me is that, sure enough, the HMO went bankrupt and the State of Illinois revoked its permission to operate but there is no indication with any involvement from HEW any place in this story in Chicago.

The other problems that Senator Nunn has referred to are also present in that case particularly selective enrollment and selective disenrollment.

I think that that pretty well covers the Illinois experience. I would just like to articulate some of the other concerns that I have.

I am troubled by the lack of any sort of efficiency ratios. As far as I know, there is no Government requirement that limit administrative costs or requires that a certain amount of HMO funds must actually be spent on health care.

I am troubled by the lack of quality controls in HMO's.

I am troubled by the HMO's that appear to be nonprofit but really subcontract with related or for-profit entities. Some of these institutions are nonprofit in the same sense that John Dillinger was nonprofit.

I would like to see some controls established. I am very much concerned about the lack of disclosure of ownership. We have made some strides in the Talmadge bill. Nevertheless, there are no penalties provided in the law if a man fails to disclose his interest in an HMO or a nursing home or any other public institution.

I would posit to you that if you were to try to establish the ownership of an HMO, you would have a good deal of difficulty. The same thing would exist if you tried to establish ownership of nursing homes.

You might go to the secretary of state's office and you will get one list of owners. If you do a title search on the facility—its property—you will get a completely different list. If you look to find out who is paying the taxes you have yet another list. In the end it is impossible to tell who owns America's health care facilities whether we want to talk about hospitals or HMO's or nursing homes or home health agencies, I think that needs to be changed.

I think there need to be some penalties for failure to correctly identify ownership of health care facilities.

I am gravely concerned about the franchising of HMO's. I am concerned because from our experience in trying to buy medicaid mills in New York, we found out that much of the ghetto has already been staked out. People who will let us rent a certain amount of space, would tell us that they are reserving the top three floors for National Health Insurance. Often they would say with a wink, we are going to put an HMO in.

I can tell you that from my own experience, that the ghetto is already being carved up in anticipation of National Health Insurance.

I am concerned about what I call the creation of medicaid malls, or one-stop health-care shopping. That is the direction we are going, everything from cradle to the grave will be available in one central location. The ticket for admission will be a medicaid card.

I am also concerned that Government dollars are going to buy the best lawyers and accountants available and these lawyers and accountants, paid by Government moneys, are being used to subvert the Government's efforts to regulate facilities and to subvert the prosecution of fraud cases.

I am also concerned about the fact that Government funds, through medicare and medicaid, are winding up in the pockets of a few unscrupulous politicians. I am very sad about the evidence that politicians have intervened improperly in the regulation of health care and in the prosecution of medicare and medicaid cases.

I am very concerned about the specter of organized crime, the involvement of the Mafia in health care. I am very, very concerned that no one seems to be doing much about defining the limits of that involvement and, doing something to stop it.

I thank you very much for your attention here today, Mr. Chairman, Senator Nunn. As I said in the beginning, it is a privilege for me to be here and I can think of no two Members of the Senate for whom I have a higher regard.

Senator TALMADGE. Thank you very much, Mr. Halamandaris, I am familiar with the excellent work you have done in this field, particularly when you were with Senator Moss' Subcommittee on Aging.

I understand that you did intensive investigative work in California for the Senate Committee on Aging. Have you found evidence of campaign contributions such as those described by Mr. Moore?

Mr. HALAMANDARIS. Mr. Chairman, it would be inappropriate for me to comment on matters that are now before the Department of Justice.

Senator TALMADGE. That are before the Department of Justice at the present time?

Mr. HALAMANDARIS. That is correct.

Senator TALMADGE. In your years of investigative work, what types of health care facilities and services have you looked into?

Mr. HALAMANDARIS. Mr. Chairman, we have looked into fraud and abuse in virtually every area of health care, concentrating on nursing homes, medicaid mills, hospitals, home health agencies, the list.

Senator TALMADGE. In which of these areas did you find evidence or allegations of organized crime involvement?

