Part 3
HEALTH MAINTENANCE ORGANIZATIONS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

ON THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

SECOND SESSION

ON

H.R. 5615 and H.R. 11728
(and all identical bills)

BILLS TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PROVIDE ASSISTANCE AND ENCOURAGEMENT FOR THE ESTABLISHMENT AND EXPANSION OF HEALTH MAINTENANCE ORGANIZATIONS, AND FOR OTHER PURPOSES

APRIL 11, 12, 13; MAY 2, 3, 4, 9, 10, 11, 16, 17, AND 18, 1972

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National Council of Community Mental Health Centers, Dr. William T. Hart, director, Region II, and director, Rochester Mental Health Center, Rochester, N.Y.

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- Bennett, Berkeley V., executive vice president.
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- Connell, Elizabeth J., public relations director.
- Griffin, James, vice president and secretary, Neighborhood Health Centers, Baltimore, Md.
- Lipitz, Roger C., president, Medical Services Corp., Baltimore, Md.
- Wilsmann, Edward J., president, Homemakers Home and Health Care Services, Inc., Kalamazoo, Mich.

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- Keller, Jane D., president, Council of Home Health Agencies and Community Health Services.

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- Tallon, James R., associate director for community relations.

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HEALTH MAINTENANCE ORGANIZATIONS

TUESDAY, MAY 9, 1972

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order. We are continuing our hearings on proposals for health maintenance organizations. Our first witness today is Mr. Berkeley Bennett, executive director of the National Council of Health Care Services, Washington, D. C.

We welcome you to the committee. We will be pleased to have you and your associates identify themselves and make whatever statements you desire.

STATEMENT OF PANEL REPRESENTING THE NATIONAL COUNCIL OF HEALTH CARE SERVICES:

BERKELEY V. BENNETT, EXECUTIVE VICE PRESIDENT, NCHCS;

PATRICK J. CALLIHAN, PRESIDENT, PROVINCIAL HOUSE, INC., LANSING, MICH., AND PRESIDENT, NCHCS;

EDWARD J. WILSMANN, PRESIDENT, HOMEMAKERS HOME AND HEALTH CARE SERVICES, INC., KALAMAZOO, MICH.;

ROGER C. LIPITZ, PRESIDENT, MEDICAL SERVICES CORP., BALTIMORE, MD.;

JAMES GRIFFIN, VICE PRESIDENT AND SECRETARY, NEIGHBORHOOD HEALTH CENTERS, INC., BALTIMORE, MD.; AND

ELIZABETH J. CONNELL, PUBLIC RELATIONS DIRECTOR, NCHCS

Mr. BENNETT. Thank you, Mr. Chairman and members of the committee. We appreciate the opportunity to appear before the committee. We have a panel to discuss a number of areas which we think will be of interest to the committee. We will summarize our testimony however, and each will cut it down so that our time will be better saved for questions.

Mr. ROGERS. Fine; we will make the full statements part of the record following your summation.

Mr. BENNETT. Thank you.

STATEMENT OF BERKELEY V. BENNETT

Mr. BENNETT. Mr. Chairman and members of the committee, my name is Berkeley Bennett and I am executive vice president of the National Council of Health Care Services, based in Washington, D.C., with member companies throughout the country. I will introduce our other panel members as we go along, if I may.

The National Council of Health Care Services represents a select group of tax-paying health care companies owning and/or managing hospitals, nursing homes, psychiatric facilities, clinics, pharmacies, home health agencies, consulting services, surgical supply companies, homemaker services, unit dose drug packaging, day care centers, paramedical training schools, and rehabilitation units. The majority of our member companies are publicly owned health care corporations and most have under active consideration the formation of one or several health maintenance organizations.

As a condition of membership, the council's member facilities, where applicable, are required to be accredited by the Joint Commission on Accreditation of Hospitals. The joint commission is a nongovernmental standard of quality care surpassing licensing, medicaid, and medicare requirements. Accreditation is voluntary and is a yardstick to the progressive facility that meets standards set by a professional knowledgeable, nationally recognized group. In addition, each member is dedicated to seeking innovative approaches to providing quality patient care in the appropriate cost-effective setting.

We believe that proprietary, tax-paying, management oriented health care companies can offer assistance in solving the problems of making the health care delivey system responsive to the needs of all and in helping to make care available to more people at the lowest possible cost.

The National Council of Health Care Services supports the development of the health maintenance organization concept. Not as the panacea for the many shortcomings of the American health system, but as one method which appears to have promise of making more effective use of scarce health resources than the present fragmented health care nonsystem.

National Council of Health Care Services member companies are presently conducting feasibility studies, contracting for services, assisting in the formation of physician groups, working with existing group practices, and carrying out the necessary planning and development activities for possible entry into HMO's. I might add that all of these functions have been performed at no cost or obligation to the Government or the taxpayer.

The National Council believes that the legislation introduced by Congressman Roy and yourself, Mr. Chairman, along with several other members of this subcommittee represents a commendable step toward improving health care delivery in this country.

Our remarks today, will be devoted to the issues of; one, for-profit involvement in the development, operation, and ownership of HMO's; two, the competitive principle in the health care arena versus franchising and comprehensive health planning; three, some examples of proprietary involvement in providing comprehensive health care services; and four, development of a continuum of care and services through the maximum utilization of nursing homes and home health services.

FOR-PROFIT INVOLVEMENT IN THE DEVELOPMENT, OPERATION, AND OWNERSHIP OF HEALTH MAINTENANCE ORGANIZATIONS

One of our major concerns with some proposed HMO legislation and national health insurance proposals is their discrimination against one type of sponsorship of health facilities, services, and systems in favor of another without regard to the quality of care being provided. We believe the acceptance of this philosophy is directly opposed to the best interests of both the consumer of health care services in America and the individual tax-paying citizen.

It is generally recognized that the success of an HMO is dependent upon the incentives built into the program—incentives for efficiency—incentives for proper utilization—incentives for the physician. Health maintenance organizations should be coordinating bodies able to bring together the appropriate type and level of care at the appropriate cost. Proprietary health care companies, such as those represented by the National Council of Health Care Services are uniquely suited to providing the business talents needed and to assembling the financial resources necessary to the formation and continuation of an HMO. We believe that it is vital to attract and recruit the best business management minds available in order to accomplish the task of delivering health care to all at a price the Nation can afford.

Under the present system, costs are soaring, manpower and resources are insufficient and misallocated. A close look at the problem will reveal the following:

EFFICIENCY IN THE HEALTH CARE INDUSTRY

When we talk about containing or slowing down the rise in health care costs, what we are really talking about is the cost of hospitalization, which not only has accounted for the largest rise in costs, but also represents in absolute terms the largest slice of the health care pie. For fiscal year 1970, the total national health expenditure was in excess of $67 billion or 7 percent of the Gross National Product. Some $58 billion of this money was for personal health care.

Just under one-half of all moneys spent for personal health expenditures goes to our Nation's hospitals and nursing homes, and the percentage is increasing each year. In the past 4 years hospital daily service charges have increased 71.1 percent compared to 29.1 percent for all medical care, 30 percent for physician's fees and 6 percent for drugs. It is readily apparent that it is the hospitals, 85 percent of which are nonprofit, that are eating us out of house and home. But why?

Any analysis of effort to control hospital costs will essentially be broken down into two broad categories: one, internal efficiency and, two, utilization control (which is defined as efficient treatment of the patient who truly needs such treatment at the proper facility level and over the appropriate time span. It does not mean exclusion from care of those who need it).

No one can deny that much of the increase in hospital expenditures comes from increased services and a "catching up" in salaries by a labor force that for years subsidized this Nation's health care system by accepting an inadequate wage structure, and a generalized inflation in other cost, but much of the increase is the direct result of a consortium consisting of an abominable cost reimbursement system, which en-

couraged and rewarded inefficiency, and a hospital management group that did not need incentives to achieve ineptitude.

The basic failure of this country's hospitals to achieve any significant degree of internal efficiency has to rest with its No. 1 problem—its self-perpetuating, nonresponsible leadership, and its lack of adequate fiscally trained, full-time management, which has led to very low level of competency in the area of controlled cost and productivity.

The hospital industry—and, more especially the emerging HMO "industry" needs full-time executives of the type and with the abilities of those men running our major industries. We do not need small donations of philanthropic time, but a primary commitment from competent organizational personnel at all administrative levels in the hospital or the HMO, from the board of directors to the purchasing agent and the housekeeping managers. Without this, no internal efficency will ever be realized.

PRODUCTIVITY AND PRIVATE ENTERPRISE

Proprietary enterprise, by its very nature, is structured to provide the incentives which are completely absent in the nonprofit field. I point out that virtually every aspect of the health care delivery system is proprietary in nature except for the general hospital, which in turn, has suffered the most phenomenal inflationary spiral.

When referring to HMO's and to "incentives" inherent in the HMO concept which should work to lower costs and keep quality of service high, what you are really talking about is the profit: motive, no matter what the semantics. The entire concept is founded upon offering financial incentives to someone or group somewhere to reduce the costs of health care. We believe that recognition of this premise is vital to the success of the HMO concept.

The National Council of Health Care Services does not believe that this country can continue to afford the price of health care provided by the subsidized nonprofits. With proper safeguards in law and regulation against abuses, the proprietary sector of the health care field ought to be encouraged to invest its capital and use its management expertise in this field. One advantage of such competition between proprietary and nonprofit should be to spur the nonprofit to operate more efficiently.

We strongly oppose the granting of further authority to CHP agencies. In any segment of the health care industry, such as the nursing home industry, where competition has a significant effect on it and where its presence is beneficial to the consumer by giving him a choice of prices and services, the membership of the National Council strongly urges that it be exempted from CHP and certificate of need authority, unless the individual facility concerned is to be built with Government funds, such as Hill-Burton.

The National Council of Health Care Services is strongly opposed to the extensions of CHP's authority to include HMO planning. Advocates of HMO's have stressed that the concept is only viable when it is offered as a "dual choice" to consumers. The HMO can only prove its worth and gain acceptance through competition. This is diametrically opposed to the concept of comprehensive health planning, and "certificate-of-need" legislation which carried to their logical extension, will effectively "franchise health care facilities and services."

Next I would like to introduce the president of the National Council of Health Care Services, Mr. Patrick J. Callihan. Mr. Callihan is also president of Provincial House, Inc., in Lansing, Mich. They own and operate 10 nursing homes, a construction company, and a computer center.

Mr. Callihan will talk about the potential role of nursing facilities and other alternatives to acute hospitals in the HMO.

STATEMENT OF PATRICK J. CALLIHAN

Mr. CALLIHAN. Thank you. As Berkely has already indicated, it is really a pleasure for us to be able to appear before this committee that historically has done so much for health care in the United States.

I mean that in all sincerity. My remarks today are going to concern themselves primarily with the question of the types and levels of benefits that should be required of any HMO. You have the text of my remarks in front of you so I will attempt to paraphrase and summarize and I promise you, I won't take longer than 5 minutes.

The health maintenance organization bills that are before the committee specify a pretty wide range of minimum benefits that would be required in order to establish a HMO. Those benefits and services as you know, range from the Kennedy bill's requirements for a whole range, a whole host of services and benefits that include mental health and treatment for drug abuse, alcoholism, and so forth, to the administration's version, where they require little more than physician care and hospital treatment.

The bill introduced by you, Congressman Rogers, as you know, takes a middle course requiring the basic things that are part of the administration's bill plus some others along with an open-ended statement which reads ". . . and other services at the Secretary's discretion." In addition to this open-ended statement, there are a couple of things about most of the bills that really give us significant cause for concern.

No. 1 is the tendency of all of the legislation to require more benefits than we feel it is economically possible to provide in the initial stages of an HMO. The second is all of our tendency to confuse add-on benefits, with alternatives to acute hospitalization.

I think that unfortunately too many of us have a tendency to lump alternatives to acute hospital care such as nursing homes and extended care facilities and home health services in with what we probably should call add-on benefits and there we are talking again about dental care and mental health care, drug abuse, alcoholism, and so forth.

At the outset I would hope that alternative methods of delivering care could be separated from the concept of benefits so that we are all talking the same language and hopefully this will enable us to make a pretty strong case for limiting, at least initially, the list of benefits that we are going to have to require while at the same time encouraging but hopefully not mandating alternative methods of delivering health care to the HMO.

To date, I think we will all agree that there are really no reliable statistics regarding the way in which costs can be cut by using nursing homes and extended care facilities and other alternatives to the acute care hospital but I think our collective experience in delivering services, health care services in a number of different environments

lead us to believe that if somehow we can encourage the use of alternatives to acute hospital care we can in fact cut health care costs significantly.

This is true whether it is in an HMO environment or whether it is in a standard fee for services environment.

I think there are many studies that will show, and some of them are detailed in our prepared testimony, that a significant proportion of all the people who are in hospitals at any given time could just as well be taken care of in some other less expensive environment.

The one that is quoted in there, the Methodist Hospital in Indiana, shows three quarters of all the hospital patients could just as well be cared for at home or in a nursing home at $17 a day rather than in a hospital at $85 a day.

In my estimation, your encouragement of the voluntary use of alternatives to acute hospitalization is the key to the success of the HMO or prepaid health care concept because, for the first time, we are going to be, through the use of both services and facilities, treating a patient's needs and his illnesses, not trying to live up to what his insurance policy says he should be getting. This would be, in my estimation, a significant innovation.

A word about benefits. In the above introduction of some of the alternatives to acute hospital care along with the proper use of a whole range of facilities and services that we refer to in our testimony, I think we will be providing the HMO member and the health care corporation with some significant cost savings.

Now, hopefully those cost savings can then be plowed back into providing the kind of benefits we are talking about. Now, if this committee or if the legislation that comes out mandates that we will provide a whole host of benefits, from the outset, you place us in a position where we can't possibly compete with the traditional indemnity medicine.

All of us who consider ourselves to be proponents of the HMO concept really stress the need for dual choice. The consumer has his choice between a traditional fee-for-service and HMO. However, I think we will all agree that the American consumer simply is not sophisticated enough to make the judgment to enroll in a health maintenance organization for three times the cost even if the HMO is going to provide him with six times as many benefits.

We have to educate the American consumer and tell him that we hope the benefit level is kept at a minimum. Specifically, Mr. Chairman, it is the position of the National Council that the minimum benefit and service requirement for HMO's that are finally written into legislation be kept to an absolute minimum and that no required services be left open-ended that will later allow changes by administrative edict. This is the problem we have gotten into in a number of health care areas. I hope we can avoid it with HMO legislation.

One additional concern. The National Council is frankly concerned about the matter of demonstration projects and the fact that the Government has a great propensity to fund in the area of nonprofit experiments and does little to help proprietary experiements.

We would hope that this committee would be able to remedy that situation and mandate some real experiments in both the nonprofit and the proprietary areas.

The National Council of Health Care Services is hopeful that this committee will report out a bill which allows the greatest flexibility for health maintenance organizations in terms of the benefits that are offered, in terms of the structure, in terms of the type of ownership that you ultimately mandate, and one that frankly encourages alternative health care delivery mechanisms.

Thank you.

Mr. ROGERS. Thank you very much.

Mr. BENNETT. Next, Mr. Chairman, I would like to introduce Edward Wilsmann, president of the Homemakers Home and Health Care Services. They are a subsidiary of the Upjohn Co. They presently operate 125 home health care agencies throughout the country.

Mr. Wilsmann will talk about home health care in relation to the HMO.

STATEMENT OF EDWARD J. WILSMANN

Mr. WILSMANN. Thank you, Mr. Chairman and members of the committee. My pleasure, of course, being here. As Pat said, I am going to brief what I have in the written testimony. I do not plan on taking more than 5 minutes either. I think to date the sick and near sick always end up in a hospital. When we are talking about a home health agency, we have no brick and motar involved whatsoever, so a home health agency allows us to match the exact skills required with the patients' needs, always at the minimum cost to that patient or whoever happens to be paying for the services necessary, and gives us the greatest proper utilization of manpower in health care delivery by being able to match in that particular manner.

We feel this very definitely should be included in the HMO approach to health care delivery so that we are able to get that patient out of a hospital bed more quickly and someone in need of that acute hospital bed will have it available to him.

Medicare and medicaid legislation, passed back in 1965, and the rules and regulations promulgated thereunder, when they talk about home health agencies, specifically eliminate the possibility of for-profit organizations to serve even the qualified, not-for-profit organizations.

We have had many people across the country, organizations of not-for-profit home health agencies, unable to deliver services, wanting to contract those services with us, but under the regulations promulgated under XVIII and XIX we are unable to serve those people.

They have had to turn to other places and ended up paying more money for the services that are available from our organizations simply because we are excluded by the regulations. I would ask please that when writing home health care into any HMO bill that provisions be stricken so that proprietary as well as nonproprietary can be involved in the delivery of health care.

If you put the two of them together, proprietary and nonproprietary, we will still fall far short of the needed manpower to get the job done. There are only 30,000 health aides operating out of 2,850 health agencies. Last year with Homemakers we had 20,000 employees ranging from the RN and the LPN all the way down to the housekeeper at the bottom end of it and that is in 125 locations, last year 114 locations. We are the world's largest. We only have 20,000 at this point and the need is for 300,000.

I think it is very evident we must include both the proprietary as well as the nonproprietary to get our health care delivery system to the point where we are really going to serve the public and the Nation. Thank you.

Mr. ROGERS. Thank you very much.

Mr. BENNETT. Next, an interesting concept that is being tried in Baltimore by Roger Lipitz, who is the president of Medical Services Corp. He is going to tell us about some flexible facility planning.

STATEMENT OF ROGER C. LIPITZ

Mr. LIPITZ. Mr. Chairman and members of the committee. I would like to expand on the other people who have commented and extend my appreciation for this opportunity to testify. In November we purchased and began the operation of a 200-bed nursing home facility and at the same time negotiated to lease a 48-bed area of this nursing home to the Baltimore County General Hospital.

The concept was to allow the hospital to expand its services without, at least at the present time, the substantial cost of building additional beds. The hospital at that time was running at almost full occupancy. These beds were leased to the hospital and they were licensed by the State as a 35-bed hospital facility.

We provide to the hospital not only the actual building area, but also dietary, maintenance, and laundry services, and the hospital provides its own nursing and medical personnel services.

We have found, even through the first few months of its operation, even though the satellite, as it is known in the community, has been operating at a somewhat lower occupancy than we hoped, approximately 60 percent, that the cost for that satellite unit is less than the cost in the base hospital area or the acute general hospital area, even though that hospital's occupancy is in excess of 90 percent.

We have avoided the duplication of ancillary hospital services that were not necessary.

I would like to deviate from the testimony for a second to mention that the main reasons that our nursing facility was licensed as a hospital were twofold. One, the hospital's desire to maintain the control over the medical care given at the institution, which is certainly logical, could have been accomplished by merging of the medical staffs of both the nursing home and the hospital.

Secondly, and more importantly, the very limited ability to obtain third party payments for people under 65 in extended care facilities. That is really the principal reason. Blue Cross and other third party payers are very restrictive in their payments to extended care facilities.

That is really the principal reason for its being licensed as a hospital. It could just as easily have been licensed as a nursing home if third party payments were available, where good quality medical care was controlling.

We found in the initial stages that acceptances of the satellite by the patients coming in from the hospitals has been overwhelmingly favorable. We have included in our report a survey of 37 patients who were at the satellite facility and their response and acceptance of the facility has been excellent. I offer that for the record as part of our testimony.

In addition, the nursing facility is an ideal environment for rehabilitative activities regardless of whether it is inpatient or outpatient in nature. If the HMO physician is free to prescribe the services that are needed in the most appropriate setting for the patient, in many instances this can be nursing facilities rather than costly hospital facilities, then everybody benefits.

In addition, we offer the opportunity for possibly the best training of paramedical personnel, in many respects even more appropriate training in some instances than the hospital. Certainly the training available in our facilities should be made available to paramedical personnel because we, as a part of the health care field, need them as well as any other segment.

We also offer an opportunity with the trained personnel we have to educate consumers of health care. Any HMO concept, if it is to work, has to allow for the education of the consumer. If this idea is to prevent illness, the consumer has to be educated as much as possible.

We offer within our facilities the training mechanism and to not only train our personnel for inservice training but also families of patients and members of possible HMO groups themselves.

