92d Congress
2d Session

CONFIDENTIAL COMMITTEE PRINT

5

STAFF DATA ON H.R. 1:

MEDICARE-MEDICAID

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

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

MARCH 8, 1972

Prepared by the staff and printed for the use of the Committee on Finance

---

U.S. GOVERNMENT PRINTING OFFICE
74-330 WASHINGTON : 1972

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

CLINTON P. ANDERSON, New Mexico	WALLACE F. BENNETT, Utah
HERMAN E. TALMADGE, Georgia	CARL T. CURTIS, Nebraska
VANCE HARTKE, Indiana	JACK MILLER, Iowa
J. W. FULBRIGHT, Arkansas	LEN B. JORDAN, Idaho
ABRAHAM RIBICOFF, Connecticut	PAUL J. FANNIN, Arizona
FRED R. HARRIS, Oklahoma	CLIFFORD P. HANSEN, Wyoming
HARRY F. BYRD, Jr., Virginia	ROBERT P. GRIFFIN, Michigan
GAYLORD NELSON, Wisconsin	

TOM VAIL, *Chief Counsel*

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Payments to Health Maintenance Organizations

Problem

Certain large medical care organizations (such as the Kaiser and San Joaquin Foundations) seem to make the delivery of medical care more efficient and economical than the medical care community at large. This is attributed, in part, to their operation on a prepaid basis at fixed amounts which may give them incentives to keep costs low and control utilization.

Medicare does not currently pay these comprehensive programs on a prepayment basis, and consequently the financial incentives to economical operation in such programs have not been incorporated in Medicare.

House Bill

Authorizes Medicare to make a single combined Part A and B payment, prospectively on a capitation basis, to a "Health Maintenance Organization," which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 95 percent of present Part A and B per capita costs in a given geographic area.

The Secretary could make these arrangements with existing prepaid groups and foundations, and with any new organization which meets the broadly defined term "Health Maintenance Organization."

Recent Legislative History

The provision is similar to the House-passed version of H.R. 17550. It does not include a number of modifications designed by the Finance Committee on Finance in 1970 as safeguards against inappropriate reimbursement and substandard quality care. The omitted Senate conditions required HMO's to provide out-of-plan maintenance therapy; required HMO's to have a minimum size of 10,000 enrollees; authorized the Secretary to make retroactive adjustment of the 95% reimbursement level based upon actual actuarial experience; and limited dollar retention on premiums for the elderly to not more than 150 percent of the amount retained for persons under age 65.

Discussion

The Committee studied the HMO provision in connection with H.R. 17550, and the staff with the approval of the Committee continued the study during 1971. A series of questions were posed to the Department of HEW, and the questions and Departmental responses

were published in September of last year. As a result of that study, the staff believes that the HMO approach offers some potential advantages for the Medicare program that should be developed. However, there are a number of serious problems with respect to HMOs which should be remedied. Consequently we have developed more comprehensive suggestions for HMO modification designed to reasonably safeguard the interests of the public programs and beneficiaries while, at the same time, not discouraging the development and recognition of qualified HMOs.

The most important of these, developed more fully below, would limit recognition of an organization as an HMO for purposes of reimbursement on an incentive per capita basis under Medicare and Medicaid to those organizations which have demonstrated capacity over a reasonable period of time, to actually provide appropriate care and treatment to a substantial number of enrollees. The virtue of this posture is that Medicare and Medicaid would acknowledge for preferential payment, known quantities and qualities only, rather than speculating on unknown groupings with uncertain capacity to fulfill obligations. An organization which has been providing care to a sizable population over time is capable of measurement in terms of what it is, in fact, doing and what it has, in fact, done. This avoids buying a "pig in a poke." Additionally, ratemaking and actuarial calculation are enhanced and made more precise where the enrollment, operations, and experience of an organization are known.

There are two overall problem areas. The first area of concern involves the quality of care which the HMOs will deliver. Most existing large HMOs provide care which is generally accepted as being as of professional quality. However, if the Government begins on a widespread basis, to pay a set sum in advance to an organization in return for the delivery of all necessary care to a group of people, there must be effective means of assuring that such organizations will not be tempted to cut corners on the quality of their care (e.g., by using marginal facilities or by not providing necessary care and services) in order to maximize their return or "profit." Under present reimbursement arrangements, although there may be no incentive for efficiency, neither is there an incentive to profit through underservicing and other corner-cutting.