Mr. HALAMANDARIS. In every area, Mr. Chairman.

Senator TALMADGE. For example, in your exposé of the medicaid mills, what indications were there of criminal involvement?

Mr. HALAMANDARIS. Mr. Chairman, that is where we obtained our best evidence and I characterized that a few minutes ago in my statement. It came when we posed as businessmen from Chicago. I wore my loud suit and represented myself as Lester Gillis. On one occasion when we answered an ad in the New York Times, we recognized the name of the man who answered on the other end of the phone.

We went to the U.S. attorney immediately and told him about the conversation. He supplied us with the hidden tape recorder.

And, in that instance, we recorded a rather frank discussion first his medicaid mill and later in the subject's car during which he described the involvement of organized crime and his deals with the Gallo and Colombo families. He described, with great particularity, the protection scheme which is being run in the Bronx, among medicaid mills on the Grand Concourse.

I do not want to be any more specific than that in public. I would be glad to provide more details in executive session if the committee is interested.

Senator TALMADGE. In your investigation, did you encounter any allegations or evidence indicating involvement by the unions, or union officials and possibly illegal activity in the health care field?

Mr. HALAMANDARIS. Yes, Mr. Chairman, that is correct. We did encounter numerous allegations. We did not follow those allegations. They were referred to appropriate agencies. We simply did not have the time or the manpower to follow them. Also, it was a little bit beyond our jurisdiction as the Senate Committee on Aging.

Senator TALMADGE. To your knowledge, do you know whether or not that investigation is being continued by the appropriate agencies?

Mr. HALAMANDARIS. Yes, sir, I can confirm that because of a conversation that I had last Wednesday with the New York U.S. attorney's office.

Senator TALMADGE. Thank you very much, Mr. Halamandaris. We appreciate your contributions to the committee's deliberations.

Mr. HALAMANDARIS. Thank you.

[The prepared statement of Mr. Halamandaris follows:]

STATEMENT OF VAL J. HALAMANDARIS

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to share with you some of my experiences investigating fraud and abuse in government health care programs.

As you know, I served as Associate Counsel to the Senate Committee on Aging. Working with Senator Frank E. Moss; I directed the Committee's investigations into clinical laboratories, medicaid mills and nursing homes. A month ago, I joined the House Select Committee on Aging. I should like to make it

clear that I am here today as a private citizen. I do not speak for either Committee or any member of Congress.

Although our investigation covered many areas over the past several years our 1976 investigation into clinical laboratories and medicaid mills received the most attention. In that investigation we established a storefront clinic and posed as physicians opening for business. We put a simple sign in the window announcing the opening and were inundated by vendors who offered us kickbacks and rebates if we would agree to channel our business to them. A second step was to pose as Medicaid patients. Armed with Medicaid cards furnished by the United States Attorney's office, we visited storefront clinics similar to the "front" which we established in Chicago and offered ourselves for treatment. Our investigation revealed a pattern of poor care and widespread abuse. The third step in our investigation was to establish a dummy corporation, Health Care Industries. We set up a phony office in a Chicago office building. In reality it was nothing more than a closet augmented by an answering service. We had equally phony business cards printed up. I was Lester J. Gillis, Vice President for Development. Lester Gillis was the real name for the gangster, Baby Face Nelson. Accompanied by a cooperating physician we answered ads in the New York Times which touted Medicaid mills for sale. Medicaid mill owners were only to glad to "bring out the real set of books" and demonstrate how profitable the Medicaid mill business was. They made frightening admission about their participation in Medicaid fraud, about Union corruption, provided the names of people within the City and State Health Department who were "connected", outlined a protection racket which the Mafia is running in the Bronx and admitted it was a common practice to set fire to Medicaid mills occasionally in order to collect the insurance.