The nursing facility may provide not only a more medically appropriate and economical alternative to hospitalization during convalescence, but in many cases, and I don't think we ever think about this, patients would prefer to leave the hospitals as soon as they can. Hospitals can be very depressing.

Where necessary or desirable the nursing facility can also do double duty, as in our satellite, especially in rural areas. Rather than creating a costly satellite of a hospital in a rural area, the nursing home offers the opportunity, where proper communications exist, for acute care hospitals to provide the services because there are many small communities where the only real inpatient care oriented facility is the nursing home. This appropriately could be used as a satellite of a hospital, again, with the proper medical control.

The examples I have just given you are a few. Going back to Mr. Callihan's testimony, the key is the maximum flexibility for an HMO to provide the services that you mandate in the most economical way.

If we are required to place people in hospitals for x days before they can go, we are just going to perpetuate the problems that have existed for years. Thank you.

Mr. ROGERS. Thank you very much.

Mr. BENNETT. Mr. Chairman, James Griffin is associated with Mr. Lipitz in Neighborhood Health Center, Inc., in Baltimore. Some 2 years ago they started planning for an inner city ghetto area, if you will, ambulatory care center. Mr. Griffin is vice president and secretary of Neighborhood Health Centers. He is going to tell of their experience with an inner city health project.

Mr. ROGERS. Mr. Griffin?

STATEMENT OF JAMES GRIFFIN

Mr. GRIFFIN. I certainly am appreciative of the opportunity gentlemen and ladies, for appearing before you today. Our company was started a little over 2 years ago. It is called "Neighborhood Health Centers," a private corporation formed in August 1970.

It is jointly owned by Medical Services Corp. and Dr. Venter, a physician, and myself. It is proposed that Neighborhood Health Centers, Inc., will be the vehicle for providing comprehensive health services on an outpatient basis to all segments of the population, initially in northwest Baltimore and ultimately it is hoped on a citywide basis.

We believe that a proprietary taxpaying management oriented health care company can offer a solution to the problems of making the health care delivery system responsive to the needs of the general patient population by providing acceptable and attractive high quality health care at a cost to the patient which is equal to or lower than some of the nonprofit organizations.

It has been brought to our attention also that one section of H.R. 11728, in effect excludes the participation of proprietary organizations as health maintenance organizations. We at Neighborhood Health Center strongly oppose such a move and this is our reason for appearing here today.

Conceding that proprietary health care is not the only panacea for all the ills of the health care system in the Nation today we remain convinced it is nevertheless a desirable alternative.

Therefore, it is our intention to briefly describe the activities of Neighborhood Health Centers in its efforts to plan, develop and operate what we have considered to be the first step toward a viable health maintenance organization.

Hopefully the membership of this subcommittee will subsequently understand our position and agree to make these changes in this section of the aforementioned proposed legislation. Our company started this particular project because of a void in health care services in the Baltimore community.

Some of you may know that the trend in the cities is to move the hospitals out of the inner city areas into the suburban communities. We worked with the group organizations, city and State health departments, community organizations and developed what we thought was a good alternative to a void in the health care system in Baltimore.

We started out approximately 15 months before we finally opened our center. We sought private conventional funds and began this project at an approximate cost of $250,000. This is a cost much less than other similar outpatient facilities, federally funded and otherwise.

We note that this project, doing it ourselves, took 5 months. Other organizations in the community started their efforts several years prior to ours and to this date they have not developed any health care system similar to ours.

We negotiated with the State health department to treat medical assistance patients at a cost of just under $20 and the services are briefly described here and I will just mention them.

No. 1, we give medical and minor surgical care, family health assessment and continuous health maintenance through outreach programs under physician's supervision, emergency services, minor psychiatric services, and extensive referrals for subspecialist care not located in our facility.

We additionally provide a number of ancillary services for which no charge is made to the State medical program. Among these services are extensive radiological services, extensive pathology and

laboratory services, social work, nutrition, podiatry and other rehabilitative services. It has been publicly stated by the Maryland State Department of Health that their intention is to provide us with a prepaid contract so that we can provide all inpatient and outpatient health services for selected populations of medicaid patients.

We work jointly with the community, with the residents in the area. We have two resident physicians who practiced in the area prior to coming into our center. We work with community organizations.

We have consumer patients on our advisory board. Though we have had problems in forming, as any organization, we have ironed them out and we are operating rather smoothly. To date, we have seen approximately 18,000 patients, we have registered a little more than 10,000.

Our cost per patient is approximately $15. The cost of the federally funded project such as ours is $50 or more.

Mr. ROGERS. You say your cost is $15 and the comparable cost is $50?

Mr. GRIFFIN. $50 or more per patient's visit. We have an average of $15 patient cost because we also treat private patients in our facility as well as medically assisted patients for which the State paid.

Mr. ROGERS. I think any figures like that if you can supply them for the record will be helpful.

Mr. GRIFFIN. We can get them.

(The information requested was not available to the committee at the time of printing.)

Mr. GRIFFIN. We believe that the entrance of NHC, a proprietary company, in the field of health care and benefited the consumers who have utilized our services and this would not have been possible if we were excluded from the HMO activities as a proprietary organization.

Since we opened our facility, others in the State have seen our progress and noted some of our successes. In doing so, others have paid us what we feel is the ultimate compliment, trying to duplicate our program elsewhere.

This applies to both private and public groups. Another possible effect of our presence, although not proven, has been the report by a hospital nearby that for the first time their emergency room visits have stabilized and that we have influenced them to begin tougher programs to reduce costs.

We realize that it would take more time than we now have to prove the efficacy of our efforts. However, the point we have tried to make here is that this joint venture has cost the taxpayer nothing for planning, development, or implementation; and for those whose care is financed by tax revenues these costs have been lower or equal to existing programs.

We have an added dimension in our facility. A number of the black patients in Baltimore facilities have been turned off by the type and level of care that they have received at neighboring hospital emergency rooms and outpatient departments.

In our facility the one thing we stress is respect and dignity for every patient. We have a mixture of indigent patients as well as patients who can pay their own freight. We cannot discriminate because we never know one patient from the other. Our patients go

by and receive the services in the facility. The paying process is at the end.

We have been complimented by hospitals in the areas, by other community organizations. We think that we have had very good success in the 9 months that we have thus far been in operation.

Thank you very much.

Mr. BENNETT. Mr. Chairman, you will find in the appendix the by-laws of their consumer advisory board which they have worked with for some year and a half before they opened their facility, a very consumer-oriented group.

Our last speaker will be Miss Elizabeth Connell, public relations director, for the national council. She will summarize some of our legislative recommendations.

STATEMENT OF ELIZABETH J. CONNELL

Miss CONNELL. I will be brief as well. The National Council of Health Care Services strongly urges this committee to create incentives to encourage private proprietary enterprise to invest its much-needed capital resources in the health care field and to lend its business management expertise to the awesome task of bringing order, efficiency, cost-consciousness and higher quality for more people in the health care area.

We believe that open-ended deficit financing removes the HMO's natural incentives to control costs and may lead to some form of cost-of-service reimbursement, so we believe that stringent limits ought to be placed on operational and developmental subsidies to any type of HMO sponsorship.

Second, we recommend that contracts, loans and loan guarantees be equally available to HMO sponsors, both proprietary and nonproprietary, which will operate in medically underserved areas. If the object of providing such Government funding is to assure that the medically underserved receive quality health care such discrimination is directly contrary to that objective.

Third, lower the barriers to entry into HMO formation by overriding State legislation that restricts or prohibits HMO development. All forms of organizations should be treated equally. We have the bill's definition of an HMO will be changed so that proprietary organizations are included.

This will allow proprietary HMO's to benefit from section 1116 of that bill, which allows the Secretary of HEW to waive restrictive State laws for HMO's which meet the bill's definition. We hope that this committee will change the relevant section accordingly even if the bill continues to restrict Federal assistance to public and nonprofit sponsors.

Fourth, we have two specific recommendations regarding comprehensive health planning both of which ask that they play no role at all in HMO development, even an advisory capacity. We think that bodies that are constituted for the purpose of eliminating competition cannot effectively encourage competition with HMO's.

Fifth, take affirmative Government action to encourage the formation of HMO's by offering backup assistance in the form of consulting services, research and information to all types of HMO's. We would hope that HEW will be able to do this.

Sixth, legislation enacted should require a standard minimum benefit package in order to facilitate price comparisons. The required package should contain only the minimum necessary services although additional services may be made available and some extra charge may be levied.

Seventh. As indicated earlier, the national council supports the approach to consumer involvement taken by your committee's bill H.R. 11728 and section 1101(e). While this section mandates consumer involvement which we think is desirable, the bill does not specify the method and thereby allows for a desirable element of flexibility.

Eighth. The HMO ought to be held publicly accountable for the care it renders, whatever its sponsorship. However, we suggest that the reporting requirement in section 1101(h) or H.R. 11728 ought to be limited to cost and utilization patterns with full disclosure to the public.

And finally, the national council supports the notion of federalizing standards relating to health care including standards and requirements for professional licensing in the States. We support the concept expressed in section 1101(g) of H.R. 11728 which requires the HMO to have organizational arrangements for an ongoing quality assurance program that stresses the processes and outcomes of services provided in addition to requiring the components of the HMO's to meet standards established by the Secretary.

In conclusion, we are happy to provide needed care under whatever standards of participation and operation this committee and the Congress in its collective wisdom see fit to write and enact into legislation with the provision that these standards be applied equally to all providers of health care whatever their ownership or sponsorship.

Thank you, Mr. Chairman.

Mr. BENNETT. In summary, Mr. Chairman, we have tried to show you how for-profit involvement in the development, operation, and ownership of HMO's can be desirable. We have discussed the competitive principle in the health care arena versus franchising and comprehensive health planning, we have given examples of proprietary involvement in providing comprehensive health care and of course the important development of a continuum of care and services through the maximum utilization of nursing homes and home health agencies.

One other thing I would appreciate being added to the record. I have here a copy of the standards that are set up by the Homemakers Upjohn Co. for delivery of home health care services.

Mr. ROGERS. Thank you. They will be made a part of the record, without objection.

(Testimony resumes on p. 844.)

(The prepared statement and appendix of the National Council of Health Care Services and the "Corporate Standards for the Delivery of Services," referred to follow:)

STATEMENT BEFORE

HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

UNITED STATES HOUSE OF REPRESENTATIVES

92nd CONGRESS, 2nd SESSION

OVERVIEW: FOR-PROFIT INVOLVEMENT IN HMO's AND ALTERNATIVES TO HOSPITALIZATION
ALTERNATIVES TO HOSPITALIZATION
Berkeley V. Bennett, Executive Vice President
National Council of Health Care Services, Washington, D.C.

POTENTIAL ROLE OF NURSING FACILITIES AND OTHER ALTERNATIVES TO ACUTE HOSPITALIZATION IN THE HMO
Patrick J. Callihan, President
Provincial House, Inc., and President
National Council of Health Care Services, Lansing, Michigan

HOME HEALTH CARE IN THE HMO
Edward J. Wilsmann, President
Homemakers Home and Health Care Services, Inc.
Kalamazoo, Michigan

FLEXIBILE FACILITY PLANNING
Roger C. Lipitz, President
Medical Services Corporation, Baltimore, Maryland

THE INNER CITY HEALTH PROJECT OF NEIGHBORHOOD HEALTH CENTERS, INC.
James Griffith, Vice President and Secretary
Neighborhood Health Centers, Baltimore, Maryland

LEGISLATIVE RECOMMENDATIONS
Elizabeth J. Connell, Public Relations Director
National Council of Health Care Services, Washington, D.C.

Testimony of BERKELEY V. BENNETT, Executive Vice President

National Council of Health Care Services

OVERVIEW: FOR-PROFIT INVOLVEMENT IN HMO's AND ALTERNATIVES TO HOSPITALIZATION

Introduction

Mr. Chairman and Members of the Committee, my name is Berkeley V. Bennett and I am Executive Vice President of the National Council of Health Care Services, based in Washington, D.C. with member companies throughout the country.

With me today are Patrick J. Callihan, President of the National Council and President of Provincial House, Inc. Lansing, Michigan; Edward J. Wilsmann, President of Homemakers-Upjohn, Kalamazoo, Michigan; James Griffin, Vice President and Secretary of Neighborhood Health Centers, Inc., a subsidiary of Medical Services Corporation located in Baltimore, Maryland; Roger C. Lipitz, Vice President of the National Council and President of Medical Services Corp. in Baltimore, Maryland; and Elizabeth J. Connell, Director of Public Relations for the National Council. Fact sheets on members of the panel and the companies they represent may be found in the Appendix of our testimony.

The National Council of Health Care Services represents a select group of tax-paying health care companies owning and/or managing hospitals, nursing homes, psychiatric facilities, clinics, pharmacies, home health agencies, consulting services, surgical supply companies, homemaker services, unit dose drug packaging, day care centers, paramedical training schools, and rehabilitation units. The majority of our member companies are publicly owned health care corporations and most have under active consideration the formation of one or several Health Maintenance Organizations.

As a condition of membership the Council's member facilities, where applicable, are required to be accredited by the Joint Commission on Accreditation of Hospitals. The Joint Commission is a non-governmental standard of quality care surpassing licensing, Medicaid and Medicare requirements. Accreditation is voluntary and is a yardstick to the progressive facility that meets standards set by a professional, knowledgeable, nationally recognized group. In addition, each member is dedicated to seeking innovative approaches to providing quality patient care in the appropriate cost-effective setting. We believe that proprietary, tax-paying, management oriented health care companies can offer assistance in solving the problems of making the health care delivery system responsive to the needs of all and in helping to make care available to more people at the lowest possible cost.

The National Council of Health Care Services supports the development of the health maintenance organization concept. Not as the panacea for the many shortcomings of the American health system, but as one method which appears to have promise of making more effective use of scarce health resources than the present fragmented health care non-system.

National Council of Health Care Services member companies are presently conducting feasibility studies, contracting for services, assisting in the formation of physician groups, working with existing group practices, and carrying out the necessary planning and development activities for possible entry into HMO's. I might add that all of these functions have been performed at no cost or obligation to the government or the taxpayer.

The National Council believes that the legislation introduced by Congressman Roy and yourself, Mr. Chairman, along with several other members of this Subcommittee represents a commendable step toward improving health care delivery in this country.

Our remarks today, will be devoted to the issues of (1) for-profit involvement in the development, operation and ownership of HMO's; (2) The competitive principle in the health care arena vs. franchising and comprehensive health planning; (3) Some examples of proprietary involvement in providing comprehensive health care services; and (4) Development of a continuum of care and services through the maximum utilization of nursing homes and home health services.

For Profit Involvement in the Development, Operation and Ownership of Health Maintenance Organizations.

One of our major concerns with some proposed HMO legislation and national health insurance proposals is their discrimination against one type of sponsorship of health facilities, services and systems in favor of another without regard to the quality of care being provided. We believe the acceptance of this philosophy is directly opposed to the best interests of both the consumer of health care services in America and the individual tax-paying citizen.

It is generally recognized that the success of an HMO is dependent upon the incentives built into the program...incentives for efficiency...incentives for proper utilization...incentives for the physician. Health Maintenance Organizations should be coordinating bodies able to bring together the appropriate type and level of care at the appropriate cost. Proprietary health care companies, such as those represented by the National Council of Health Care Services are uniquely suited to providing the business talents needed and to assembling the financial resources necessary to the formation and continuation of an HMO. We believe that it is vital to attract and recruit the best business management minds available in order to accomplish the task of delivering health care to all at a price the nation can afford.

Under the present system, costs are soaring, manpower and resources are insufficient and mis-allocated. A close look at the problem will reveal the following:

Efficiency in the Health Care Industry

When we talk about containing or slowing down the rise in health care costs, what we are really talking about is the cost of hospitalization, which not only has accounted for the largest rise in costs, but also represents in absolute terms the largest slice of the health care pie. For fiscal year 1970, the total national health expenditure was in excess of $67 billion or 7% of the Gross National Product. Some $58 billion of this money was for personal health care.

Just under one-half of all monies spent for personal health expenditures goes to our nation's hospitals and nursing homes, and the percentage is increasing each year. In the past four years hospital daily service charges have increased 71.3% compared to 29.1% for all medical care, 30% for physician's fees and 6% for drugs. It is readily apparent that it is the hospitals, 85% of which are non-profit, that are eating us out of house and home. But why?

Any analysis of effort to control hospital costs will essentially be broken down into two broad categories: (1) internal efficiency and (2) utilization control (which is defined as efficient treatment of the patient who truly needs such treatment at the at the proper facility level and over the appropriate time span. It does not mean exclusion from care of those who need it.)

No one can deny that much of the increase in hospital expenditures comes from increased services and a "catching up" in salaries by a labor force that for years subsidized this nation's health care system by accepting an inadequate wage structure, and a generalized inflation in other cost, but much of the increase is the direct result of a consortium consisting of an abominable cost reimbursement system, which encouraged and rewarded inefficiency, and a hospital management group that did not need incentives to achieve ineptitude.

The basic failure of this country's hospitals to achieve any significant degree of internal efficiency has to rest with its number one problem--its self-perpetuating, non-responsible leadership, and its lack of adequate, fiscally trained, full-time management, which has led to very low level of competency in the area of controlled cost and productivity. The general problem areas are (a) part-time trustees, who may be some of the finest, most humane and civic-minded men in this country, but who by the very lack of involvement and primary commitment cannot make a significant contribution to as complex and costly an organization as a major general hospital (as no man could in four or five or ten hours a month); and (b) behind the trustee, in the area of primary responsibility, we have had poor fiscal training at all levels of administration. Hospital administrators are trained to coordinate the services within the hsopital, so that a facility can offer the required medical

care. However, they are usually not trained in discovering or achieving the most efficient mechanics for the delivery of their required commodity. The traditional non-tax-paying and non-profit hospital has failed to attract superior, aggressive and innovative talent (with some notable exceptions) due to the inherent structure of the organization and the very fact that the institution is non-profit. There is a lack of incentive, a lack of upward mobility, and usually inadequate compensation to attract superior personnel. In short, the traditional non-profit hospital system does not have now adequate managerial capacity to achieve any significant degree of efficiency.

This in turn creates a very substantial doubt as to whether prospective reimbursement, capitation payment, or any of the budgeting programs contemplated in the various legislative proposals before Congress today can be meaningful. How can there be realistic budgeting or the ability to live with prospective reimbursement when there is, in fact, no sound fiscal management.

The hospital industry--and, more especially the emerging HMO "industry" needs full time executives of the type and with the abilities of those men running our major industries. We do not need small donations of philanthropic time, but a primary commitment from competent organizational personnel at all administrative levels in the hospital, or the HMO from the Board of Directors to the purchasing agent and the houskeeping managers. Without this, no internal efficiency will ever be realized. No program or national program with restricted drive to control the rise in costs will succeed unless there are built into the legislation adequate incentives to increase productivity. Management capable of responding to incentives such as budgeting or to other types of cost control devices as may be legislatively imposed upon hospitals and health delivery systems will not be developed overnight. Twenty-five years of cost reimbursement and the knowledge that the hospital could increase its charges to cover its costs regardless of its efficiency has prevented the present institutional health care establishment from acquiring sound fiscal management. Time is going to be needed to develop this capacity... time and an environment conducive to the development or attraction of proper talent.

Cost reimbursement, as we have known it, created in addition a traditionally cheap labor environment in our hospitals - but it is not so cheap any more. Some 15 years ago, the average general hospital required 1.4 employees to take care of one patient. Today, the requirement is almost 3 employees per patient. During the same period of time, the services required or offered did not double, as did the number of employees, but the inefficiency factor magnified. Particularly since the advent of Medicare, the query in many hospitals, if not most, when adding an expense was not "Is this expense necessary" but "Is this expense reimbursable?"

Productivity and Private Enterprise

Proprietary enterprise, by its very nature, is structured to provide the incentives which are completely absent in the non-profit field. I point out that virtually every aspect of the health care delivery system is proprietary in nature except for the general hospital, which in turn, has suffered the most phenomenal inflationary spiral.