The second problem area involves the reimbursement of HMOs. If an HMO were to enroll relatively good risks (i.e., the younger and healthier Medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustments—could result in large "windfalls" for the HMO, as the current costs of caring for these beneficiaries might turn out to be much less than Medicare's average per capita costs. Additionally, ceilings on windfalls might be evaded because an HMO conceivably could inflate charges to it by related organizations thereby maximizing profits through exaggerated benefit costs.

It may not always be possible to detect and eliminate such windfalls through actuarial adjustment. Further, once a valid base reimbursement rate is determined, an issue remains as to the extent to which the HMO, and the Government should share in any savings achieved by an HMO.

Suggestions Regarding HMO Provisions of H.R. 1

Recognizing the foregoing problems and agreeing with the desirability, in a pluralistic health care system, of authorizing reasonable per capita payments (as an option along with fee-for-service payment) to organizations which have reasonably demonstrated a capacity to provide quality health care in an organized and effective manner, the Department and the staff suggest the following approach as a modification of the HMO amendment in H.R. 1:

ELIGIBILITY

Established HMO's

The Secretary should be authorized to contract on a prepaid per capita basis for Medicare services with substantial, established HMOs: (1) with reasonable standards for quality of care at least equivalent to standards prevailing in the HMO's area, and which can be adequately monitored, and (2) which have sufficient operating history and sufficient enrollment to provide an adequate basis for evaluating their ability to provide appropriate health care services and for establishing a combined Part A-Part B capitation rate.

General Requirements

Such reimbursement could be authorized for HMOs which: (1) have been in operation for at least two years, and (2) have a minimum of 25,000 enrollees, not more than one-half of whom are age 65 or over.

Exception

The Secretary would be authorized to make exceptions to the minimum enrollment requirement in the case of HMOs in smaller communities or sparsely populated areas which had demonstrated through at least 3 years of successful operation, capacity to provide health care services of proper quality on a prepaid basis and which have at least 5,000 members.

HMOs with less than 25,000 enrollees would present special problems because of the difficulty of determining a valid rate on a relatively small population base, and because such organization will have less in-house capacity to provide medical specialty services.

Accordingly, exceptions to the 25,000 minimum enrollment principle should not be permitted unless the Secretary is adequately satisfied that the smaller HMO has (1) established effective referral mechanisms to assure that its enrollees have the benefit of appropriate specialty services so that they are not disadvantaged with respect to quality of care as compared with other residents of the same geographical area, and (2) has operating experience and an enrolled population sufficient by reason of nature and number to provide a reasonable basis for establishing a valid reimbursement rate.

New HMO's

HMOs with less than two years operating experience are not apt to have a Medicare population sufficient to provide a satisfactory basis for evaluating their actual ability, in fact, to deliver health care serv-

ices in satisfactory fashion to beneficiaries and for actuarial rate determination. Nor will their operating experience be sufficient to provide a sound basis for estimating financial requirements for a year in advance. Thus, a per capita reimbursement rate would be difficult to develop and administer, and would involve excessive uncertainty both for the Government and for the HMO.

However, it may be that new HMOs desire to function under a payment method that simulates the per capita rate system of payment so that the organization can become accustomed to planning and functioning on the basis of a predetermined budget rather than in traditional fee-for-service terms. Accordingly, the Secretary could be authorized to contract with developing HMOs for an interim periodic payment method of reimbursement to cover both Part A and B services (provided the HMO undertakes responsibility for providing or arranging all such services). This payment would be interim only and would be subject to adjustment at the end of the contract period to reflect the HMO's actual costs (not including any amounts not otherwise reimbursable under Medicare).

Under this option, developing HMOs would neither have an opportunity to profit nor be at risk.

HMOs in the developing category might, of course, be eligible for grant, loan, and loan guarantee assistance under existing authority or future HMO assistance legislation currently pending before the Congress.