What we learned was that Medicaid fraud was pervasive. For example, 12 labs controlled most of the Medicaid business in Illinois. Eleven of the 12 labs visited our phony clinic and offered us illegal kickbacks. That investigation was featured on CBS "Sixty Minutes." In more than half of our visits as Medicaid patients we found outright fraud. Billings received by the State indicated that we had been seen by providers we hadn't seen and were given tests we didn't have for a broad range of illnesses—perfectly healthy Senate investigators were diagnosed as having everything from syphillis to a heart murmur. In an audit performed by the General Accounting Office of patient's personal funds held in trust by nursing homes in five states, the GAO was startled to learn that every nursing home in its sample was misusing funds to one extent or another.

I want to assure you that I share your feeling that the Medicare and Medicaid programs are vitally important. And like you on this Committee, I am concerned by the fact that many Americans are going without the health care they need. When you feel as I do that these programs are not only something that we should do but that we must do if we call ourselves civilized, it is a severe shock to learn the extent to which government programs have been perverted. The experience is a little bit like having to watch while someone corrupts your daughter.

I was asked to share with you my experience as it relates to health maintenance organizations (HMOs) which provide a broad range of health care services to groups of individuals at a fixed rate per individual or per family per month. I think HMOs are an excellent concept but there have been some severe porblems with them that we will need to correct. Our experience with HMOs primarily focused on the State of Illinois.

It started with the following letter which I would like to read to you.

DECEMBER 16, 1975.

Sen. FRANK B. MOSS,
Long Term Care Subcommittee, Senate Special Committee on Aging, U.S. Senate, Washington, D.C.

SIR: I have to report that I have been approached by a case worker for the Illinois Department of Public aid to join a HMO.

The worker said that if I didn't join I could lose my welfare card. I asked some of my friends in different parts of the city if this ever happened to them, and it did.

I thought that I still had freedom of choice as to what doctor and what hospital I wanted to go to. The locations of the HMO is not near my home and this would mean that I would have to spend money to see a doctor when now all I have to do is walk a few blocks.

I thought that welfare people's names are not to be made public and if so how did they get my name.

I think something should be done about this.

The welfare workers must be getting something back from the owners of the HMO.

I am holding back my name for fear for loosing my card.

Thank You.

After a raft of similar cards and letters we began investigating the first and largest HMO in the state of Illinois. The politically connected firm received $4.3 million in Federal and State funds and served the predominantly black community on the Westside of Chicago. In the process we encountered two young black attorneys who were in the process of preparing a law suit against the HMO and the state Welfare Department. The suit alleged that individuals were forced to sign up for the HMO and that officials of the welfare department were acting as agents for the HMO. The Court records describe the plight of many people.

Take Dorothy Keys for example, a young black mother in her early forties with two children to support. Mrs. Keys suffers from multiple sclerosis and was legally blind. Salesmen from the HMO came to her home and described the "greatest medical care in the world" for her children and herself if she would only sign the form. It was represented to her that she would not lose her Medicaid card or her right to select the physician and hosptial of her choice. The HMO was described as a wonderous new benefit available only to welfare mothers with special disadvantages. To her surprise, Mrs. Keys did not receive her Medicaid card the following month. She needed the services of a physician for one of her children and was turned away because she did not have a card. Her trips to the welfare department were fruitless, she was directed to the HMO which now controlled her destiny. Until they released her she couldn't get a card she was told. The next 9 months were spent ice-skating back and forth between the welfare department and the HMO trying to get disenrolled. Mrs. Keys needs became quite acute. The sight returned in one eye but it was blurred and she needed glasses but was not able to obtain any.

Gertrude Henry is a 69 year old lady who is the legal guardian for two grandchildren. In November of 1974, she and her children did not receive their Medicaid cards as usual. She called the welfare department. They told her she was no longer qualified since she had joined the HMO. Mrs. Henry said she didn't join anything. Nevertheless she had to visit the HMO to disenroll. Only then would her Medicaid card be returned. Mrs. Henry protested that she didn't see why she had to sign to disenroll when she hadn't signed anything to enroll. After repeated trips first to the HMO and then to the welfare office over a period of a year, her Medicaid card was never returned to her. In the meantime, her grandson developed a lung condition and could not receive care.