The entire philosophy of encouraging the development of marginally managed institutions and systems of a "non-profit" nature, while at the same time discriminating against, or even eliminating the participation by responsible, proprietary, tax-paying enterprises, as some proposed legislation seems to do, is built on a series of false premises, most of them centered around the concept that profit motivation has no place in health care. Yet there is no more reason for excluding private enterprise in the field of health care delivery than there is for excluding it from any other realm of vital life functions, such as the production of food or other essentials required for daily life and which are, on a day-by-day basis, more essential than remedial health care. Not only is proprietary activity, as such, in health care an existing and vital fact of life, it is a driving force in many so-called non-profit organizations, such as in the proprietary aspects of the Permanente Medical Group of the Kaiser Foundation Plan.

When referring to HMO's and to "incentives" inherent in the HMO concept which should work to lower costs and keep quality of service high, what you are really talking about is the profit motive, no matter what the semantics. The entire concept is founded upon offering financial incentives to someone or group somewhere to reduce the costs of health care. We believe that recognition of this premise is vital to the success of the HMO concept.

The National Council of Health Care Services does not believe that this country can continue to afford the price of health care provided by the subsidized non-profits. With proper safeguards in law and regulation against abuses, the proprietary sector of the health care field ought to be encouraged to invest its capital and use its management expertise in this field. One advantage of such competition between proprietary and non-profit should be to spur the non-profit to operate more efficiently.

I should like to support some remarks presented to The Senate Subcommittee on Health in November 1971, by Dr. Harold Upjohn, Chairman of the Board of Health Maintenance, Inc., and I paraphase: "There is a lot of confusion about what 'non-profit' means, for instance, if your doctors are profit-making, if you are making profits on ancillary service businesses like the pharmacy or the laboratory, if the bank is making 12 percent on a loan to build new facilities, and if a construction company makes a profit on construction of your hospital, the equipment and supply manufacturer makes profit, how can it be said in all honesty that health care is being delivered on a non-profit basis?" We would also agree with Dr. Upjohn that incentives must exist and they are a reality. Call it what you may, the profit motive generates the required incentives.

profit motive generates the required incentives.

Along these lines, the HMO-- or any health system for that matter, must create incentives for the physician to involve himself in the economics of patient care. For generations, American physicians have made a tribal fetish out of dissociating themselves from the economics of patient care, taking the attitude that care of the patient involves only medical skills, and that economic aspects of patient care should somehow be left to the administrators. It is now painfully clear that the medical and the economic aspects of patient care cannot be separated and that any attempt to continue to do so will result in continued inflation of medical costs.

Potential Problem Areas Caused By For-Profit HMO's.

The most often-cited potential problem area which for profit HMO's might generate is a forced under utilization of needed services in the HMO in order to generate more profits. Undoubtedly, the potential for this situation does exist, but several factors will militate against such a development in proprietary HMO's.

1. It is questionable that "over economizing" is a risk associated exclusively with for-profit HMO's. If physicians are to respond to the incentives that HMO-type care is supposed to introduce, they must be given a financial stake in the outcomes of particular cases. In most HMO's, this is done through some form of profit-sharing arrangements, and it would appear that these profit-sharing arrangements would be made in HMO's regardless of the type of ownership or sponsorship of the HMO itself.

2. The threat of malpractice suits against the HMO ought to cause the HMO to eliminate insofar as possible any potential situations of this type.

3. The HMO would have a powerful incentive to give the best possible health care to its subscribers -- retaining consumer confidence and support. Any HMO providing substandard or inadequate health care would soon lose substantial numbers of its subscribers.

4. If fears still exist regarding inadequate care by proprietary HMO's, reinsurance might be required against those risks that seem most likely to produce the greatest temptations to render inadequate care.

5. The National Council of Health Care Services believes that if the Federal government sets and enforces high standards that are uniform for all types of ownership and sponsorship of HMO's, most of the problems of assuring quality care in HMO health care delivery should be solved.

Consumer Involvement

The role of the consumer in the development and operation of the HMO is pivotal, whatever the sponsorship of the HMO. Because an HMO is operated on a for-profit basis does not preclude or limit in any way the responsible participation of consumers. Perhaps it even allows for more participation. For instance, where a profit-making HMO allows consumers to purchase shares in the corporation, the success of the HMO will be to the financial advantage of the subscriber-shareholder, who now has another incentive to maintain his health and to use costly resources sparingly.

Another way in which the voice of the consumer will be heard is Dual Choice. The consumer must have a choice as to how he is to receive his medical care -- whether in an HMO, in the traditional fee-for-service system, or, he may also have the option of choosing from more than one HMO.

The notion of competition is vital to the success of the HMO concept; an HMO in an monopolistic setting will not be motivated to achieve the same efficiencies that an HMO competing against other forms of delivery and other HMO's will have the potential to reach.

In terms of consumer involvement, the effect of giving the consumer a choice is perhaps the most far-reaching method of giving him a voice in the operation of the HMO. Obviously, for a proprietary HMO, the incentives are there to provide good care to its subscribers and to attract new subscribers, since the very continued existence of the proprietary HMO, which cannot depend on government funds to cover operating deficits, depends upon maintaining the confidence of the subscriber.

We believe that the concept of having an "Ombudsman" to represent the consumer both as to grievances and in operational matters to the HMO management is sound and is one of several methods for assuring meaningful consumer participation. We are in full accord with the provision in Congressmen Roy and Rogers' bill which states that the HMO must be organized to assure members a meaningful policymaking role in the health maintenance organization and that the HMO must provide for hearing and grievance procedures between members and the HMO and between individuals providing services and the HMO. We would hope, however, that this provision be adopted without specifying methods, number or percentage of consumer representatives, etc. to allow for the greatest possible flexibility according to the individual case. While most consumers lack the necessary skills, professional training, and knowledge to actively participate in many of the decision making processes involved in the rendering of medical care, a trained person acting on behalf of the consumer-member could be a practical method of gaining a greater voice for the subscriber.

Consumer Education

The most important factor in giving the consumer a meaningful voice in the direction of health care is to educate him. The consumer must learn what he can and should expect from his visit to the physician, when to go to the doctor, how to use paramedical personnel, basic symptomology. Until the consumer is educated to seek the appropriate kind of care, until he stops believing that the best care consists of daily visits in a private hospital room by a specialist, then we, in this age of consumerism, will not be able to use scarce resources effectively.

In the course of our presentation, Mr. Griffin will discuss an example of consumer involvement in a proprietary company which provides comprehensive ambulatory health care services to an inner-city population group in Baltimore, Maryland.

The Competitive Principle in the Health Care Arena vs. the Franchising Issue and Comprehensive Health Planning

One of the major areas of concern to the National Council is the relationship of health maintenance organizations to comprehensive health planning. Carried to their logical conclusion, the objectives of CHP are in direct conflict with the principles of competition and dual choice which most HMO advocates see as cornerstones. We fear that reliance of any kind on comprehensive health planning bodies may stifle the development of HMO's and may discriminate based on type of sponsorship.

The philosophy behind comprehensive health planning is simple and sound: Duplication of health services and facilities is wasteful and the resultant under-utilization accounts in part for the spiralling cost pattern in the health care industry. Therefore, eliminate the duplication and wasteful over-building and over-provision of services. The CHP principle appears even sounder when one considers it in light of the overwhelmingly non-profit hospital industry which is heavily dependent on government funding both for capital and reimbursement for care and the traditional method of reimbursing hospitals which is based on the individual institution's cost of providing the care received without regard to prevailing community rates.

Where true competition is not possible, the idea of comprehensive health planning and "certificate-of-need" as a method of controlling hospital building and therefore slowing rising costs is acceptable to the Council.

We strongly oppose the granting of further authority to CHP agencies. In any segment of the health care industry, such as the nursing home industry, where competition has a significant effect on it and where its presence is beneficial to the consumer by giving him a choice of prices and services, the membership of the National Council strongly urges that it be exempted from CHP and certificate of need authority, unless the individual facility concerned

is to be built with government funds, such as Hill-Burton.

The National Council of Health Care Services is strongly opposed to the extension of CHP's authority to include HMO planning. Advocates of HMO's have stressed that the concept is only viable when it is offered as a "dual choice" to consumers. The HMO can only prove its worth and gain acceptance in competition with traditional modes of health care delivery and by competing with other HMO's. This is diametrically opposed to the concept of comprehensive health planning, and "certificate-of-need" legislation which carried to their logical extension, will effectively "franchise" health care facilities and services.

We would like to see a wide-ranging public debate centering on whether or not this nation should or desires to preserve the principle of competition in those parts of the health care field where it still operates and where it can spur the development of emerging health systems such as HMO's. We hope that this discussion can take place before the passage of any additional legislation directed at increasing the sphere of comprehensive health planning's authority.

Testimony of PATRICK J. CALLIHAN, President

Provincial House, Inc., and

President of the National Council of Health Care Services

POTENTIAL ROLE OF NURSING FACILITIES AND OTHER ALTERNATIVES TO ACUTE HOSPITALIZATION IN THE HMO

It is a great pleasure for me to be able to appear today before this Committee which has done so much to raise the standards of health care in America over the years.

My remarks today will concern the question of types and levels of benefits which should be required in an HMO as well as some of the varied uses which can be made of nursing facilities and other institutional alternatives to acute hospitalization in the HMO.

The two health maintenance organization bills which are before your Committee, H.R.11728 and H.R.5615, along with Senator Kennedy's bill S.3327, specify widely varying minimum benefits and services which an organization would have to provide in order to qualify as an HMO. Minimum benefits and services range from the Kennedy bill's requirement that HMO's provide, at the outset, a comprehensive range of services, including dental care and treatment for drug abuse and alcoholism.....to the Administration's approach of requiring only inpatient hospital and physician care, ambulatory physician services, emergency care, and outpatient preventive medical services. H.R.11728, introduced by Congressmen Roy and Rogers, takes a middle course, requiring, in addition to the basic benefits of the Administration's bill diagnostic laboratory and diagnostic and therapeutic radiologic services, rehabilitation services including physical therapy, extended care facility services, home health services, and other services as the Secretary of HEW shall require. However, it is possible to interpret the minimum requirements of the Roy bill as being almost as comprehensive as the Kennedy bill, given the fact that the Secretary is given complete latitude to establish unlimited additional requirements. In addition, the required "preventive health services" are not defined in the bill and thus it gives open-ended authority to the Secretary to define mandatory benefit levels.

Levels of Benefits

Testimony already presented to this Committee by the Administration, the Group Health Association of America and others has suggested that the required level of benefits for HMO's should be kept at a minimum, so that the HMO's rate to subscribers will be competitive with indemnity policy

rates. We agree with this line of reasoning and believe that benefit levels set at too high a level at the outset will cripple the potential of HMO's in competition with traditional indemnity policies. We would like to make the following distinction between categories of benefits.

Critics of compulsory comprehensive benefits lump alternatives to the acute hospital, such as nursing home or extended care facilities and home health care in with "add-on" benefits such as dental care and benefits for drug abuse and alcoholism. While we agree with the importance of such "add-on" benefits in considering the total health maintenance needs of a modern population group, we suggest that the "alternative" benefits group be separated from the "add-on" benefits.

There are as yet no reliable statistics concerning the effect on HMO costs of providing through the HMO (either directly or through arrangements with others) sub-acute or nursing home and home health services. However, based on our experience in the provision of a variety of health services and with the Medicare and Medicaid programs, we strongly believe that it could be shown that having ALTERNATIVES to high-cost acute hospitalization available through the HMO would lower the cost to the HMO of treating illnesses. Where no alternative to the acute hospital is available, a patient in need of institutionalization, but who does NOT require acute hospitalization will have to remain in the acute hospital until he is able to return to his home, even if the care is provided through an HMO. In some cases he may have to remain in the acute hospital still longer if the HMO does not provide home health care services once his need for institutionalization has passed.

Thus, even though the existing HMO's have shown an ability to reduce the incidence of hospitalization and thereby cut down on the number of patient days in the hospital, we would submit that in many instances, this reduced hospitalization figure results from a lower incidence of often unnecessary elective surgery, etc., and could be lowered still further through the medically appropriate use of lower cost alternatives.

In support of this premise, I would like to cite some figures from a study recently performed by the Methodist Hospital of Indianapolis, Indiana. While Methodist Hospital is not part of a health maintenance organization, I believe that the statistics are relevant. According to this study, "Approximately 44.5% of all the patients at any given time at Methodist Hospital could be placed in the Category III level of patient care. This category includes those patients that require very little nursing care but who will need help with medication, dressings, patient education and any treatments required. Basically this patient can use self care and could be easily taken care of at home if someone is there to do the treatments for him, assist and prepare medication and any other home nursing type care.

"Approximately 30.1% of all patients at Methodist Hospital at any given time can be placed in Category II level of patient care. This category involves those

patients who require partial nursing care but who are able to do some things for themselves. They may require bed rest but would be allowed to be up to the bathroom once or twice a day only.

"Finally, approximately 25.4% of all the patients at any given time at Methodist Hospital can be placed into Category I which involves those patients who are seriously ill who require total nursing care. They are unable to do anything for themselves.

"In other words, a total of approximately three-fourths of all the patients at Methodist Hospital at any given time require either partial nursing care or very little nursing care."

While this does not represent an HMO hospital these figures indicate, for any type of health care delivery system without lesser cost, more appropriate alternatives to acute hospitalization, a significant proportion of the hospital inpatients at any given time could be treated at a lesser cost in a more medically appropriate setting -- to say nothing of the inefficient and wasteful use of scarce medical personnel!

Needs vs. Covered Services

The HMO concept is based upon a use of services and facilities motivated solely by the kind of care or service needed in a particular case and not, as in traditional fee-for-service indemnity medicine, on what is covered under the patient's insurance policy. We believe that significant economies may be achieved in the HMO through the use of an integrated spectrum of facilities and services to be used in the care and treatment of subscribers.

Let me emphasize that the concept of flexibility within the HMO depends for its success on physicians and HMO managers who are trained in both modern business management and the medically appropriate use of a wide range of levels of care.

Flexibility is Important

In spite of the fact that accredited nursing facilities constitute the major part of the membership of the National Council of Health Care Services, it is the position of the Council that minimum benefit and service requirements for HMO's written into legislation be kept to a minimum and that no required services be left undefined or open-ended. The Council supports the relevant provision of H. R. 5615 (Sec. 1101 (l) (B)) in this area, with the provision that diagnostic laboratory and diagnostic and therapeutic radiologic services be required.

The National Council also recommends that the Secretary of HEW be directed to authorize HMO demonstration projects, under both proprietary and non-profit sponsorship, of a sufficiently broad application to test the concept of providing a broad spectrum of alternatives to acute hospital care. Such demonstration projects should be set up so that valid cost comparisons can be made with HMO's which offer only outpatient physician services and inpatient acute hospital care.

In addition, some sort of quality-of-care monitoring devices should be employed, perhaps the sort of quality of process and outcomes approach taken by H. R. 11728 or perhaps modelled along the lines of the certification process for group practices developed over a 15-year period by the American Association of Medical Clinics. The kind of quality indices we would like to see would be able to compare the care received by a patient in an acute hospital to the care received by a patient with a similar condition receiving his treatment in a variety of modes.

The reason for suggesting that legislatively-mandated services in an HMO be kept to a minimum is simple: We believe that the HMO concept, while not new, is still in an experimental stage, especially when we are talking about making such an alternative available to the great majority of the American population.

Dual Choice

Proponents of the HMO concept stress the necessity of "dual choice". That is, the consumer must have a choice between the HMO and traditional fee-for-service care. Realistically speaking, the American consumer of health care services is not sophisticated enough in most cases, to make a decision to pay three times more to receive his health care in an HMO than he would have to spend to buy a traditional indemnity policy--even if the HMO offered six times as many benefits. Until the typical consumer throughout the country has been educated about health maintenance organizations and until he shows a far greater acceptance of and desire for implementation of the HMO concept of medical care, then comprehensive requirements such as those proposed by the Kennedy bill, and perhaps even the lesser benefit levels required by H. R. 11728, will be self-defeating in terms of encouraging the formation of HMO's. The National Council agrees with President Nixon's remarks in his Message to Congress, "Building a National Health Strategy" (February 18, 1971), when he said about the HMO: "Such an organization can have a variety of forms and names and sponsors. One of the strengths of this new concept, in fact, is its great flexibility."

As nursing facility proprietors and operators of the home health care service, and as businessmen who wish to participate in the formation and operation of health maintenance organizations, we are confident that experiments will demonstrate to the satisfaction of all that the addition of subacute alternatives and home health care to the acute hospital will not be cost "add-ons" for an HMO. Rather, given the flexibility of the HMO structure, they will be able to significantly lower the HMO's hospitalization factor still further and will provide the HMO member-subscriber and his physician with a wider range of suitable services. Projected cost-savings from the efficient and proper use of a range of facilities and services may allow the HMO to offer other actual "add-on" services such as mental health services at minimal or no additional cost to subscribers and thereby improve the HMO's competitive position vis-a-vis other HMO's as well as fee-for-service care.

Because skilled nursing facilities are no longer devoted exclusively to the senior citizen, more and more, sub acute institutional care is being recognized as a legitimate element in the continuum of health care services for persons of all ages.

Perhaps the most meaningful kind of consumer participation in the health care area lies in giving him a choice of how and where he receives his medical care.

Testimony of EDWARD J. WILSMANN, President

Homemakers Home and Health Care Services, Inc.

Subsidiary of the Upjohn Company

HOME HEALTH CARE IN THE HMO

Institutionalization of the sick and near sick has become a "way of life".... but not exactly the "way of life" that necessarily promotes maximum recovery and rehabilitation. The advantages of the home environment after or instead of hospitalization include the happiness and well being of the patient, faster recovery, and the preservation of the dignity of the individual. Other factors important to the patient include the easy transition from the hospital or institutional environment to normal living while extending the required medical and nursing care and service on a continuing basis.

The use of home health services may also prevent the "ping-pong" effect of the patient sent home from the hospital whose condition deteriorates because no one is available to provide for his needs in the home environment and who must be readmitted to the acute hospital.

A Definition of Home Health Care

Home health care can be defined as a coordinated system of individual health care delivered to patients in their homes by professional and allied health personnel under the direction of a physician. These services are organized and provided so that the patient is either restored to full health or achieves maximal rehabilitation with the least possible disruption to his usual pattern of daily living.

Home health services include intermittent nursing care, physical therapy, occupational therapy, speech therapy, social service, home health aides, housekeeping services, and medical equipment and supplies as ordered by the physician.

Home health services have applicability for physical illness, short or long term disabilities, emotional illnesses and crises which threaten the normal pattern of living.

In addition to cutting down on the number of days a patient must remain institutionalized at the end of his stay, home health services may be able to delay entrance into an institution where appropriate.

All of these services can be provided by a well-organized, centrally managed home care service through coordination, planning, evaluation, and follow-up procedures. All at less cost than institutional care.

Utilization vs. Continuum of Care

What an opportunity Health Maintenance Organizations have to place the HMO patient in the proper setting and the proper level of care. What an opportunity to prove that continuum of care can be more than just a concept--but instead a desirable reality, which has been largely unavailable to date through our traditional, fragmented fee-for-services, indemnity insurance system.... A system where the patient receives his care on the basis of what his insurance policy covers, rather than what is medically appropriate to his needs.

We believe that the HMO offers an ideal growth medium for a true continuum of care and services, where the patient-subscriber moves through the system, receiving care of various types and levels based only on what is appropriate medically for him as an individual.

Those services which represent that part of the continuum that lies in-between the acute hospital and outpatient visits to a physician have never really "caught on" with significant segments representing all age groups of the population. Not because they are unacceptable or medically inappropriate, but because traditional indemnity health insurance policies have not covered them. As the HMO concept becomes more widely known and accepted by the population at large, if the HMO uses a range of alternative levels of care well and appropriately, then the consumer who continues to receive his care through fee-for-service will also begin to demand that more alternatives be made available to him through his insurance policy.

Medicare and Medicaid have served to bring to light the inadequacies and improper utilization of facilities and manpower in the traditional system. You have just heard from Mr. Callihan about the conditions of the patients in the Indianapolis Methodist Hospital ....44.5% require only the type of care usually classified as "intermediate" care or home health care and an additional 30.1% require only the kind of care which is provided in skilled nursing facilities. Certainly the proper utilization of existing nursing facility beds would remove most of the pressure for more hospital beds. Home health care could also free acute hospital beds for those in need of them while permitting the patient to return to more natural surroundings at the earliest possible moment.