After two years of operation and the enrollment of a minimum of 25,000 enrollees, such HMOs would become eligible to apply for reimbursement as established HMOs. The same would be true after three years of operation in the case of HMOs in smaller communities and sparsely populated areas with 5,000 enrollees under the exception provisions previously discussed. The 2 or 3 year operating period would not be deemed to commence until the organization was, in fact, functioning as an HMO with a significant enrolled population; that is, starting with the time when it has enrolled at least one-third of the minimum enrollment requirements.

To provide additional flexibility, the Department and the staff also recommends that new HMOs which are divisions or subsidiaries of an established HMO and for which an established HMO is willing to assume responsibility for financial risk and assurance of adequate management and supervision of health care services would be eligible for treatment as an established HMO and would not be required to demonstrate actual experience. In addition, two or more independent HMOs might be permitted to combine through merger or effective affiliation arrangements, in order to satisfy the minimum enrollment standard. As in the case of the limited exception to the minimum size requirement previously discussed, the Secretary would be expected to exercise careful judgment to assure that the relationships between established and new HMOs or between 2 or more smaller HMOs which wish to combine to meet the 25,000 member standard are effective and viable, rather than pro forma.

The following recommendations apply to established HMOs and, where applicable (but not as to reimbursement), to new HMOs with which the Secretary contracts on a simulated per capita basis.

Definition

For the purposes of H.R. 1, in addition to the various requirements, the staff recommends a minimum definition embodying the following elements:

(*a*) The organization (or group of cooperating organizations) constituting the HMO shall organize delivery of health care services with clearly identifiable focal points of responsibility for all managerial, administrative and health service and health coordinative functions.

(*b*) It should assume responsibility for providing (or effectively arranging for) reasonably comprehensive health care services (including at least those basic physician and hospital services which are generally available to the general public in the HMO's service area) on a prepaid basis to voluntarily enrolled participants.

(*c*) It should receive compensation for such services to its enrolled participants, primarily on the basis of a predetermined periodic rate; it may serve non-enrolled beneficiaries on a traditional payment basis, and may require modest co-payments to supplement its predetermined periodic rate for services to enrollees.

(*d*) It should be responsible for providing all covered services for a contract period with the revenue provided through the predetermined rate and predetermined co-payment method of reimbursement, under arrangements whereby the organization bears, and the cooperating units within the organization (including individuals or groups responsible for professional medical services) share responsibility for the appropriate and effective utilization of health care resources to meet the health care needs of the enrollees.

Other Requirements

An HMO, as defined above (subject to the distinctions between "Established HMOs" and "Development HMOs" discussed above), would be eligible to contract for Medicare services under the incentive per capita reimbursement systems, if it met the following additional requirements:

(*a*) It would contract for Medicare services on an annual basis, with an annual open enrollment period for Medicare beneficiaries under which it accepts Medicare beneficiaries on a first-come, first-served basis, and without underwriting restrictions up to the reasonable limits of its capacity. However, an HMO might maintain a policy of enrolling a reasonable cross-section of the population in its service area in which event its capacity for Medicare enrollees would not be required to exceed by more than 10 percent that portion of its enrolled population which would be equivalent to the percentage of over-65 persons in the general population in the service area.

(*b*) It should offer on an optional basis, a Medicare supplemental plan (or plans) providing appropriate health maintenance services in addition to Part A and Part B services and it may also offer additional benefits supplemental to Medicare coverage. It

may charge a reasonable premium for coverage supplemental to Medicare benefits.

(*c*) It should have and maintain an appropriate mix of primary care and specialty care physicians in relation to its size and in relation to the physician manpower mix in the general geographical area; HMO associated physicians should not be classified as specialists unless they are board certified or eligible for specialty board certification; provided, however, that for good cause and under unusual circumstances the Secretary might recognize a physician as a specialist if, in fact, such physician can show substantial equivalence of training and experience, and a record of demonstrated proficiency.

The HMO would be expected to assure that the appropriate mix of specialists is properly assigned and utilized. Thus, for example, in an area where major surgery is generally done by board eligible or board certified surgeons, it should not be acceptable for an HMO to utilize general practitioners for the performance of major surgery except in cases of emergency or other highly unusual circumstances.