Henriette Lee, who supports seven children had an identical story. She had a kidney stone operation in February of 1975 but was unable to obtain follow-up care. Her daughter was suffering from double vision and went untreated.

Gloria Lenisey was one of those who got a visit from an official of the welfare department. He told her of the wonders of the non-profit HMO, described how the medical plan was good all over the world and was explicit that she would not lose any existing privileges. Of course she did lose her card. Inevitably her child became ill with a 106 degree temperature. The welfare department callously referred her to the HMO. The HMO told her she had to go to the downtown office to disenroll. The downtown office told her she had to go back to the HMO clinic on the Westside. In the meantime the child developed an even more severe problem.

The natural question is what did these welfare mothers have to do to get care for their children. Carrie Montgomery gives us the answer. She too, was approached by a caseworker from the Illinois Department of Public Aid and enticed to join the HMO. She said the man knew a great deal about her. She was distraught with the manner in which the man threw confidential information around. She too was told she would not be losing her freedom of choice and the right to continue using a Medicaid card. A month later she got the bad news.

Mrs. Montgomery soon thereafter began to suffer from severe chest pains and went to the HMO for some of the promised best care in the United States. The doctor she saw told her to disenroll and go back to her private physician. She tried for two months to disenroll without success. Finally her child was involved in a car accident and a physician sent them both to a private hospital using an

old Medicaid card number thereby subjecting Mrs. Montgomery to financial and criminal liability.

As a final example, there was Joyce Gradley and her 5 children. A saleman for the HMO told her that she was eligible for a special program designed to assist welfare mothers. If she could prove she was a welfare patient she would be enrolled in a Consumer Buying club which would teach her how to save one-third to one-half of normal retail prices. She showed the man her card. The next month she did not receive her Medicaid card. She inquired and was told she had enrolled in an HMO. She called the HMO and two salesmen visited her with the "greatest medical care in the world speech". Her child was hit by a bus and was taken to the hospital where the physician indicated the child needed surgery. The child was discharged after a three week stay. The hospital had not been able to straighten out who would pay for the little girl's operation. On a follow-up visit the child condition proved so serious the physician tried to have her admitted. Finally, the desperate mother explained that she has received a new card but had left it home. Giving the number from her old card the child was finally accepted for care.

After the child's release, the charade went on for several more months. Mrs. Gradley received huge bills which the hospital expected her to pay. Welfare refused to accept responsibility. The HMO refused to disenroll the family.

These are but a few of the more dramatic examples from court testimony which ultimately ended with Medicaid cards being restored and the Illinois Department of Insurance opened an investigation.

Two of the partners in the HMO had a falling out. One charged the other with siphoning off hundreds of thousands of dollars. The Chicago Sun-Times disclosed severe financial irregularities. An audit was commissioned by the Insurance department.

The confidential audit by Ernst and Ernst disclosed that hundreds of thousands of Medicaid funds were used to pay for questionable items including trips to Las Vegas, Nevada, Florida and California. Funds meant to purchase health care for the poor were used to buy liquor, flowers, art sculpture, clothing and to support the HMOs directors in an opulent life style, leaving a trail of expensive restaurants across the country. There were $1,000 for hams and turkeys which were furnished for the HMOs Christmas party.

There was evidence of double billing practices in which the HMO physicians billed patients for care which was already paid for by the monthly capitation fee paid to the HMO.

Almost $200,000 in legal fees were paid to two lawyers who has been partners; one was a director and founder of the HMO.

There was also evidence of "loans" to HMO officials in charge of recruiting new members.

All of these charges, of course, came out of the till of the not-for-profit HMO. Not surprisingly, the plan became insolvent and the Welfare Department belatedly refused to renew its contract with the plan.