A three-year research study conducted at Mt Sinai Hospital in Milwaukee, Wisconsin entitled "Home Care in Comparison With Continued Hospitalization" indicated the following: (1) Home health care was evaluated by 50 physicians as approximately equal to continued hospitalization in regard to medical care and was rated as predominantly better than hospitalization in four other aspects of care; (2) Some patients and their families had mixed emotions about home care at first. However, 84% of those actually receiving home health services preferred it over continuation of hospitalization.

Prevention and Education

If HMO planners truly insist that HMO's live up to their name and concentrate efforts on prevention of unnecessary illness and maintenance of health, then the home health nurse-home health aide are ideally suited to carry out training and educational programs.

The encouragement of HMO subscribers to exert effort toward the prevention of illness and health maintenance must come from sources familiar with the personal health aspects of the subscribers. Aside from the subscriber's physician, who could be more intimately involved in the personal health life of the patient-subscriber than home health care personnel who see patient-subscribers in their homes. The well-trained, well-equipped aide has the opportunity to educate and train patients and subscribers and their families on such vital subjects as nutrition, cleanliness, independent living, sick care, self care, and preventive measures. The use of home health aides to train HMO subscribers in health maintenance and disease prevention concepts will merely help solve the problems of ignorance and indifference among the well and near well population. We believe in fact that there must be a massive public relations and advertising effort to motivate the public on prevention of disease and health maintenance and HMO workings.

Cost and Home Health Care

Traditionally, the health insurance industry has regarded home health care as an "add-on" benefit or has completely ignored its existence. Where home health has been a covered service, significant savings are apparent. In Denver, New York, and Rochester the statistics on early hospital discharge where home health care is available are impressive. And cost savings are also significant when the patient returns home, receives appropriate home health care and recovers, as opposed to the patient who returns home, does not receive needed care, deteriorates, and must return to the hospital. Additional cost savings result when the home health services are provided by a well-managed, coordinated, quality conscious home health agency.

It's refreshing to note that home health care requires no bricks and mortar, no expensive medical equipment, no high administrative costs and that the services can be used and paid for on an as-needed basis.

Role of Proprietary Home Health Agencies

As the nation's largest provider of home health services as well as a tax-paying enterprise, Homemakers is hopeful that this Committee will not adopt language contained in H.R.5615 which uses Medicare standards (conditions of participation) to govern the eligibility of the various institutional and service components of health maintenance organizations.

The National Council of Health Care Services believes that in order to provide complete, comprehensive and workable health programs, the resources of both public and proprietary health care providers must be involved. This can be

stated as an axiom regardless of any suspicions cast on the for-profit sector or claims of bureaucratic inefficiencies directed at the public and non-profit sector for one simple reason: Combining all the public and private, tax-paying and tax-supported providers together, there still is currently and projected for in the future a shortage of manpower, financial resources and coordination. Therefore, there seems to be no alternative but to combine the resources of both the private proprietary health care industry with the public not-for-profit providers of health care.

The key to a successful co-existence of both types of providers is a set of adequate but not restrictive controls on standards, accountability, organization and incentives for efficiency. To determine the eligibility of a provider of health care on the basis of the provider's profit or non-profit structure is discriminatory and wasteful. Participation must be based on quality, availability and reasonableness of cost of service which will encourage competition for the provision of these services.

Many of the current proposals for health care legislation encourage participation from the private sector of health care providers. This is particularly true in some of the variations of the Health Maintenance Organization concepts that have emerged. However, in some HMO proposals that we have analyzed, the standards of eligibility for providers of service are generally based on Section 1861 of Title XVIII of the Social Security Act, for example H. R. 5615. These standards are restrictive in that there is definitely a discriminatory approach taken against the private, for-profit provider. The regulations implementing Sec. 1861 further complicate the position of the proprietary provider.

Time after time proprietary home health care providers have been approached by non-profit certified home health agencies to provide supplemental services that the agency itself was unable to provide. In most instances the services of the proprietary agencies met every test of the Medicare regulations under 1861 (0) except that they were and are tax-paying organizations. The results being that in many cases the required services that could not be provided by the certified agency went unprovided or, in some instances, the service was ultimately arranged with a public or not-for-profit agency at a higher cost to the certified agency.

We are actively involved with the Standards Committee for the National Council for Homemakers Home Health Aide Services, and with the Joint Commission on Accreditation of Hospitals. We are a firm believer and promoter of high standards for home health care and intend to promote this position regardless of our ability to participate in providing services under the Social Security Act. We feel, however, that the exclusion of the proprietary for-profit agency from providing basic and supplemental services is causing many home health needs to go unmet.

We have in the past made attempts to determine the rationale behind the discrimination of theprivate for-profit (tax-paying) organization in health legislation. The answers to our inquiries have been in our minds weak and, if factual, without grounds. It is time to recognize the contributions proprietary health care can make to cost control and quality care.

Recommendations, Experimentation, and Flexibility

...1. Encourage experimentation in the uses of home health services in the HMO, but the legislatively-required benefit package for HMO's should be kept to a minimum so as to encourage experimentation, allow for flexibility, and to allow the HMO to retain a good competitive position vis-a-vis traditional health insurance plans.

...2. Because home health services are in short supply (there are some 30,000 employees in 2,850 agencies at the present time and it is estimated that there is a need for 300,000 employees), encourage the development of quality services through loan guarantees for planning and start-up costs to responsible applicants regardless of type of ownership.

...3. Encourage the Federal and State governments to negotiate capitation contracts, where feasible, for Medicare and Medicaid recipients. Significant numbers here would give the HMO an immediate cash flow and would obviate or do away with the necessity for government funding for operating losses.

...4. Require quality standards and monitoring such as these voluntary, self-policing standards developed by Homemakers-Upjohn which are being submitted for the record.

Whatever standards are enacted, they must be uniform and apply equally to all, regardless of type of ownership.

Testimony of ROGER C. LIPITZ, President

Medical Services Corp.

FLEXIBLE FACILITY PLANNING

In addition to its role as an alternative to hospital care, the nursing or extended care facility in the HMO should have the capacity to function in a number of other areas.

1. The properly qualified nursing facility may be used to expand, on short notice, the number of acute hospital beds available to a hospital or HMO. This enables the hospital to avoid making costly capital expenditures for partially utilized services, or can assist the hospital to meet a pressing need for additional beds during a crisis or while new additions are being made. One of my company's nursing homes has such an arrangement with a hospital which I would like to describe.

The Randallstown Nursing and Convalescent Center was purchased by Medical Services Corp. in November 1971. All of its beds are licensed as skilled nursing beds. Its present occupancy is 85% Medicaid patients and 15% private patients. The facility offers full 24-hour nursing services and provides full time occupational and physical therapy.

In January 1972, Baltimore County General Hospital, a non-profit voluntary general hospital, signed a lease agreement with MSC agreeing to pay MSC a flat rate per month for the use of 48 beds at the Randallstown nursing center as an acute hospital unit. The state of Maryland has licensed 35 beds at the nursing facility as acute hospital beds. The MSC nursing facility provides dietary service, maintenance and laundry, and the hospital provides its own nursing and medical personnel.

Two interesting conclusions have emerged from a survey conducted by the hospital after the first few months of operation of "Satellite Unit I":

1. Although the agreement calls for a flat payment by the hospital for a certain number of beds, regardless of the number of beds occupied at any given time, it was shown that the overall patient-day cost for the acute patients in the Satellite Unit was significantly less, even with low occupancy, than the overall patient-day cost at the hospital itself, even though the hospital itself has an average occupancy rate of more than 90%.

2. Patients who were transferred from the hospital to the Satellite Unit at the nursing facility overwhelmingly expressed their satisfaction with all aspects of the care they received at the Satellite Unit in a survey, the results of which are attached. Thirty-five of thirty-seven patients surveyed responded "Yes" when asked "If re-hospitalization becomes necessary, would you want to return to Baltimore County General Hospital and be transferred to the Satellite when your condition warranted?"

I might add that this sort of arrangement does not require that the hospital and nursing facility be adjacent or connected. The Randallstown nursing facility is located approximately one mile from the hospital. However, we did find that physicians were reluctant to make the extra trip which the Satellite Unit's location necessitated. In addition, a physician was not on duty 24-hours per day.

This is not an isolated example; other members of the National Council have nursing facilities with similar arrangements with acute hospitals.

3. The nursing facility is an ideal environment for rehabilitative activities. With no restrictions on whether the treatments are rendered on an inpatient or outpatient basis, the HMO physician would be free to prescribe the proper regimen of rehabilitative activities to be conducted in the nursing facilities. In most cases, the only justification for making the acute hospital responsible for rehabilitation is that no less costly and more appropriate alternative exists.

4. The nursing facility offers a place for the appropriate wider use of paramedical personnel. Many supporters of the HMO concept have suggested that it offers an opportunity to use paramedical personnel effectively and to expand their now limited roles.

At the same time, however, we do recommend that uniform national standards for various types of paramedical personnel be developed and that paramedical personnel in HMO's be required to meet these standards. Perhaps, if this condition were met, they could be held exempt from restrictive State laws.

5. The nursing facility, with its complement of trained personnel, is an ideal location for consumer education in health maintenance and health care, a cornerstone of the true HMO and unfortunately, non-existent in many existing HMO's. Many nursing homes have already established themselves as community centers. For example, some of the Council's member nursing facilities sponsor classes in childbirth and prenatal care, provide training in care of the ill-elderly or bedridden for families with an old or ill person living in the home, and provide classes in nutrition and proper diets.

The National Council believes that consumer health education should be mandatory in health maintenance organizations and that the nursing facility is well suited to providing requisite educational activities.

6. The nursing facility may provide not only a more medically appropriate and economical alternative to hospitalization during convalescence, but, in most cases, patients would prefer to leave the hospital at the earliest possible moment.

7. Where necessary or desirable, the nursing facility can do "double duty" as a "satellite" or medical clinic. In an HMO serving a rural or sparsely populated area, this might be particularly applicable. In many small towns and villages, the community nursing home is the only medical facility available. With the proper communications networks, such facilities could be used to provide emergency care and to do preliminary screening of subscribers. It would appear to be a waste of limited health care dollars to build a series of satellite clinics or hospitals beds for which in many cases, no trained personnel could be found -- when the facilities and trained personnel already exist and could be adapted to meet new challenges.

The aforementioned are only a few ways in which the sub-acute care nursing facility may be "put to work" in the HMO to achieve truly an integrated, comprehensive spectrum of care. Of course, they may also be implemented in the traditional system, where the fragmented delivery system permits.

BALTIMORE COUNTY GENERAL HOSPITAL

Dear Patient:

Now that you are being discharged from the Baltimore County General Hospital Satellite Unit, I would like to ask that you assist us in evaluating our services to patients. Would you then please complete the following questions and return them in the enclosed self-addressed envelope.

	Yes	No
1. Were the arrangements for transfer to the Satellite satisfactory?	37	0
Did you experience any unusual discomfort as a result of the transfer?	0	37
2. When you arrived at the satellite,		
(a) were you treated in a friendly, courteous manner?	37	0
(b) were your questions answered clearly and promptly?	36	1
(c) were parking facilities adequate?	35	2
3. While at our Satellite, did you feel that,		
(a) your room was		
attractive?	37	0
quiet and comfortable?	37	0
kept neat, clean and cheerful	37	0
(b) Your food was		
served hot when it should have been hot and cold when it should have cold?	29	8
tastefully prepared?	32	5
served in adequate portions?	34	3
served in an attractive, appetizing way?	35	2

4. Did Satellite personnel perform their duties to your satisfaction? (If not, please comment in the space provided).

Yes 37 No 0

	Yes	No
5. When you left Baltimore County General Hospital satellite,		
(a) were financial matters handled quickly and smoothly?	37	0
(b) was your bill easy to understand?	37	0
(c) if you had questions about your bill, were they answered pleasantly and clearly?	37	0
6. If re-hospitalization became necessary, would you want to return to Baltimore County General Hospital and be transferred to the Satellite when your condition warranted?	35	2

Comments and Suggestions: We are particularly interested in your remarks concerning those areas which were unsatisfactory to you.

The only complaint was the food being served when cold

Thank you for your assistance.

Alton E. Pickert
Executive Vice President

Testimony of JAMES GRIFFIN, Vice President and Secretary

Neighborhood Health Centers, Inc.

THE INNER CITY HEALTH PROJECT OF NEIGHBORHOOD HEALTH CENTERS, INC.

Neighborhood Health Centers, Inc. Inc. (NHC) is a private corporation formed in August 1970. It is jointly owned by Medical Services Corporation (MSC), a publicly held health care company headquartered in Baltimore, Maryland and by Charles Venter, M.D. and myself.

It is proposed that NHC will be the vehicle for providing comprehensive health services on an outpatient basis to all segments of the population, initially in Northwest Baltimore and ultimately, it is hoped, citywide. We believe that a proprietary, tax-paying, management-oriented health care company can offer a solution to the problems of making the health care delivery system responsive to the needs of the general patient population by providing accessible and attractive high quality health care at a cost to the patient which is equal or lower than similar non-profit organizations.

It has been brought to our attention that one section of H. R. 11728 in effect excludes the participation of proprietary organizations as health maintenance organizations. We at NCH strongly oppose such a move and this is our reason for appearing here today. Conceding that proprietary health care is not the only panacea for all of the ills of the health care system in this nation today, we remain convinced that it is, nevertheless, a desirable alternative. Therefore, it is our intention to briefly describe the activities of NHC in its efforts to plan, develop and operate what we have considered to be the first step toward a viable health maintenance organization. Hopefully the membership of this Subcommittee will subsequently understand our position and agree to make necessary changes in this section of the aforementioned proposed legislation.

NHC Health Care Involvement

In late 1970 our company made a decision to conduct an experiment in the delivery of primary health care to a primarily black, inner city poverty population. This commitment was made because we observed certain trends in the delivery of health care in the city and felt we could fulfill a need, gain valuable experience in new areas and also cut costs to consumers while maintaining profitability. In order to implement this decision we sought assistance from various sources so that we might find a location in the city with a significant need for the kind of facility we envisioned. The final decision as to location was based on the following major criteria:

1. shortage of primary health care
2. inner city
3. hospital outpatient or emergency department as prime source of care for the area
4. need for competition
5. viable community consumer group, which would be willing and able to assist with planning and to maintain an ongoing advisory role as the service developed.

We finally settled on an area in Northwest Baltimore City because all of the above criteria were met. Additionally, the State of Maryland, through its Medicaid program, agreed to work with us in developing a unique reimbursement contract for persons who were medically indigent in this community. The contract signed between NHC and the Maryland State Department of Health and Hygiene is not a prepaid type although NHC had expressed a desire to negotiate this type of reimbursement originally. However, the present arrangement between the above does have similarities to prepayment. As operating presently the contract provides a single reimbursement for any and all of the following:

1. Medical and minor surgical care
2. Family health assessment and continuous health maintenance through outreach programs under physicians' supervision
3. Emergency services
4. Psychiatric services (minor)
5. Extensive referrals for subspecialist care not located in the facility.

Under the contract NHC has also agreed to provide a variety of "ancillary services" for which no charge is made to the State Medicaid program. Among these services are extensive radiological services, extensive pathology and laboratory services, social work, nutrition, podiatry, rehabilitation services and a variety of other services.

It has been publicly stated by the Maryland State Health Department that their intention is to contract eventually with us on a prepaid basis to provide all inpatient and outpatient health services for a selected population of Medicaid patients.

Prior to the securing of the site of the health center we set out to see if we could: 1. recruit a group of physicians to provide the primary medical care needed in the area, and 2. organize a group of community residents who would be able to give advice and support as appropriate. Throughout this venture it has been our goal to provide an attractive alternative to what many patients feel is second-class health care while at the same time minimizing unnecessary costs so that the consumer would opt for our service in an area where prior to our entrance he had little choice.

Early in 1971 we began the renovation of a ten thousand square foot facility. Financing of this venture came solely from conventional private sources. We might add here that no effort was made to investigate the possibilities of securing other types of financing, primarily because of the belief that it would result in long delays for the project. With renovations completed, we opened the facility to the public August 18, 1971. It is of interest to note here that the entire project took approximately 15 months from inception to delivery. Simultaneously, at least four organizations were planning similar facilities for the city with monies received from various public sources and to date none of these organizations have successfully opened such a facility.

The implementation of this project has not been without problems. In the area of consumer participation there have been times when mistrust among the participants has threatened the entire existence of the project. We have also experienced, not atypically, internal power struggles within the community, conflicts between the consumer advisory board and the professional staff in medical policy areas, and criticism from a local medical society for distributing what we consider educational literature about the facility. In reference to the point immediately proceeding we believe it is significant that at least three other organizations which happen to be non-profit carried out more intensive "educational" programs and to our knowledge received no criticism from the same medical society.

During the initial seven months of operation the facility has registered approximately 10,000 individuals. The number of patient visits during this period has been approximately 18,000. Slightly less than 40% of the visits have been made by persons covered under the Maryland Medical Assistance Program (Medicaid).

We believe the entrance of NHC, a proprietary company, in the field of health care has benefited the consumers who have utilized our services and this would not have been possible if we were excluded from the HMO activities as a proprietary organization. Since we opened our facility others in the state have seen our progress and noted some of our successes. In doing so others have paid us what we feel is the ultimate compliment--i.e., trying to duplicate our program elsewhere. This applies to both private and public groups. Another possible effect of our presence, although not proven, has been the report by a hospital nearby that for the first time their emergency room visits have stabilized and that we have influenced them to begin tougher programs to reduce costs.

We realize that it would take more time than we now have to prove the efficacy of our efforts. However, the point we have tried to make here is that this joint venture has cost the taxpayer nothing for planning, development, or implementation; and for those whose care is financed by tax revenues these costs have been lower or equal to existing programs.

Testimony of ELIZABETH J. CONNELL, Public Relations Director

National Council of Health Care Services

LEGISLATIVE RECOMMENDATIONS

R. # 1. Incentives for Proprietary Involvement

The National Council of Health Care Services strongly urges this Committee to create incentives which will encourage private, proprietary enterprise to invest its much-needed capital resources in the health care field and to lend its business management expertise to the awesome task of bringing order, efficiency, cost-consciousness, and higher quality for more people to the health care arena, rather than discriminating against for-profit involvement in HMO's. Encourage competition among non-profit HMO's and for-profit HMO's. This should compel efficiency and would work to eliminate the monopolistic practice of pricing health services in accordance with ability to pay.

Stringent limits should be placed on operational and developmental subsidies to non-profit sponsors of HMO's concomitant with requirements that an HMO, whatever its sponsorship or organizational form, be able to provide the Secretary of HEW with assurances that it will become self-supporting within a short, specified period of time. Dependence on long-term government funding is apt to lead to the organization providing care at excessive cost because it does not have to depend solely on self-generated income. Open-ended deficit financing removes the HMO's natural incentives to control costs and may lead to some form of cost-of-service reimbursement.

R. # 2. Financial Incentives to Provide Services for Medically Underserved

We recommend that contracts, loans, and loan guarantees be equally available to HMO sponsors both proprietary and non-proprietary which will operate in medically underserved areas. In addition, funding to cover the cost of HMO care for the near-poor not eligible for Medicaid or for experimental job training programs for underskilled persons sponsored by an HMO, or for extra or innovative services and programs in the area of preventive health care and health education should be equally available to any HMO willing and qualified to provide the service without regard to type

of ownership. To accomplish this, we would suggest that monies appropriated for this purpose be undesignated as to whether for contracts or for grants, and that awards be made based solely on the need for and quality of the proposed services.

If the object of providing such government funding is to assure that the medically underserved receive quality health care, such discrimination is directly contrary to that objective.

The present system of restricting funding for providing health care services for the poor and under served has not been successful in making quality care either generally available or acceptable to these population groups. If uniform standards are met and adhered to, the welfare of these individuals could best be served by making every effort and using every available resource to provide health care of high quality.

R.# 3. Restrictive State Laws

Lower the barriers to entry into HMO formation by overriding, Federally if necessary, State legislation that restricts or prohibits HMO development. All forms of organization should be treated equally.