(*d*) It should have effective referral arrangements to assure that HMO members would, in cases of medical necessity, have access to qualified practitioners in those specialties which are generally available to the general public in the service area but not included within professional staff directly associated with the HMO.

(*e*) Its responsibilities should include coverage of emergency services including services reasonably obtained by beneficiaries from non-HMO sources and emergency and urgently needed services obtained outside of the HMO's service area, subject to reasonable restrictions. The intent of this suggestion is not to encourage HMO enrollees to seek elective services from other sources but simply to assure that they are not denied Medicare benefits for emergency and urgently needed services because of temporary absence from the HMO's service area—such as a vacation trip.

(*f*) HMOs would be a part of the quality of care monitoring process in accordance with the Professional Standards Review Amendment previously approved by the committee.

Reimbursement

The Department and staff recommend that the combined Part A-Part B per capita payment be determined and administered as follows:

1. An eligible HMO approved by the Secretary for per capita reimbursement would submit, at least 90 days prior to the beginning of a prospective Medicare contract year, an operating costs and enrollment forecast. On the basis of the estimate and available information regarding Medicare costs in the HMO's area, the HMO and the Secretary would arrive at an interim per capita reimbursement rate. The rate would reflect estimated costs of the HMO for its enrolled population but might not exceed 100 percent of the estimated "adjusted average per capita cost" (as defined below).

2. At the beginning of the contract period, the HMO would be paid monthly, in advance, the interim per capita prepayment for the Medicare beneficiaries actually enrolled. The HMO would submit interim cost reports on a quarterly basis and the interim payment would be adjusted as indicated in such cost reports, subject however to the limitations set forth below.

3. The HMO would submit, annually, independently certified financial statements, including certified costs statements allocating HMO operating costs to the Medicare population in proportion to utilization of HMO resources. Allocations may use statistical, demographic and utilization data collection and analysis methods acceptable to the Secretary in lieu of fee-for-service or cost-per-service methods in the case of an HMO which does not operate on a fee-for-service basis. Such statements would be developed in accordance with Medicare accounting principles. All HMOs would be subject to audit in accordance with the selective audit procedures of the Bureau of Health Insurance and would also be subject to audit and review by the Comptroller General (and the Inspector General for Health Care administration).

4. The Secretary would retroactively determine on an actuarial basis what the per capita costs for Part A and Part B services for the HMOs' Medicare population would have been if the population had been served through other health care arrangements in the same general area and not enrolled in the HMO. That is to say there would be a calculation, on the basis of experience in the same or similar geographical areas, of the cost for a non-HMO group of similar size, age distribution, sex, race, institutional status, disability status, cost experience for the Medicare contract year in question, and other factors deemed by the actuaries to be relevant and material such as unusual usage of low-cost hospitals and non-usage of specialists. This figure defined as "adjusted average per capita cost" would be determined as promptly as practical after the end of a contract period. Many of the difficulties and uncertainties of previously suggested methods of rate determination are minimized or eliminated by making this determination after the fact. For example, the makeup of the enrolled population and Medicare cost experiences—within and outside of the HMO—would be known, rather than merely estimated.

5. The staff recommends that if the HMO's costs are less than the adjusted average per capita cost the difference, called "net savings" would be divided and allocated as follows:

> Savings between 90 percent and 100 percent would be divided equally between the Government and the HMO. Savings between 80 percent and 90 percent would be divided 75 percent to the Government and 25 percent to the HMO. Savings below the 80 percent level would be allocated entirely to the Government.

Thus, assuming an HMO operated at 80 percent of adjusted average per capita costs, it would received a share equal to 7½ percent of the adjusted average per capita costs and the Government would retain 12½ percent of those costs.

6. At the option of the HMO, it could apply any amount of its share of the saving toward improved benefits, reduced supplemental premium rates, or other advantages for beneficiaries or retain the money. It could not, however, make cash refunds to beneficiaries.

7. If, on the other hand, HMO costs exceed adjusted average per capita costs, the "excess costs" would be allocated between the government and the HMO in the following manner:

> Any amount of excess between 100 percent and 110 percent would be divided equally between the Government and the HMO. Excess costs between 110 percent and 120 percent would be borne 75 percent by the HMO and 25 percent by the Government. Costs in excess of 120 percent would be borne entirely by the HMO. Any losses incurred would carry forward and be recovered, proportionally, by the HMO and the government from future year(s), favorable experience. Any losses by the Government would have to be recovered in full before any "savings" could be paid to an HMO in future years.