There is no indication of HEW involvement anywhere. Action was taken only because of disclosures in the Chicago Sun-Times and because of a pending suit.

All of these problems are familiar to the Senate Finance Committee. You have heard about other abuses. There is selective enrollment. The Illinois plan would sometime arrange to give patients a full physical in Medicaid mills said to be related and then have them enrolled in the HMO. The advantage is screening and billing the program for additional services.

Then there is the problem of selective disenrollment. Thos who are really sick are often told, like the lady in my example, to go back to their regular doctor.

It's my feeling, that door to door salesmen creat serious problems. They can apply considerable pressure on uneducated people to cause them to enroll. The problem with misrepresentation of services is obvious. In many cases the names of those supposedly enrolled have been forged.

I am troubled by the fact that there are no efficiency ratios for HMOs. There is no limit on administrative costs. I believe there should be minimum efficiency ratios delinlating that a certain amount of HMO funds must be spent on health care.

I am disturbed by the lack of quality control in HMOs.

I am concerned by the HMOs which appear non-profit but who contract with related for profit firms. Because of the paucity of data, it is impossible to tell who owns the various entities affiliated with an HMO. The opportunities for

self-dealing are limitless. There are no penalties for failure to accurately disclose financial or beneficial interests to the government.

I am gravely concerned about the possible franchising of health care services, particularly HMOs. In posing as mobsters trying to buy Medicaid mills, we learned that much of the ghetto has already been staked out. People were willing to rent us certain space here or there and would pass out comments such as: "We're saving the top three floors, we're going to put in an HMO. We'll be ready when National Health Insurance comes along." It was amazing to me to learn the degree to which these ghetto operators were apprised of what was happening here in Washington.

I am concerned that health care wheeler dealers will seize on the HMO and begin opening their own Medicaid mills. By that I refer to one-stop shopping in health care; the medical shopping center. I worry that their purpose will be making money not providing health care.

I am concerned that government money from Medicare and Medicaid is presently being used to hire the best lawyers and accounts which are used to subvert the government's efforts to regulate health care and fight fraud.

I am concerned that taxpayers dollars paid to Medicaid providers is also finding its way into the pockets of a few unscrupulous politicians who have improperly intervened in the prosecution of Medicare and Medicaid fraud cases.

I am even more concerned that for all our efforts we seem only to be able to prosecute a few lawbreakers who actually run medical mills or clinical laboratories. We don't seem to be able to make criminal cases against those involved at higher levels.

I am concerned about the spectre or organized crime in the health care field and the fact that no one is doing anything to prevent the Mafia from muscling into Medicare and Medicaid.

I think it can accurately be said that we have accomplished a great deal to sensitize the public with respect to the problems of fraud and abuse. When we strated out three years ago with hearings concerning Rabbi Bernard Bergman, we learned that 23 states had never referred a single case of Medicaid fraud for prosecution; 22 states had never audited a single provider. Thanks to your leadership Senator Talmadge, we now have an Inspector General in HEW who is charged with rooting out fraud. We have state Medicaid fraud units which are springing into action.

Yes, there has been some progress but there is still so much that must be done. Our time to do it grows short. The public demand for national health insurance is increasing. People are becoming impatient for the services they need. Before we move forward to the national health insurance program we all desire we must do everything possible to secure the financial integrity of Medicare and Medicaid. We can then apply those lessons to prevent the new national program from being another gigantic ripoff.

Thank you for your attention.

Senator TALMADGE. I would suggest, gentlemen, that the staffs of our subcommittees get together and look at these various documents.

Wherever it is appropriate, I suggest that we refer the testimony and documents to the Secretary of HEW, the Inspector General of HEW, the General Accounting Office, the Department of Justice, and the Internal Revenue Service, all where appropriate.

Thank you very much.

The committee will stand in recess, subject to the call of the Chair.

[Thereupon, at 11:15 a.m. the subcommittee was recessed, to reconvene at the call of the Chair.]

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