The National Council of Health Care Services recommends that the definition of an HMO contained in H. R. 11728 be changed so that proprietary organizations are included under it. This would allow proprietary HMO's to benefit from Section 1116 of that bill which allows the Secretary of HEW the authority to waive restrictive State laws for HMO's which meet the bill's definition. We hope that this Committee will change the relevant section accordingly even if the bill continues to restrict Federal financial assistance to public and non-profit sponsors.

R. # 4. Comprehensive Health Planning

The National Council makes the following specific recommendations concerning the relationship between HMO's and comprehensive health planning mandated by proposed legislation:

a. That no comments be solicited from comprehensive health planning agencies which would be permitted to have any bearing whatsoever on any type of funding for any prospective HMO, much as stated in Senator Kennedy's bill S. 3327. Even though both H. R. 11728 and H. R. 5615 give CHP's a purely advisory function, we believe that it would be a serious and costly mistake to establish a precedent for allowing bodies which exist for the purpose of eliminating competition to make recommendations on the "need" for a new system which must depend for its eventual success on competition and which will undoubtedly involve some duplication of existing services if not facilities.

b. We suggest that H. R. 11728 be changed to delete the requirement that the Secretary consult with CHP agencies in determining what constitutes a

"medically underserved" area, so as to give the Secretary wider discretion in the determination of a medically underserved area. This would not preclude the Secretary from consulting with these agencies. However, the possibility exists that an adverse comment by the agencies may stultify HMO growth and development in areas where they are needed.

R. # 5. Technical Assistance Needed

Take affirmative government action to encourage the formation of HMO's byoffering backup assistance in the form of consulting services, research, and information to all types of HMO's.

R.# 6. Standard Minimum Benefit Package

Legislation enacted should require a standard benefit package in order to facilitate price comparisons for the consumer. The required package should contain only the minimum necessary services, although additional services may be made available and some extra charge may be levied. We prefer the benefit package required by H. R. 5615, with the addition of diagnostic and therapeutic radiologic services, as provided in H. R. 11728. The HMO needs flexibility to compete successfully with traditional medicine.

R. # 7. Consumer Involvement

As indicated earlier in this testimony, the National Council of Health Care Services supports the approach taken by the Roy bill, Sec. 1101 (E) of H. R. 11728. While mandating consumer involvement, the bill does not specify methods, etc. and thereby allows for a desirable element of flexibility.

We are also in favor of educating the consumer, about what constitutes good health care, preventive health, and health maintenance, so that his involvement may be more meaningful.

R. # 8. Accountability

The HMO ought to be held publicly accountable for the care it renders, whatever its sponsorship - proprietary or non-profit. However, with regard to Section 1101 (H) of H. R. 11728, we believe that statistical information on such issues as accessibility and availability is difficult to ascertain reliably and objectively. We suggest that reporting requirements in this provision ought to be limited to HMO cost and utilization patterns with full disclosure to the public.

R. # 9. Uniform Standards

The development, implementation, and (perhaps most important) enforcement of uniform Federal standards for institutional providers, health systems, and health professionals and paramedical personnel should serve to assure the consumer that the care he receives meets high minimum standards wherever he receives that care. The National Council supports the notiond Federalizing standards relating to health care, including standards and requirements for professional licensing in the States. We believe that among the standards for medical professionals ought to be requirements for continuing education and special requirements for various medical specialties.

We support the concept expressed in Section 1101 (G) of H. R. 11728 which requires the HMO to have organizational arrangements for an ongoing quality assurance program that stresses the processes and outcomes of services provided, in addition to requiring the components of the HMO to meet standards established by the Secretary. Assessment of processes and outcomes should prove to be a far more reliable and precise method of assessing the quality of care provided than the present reliance on component standards. The HMO which brings all the services together and controls their use should be an ideal medium for use of this sort of method. Wisely, in our judgement, H. R. 11728 refrains from specifying the quality assurance method. Since no one system has yet been proven demonstrably superior or even viable, we hope to see experiments and demonstration projects in this area and would hope that at least initially, until the results of demonstrations are in, the Secretary will be permitted to withhold regulations and evaluate HMO quality assurance programs on a case-by-case basis.

In conclusion, we are happy to provide needed care under whatever standards of participation and operation this Committee and the Congress in its collective wisdom see fit to write and enact into legislation, with the provision that these standards be applied equally to ALL providers of health care, whatever their ownership or sponsorship.

APPENDIX

FACTS SHEETS ON:

Fact Sheet on BERKELEY V. BENNETT

A native of New England, Mr. Bennett was educated in Business Administration at the Wharton School of Commerce and Finance of the University of Pennsylvania. He served four years as a gunnery officer in the Air Force. After World War II, Mr. Bennett's experience has been concentrated in health related industries and association management, with emphasis in the pharmacy, medical consulting, and nursing home fields.

Following military service from 1942 to 1946, he was a management trainee with Vick Chemical Company, sales training director of Johnson & Johnson's Chicopee Division; public relations director of the National Wholesale Druggists' Association; management consultant to nursing homes; and executive director of the Vermont Nursing Home Association, the New Hampshire Association of Licensed Nursing Homes, and the Vermont Pharmaceutical Association. In addition, Mr. Bennett was a co-founder of the American Society of Consultant Pharmacists, an association composed of pharmacists serving as consultants to health facilities, and served as its first Executive Director.

Mr. Bennett has also served as nursing home consultant to Gilman Brothers, Johnson & Johnson, and the National Wholesale Druggists' Association. He also serves on the editorial board of Modern Nursing Home and writes for Drug Topics as well as serving on several government advisory boards, including the Vermont Small Business Administration and the White House Conference on Aging.

Mr. Bennett serves as Executive Vice President of the National Council of Health Care Services, the trade association representing multi-facility health care companies, headquartered in Washington, D.C.

Mr. Bennett was among the first industry leaders in Washington to recognize the potential of HMO's to deliver health care more efficiently. Since the summer of 1970 he has worked with DHEW, HSMHA, BHI, SSA, MSA, his member companies and other groups and consultants to educate Council members on HMO's and to generate interest in their development. In addition, Mr. Bennett has studied with existing HMO's across the country extensively and serves as a coordinator and consultant to his member companies involved now in HMO planning.

Published Articles

Drug Topics: "Vital Market Open to Pharmacists", December 12, 1966.
"Today's Nursing Home Expects More of Pharmacist", June 1967.
"33 Questions To Ask", November 17, 1967.

Nursing Homes: "Nursing Homes In Public Ownership", January, 1971.

Pharmacy Times: "Tomorrow's Successful Nursing Home Consultant", May, 1968.

Modern Nursing Home: "Where and How Nursing Homes Buy Supplies", September, 1968.
"Good Nursing Homes Make Good News", July, 1965.
"Multi-Facility Health Care Services", June,1970
"Inventory Control Built Into Drug Units", November,1966
"Unit Dosage Simplifies Nursing Care", July 1968

Pharmacy News: "Nursing Home Pharmacy Hits Snage ", Winter, 1969

Membership on Editorial Advisory Boards:
Modern Nursing Home (McGraw-Hill)
Drustar Digest

Papers on Health Care Topics delivered:
Northeastern University
Butler University
American Nursing Home Association
Federal Wholesale Druggists' Association
American College of Apothecaries
National Public Radio
National Wholesale Druggists' Association
Purdue University
Mid-American Health Congress

Testimonies on Health Care Legislation delivered:
Senate Committee Labor and Public Welfare, Health Subcommittee
Senate Finance Committee
Senate Special Committee on Aging, Subcommittee on Long Term Care
House Committee on Ways and Means
House Special Studies Committee

Fact Sheet ELIZABETH J. CONNELL

Ms. Connell attended Cornell University and was awarded an A.B. degree in 1967, graduating with honors on the Dean's list.

From September 1967 to May 1968 she was Administrative Assistant at the American Political Science Association where she assisted in administering the Congressional Fellowship Program funded by the Ford Foundation. Ms. Connell was then actively involved in fund raising for Hubert Humphrey in the 1968 Presidential Campaign involving personal, telephone and mailing contact with prominent presonages. She also worked on the planning for several major fund raising dinners. Following the campaign Ms. Connell was made director of Correspondence at the Democratic National Committee where she supervised six persons in answering sensitive political and general correspondence for the Chairman, Senator Fred R. Harris. She was also responsible for interpreting Demoncratic Party positions on issues as well as for researching party positions.

Since February 1970, Ms. Connell has served as Public Relations Director and Special Assistant to the Executive Vice President of the National Council of Health Care Services. In this position she replaced an outside public relations firm and was in charge of all aspects of the Council's public relations and communications programs. This included writing a weekly confidential bulletin detailing Washington news, of all association position papers and the preparation and presentation of testimonies before some seven Congressional Committees.

Ms. Connell's duties include contacting Congressmen, Senators and administrative aides regarding legislation and appropriations bills of interest to the health industry. It is also necessary to be in close contact with the various agencies of the Department of Health, Education and Welfare. Ms. Connell has done extensive research in the HMO area and has been involved in a number of seminars and workshops on the subject.

In the absence of the Executive Vice President, Ms. Connell serves as Acting Director of the Council.

Fact Sheet on PATRICK J. CALLIHAN

Nursing Home Chain Executive; Born in Flushing, Michigan, March 10, 1928; parents, Dale M. and Eva C. (Burt); B.A. Michigan State, 1953; M.A. in Administration, 1957; Married to Coilah A. Pirochta, September 14, 1950; Children, Michael James and Daniel Scott. Mr. Callihan is President and Director of Provincial House, Inc.; President and Director of the National Council of Health Care Services; Director, Extended Care Conference American Hospital Association; Officer and Director of the Michigan Nursing Home Association; Presidential Appointee to the National White House Commission on Aging; Member of the U.S. Department of Commerce Consumer Committee on Health; Member Blue Cross Extended Care Facility Relations Committee; Officer and Director of Compu-Link Corp.; Officer and Director of P.H.I. Construction Co. Formerly Associate Professor at Michigan State University and Manager of WMSB-TV, Executive Assistant for Network Affairs and Director of Field Services for National Educational TV, NYC; President and Director of Charter Development Co., Lansing, Michigan 1964; President and Director of Secured Mortgage, 1965; Trustee of Eastern Educational TV Network; Served with USNR 1946-48; Member of the Public Relations Association of Michigan National Association of Educational Broadcasters, Alpha Epsilon Rho, Home at 1324 Pepper Hill Drive, Lansing, Michigan, Office: 4000 North Grand River Avenue, Lansing, Michigan.

The above information is from Who's Who in Commerce and Industry and Who's Who in the Midwest.

Fact Sheet on PROVINCIAL HOUSE, INC.

Provincial House is located in Lansing, Michigan and operates nine convalescent care centers, a construction subsidiary, and a computer corporation. The company operates 1100 skilled nursing home beds served by 715 employees.

Provincial House has been working with the Lansing, Michigan Capital Area Comprehensive Health Planning Agency to develop a prepaid health plan, and is at the present time in the process of amalgamating three groups of physicians in the area.

A wholly owned subsidiary, Compu-Link, serves a wide variety of clients in addition to Provincial House with complete data processing and system development. The computer provides perpetual inventory, general accounting, financial statements and comparative statistics on all facilities. A wholly owned construction company is mainly involved in the building of hospitals, nursing homes and college buildings throughout the country.

Provincial House is a publicly held company with financial resources and capabilities to develop the needed capital for the start-up and continuation of HMO's.

Among the other areas that the company is developing are day-care centers, congregate housing, housing for the retarded, meals-on-wheels and an administrators training program for students at Michigan State University.

Provincial House was also instrumental in the formation of a discharge planning group of all health facilities in the Lansing area to coordinate services. The company is starting this in three other cities as well.

Fact Sheet on EDWARD J. WILSMANN

Edward J. Wilsmann, President, Homemakers, Inc., The Upjohn Company, was born in Neilsville, Wisconsin June 6, 1924.

He attended Two Rivers High School and Wisconsin State University, Whitewater, Wisconsin, where he received a B. Ed. degree in 1950 and Northwestern University in Evanston, Illinois to get his M.B.A. degree in 1956. He is a CPA of Wisconsin in 1956 and Illinois and Indiana by reciprocity.

Mr. Wilsmann was a partner of Brabec and Wilsmann, CPA's, prior to forming Homemakers, Inc. in 1966 as President. Homemakers was acquired by The Upjohn Company in November 1969.

He is a member of the American Institute of CPA's, Illinois Society of CPA's, has been three term director, one term president of the Society for Advancement of Management, and two term president of the Credit Association of Greater Joliet.

Mr. Wilsmann is married to the former Delores C. Piambino of Philadelphia, Pa. He has four children: Leni Ann, Jo Ann, Edward A. and Christine Ann. They attend the Immanuel Lutheran Church.

Fact Sheet on HOMEMAKERS, HOME AND HEALTH CARE SERVICES
SUBSIDIARY OF THE UPJOHN COMPANY

Homemakers is a new health care service which makes supportive services to home and to health care institutions available at the lowest possible cost.

Headquartered in Kalamazoo, Michigan, Homemakers is a wholly-owned subsidiary of the Upjohn Company, a leading pharmaceutical manufacturer.

Homemakers has offices in 114 major metropolitan areas across the country. The company's personnel in each office include registered nurses, licensed practical (or vocational) nurses, nurse aides, companions, visiting housemothers and housekeepers. Because Homemakers is not an employment agency, the company is responsible for the services rendered by its employees. Homemakers personnel are skilled, reliable individuals, bonded and insured in the performance of their duties.

In addition to home services, Homemakers provides staff substitutions in hospitals, nursing homes, clinics, and doctors' offices.

Homemakers recruits its own employees. Some of them are from that segment of the labor market desiring work on a part-time basis while others seek full-time employment with the challenge and interest of varied work assignments. Because of these latitudes, Homemakers is able to provide its many services efficiently, while making available to people with critical skills in the community a broadened opportunity to use them.

The company's services enable hospital patients to return home upon authorization by the attending physician. The physician determines the need or degree of supportive services required for home convalescence.

Homemakers relates the skills possessed by an employee to the services prescribed. As recuperation occurs or the status of the convalescent changes, the skills and services rendered by Homemakers are adjusted in accordance with the physician's decision. A patient--or his family--secure only the attendant services necessary for recuperation. As the convalescent resumes normal functions, less care may be needed.

Homemakers continues to adjust its services to meet the individual requirements of the patient's care until full health is restored. Such a health care service frees professional skills and supportive services for other duties as quickly as safely possible.

Care in the home environment can represent a considerable financial saving. Expensive laboratory and technical skills, which are part of a hospital's overhead, are often no longer needed in convalescence. In cases of chronic illness or long term disability, physicians recognize the possible psychological advantages of returning the patient to the home to rejoin the family. In many cases the patient views the return home as an important step on the road to recovery. The family, with assistance as needed from Homemakers, is able to function as a unit again without daily worry regarding the patient's welfare, hospital visits, and mounting hospital expenses.

Fact Sheet on ROGER C. LIPITZ

Education:

B.A. University of Maryland (Accounting)

Career:

President, Chief Operating Officer of Convalescent Care Centers and its predecessor companies 1965-1968

President, Chief Operating Officer - Medical Services Corporation 1969 - present

Mr. Lipitz has direct responsibility for all nursing home operations of Medical Services Corporation as well as the company's pharmacy operations. He is a past president of the Maryland Nursing Home Association, and former Secretary (now Vice President) of the National Council of Health Care Services.

Mr. Lipitz serves on the Maryland Licensure Board for Nursing Home Administrators and was formerly a member of the Maryland Medicaid Citizens Advisory Board.

Fact Sheet on MEDICAL SERVICES CORPORATION

Medical Services Corporation presently owns 15 nursing centers with 1,700 beds, two pharmacies and an ambulatory care center. MSC employs 1,300 people, and is active in developing a hospital project as well as experimental outpatient services.

In August 1971 the company opened an ambulatory care center in a poverty area of north Baltimore in conjunction with a group of four full-time physicians and several part-time specialists. Non-medical policy for the center is set by an elected neighborhood consumer advisory board. The ambulatory care center is under contract with Maryland Medicaid to provide comprehensive physician services, and in the first three months of operation has served an average of over 600 patients per week. MSC is actively planning additional centers in other cities as the first step toward HMO developments.

Medical Services Corporation has eight facilities in Maryland and others in Indiana, Illinois, Nebraska, and Texas. The company is one of the first to employ a full time medical director for their Maryland nursing facilities. One of the major undertakings in the development of the ambulatory care center has been the development of an improved medical records system.

Medical Services Corporation is a publicly held stock company, and has access to funds for operations, capital spending, and innovative program development.

Fact Sheet on JAMES GRIFFIN

Education:

B. S., John C. Smith University

Physical Therapy Certificate, Sargent College of Boston University

M. S. in Rehabilitation Counseling, Richmond Professional Inst.

Career and Community Service:

Vice President and Secretary, Neighborhood Health Centers, Inc. (a subsidiary of Medical Services Corporation) 1969 to present

Director, Northwest Community Medical Center

Member, Congress on Racial Equality (CORE) 1963 - 1968

Vice President, Baltimore City School Board 1968 to present

Member of the Board of Directors, Scholarship Education and Defense Fund for Racial Equality (SEDFRE)

Member of the Board of Directors, Humanic Designs Corporation 1969 to present (involved in skill upgrading projects for low income and underutilized workers)

Member, Work Experience Program of Baltimore Mental Health Association 1970

Executive Board, Black Caucus of the National School Board Assn.

Member, Rep. Parren J. Mitchell (D-Md.) Task Force on Corrections

Mr. Griffin is a native of Baltimore and is devoting his time and efforts to improving the quality of life for his fellow Baltimoreans.

INNER CITY HEALTH CENTER PROJECT

NEIGHBORHOOD HEALTH CENTERS, INC.

Initial Design and Objectives (Sept.1,1970)

Neighborhood Health Centers, Inc. is a private corporation formed August 7, 1970 as a subsidiary to Medical Services Corporation. Medical Services Corporation is an independent, profit-making public company which is presently involved in the ownership and management of a chain of nursing homes, pharmacies and other related medical enterprises. The Board of Directors of Neighborhood Health Centers, Inc. is comprised in part of Mr. Allan Zalesky who is Chairman of the Board of Medical Services Corporation. Dr. Charles Venter is President of the Neighborhood Health Centers, Inc. and Chairman of the Board of Directors. Mr. James Griffin is the Executive Vice President of the company and Secretary of the Board of Directors. The company will be 80% owned by Medical Services Corporation and 10% each by Dr. Venter and Mr. Griffin. Control, however is shared equally between Medical Services Corporation and Dr. Venter and Mr. Griffin. Dr. Venter is an Internist, graduate of Howard Medical School and a practicing Physician in the Baltimore Area. Mr. Griffin is a physical therapist, past President of C O R E and Vice President of the Baltimore School Board.

It is proposed that Neighborhood Health Centers,Inc. will be the vehicle for providing comprehensive health services, on an out-patient basis, to all segments of the population, initially in the Park Heights area and ultimately, it is hoped, city wide. The three principal types of patients to be treated are;

1. "Public and Medical Assistance Patients"

2. "Medically Poor Patients"

3. "Paying Patients on Fee-For Service Basis"

The "Public and Medical Assistance Patient" - A contract will be proposed to the State of Maryland to provide comprehensive, out-patient care to a fixed number of patients covered under the State Medicaid Program on a pre-paid basis. Under this contract Neighborhood Health Centers, Inc. would be responsible for 24 hour a day out-patient care of these patients and would provide the following services:

1. Medical and minor surgical care

2. Immunization

3. Vision and eye examination

4. Routine check-ups and diagnostic services

5. Social services

6. Counseling

7. Training programs

8. Physical therapy and rehabilitation

9. Consultation as needed

10. Medical backup will be enlisted from hospitals, existing medical groups, and private practitioners

The "Medically Poor Patient" - will be managed in conjunction with community volunteers and other profesional volunteers on as yet to be determined basis. No funds from any level of government (Federal, State or City) are currently available to serve the need of this group of patients.

The "Paying Patients" - will be treated on a strict fee-for-service basis. Neighborhood Health Centers, Inc. has devised a highly sophisticated cost-related system to determine the exact fee to be charged for the actual service performed, the person(s) so performing, and a minimal profit factor; i.e., if a patient required $4.00 worth of service, he will be charged only $4.00 + the profit factor.