The Department, however, recommends the following distribution of any savings.

HEW's position is that all savings achieved through economic operation of an established HMO should be shared 50–50 by the Federal Government and the HMO, with the added proviso that if the HMO uses some portion of its savings to provide additional advantages for beneficiaries then the Government will match that amount up to 2½ percent. Any savings below the 80 percent level would accrue to the Federal Government.

In the case of a developing HMO which is able to achieve savings, these could not innure to the benefit of the HMO but an amount up to 5 percent derived from 50 percent of what would otherwise be the HMO's share and 50 percent of what would otherwise be the Government share could be applied to beneficiary advantages.

Other Reimbursement Provisions

1. To avoid excessive payments in the case of related organizations (those with overlapping financial interests, either direct or indirect) the HMO provision should require that all financial statements called for, be submitted on a consolidated basis. Thus there would be a single statement disclosing actual costs, and charges if different, pertaining to Medicare services furnished by the related organizations.

The provisions should also authorize the Secretary to recover or adjust amounts found on the basis of comparative data to constitute excess payment to related organizations (using in general, medicare limitations on such payments) owners, controllers or sponsors of the HMO or HMO associated physicians.

Such provisions and appropriate implementing regulations should prevent an HMO and associated organizations or individuals from profiting through the artificial inflation of costs and self-dealing.

2. An HMO assuming responsibility for institutional (hospital and extended care) services under Part A would be free to undertake such arrangements with such institutions subject to the following limitations:

> (*a*) If the institution is an affiliated unit, the consolidation provisions, and restrictions on payments to related organizations and excessive compensation set forth above, would apply. If the HMO maintains that it should compensate an institution at a level greater than the regular Medicare level of payment (or equiva-

lent) to that institution it would be required to provide justification satisfactory to the Secretary for the excess payment.

(*b*) Where the HMO finds this a more feasible and economical arrangement, an HMO would have the alternative of letting the Social Security Administration pay for Part A institutional services directly under the Medicare payment system, and charge the HMO's account for such services.

3. In general, Medicare reimbursement principles applicable to overhead items would be applied in determining acceptable HMO costs. In view of the open enrollment requirements under which HMO's will need to communicate with Medicare beneficiaries in their service areas regarding open enrollment periods, reasonable costs incurred in satisfying the open enrollment requirement would be treated as allowable administrative costs.

4. In general any reinsurance costs—including underwriting of risk above 100 percent of adjusted average per capita costs—would not be treated as allowable cost for HMO cost determination purposes.

5. An HMO should not be permitted to switch back and forth between the per capita rate reimbursement system and the regular cost reimbursement system, depending upon which appears more advantageous at any particular time. Accordingly, the staff recommends that an HMO which has commenced contracting on a per capita rate basis be permitted to switch back to the regular reimbursement system, subject to the condition that it will not again be accepted to contract on a per capita rate basis.

6. Before approving an HMO for contracting on an incentive per capita reimbursement basis the HMO should submit evidence satisfactory to the Secretary that it is financially responsible and will be able to carry out its contractual commitments.

The staff suggests that, at a minimum, the HMO should be able to present evidence satisfactory to the Secretary that in the event of adverse experience it has the capacity to meet its proportionate share of risk on up to 20 percent above total estimated adjusted average per capita costs during the prospective Medicare year.

Report

Finally, the staff recommends that the Secretary report to the Congress within a reasonable period after the first annual reports by HMOs are submitted, and annually thereafter, in the HEW Annual Report, regarding experience with the HMO provision. Such reports should include general evaluation of the HMO provision in operation, and should specifically cover cost experience, quality of care considerations, numbers of beneficiaries who enroll, enrollment trends, and other relevant information including evaluation of the performance of the different types of HMOs. Enrollment trends are particularly significant as the Medicare program would not benefit directly in a financial sense from the possible efficiencies of HMOs until a substantial number of Medicare beneficiaries, not presently enrolled in HMOs, chose to enroll in such organizations.

○