The presently proposed facility will be located in the Park Lane Shopping Center at Park Heights Avenue and Coldspring Lane in what was before the Acme Market. The facility comprises approximately 10,000 square feet. It will be re-modeled in relation to the services to be provided. Our projected completion date will be within the next two months.

Neighborhood Health Centers, Inc. will have a Board of Directors - currently proposed to be nine(9) members. In addition an Advisory Board will function with twelve (12) residents of the Park Heights area and six (6) city-wide representatives. It is the intent that the two Boards will function jointly in the determination of the center's policy with the Board of Directors having the responsibility of carrying out the Advisory Board's decisions.

The philosophy behind Neighborhood Health Centers, Inc. is that everyone is entitled to good health care, promptly delivered, and the review of services rendered should lie with the patients treated and the community involved. It is our further intent that training programs be designed primarily for neighborhood residents. Profits, if any, will be plowed back into the company for the expansion of clinic services wherever needed.

Status as of February 1, 1972

The initial medical center, the Northwest Community Medical Service Center was opened August 15, 1971 at 4432 Park Heights Avenue in Baltimore. The site of the center is a 10,000 square ft. former Acme supermarket which was converted into a modern, attractive, comprehensive health center at a total cost of approximately $225,000 including equipment. Facilities of the center include physician offices, X-ray, laboratories, physical therapy, social service, nutritional, dental,etc. This was a joint effort of three groups;

1. Neighborhood Health Centers, Inc. -

the developer, manager and financer of the project

2. Braxton-Carter Associates, P.A.
   a professional corporation of physicians organized to staff the center

3. the Northwest Community Medical Service Center Advisory Board -
   a group of community residents who advise the center.

All three entities are joined by contracts.

The prepaid contract originally (see above) was not signed with the State of Maryland. Instead a contract was signed with the State on a fixed fee per physician visit which is designed to be sufficient to include all ancillary services (see copy of State contract). The stated intention of both the Medical Center and the State of Maryland was to convert this arrangement into a prepaid program at either the end of the first or second year.

BY-LAWS

OF

NORTHWEST COMMUNITY ADVISORY BOARD, INC.

ARTICLE I. NAME OF CORPORATION

The name of the Corporation is NORTHWEST COMMUNITY ADVISORY BOARD, INC.

ARTICLE II. PURPOSE

The purpose of the Corporation (Advisory Board) is to help promote, develop and institute citizen participation in a community health program, including all phases of such program such as planning and construction of facilities; selection, employment and training of staff and employees; and administration and operation of the program.

More specifically, it is a function of the Advisory Board to represent the interest of the community, including the consumers and prospective consumers of the Northwest Community Medical Service Center at 4432 Park Heights Avenue in Baltimore City, State of Maryland, through a joint undertaking with the Park Heights Medical Associates (the management of the Center) and the Braxton Carter Associates, P.A. (the professional corporation providing medical services at the Center) to (a) determine the goals and policies of the community health care program, (b) periodically review available services and facilities and determine the health program needs; (c) periodically review the progress of the health program and undertake actions needed for further improvement, and (d) determine the appropriate allocation of funds in accordance with agreed upon priorities.

ARTICLE III. DEFINITIONS

Section 1. The term "Corporation" as used in these By-Laws shall mean the Northwest Community Advisory Board, Inc.

Section 2. The term "Advisory Board" as used herein means the entire membership of the Corporation; that is, all persons who have and remain qualified as members following their certification to membership at a duly authorized meeting of the Advisory Board.

ARTICLE IV. MEETINGS OF ADVISORY BOARD

Section 1. Location Advisory Board meetings shall be conducted at the Northwest Community Medical Service Center, 4432 Park Heights Avenue, Baltimore City, Maryland.

Section 2. Time of Meetings (1) Regular meetings shall be held on the first Monday of each month at 8:30 p.m.

(2) Special meetings may be called by the Chairman or his delegate upon at least 24 hours notice to members and said notice shall state the purpose of the meeting.

Section 3. Conduct of Business Advisory Board may at its regular meetings, pass on any item of business, subject to the provisions of the Articles of Incorporation and these By-Laws. Business transacted at special meetings shall be limited to the purposes in the notice given for said meeting.

With the exception of impeachment proceedings, hereinafter set forth, and amendments of the by-laws, a majority vote is required to pass on the business of the Advisory Board.

Section 4. Quorum All business transacted at any Advisory Board meeting shall be null and void unless a quorum is present. A quorum at regular meetings shall be nine (9)

members; a quorum at special meetings shall be seven (7) members.

Section 5. Voting Each member of the Advisory Board shall be entitled to one vote.

ARTICLE V. MEMBERSHIP

Section 1. Eligibility All persons, age 18 and over, residing in Baltimore City, and approved by a majority vote of the existing Board present at a duly called meeting, shall be eligible for membership in this Corporation.

Section 2. Number of Members There shall be no more than seventeen (17) members of the Advisory Board.

Section 3. Termination of Membership A person's membership in this Corporation shall be terminated by:

(1) his or her absence for three consecutive regular meetings; or

(2) the vote of 2/3 of all members present at a regularly scheduled meeting in support of termination, provided that the grounds for termination are based on a member's failure to conduct himself in a manner consistent with the best interest of the Corporation.

ARTICLE VI. BOARD OF DIRECTORS

Section 1. Function The Board of Directors shall manage the business and affairs of the Corporation.

Section 2. Number of Directors The Board of Directors shall be comprised of the seventeen (17) members of the Corporation.

Section 3. Quorum A quorum for the Board of Directors shall be the same as for the Advisory Board. See Article IV, Section 4.

ARTICLE VII. OFFICERS

Section 1. Enumeration There shall be five (5) officers of the Corporation, as follows: Chairman, Vice-Chairman, Recording Secretary, Corresponding Secretary, and Treasurer.

Section 2. Term of Office Officers shall be elected for a term of two years. Vacancies created during the term of office shall be filled by nominations of not more than two persons for the vacant office and an election to the office by the greater number of votes of the Board members.

Section 3. Method of Election All officers shall be members of the Board of Directors.

Two members shall be nominated for each office. The member receiving the greater number of votes shall be elected to that office. The vote shall be carried out by written ballot.

Section 4. Duties and Responsibilities of Officers

a. The duties and responsibilites of the Chairman of the Corporation are to: chair all Board meetings, appoint the heads of standing committees, prepare an agenda for such meetings, be chairman of the Executive Committee, be an ex officio member of all standing committees, be the official spokesman and representative of the Corporation and appoint a parliamentarian.

b. The duties and responsibilities of the Vice Chairman are to act with the full authority of the office of the Chairman in the Chairman's absence and to act as the first assistant

to the Chairman. He shall be an ex officio member of all Standing Committees.

c. The duties and responsibilities of the Recording Secretary are to keep accurate records of all Board meetings, to keep attendance roll, to make the records available to Corporate members and, at the discretion of the Board, to mail copies of such records to the members.

d. The duties and responsibilities of the Corresponding Secretary are to mail required notices of meetings to Board members and other correspondence at the direction of the Chairman of the Board.

e. The duties and responsibilities of the Treasurer are to keep accurate financial entries, to report on the financial position of the Board monthly at the discretion of the Chairman of the Board, to have the care and custody of all funds held in the name of the Corporation, and deposit all such funds in the name of the Corporation in such bank or banks or trust companies as the Board may designate and to exhibit at all reasonable times his books and accounts to any officer or member of the Corporation and to give such security for the faithful discharge of his duties as the Board may deem necessary

ARTICLE VIII. IMPEACHMENT

Section 1. Officers may only be removed for cause. An officer who (a) is negligent or delinquent in the performance of his duties or (b) breaches his fiduciary duty of trust and loyalty to the Corporation or (c) fails to fulfill his responsibilities to the Corporation may be removed at any time by a vote of a majority of the members at any special meeting called for the purpose of impeachment at which a quorum is present. The officer sought to be impeached shall

be notified of the charges and given an opportunity to be heard at such meeting.

Section 2. Impeachment of an officer shall be carried by a two-thirds vote of Board members present at a duly called meeting.

ARTICLE IX. EXECUTIVE COMMITTEE

Section 1. Enumeration The Executive Committee shall be composed of all elected officers and the chairmen of the standing committees. This Committee shall effect the policies of and act for the Corporation when the Board is not in session. The Chairman of the Corporation shall act as Chairman of this Committee.

Section 2. Additional standing committees may be formed by vote of the Executive Committee or the Board. The Chairmen of these Committees shall be appointed by the Chairman of the Corporation.

Section 3. Committee meetings Committees shall meet at the discretion of their respective chairmen or at the direction of the Chairman of the Corporation.

Section 4. Committee Reports All committees shall report at every regular Board meeting.

ARTICLE X. CONTRACTING AUTHORITY

The Chairman of the Corporation shall have the authority to sign contracts and leases on behalf of the Corporation upon the approval of a majority of the Board of Directors at a duly called meeting.

ARTICLE XI. FINANCE

Section 1. Source of Funds The funds of the Corporation shall be derived from any source desiring to or required to

support the activities of the Corporation.

Section 2. Appropriations The Board of Directors is vested with the authority to appropriate and disburse funds consistent with the objectives of the Corporation.

Section 3. Signatory Authority Checks, drafts, bills of exchange or any other documents or instruments drawing on the funds of the Corporation or on the funds within the control of the Corporation must be signed by any two of the following three officers of the Corporation: Chairman, Recording Secretary or Treasurer.

ARTICLE XII. AMENDMENTS AND INTERPRETATIONS OF BY-LAWS

Section 1. Submission of Amendments Proposed amendments to these By-Laws may be submitted in writing to the Board at its regular meeting. Upon approval by majority vote, each member of the Board shall be promptly notified in writing that the proposed amendment will be acted upon at the next regular meeting of the Board.

Section 2. Approval of Amendments Proposed Amendments must be approved by two-thirds vote of the Board present.

Section 3. Interpretation These By-Laws shall be construed liberally so as to effect the wishes of the members of the Corporation and specific provisions herein shall govern the general provisions.

This Agreement by and between NEIGHBORHOOD HEALTH CENTERS, INC., hereinafter referred to as CENTERS, and COMMUNITY ADVISORY BOARD of NEIGHBORHOOD HEALTH CENTERS, hereinafter referred to as ADVISORY BOARD, witnesseth that:

WHEREAS CENTERS is a profit corporation under contract with NEIGHBORHOOD MEDICAL SERVICES, INC. (NMS) to lease space and facilities to the latter at 4432 Park Heights Avenue, Baltimore, Maryland 21215, and to provide administrative and quasi-professional personnel and management services to NMS in support of the latter's contract with the State Department of Health, attached hereto as Exhibit "A"; and

WHEREAS CENTERS has diligently sought and hereby endeavors to promote full community participation and representation in the planning, organization, and administration of the community health care program; and

WHEREAS ADVISORY BOARD is an unincorporated association composed of eighteen persons at least one-half of whom are enrollees in the program referred to in Exhibit "A". The names and addresses of these persons are set forth on a paper attached hereto and marked Exhibit "B"; and

WHEREAS, the members of this ADVISORY BOARD, chosen by, and representing the community at large, seek to provide and assure maximum community participation in the health care program offered by CENTERS.

NOW, THEREFORE, in consideration of the mutual and reciprocal efforts, benefits, undertakings and interests hereinafter

set forth, CENTERS and ADVISORY BOARD agree as follows:

1. CENTERS acknowledges and designates ADVISORY BOARD as the advisory board referred to in Section 6.06 of the by-laws of CENTERS attached hereto as Exhibit "C".

2. CENTERS and ADVISORY BOARD shall, among other undertakings, and with respect to the community health facility at 4432 Park Heights Avenue, Baltimore City, Maryland (hereinafter referred to as the "Facility"), jointly (a) determine the goals and policies of the community health care program, (b) periodically review available services and facilities and determine the health program needs, (c) periodically review the progress of the health program and undertake actions needed for further improvement; and (d) determine the appropriate allocation of funds in accordance with agreed upon priorities. It is understood that subparagraph (d) of this paragraph 2 does not refer to the allocation of any operating surplus of CENTERS; provided, however, that there will be no allocation of any operating surplus derived from the Facility which impairs the ability of CENTERS to provide the services it has agreed to provide at the Facility.

3. ADVISORY BOARD shall be empowered to elect two of its own members or 20% of the Board of Directors, whichever is greater, to the Board of Directors of CENTERS.

4. It is the intention of CENTERS, as both a profit-making corporation and an organization devoted to community service, to devote a portion of the net profits which it earns

from the operations of the Facility to the betterment of the community in which the Facility is located. In order to confirm this intention, and in expression of the means for giving effect thereto, CENTERS agrees that it will make a charitable contribution, within 90 days after the end of each of its fiscal years, in an amount equal to the lesser of $5,000 or 5% of the net profits (before deduction of Federal and State income taxes but after deduction of all other taxes, expenses and other deductible items) earned by CENTERS from the operations of the Facility during such year. In addition, CENTERS will make a charitable contribution, within the same period of time, in an amount equal to 1/2% of the net profits (computed in the same manner as stated above) in excess of $100,000 earned by CENTERS from the operations of the Facility during the preceding fiscal year. Such contribution shall be made to ADVISORY BOARD or its successor if at the time thereof ADVISORY BOARD or its successor is a qualified charitable organization of the kind described in Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, and such contribution is tax deductible under Section 170 of said Code, and the primary purpose of the ADVISORY BOARD or its successor at such time is the betterment of the community in which the Facility is located. In the event that any of the foregoing conditions are not satisfied, CENTERS will make said charitable contribution

to an organization designated by ADVISORY BOARD or its successor whose primary purpose is the betterment of the community in which the Facility is located if such organization is a qualified charitable organization as aforesaid and such contribution is tax deductible as aforesaid.

5. ADVISORY BOARD may, within its own discretion, establish a grievance procedure to resolve or attempt to resolve the complaints or problems of persons receiving or attempting to receive services from CENTERS at the Facility. A written record of the recommendation of ADVISORY BOARD and the decision of CENTERS shall be made in each case.

6. CENTERS and ADVISORY BOARD shall meet at least once a month with the Board of Directors of Neighborhood Medical Services, Inc. to consider, discuss and act upon any business pertaining to the community health program at the Facility. At such meeting CENTERS will (a) furnish ADVISORY BOARD with a progress report on the operation of the program at the Facility, (b) consult with ADVISORY BOARD with respect to any significant plan or contemplated action with respect to the Facility for the future; and (c) make every effort to answer questions about the program at the Facility propounded by members of the ADVISORY BOARD. ADVISORY BOARD will (a) offer its evaluation and recommendations with respect to all or any part of the health care program at the Facility, (b) present such complaints or grievances as it deems appropriate, (c) decide jointly with CENTERS what goals and/or policies should be undertaken with respect to the Facility, and (d) decide jointly on all

other matters with respect to the Facility within their appropriate concern.

7. CENTERS shall adopt appropriate by-laws or modify existing by-laws where necessary to incorporate or reflect the terms of this Agreement.

8. ADVISORY BOARD shall be consulted with respect to, and shall, jointly with Assoc. CENTERS, decide on the discharge of all non-physician employees of the Facility. ADVISORY BOARD shall also have the right to veto the employment of non-physician employees of the Facility at the next meeting of ADVISORY BOARD following the hiring of such employees by Assoc. CENTERS. ADVISORY BOARD and Assoc. CENTERS agree to decide jointly on the general hiring criteria to be applied by Assoc. CENTERS in the employment of non-physician employees of the Facility. Notwithstanding the foregoing provisions of this paragraph, ADVISORY BOARD agrees that it will not unreasonably withhold its approval of the hiring or proposed discharge of any non-physician employee of the Facility. Specifically, ADVISORY BOARD agrees that such approval shall not be withheld on the ground of race, color, creed, national origin, education, place of residence or political or community affiliation, or on any ground other than the competency or incompetency of the particular employee or his demonstrated ability or inability to perform the assigned jobs in the expected manner. The veto of ADVISORY BOARD with respect to the hiring of any non-physician employee may be overridden by a 2/3 vote of the ~~Board of Directors of CENTERS.~~ Mgt. Comm. of Assoc.

9. The policies hereinabove referred to in Paragraph 2(a) on which joint decisions will be made shall include, but not be limited to, the following:

(a) The kind and scope of health care services provided or to be provided by CENTERS at the Facility, not inconsistent with the terms, schedules and Exhibits attached hereto as Exhibit "A". It is understood that this provision does not include any matter pertaining to the practice of medicine or within the special disciplines of the professional staff.

(b) Hours for delivery of health care services, subject to the limitation that CENTERS will not be required to keep the Facility open during any hours when the demand for health care services does not justify the expense or other hardships thereof on CENTERS or on the staff of the Facility.

(c) Standard or criteria of eligibility for indigent persons, consistent with the best interest of the health care program at the Facility as a whole and with the best interests of CENTERS and not inconsistent with the terms of the Agreement attached hereto as Exhibit "A".

(d) Use of training programs, other resources or public funds for the benefit of the health care program at the Facility.

10. ADVISORY BOARD agrees to cooperate to the fullest extent possible with CENTERS and to use its best efforts to:

(a) Recruit Enrollees for the Facility under any contracts for the provision of public health services entered into with respect to the Facility;

(b) Expand the operations of CENTERS to other facilities within the City of Baltimore and elsewhere in the State of Maryland;

(c) Maintain good relations (to the extent deserved) between CENTERS and the community and between CENTERS and the City,

State and Federal government and departments and agencies thereof;

(d) Help solve the problems presented by medically indigent patients of the Facility and minimize the losses caused by treatment of such patients, including, without limitation, assistance in the collection of sums due to CENTERS from such patients and cooperation in other means of obtaining funds to defray the costs of treating such patients.

11. Nothing in this Agreement shall be construed to authorize or permit CENTERS or ADVISORY BOARD to do any act or thing whatsoever which interferes in any respect with the confidential relationship or privacy between physicians and patients or with the absolute authority and discretion of the physicians and other professional staff of the Facility with respect to the manner of providing preventive, diagnostic, therapeutic, advisory and rehabilitative services to specific patients.

12. This contract shall be binding upon the parties and their successors, including any corporation formed by the ADVISORY BOARD and having initially a Board of Directors comprised of at least a majority of the present ADVISORY BOARD.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and sealed by their respective representatives this 2nd day of November, 1970.

ATTEST:

/s/ Earl L. Linehan
Asst. Secretary

NEIGHBORHOOD HEALTH CENTERS, INC.

By: /s/ Charles R. Venter, M.D.

COMMUNITY ADVISORY BOARD OF NEIGHBORHOOD HEALTH CENTERS

/s/ Lorine Vincent

By: /s/ Elsie E. Bumbray

/s/ Stanley D. Madron, M.D.
/s/ Sarah Smith
/s/ Mary Davis
/s/ Mrs. M. Day
/s/ Goldie Baker
/s/ Vincent L. Pikes
/s/ Margaret Dorkins
/s/ Linwood J. Bridgeforth

On this 2nd day of November, 1970, I, Earl L. Linehan Secretary of NEIGHBORHOOD HEALTH CENTERS, INC. (the "Corporation") do hereby certify that Charles R. Venter of the Corporation has been duly authorized to execute the foregoing Agreement on behalf of the Corporation, that I have been duly authorized to affix the seal of the Corporation to this Agreement and that neither authorization has been revoked or modified prior hereto.

/s/ Earl L. Linehan
Asst. Secretary

On this 2nd day of November, 1970, I Rose Boone Secretary of COMMUNITY ADVISORY BOARD OF NEIGHBORHOOD HEALTH CENTERS do hereby certify that the Board has been duly authorized to execute the foregoing Agreement.

/s/ Rose Boone
Secretary

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

LONG TERM CARE FACILITY ACCREDITATION PROGRAM

In 1952, after much discussion among the organizations concerned with high standards in the health care field, an independent, voluntary, nonprofit organization, the Joint Commission on Accreditation of Hospitals, was created to take over the responsibility for accreditation of hospitals from the Program of Hospital Standardization, which had been inaugurated in 1918 by the American College of Surgeons.

The Joint Commission on Accreditation of Hospitals is incorporated under Illinois law and is co-sponsored by the following member organizations of the Commission: the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association. In 1966, the Joint Commission on Accreditation of Hospitals undertook the additional responsibility for accreditation of health care facilities other than hospitals. Two additional groups, the American Association of Homes for the Aging and the American Nursing Home Association, were added as participating organizations, with representation on the Board of Commissioners.

The purposes of the Joint Commission as stated in its certificate of incorporation, are:

(a) To establish standards for the operation of hospitals and other health care facilities and services

(b) To conduct survey and accreditation programs which will encourage members of the health professions, hospitals and other health care facilities and services voluntarily to:

(1) apply certain basic principles of physical plant safety and maintenance, and of organization and administration of function for efficient care of the patient

(2) promote high quality of care in all aspects in order to give patients the optimum benefits that medical science has to offer

(3) maintain the essential services in the facilities through coordinated effort of the organized staffs and the governing bodies of the facilities

(c) To recognize compliance with standards by issuance of certificates of accreditation

(d) To conduct programs of education and research and publish the results thereof, which will forward the other purposes of the corporation, and to accept grants, gifts, bequests and devises in support of this purpose

(e) To assume such other responsibilities and to conduct such other activities as are compatible with the operation of standard-setting, survey and accreditation programs

Because of the dynamic complexity of the health care field, the standards that are acceptable are continually changing and being upgraded. In adopting revisions, the Joint Commission considers the recommendations not only of the member organizations but also of organizations in the health field not presently represented on the Commission.

The certificate, "Accredited by the Joint Commission on Accreditation of Hospitals," is highly valued by those facilities that have attained the right to display it. It is symbolic of the striving for excellence in promoting high standards of health care.

Accreditation is voluntary. It is offered as a yardstick to the progressive institution that wishes to meet quality standards set by a professional, knowledgeable, nationally recognized group. The accredited facility is the one which has voluntarily chosen to operate on a higher level than that legally required.

The Joint Commission on Accreditation of Hospitals, in establishing a program for the appropriate recognition of health care facilities, follows these objectives:

1. To establish standards of quality relating to an acceptable level of patient care, to promote them, and to assist in their attainment
2. To conduct requested surveys of medical and nursing care facilities to measure the quality of care provided, in terms of the standards
3. To recognize substantial compliance with the standards through issuance of an accreditation certificate
4. To make public a list of health care facilities which satisfactorily comply with the standards

The standards and interpretations established by the Joint Commission are based on the principle that the patient shall be under a continuing planned program of care, which focuses on his total needs. This program shall be rendered in a physical and social environment that provides for the patient's safety and the achievement and

maintenance of an optimum level of rehabilitation. Substantial compliance with all the standards is necessary for accreditation.

DEFINITIONS

Category I—Hospitals

Category II—Extended Care Facilities

Establishments with organized medical staffs and with continuous professional nursing service that are established to provide comprehensive inpatient care (which is usually post acute hospital care), for the most part of relatively short duration, and to serve convalescent patients who are not in an acute episode of illness or in a stable stage of illness and who have a variety of medical conditions.

Category III—Nursing Care Facilities

Establishments with medical staffs or a medical staff equivalent and with continuous nursing service under professional nurse direction. They provide, usually, long-term inpatient care (not necessarily post-hospital) to patients who have a variety of medical conditions requiring service.

Category IV—Resident Care Facilities

Establishments providing safe, hygienic, sheltered living for residents not capable of or desiring fully independent living. They furnish regular and frequent but not continuous medical and nursing services and they furnish continuous supportive, restorative and preventive health services.

GENERAL POLICIES AND PROCEDURES ON ACCREDITATION

A. ELIGIBILITY CRITERIA AND APPLICATION

Facilities to be eligible for survey:

- Shall meet the definition as stated for an Extended Care Facility, a Nursing Care Facility, or a Resident Care Facility
- Shall have been in operation under the same ownership for at least six (6) months prior to survey
- Shall have a current unrestricted license to operate as required by the state
- Shall provide on the application form the information requested, together with full payment of the survey fee

The Joint Commission will survey all facilities requesting accreditation if the foregoing criteria have been met.

Requests for survey should be addressed to the Joint Commission office, 645 North Michigan Avenue, Chicago, Illinois 60611. The institution will be sent Survey Form-Part I which shall be *completed and returned* to the Joint Commission. The fee for an accreditation survey is based on the actual cost of the survey. The number of days assigned for conducting a survey will be at the discretion of the Joint Commission. An invoice billing will be sent to the facility for payment prior to the survey date.

The facility will be notified of the survey date approximately 30 days in advance of the survey. At the time of survey, Survey Form—Part I will be reviewed by the field representative with the Administration of the facility. Survey Form—Part II will be completed by the field representative and this, together with the information on Survey Form—Part I, prepared by the institution, will be forwarded to the Joint Commission for staff evaluation and approval by the Board of Commissioners. Approximately six to eight weeks later the institution will be notified of the results.

B. ADMINISTRATIVE REGULATIONS

- Accreditation shall be granted for two years or until a resurvey is made. A two-year accreditation indicates the institution is in substantial compliance with the standards.
- Where indicated, accreditation may be granted for one year or until a resurvey is made. A one-year provisional accreditation indicates the institution is in substantial compliance with the standards but is weak in some areas and is advised on recommendations for improvement.
- Institutions not granted accreditation may be resurveyed upon reapplication after at least six months and payment of fee.
- An institution granted accreditation may be resurveyed at any time.
- Accreditation is not transferable, and the new owners must apply for resurvey. In the case of the sale of a corporation, new officers will be considered to constitute a change in ownership.
- Institutions offering more than one category of care e.g., Extended Care, Nursing Care, and/or Resident Care, shall be accredited in each category for the specific number of beds as licensed by the state.

- Facilities which fail to receive initial accreditation or re-accreditation or whose accreditation is revoked shall, upon written request, within 30 days of notification, be entitled to a hearing thereon before the Board of Commissioners or a subcommittee thereof designated by the Board for that purpose.

C. CERTIFICATES

- A certificate of Accreditation shall be issued to an institution that is granted a two (2) year accreditation. An institution re-accredited for two (2) years may retain the old Certificate showing continuous accreditation or may receive a new one if so desired. It cannot have both.

- Institutions receiving a one (1) year accreditation on the initial survey do not receive a Certificate. An institution that is accredited for one (1) year following a previous two (2) year accreditation may keep the Certificate for one (1) year. If, on the next survey, the institution is again granted a one (1) year accreditation, the Certificate shall be returned to the Joint Commission.

- There is no charge for the Certificate; it is the property of the Joint Commission. If the institution loses its accreditation, has a change in ownership or corporate structure, or changes the type of care given, the Certificate must be returned to the Commission.

- The Certificate of Accreditation serves as an indication that the institution voluntarily adheres to the most rigid self-imposed standards.

CORPORATE STANDARDS FOR THE DELIVERY OF SERVICES

1972 HOMEMAKERS HOME AND HEALTH CARE SERVICES, INC., SUBSIDIARY OF THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

PREFACE

Homemakers Home and Health Care Services, Inc., a subsidiary of The Upjohn Company, provides quality nursing care and other allied and ancillary health and social services, whether in the home or institution. The standards that follow are neccessary to govern the home health care concept and assure quality of service. They have been synthesized from the best understandings of various national and state professional organizations, from legislative requirements, from accrediting and licensing organizations and, most importantly, from our own corporate experience as the nation's largest single supplier of home and health care services. These standards shall be continually updated to reflect changing service needs.

PURPOSES

We believe that standards of performance are essential in order to achieve corporate objectives and purposes through effective management. Those objectives and purposes are:

1. To provide the consumer of services with the highest possible level of quality care.
2. To guarantee and assure that level of care by the provision of control mechanisms and protections to the consumer.
3. To comply with all legislative regulations and contractual requirements.
4. To cooperate and work with professional nursing, social service, and allied associations in maintaining quality standards for the delivery of home health care.
5. To maintain sound management practices and effective control of operations.
6. To develop and correctly utilize the organization's human resources.
7. To at all times be in the vanguard in the delivery of better service and to maintain this position of pre-eminence through sophisticated informational, developmental, and operational procedures.

It is the corporate intent and commitment that these ends be realized. The right of all men to enjoy a higher standard of healthful living is recognized and affirmed.

DEFINITION OF ORGANIZATIONAL GROUPS

Several groups are involved in the organization and its functioning. Their areas of responsibility are defined below:

1. *Governing body.*—Comprised of the Board of Directors of Homemakers Home and Health Care Services, Inc. and top corporate officers as assisted by the Home Office Staff.
2. *Field management.*—Zone Managers responsible for the operation of all company-owned offices nationwide and Group Directors who supervise Zone Managers and maintain liaison with Licensees.
3. *Licensee group.*—Licensed managers having proprietary rights in specified geographic areas. Governed by a licensee agreement, national standards, and corporate controls.
4. *Standards and procedures committee.*—Comprised of professional nurses and other health and social service professionals directly involved in rendering of the service who recommend policy standards and operational procedures to the Governing Body for adoption and implementation.
5. *National advisory council.*—Comprised of selected Zone Managers and Licensees who represent their respective groups in advising the Governing Body and in reviewing proposed programs.
6. *Local advisory committees.*—Local groups established to advise Zone Managers and Licensees on the overall functioning of the service in the community and to suggest areas for improved or new services in consultation with comprehensive health planning groups.
7. *Local utilization review committees.*—Local groups established to advise Zone Managers and Licensees on the effectiveness of health services. The primary function is to evaluate the program and the quality of service being rendered.

8. *Manager of personnel and training.*—Member of the Governing Body staff responsible for personnel and training programs and the monitoring of policies in these areas in consultation with the Standards and Procedures Committee.

9. *Manager of national consumer affairs.*—Member of the Governing Body staff responsible for investigation and handling of consumer affairs in consultation with the Standards and Procedures Committee.

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SECTION I—ORGANIZATION AND MANAGEMENT

STANDARD I–1—EACH OFFICE SHALL HAVE LEGAL AUTHORIZATION TO OPERATE

INTERPRETATION

A. Each office shall be in conformity with all applicable Federal, state, and local laws and shall be currently licensed in accordance with applicable laws.

IMPLEMENTATION

The Zone Manager or Licensee will obtain appropriate licensure and will observe all legal requirements at the local and state level.

The Governing Body will establish policy in relation to national legislation and will monitor compliance of individual offices nationwide. In the case of Licensee offices, this auditing function may be handled through Licensee visitation programs. In the case of Company-owned offices, it will be handled by the line management structure.

STANDARD I–2—THERE SHALL BE AN APPROPRIATE AND DULY CONSTITUTED AUTHORITY IN WHICH RESPONSIBILITY AND ACCOUNTABILITY ARE LODGED FOR EACH FUNCTION

INTERPRETATION	IMPLEMENTATION
A. The Governing Body is responsible for all corporate aspects of the service in budgeting, legal authorization and standards of service. This general management function applies to Company-owned and Licensee-owned offices.	Organization and reporting relationships as presently constituted.
Policies and procedures affecting professional and ancillary health and social services shall be reviewed and recommended to the Governing Body by a Standards and Procedures Committee. This Committee shall be permanently established with a rotating membership and shall be comprised of professionals directly involved in rendering the service.	Regular meetings shall be held by a Standards and Procedures Committee comprised of service and health professions within the corporation.
B. The field management group is responsible for the effective operation of their offices under the direction of the Governing Body and its policies.	Field management carries out national programs and innovates within the framework of national policies to meet local conditions.
C. The Licensee group is responsible and accountable for the effective operation of their offices in line with the terms of the Licensee Agreement and in compliance with national policies.	The Licensee operates under the terms of the agreement. The Licensee's operations are flexible within the guidelines set forth in the Licensee Agreement. The Licensee carries out national programs and innovates within the framework of national policies to meet local conditions.

STANDARD I–3—INSURANCE PROTECTIONS SHALL BE AFFORDED BOTH CONSUMERS AND EMPLOYEES

INTERPRETATION	IMPLEMENTATION
A. Insurance protections shall include general liability, malpractice, malplacement, and bonding in addition to other coverages as legally required. Minimum amounts of insurance shall be specified to both consumers and employees.	The scope of insurance protections will be continually reviewed to meet service needs.

STANDARD I–4—THE GOVERNING BODY SHALL EVALUATE THROUGH REGULAR SYSTEMATIC REVIEW ALL ASPECTS OF ITS ORGANIZATION AND ACTIVITIES IN RELATION TO THE SERVICE'S PURPOSES AND NEEDS OF THE COMMUNITIES BEING SERVED

INTERPRETATION	IMPLEMENTATION
A. Regular reports shall be made to the Governing Body by field offices for review. Other methods for evaluation including office visitation, normal line management functioning, and audit reporting shall be used. Additionally:	Continued field practice.

INTERPRETATION	IMPLEMENTATION
1. The Standards & Procedures Committee shall monitor office compliance with established standards and report to management. 2. The Manager of National Consumer Affairs shall investigate problem areas and recommend adaptions in the service. 3. The Advisory Council shall be consulted for review of proposed programs and shall offer input on problem and new service areas.	Reports and recommendations shall be reviewed and implemented through line management.
B. Advisory Committees shall be established: 1. As required if the office is operating as a provider of services utilizing public funds or as part of a contractual agreement, or 2. As deemed necessary by local management. The establishment of such boards in states not requiring them is deemed advisable. It is anticipated they will be required under Federal and state statutes in the future. One or more advisory groups may be needed by Zone or Licensee area as determined by geographic separation of service areas, population variances, or as required by contracting or funding sources.	Patterns of membership may be specified by regulations or contractual agreement. Regardless of specification, the pattern as outlined below shall be considered as minimally required. Committee members are drawn from the community and should include a physician, a Registered Professional Nurse or a Public Health Nurse, other health and social service professionals and lay persons, and consumer representation. Members of the service's staff may participate on this committee.
C. Utilization Review Committees shall be established: 1. As required if the office is operating as a provider of services utilizing public funds or as part of a contractual agreement, or, 2. As deemed necessary by local management. The establishment of such boards in states not requiring them is deemed advisable. It is anticipated they will be required under Federal and state statutes in the future. The Utilization Review Committee may function as a subcommittee of the Advisory Committee and should be comprised of outside local professionals only.	Patterns of membership may be specified by regulations or contractual agreement. Regardless of specification, the pattern as outlined below shall be considered as minimally required. Committee members are drawn from the community and should include a physician, a Registered Professional Nurse or a Public Health Nurse, and other health and social service professionals. Service personnel from outside groups who function similarly to Homemakers should be included.
D. Service evaluation conferences will be held as an ongoing process by the service staff in order to review case load and case problems, communications, nursing evaluation, counseling services, and to assure proper follow-through and implementation. The functioning of these conferences will vary depending on local needs and circumstances.	Continued field practice.

SECTION II—ADMINISTRATION OF SERVICES

STANDARD II–1—ADEQUATE AND APPROPRIATE SUPERVISION OF THE SERVICE AND ITS FIELD WORKERS SHALL BE PROVIDED

INTERPRETATION	IMPLEMENTATION
A. Services shall be supervised by appropriate professional personnel as specified by legislation or contractual agreement. Regardless of regulatory requirements of contractual specifications, services, when rendered, shall at all times be supervised in accordance with the following minimum requirements:	Field management will continue practice of hiring capable professional personnel for supervision of services.
Registered and licensed nursing services—Registered Professional Nursing services or Licensed Practical (Vocational) Nursing services shall be supervised by a Registered Professional Nurse or Public Health Nurse currently licensed by the state in which practicing. Additionally, this person shall have knowledge of social casework etiology and procedures.	
Nurse aide, homemaker-home health aide, and ancillary health services—Shall be supervised by a Registered Professional Nurse or Public Health Nurse. Additionally, this person shall have knowledge of social casework etiology and procedures. Other appropriate patterns of professional supervision may be used when specified by legislation.	
Social services—Shall be supervised by a qualified Social Worker.	
Physical, occupational and speech therapy services and diet counseling—Shall be supervised by the appropriate qualified professional in these specialties.	
Nonpersonnel services—Shall be supervised by an appropriate member of the service supervisory staff.	
B. The supervision of services is responsible for:	Continued delegation of these duties to the supervisor of services and inclusion of these duties in the job description of positions.
The initial assessment and plan of care in cooperation with other participating health professionals.	
The continuing evaluation of the care and services rendered.	
Making sure that field personnel meet job description requirements.	
The selection and assignment of field employees.	
C. The supervisor of service may delegate some duties to other appropriate members of the staff. In instances where this is done, the person to whom these duties are delegated will be accountable to the supervisor of service for the proper discharge of these delegated duties. Persons to whom duties are delegated may report to someone else in the organization for those job functions that are not related to the service being rendered.	Office organization charts shall show the proper reporting relationships.

INTERPRETATION	IMPLEMENTATION
Due to the close proximity of some Homemakers offices within certain Zone and Licensee geographic areas, it is not required that a professional supervisor of the service being rendered be present in each office if appropriate supervision is readily available. However, except for the unusual circumstance of close proximity, it is expected that the normal pattern of operation will provide for appropriate professional supervision within each office area.	
D. Written nursing, medical and social service policies and procedures shall be maintained in each location.	All nursing and medical policies and procedures will be continually reviewed by the Standards and Procedures Committee.

STANDARD II–2—THERE SHALL BE AN APPROPRIATE PROCESS FOR ASSESSING SERVICE NEED AND ESTABLISHING A PLAN OF CARE

INTERPRETATION	IMPLEMENTATION
A. An initial assessment of need and a plan of care shall be established for all cases. This assessment shall include applicable physician orders, referral information from other agencies, and an evaluation by the supervisor or designate. Pertinent case information will be shared with assigned field employees where applicable.	Continued implementation through local management.
B. On-site visits shall be made in assessing case need where legislatively or contractually required. When not required by the above, the supervisor of service or designate shall make an on-site visit in assessing case need where indicated. 1. Initial visits shall be made in accordance with the attending physician's diagnosis and anticipated case duration, and as deemed necessary by service supervision. 2. In all cases, verification that the initial assessment was adequate will be made by consulting with the assigned field employee.	Continued implementation through local management.
C. For health care cases, as part of the initial assessment process, contact will be made with the attending physician for any applicable orders. Written authorization from the attending physician shall be obtained.	Continued implementation through local management. Governing Body will submit form for national uniformity of application.
D. Reassessment of case need shall be performed as determined by the supervisor of service, or as required by contractual arrangement or legislation. This reassessment may be performed by an on-site visitation, conferences with the attending physician and other involved professionals, and through contacts with the field employee assigned to the case.	Continued implementation through local management.

STANDARD II–3—INDIVIDUAL CASE RECORDS AND REPORTING SYSTEMS TO MEET ALL APPLICABLE REQUIREMENTS SHALL BE MAINTAINED

INTERPRETATION	IMPLEMENTATION
A. Records used in the delivery of service shall include where appropriate: 1. Service Request Form—Used in the assessment and plan of care and kept as part of the consumer's file. 2. Service Record—A progress notes sheet for recording changes in physical, mental or social status as kept by the field employee. Periodically returned to the local office for inclusion in the consumer's file. 3. Physician's Orders Form—Authorization for treatment, medication, and other directives. Additional recordkeeping requirements of agencies or institutions being served shall be met.	All forms and records used in local offices shall be reviewed and approved by the Standards and Procedures Committee and the Governing Body. It is not intended that local needs be made subservient to national decision making, but rather that more effective results be achieved through a focused program. Principles that will be followed in forms design are: 1. Flexibility of Content—A few forms designed for a number of uses rather than producing many forms, each with a single purpose. 2. Impact on Systems—Individual forms changes will be authorized in the context of the systems of which they are a part.
B. Case information shall be treated confidentially and shall be accessible only to authorized persons. Appropriate measures shall be taken to safeguard case records.	Security measures will be implemented by local management.
C. Records shall be retained for the length of time necessary to fulfill legal requirements.	Standards & Procedures Committee will investigate legal retention requirements by state as well as by type of record.

SECTION III—HUMAN RESOURCE UTILIZATION

STANDARD III–1—THE SERVICE SHALL HAVE WRITTEN PERSONNEL POLICIES

INTERPRETATION	IMPLEMENTATION
A. All office and field employees shall receive written personnel policies and business procedures upon employment.	Manager for Personnel & Training will provide employee handbooks containing pertinent information. Line management will continue present communication practices.
B. Policies and benefits for regular part-time and full-time office personnel in Company-owned offices shall include: Liability insurance coverages, Social Security, Workmen's Compensation, Unemployment Compensation, Vacation plan, Holiday schedule, Sick leave, Medical and life insurance, Transportation costs compensation, and Professional Service Compensation Plan (when applicable). Plans and procedures will be continually updated.	Manager for Personnel & Training will develop, catalog and refine national personnel policies.
C. Policies and benefits for temporary field employees of Company-owned offices shall include: Liability insurance coverages, Social Security, Workmen's Compenscation, Unemployment Compensation, Vacation plan, and Transportation costs compensation. Other policies and benefits will be provided when required by contract and updated to reflect service needs.	Manager for Personnel & Training will develop, catalog and refine national personnel policies.

INTERPRETATION	IMPLEMENTATION
D. It is strongly recommended that licensees pattern their personnel policies after those of Company-owned offices to achieve employee parity as well as service uniformity in regional contracting with consuming institutions and agencies.	Licensees shall be consulted as a group or through the Advisory Council by the Manager of Personnel & Training. Their input shall be considered in the adoption of policies.

STANDARD III–2—THERE SHALL BE NO DISCRIMINATORY PRACTICES BASED ON RACE, COLOR, CREED, SEX, AGE, NATIONAL ORIGIN OR ANCESTRY

INTERPRETATION	IMPLEMENTATION
A. Non-discriminatory personnel practices are based upon longstanding corporate commitments in this area and national and state legislation.	Governing Body interprets Federal legislation for field implementation and audits compliance. The corporate Affirmative Action Program and policy statements shall serve as the governing documents in this area. Local management establishes non-discriminatory practices in line with corporate directives and state and local laws.

STANDARD III–3—THERE SHALL BE A WRITTEN JOB DESCRIPTION FOR ALL OFFICE AND FIELD POSITIONS WHICH ARE PART OF THE SERVICE

INTERPRETATION	IMPLEMENTATION
A. Job descriptions for each job category shall include a job title, delineation of job responsibilities and duties, personal and educational requirements, experience requirements and inter-staff reporting relationships. These descriptions shall serve as essential base documents for continuing training programs development.	Job descriptions for all office and field positions shall be prepared by the Standards and Procedures Committee for management adoption and updated as needed.
B. Organization charts will be maintained to represent lines of authority and reporting relationships.	The Governing Body is responsible for maintaining and disseminating Home Office, line management, and local office charts. Field management is responsible for communicating job content of positions in local offices.
C. Job titles and descriptions shall be standardized for national usage. Due to local variances and acceptability, it may be necessary to use other job titles, but job content will be stabilized for the purpose of training programs development.	The Standards & Procedures Committee shall recommend standard job titles and descriptions for office and field positions.

STANDARD III–4—THERE SHALL BE AN EFFECTIVE PROCESS UTILIZED IN THE SELECTION OF EMPLOYEES THAT WILL ASSURE CONTINUING QUALITY OF CARE

INTERPRETATION	IMPLEMENTATION
A. The selection process shall include personal interviews with each applicant and an orientation of the employee to his employer's procedures and policies. A central employee file will be maintained for each active employee.	Continued field practice and development of additional selection procedures.
B. Interview impressions shall be confirmed by reference checking before assignment:	Continued field practice.

INTERPRETATION	IMPLEMENTATION
1. Multiple work references shall be obtained. 2. In instances where work reference information is unavailable, educational and/or personal references shall be obtained. 3. Notes should be made of telephone reference check information. 4. All reference check information shall be kept in a confidential file.	Work references shall be reviewed for total work experience with attention to duration of time on each job, and reasons for leaving which may indicate a change in skill or responsibility levels.
C. Screening of each employee's health shall be performed before employment: 1. A physical history check list must be completed by each employee.	The Standards & Procedures Committee shall continue research on suitable checklist items.
2. The applicant must provide written evidence of a negative TB test or chest X-ray in accordance with local public health practices. These test results must be renewed annually.	Availability of testing services may be found through the Public Health Department, TB Association, or other health organization.
3. Other physical examination procedures will be performed as required by state legislation, contractual agreement, or at the option of local management.	
D. Before employment, each candidate will be evaluated against the criteria contained in the job description. A written record of this initial evaluation shall be kept.	Continued field practice and development of additional evaluation procedures.
After hire, there shall be an ongoing process of evaluation of each employee as part of the service evaluation process in assuring continuing quality care. 1. An ongoing assessment of the employee's performance will be conducted by supervision. 2. A record of such evaluations shall be kept. 3. The results of evaluation will be shared with the employee.	

STANDARD III–5—ALL EMPLOYEES SHALL HAVE HAD APPROPRIATE AND ADEQUATE TRAINING

INTERPRETATION	IMPLEMENTATION
A. Professional employees shall have completed an accredited program in their discipline and be currently licensed in the state in which they are currently practicing if required.	Normal employment screening procedures.
B. For non-professional categories, appropriate experience or adequate training is required to meet job demands. Additionally, these employees must be certified if required by the state.	The Standards & Procedures Committee shall review and endorse training outlines having appropriate content.
C. A program of continuing inservice education shall be established that is appropriate to each job category.	The Standards & Procedures Committee shall review and endorse inservice education materials and programs.
D. It is the corporate intent to make available career advancement opportunities through training and development programs.	The Personnel & Training Manager shall develop the career ladder concept and sequential training programs.

Section IV—Community and Consumer Relations

Standard IV–1—There Shall Be Written Consumer Relations Policies

Interpretation	Implementation
A. The service will continue to be responsive to the needs of the consumer. Questions regarding quality of service, human relations, nursing practices, and other critical areas affecting the consumer shall be investigated by management. Policies and practices will be modified accordingly. All consumer inputs will be dealt with courteously and expeditiously.	The Manager of National Consumer Affairs shall monitor policies affecting quality service to the consumer and recommend appropriate adaptations. Consultation with health and social service professionals shall be sought where appropriate.
B. It is the intent of the organization that there shall be no limitation on service provided in terms of eligibility of consumers, groups or individuals, on the basis of age, sex, race, religion, normal geographical service area, hours (beyond normal local minimums) and days of service, social and health needs, number of children in the home, emergency service, or referral sources. The health care needs of communities served dictate total service capability.	Continued field practice.
C. It is recognized that there will be occasions where service cannot be rendered due to the consumer's inability to mobilize economic resources or a shortage of employee inventory. In cases where the organization is unable to meet a request for service, the consumer shall be referred to other service agencies or sources of assistance.	Continued field practice.
Every effort will be made by Homemakers Governing Body and field management to encourage all fiscal intermediaries, Federal and state funding sources, and other involved parties to structure coverages to fit the needs of the consumer.	

Standard IV–2—The Service as an Integral Part of the Community's Health and Social Service Delivery System Shall Continue To Assume an Active Role in Assessment of Community Needs

Interpretation	Implementation
A. Appropriate adaptations in the service shall be made based on local management's assessment of the community's needs. It is the intent of the organization to continue in cooperative relationship with all parties interested in improving the quality of services, including comprehensive health planning groups.	Continued field and corporate practice of active community involvement.
B. An ongoing program interpreting the service to the public shall be undertaken. The availability and purposes of the service shall be made known to the public through the use of the news media and other pertinent avenues of communication.	The Governing Body will continue to structure national promotional policies and programs. Local management will continue to implement programs that will inform the public of the service.

STANDARD IV–3—WHEN MORE THAN ONE AGENCY PARTICIPATES IN THE PLAN OF CARE, AN AGREEMENT SHALL BE ENTERED INTO BETWEEN THE AGENCIES TO CONFIRM THE MUTUAL UNDERSTANDING OF THE PARTICULARS OF THE SERVICE TO BE PROVIDED

INTERPRETATION	IMPLEMENTATION
A. When an agreement is entered into for shared responsibility in the delivery of the service, the consumer will be provided with:	Governing Body will supply sample agreements for local use.
1. The services of the field employee under professional supervision.	
2. An adequate assessment and plan of care.	
B. The items which shall be included in the agreement are:	Governing Body will provide sample agreement format for national use.
Description of the service to be purchased.	
Duration the agreement is in force.	
Delineation of respective roles of each agency.	
Requirements regarding qualifications of supervisory and field personnel.	
Delineation of fiscal arrangements between the two agencies.	
Delineation of liability.	
Assurance of compliance with Federal and state regulations.	
Additional contract items may be included as specified by regulations or contractual agreement.	

Mr. ROGERS. Thank you for your testimony. I think it has been most helpful. We will have some questions. Before we begin questioning, however, I would like to recognize the president of a very distinguished group of senior citizens who are here from Rockville, Md. I understand at the request of our good colleague, and most distinguished colleague, Congressman Gude.

We welcome you to the committee. We are having hearings this morning on health maintenance organizations where people can pay a certain amount of money at the beginning of the year, and their health care for that year will be taken care of in a most comprehensive way.

We are now trying to determine the measures of the bill, what it should require. We have just had some experts from the field testifying now, and the committee will begin questioning.

Let me just ask two or three quick questions. What should the basic benefits be? You say they should be limited, they should not be overly extended. What should they be?

Mr. CALLIHAN. I really think that the bill that you have introduced covers it in grand shape. If you would add radiological services, diagnostic radiological services, and a couple of other areas, you would be in good shape in our estimation.

Mr. BENNETT. The administration bill really lays out the four areas.

Mr. CALLIHAN. Right, plus the diagnostic services.

Mr. BENNETT. You notice we are not including nursing home services or home health care.

Mr. ROGERS. Should we have home health care?

Mr. CALLIHAN. Not specified as a benefit.

Mr. ROGERS. Why not?

Mr. CALLIHAN. It is like using a nursing home or extended care facility. If the HMO is going to survive in the marketplace against the traditional indemnity suppliers, it must use home health services, and nursing homes, and extensive care facilities as alternatives to acute care hospitals.

If you mandate it going in as a benefit, it puts it in a different category and forces us into an unfair competitive position we cannot stand. If that HMO is to survive, it will use both extended care facilities and home health services.

Mr. ROGERS. Suppose we place in the legislation which the committee is considering similar minimum standards for all health insurance policies sold in America.

Mr. BENNETT. That makes it a different story.

Mr. ROGERS. If we are going to move in preventive medicine, aren't we going to have to take steps like this, have home care, visits to the doctor's office, examinations paid for either by health insurance or by your HMO?

Mr. CALLIHAN. In that case, fine.

Mr. BENNETT. That would be different, yes, indeed.

Mr. ROGERS. How do we assure the public, where you have a proprietary operation that you own for profit, that when the money gets tight, you are not going to give underutilization or underservices to people?

In other words, we hear from the nonprofits that if we allow the profit people into this field, encourage them, then when they find out in the ninth month that the money which has been paid in is going to run low, they will say, "Well, let us keep everybody out of the hospital," or "Cut out this type of pill or this type of medication." Is there a validity to that argument?

Mr. BENNETT. I firmly believe it would be a common problem regardless of the type of ownership of the HMO. However, as we have talked about, when you are talking about HMO's, you are talking about incentives, and perhaps the one person who has the most incentive to provide good care is the physician because, in most cases, he is in some kind of a position where he is under a profit-sharing arrangement with the HMO.

They certainly have the threat of malpractice suits just as the HMO does that would keep the consumer happy. We think that competition will keep the HMO's providing the kind of services that are required, and, of course, satisfying the consumer of HMO's is extremely important.

If one is not performing, they should be able to choose another mode or another HMO.

Mr. LIPITZ. In line with our whole concept of government, of checks and balances, in any prepaid group or any kind of medical care today, it requires some kind of audit of that care, both from the utilization standpoint, which is required in medicare and medicaid, and also from a quality care standpoint.

Medical audits in both proprietary and nonprofit would be most appropriate. We have no objections to that to assure that high quality care is given consistent with the dollars being spent.

Mr. ROGERS. I understood from your testimony that you did not recommend any such qualification be written into the law, that you would rather not get into that.

Mr. BENNETT. We talked about audits and accountability. When we talk about monitoring standards, we would do this through peer review. We would do it through consumer involvement and ombudsman.

Mr. ROGERS. Mr. Griffin, what about your outpatient care which sounds like a very interesting program where you have evidently reduced costs?

How do you monitor whether they are getting the quality of care they should? Do you have an outcomes evaluation? How do you evaluate outpatient care? I can see how you can evaluate inpatient care on an easier basis, but how do you monitor outpatient care, or do you?

Mr. GRIFFIN. As I mentioned, we have half of our advisory board residents in the community, who are also patients in our center. They have a policymaking function on our advisory board with the physicians, and with management.

They help us monitor the quality of our care as well as the peer review system that we are setting up. We also have the State Health Department which also comes in and advises us and tells us about the quality of care.

We also have our own review professional staff and physicians. We also have the Baltimore City Medical Society.

Mr. ROGERS. I think it would be well if we could have set forth the actual technique used in various evaluations, and if you do use simply a complaint system or real evaluation of outcome and so forth, if you could let us have that.

(The information was not available to the committee at the time of printing.)

Mr. GRIFFIN. Also, I might mention one other thing. On an everyday basis, we have an influx of new patients which tells us that the word gets around by the other patients who are treated that we are doing a good job, because new patients would not continually come.

Mr. ROGERS. Not necessarily. If there is no other system of delivery, they would have no alternative.

Mr. GRIFFIN. But, they do now. They have other outpatient facilities in the city.

Mr. ROGERS. In the ghetto areas, they had the public health hospital, but they have moved it out, haven't they?

Mr. GRIFFIN. Yes.

Mr. ROGERS. So there is not too much alternative in that particular area.

Mr. GRIFFIN. Yes, we have other facilities.

Mr. ROGERS. HMO's?

Mr. GRIFFIN. Not HMO's, but we have private medical buildings with physicians, not in the kind of group practice and comprehensive setup that we have.

Mr. ROGERS. Yes, you have a few private physicians, but not too many in the area. I think the choice is quite limited, as I understand, in the Baltimore area that you serve.

I have tried to restrict myself. I think maybe if we could hold the first round to 5 minutes. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman. I was very interested in Mr. Griffin's statement that you started your operation with $250,000. I wanted to congratulate you on really stretching out those dollars, making them do such a good job.

In what way would the legislation we are considering restrict your type of operation, a privately owned, proprietary operation? How would it stop you from expanding the way you would like to expand?

Mr. BENNETT. Miss Connell will respond.

Mr. NELSEN. Is there any other restriction that stands in your way?

Miss CONNELL. As one of our recommendations stated, in H.R. 11728, there is a provision in the bill which exempts HMO's qualified under that bill from restrictive State legislation.

We are not talking about Federal dollars here. If proprietary HMO's are not included in the definition, then they obviously don't benefit from that provision.

Mr. NELSEN. I see. That is important. Now, another point is, of course, the Federal money that might go into an HMO. One of the things that has bothered many of us is if Federal dollars go into this type of operation, do we put others at a disadvantage by the funneling of dollars to a nonprofit organization only?

You may have an existing hospital or you may have a proprietory HMO operating, going along on their own. So, we begin to funnel Federal dollars into the nonprofit organization, putting others at a disadvantage, putting other facilities at a disadvantage. Do you have an observations on this? I think your testimony would indicate that you do have.

Mr. BENNETT. Definitely, it would place us at a disadvantage. However, the competitive factor, we think in the long run, will prove out, that we can provide the services and probably at a lower cost.

Mr. NELSEN. I want to complement Mr. Griffin and the group here because you have made it on your own. You have done a job with your own funds, and you have supplied the community with a health service that has been very good.

One of the things I fear in an extensive HMO program using Federal dollars is that you create a dependency and overlook those who are lambing it alone. We don't want to discourage them because really we never have enough dollars to do a total job.

I want to congratulate you, Mr. Griffin, for the job you obviously have done. Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy?

Mr. ROY. What experience have you had with for-profit HMO's? I will preface that by saying, as I understand your testimony, none of you are opening for-profit HMO's.

Mr. BENNETT. That is right.

Mr. ROY. What experience have you had with for-profit HMO's?

Mr. BENNETT. I don't think we have had any. As you know, there are a couple of fledgling proprietary HMO's, but none with any real track record as yet. I guess that is why we are asking for nothing restrictive, but let us be flexible and experiment.

Mr. ROY. Why haven't there been for-profit HMO's?

Mr. BENNETT. I think a number of things. First of all, I think if you are involved in any of the large kinds of health care delivery, you are concerned about legislation, and legislation has not come along as yet, as you are well aware.

We also have had the bad taste of medicare that we have been living with for 6 years, and know what can happen without more definitive legislation. I think we are all ready to see what we can do to develop the system better, but there is definite need for legislation.

Mr. LIPITZ. I think in some respects, also, restrictive State laws have hampered. In Maryland, physicians are allowed to be employed by nonprofit groups, but not proprietary groups.

Mr. ROY. Isn't it true, however, that with the restrictive State laws, we have had, we still have about 6.5 million people being taken care of by what you might call prototype nonprofit HMO's?

Mr. BENNETT. I like Dr. Gumbinder's definition of his operation as being "entrepreneurial nonprofit".

Mr. ROY. Would you like to define "for-profit" for me?

Mr. CALLIHAN. One that pays and reports dividends, if any.

Mr. ROY. What is your necessary return on capital?

Mr. CALLIHAN. Necessary return and what we realize are two different things.

Mr. ROY. In order to attract capital, what do you think your promised return on capital needs to be?

Mr. BENNETT. I can tell you on gross income.

Mr. CALLIHAN. Go ahead.

Mr. BENNETT. I think many health care companies in the nursing field shoot for a 5 percent after-tax return on the gross income.

Mr. ROY. That really does not tell us much.

Mr. LIPITZ. I think the reason we can't answer is because it is so new. You know, there are no parameters, there are no guidelines to say you are doing very well, and he is not doing well.

We really don't know. Of course, capital is invested in different ways. If you can earn more than the interest you are paying at the bank, that is a reasonable return. There are a lot of definitions of how you raise capital. We are just not sure.

Mr. ROY. We have been told they are requiring about 12 to 20 percent return on capital.

Mr. CALLIHAN. In our operation last year, we made a 6.2 percent return on capital. Obviously, we can't borrow money for that. We can make more money in Government bonds. It has to be between there and 12.5 to 14 percent.

Mr. ROY. If you add on 12 to 14 percent as a margin of profit, they then indeed cannot compete with our present health care system of indemnity insurance for-fee service.

Mr. LIPITZ. Our assumption is that we can provide the same service more efficiently, and draw our profit out of savings, not out of additional cost.

Mr. ROY. It is still an assumption because we have not had any experience.

Mr. CALLIHAN. It is assumption in HMO's but not in general health care delivery. It has been proven throughout the United States that proprietary operators repeatedly deliver health care at a much lesser cost than do nonprofit organizations. I will be glad to give you the statistics.

Mr. ROGERS. I think that it would be helpful to have that.

(The following letter was received for the record:)

HOMEMAKERS HOME AND HEALTH CARE SERVICES, INC.,
SUBSIDIARY OF THE UPJOHN CO.,
Kalamazoo, Mich., May 22, 1972.

Congressman PAUL G. ROGERS,
2417 Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Per your request for additional factual information of specific cases where for-profit health care deliverers have been able to deliver services more economically than not-for-profit organizations I'd like to refer you to my testimony before the Ways and Means Committee hearing on National Health Insurance on November 11, 1971. In response to a question put to me by Congresswoman Griffith, I offered to contract with the Secretary of H.E.W. to provide all of the Home Health Aide services required under Titles 18 and 19 in all of New Orleans, Louisiana at a rate of $4.50 per hour—a $2.00 per hour savings by comparison to the two not-for-profit organizations currently delivering that service at $6.50 per hour.

We will be reporting other specific cost savings thru the National Council of Health Care Services (Mr. Bennett and his staff are currently collecting such data to comply with your request) but I thought I should write to you directly primarily because of the line of questioning Dr. Roy used with me and other members of our panel the day we testified in front of your committee.

It appeared that Dr. Roy's prime concern with for-profit providers of health care was a fear of "profiteering" rather than a concern for cost savings. Cost savings, it seems to me, should be the number one consideration in all Congressional planning for health care regardless of whether the subject be National Health Insurance, HMO's, Medicare, Medicaid or any of the many provisions under Title 45 of the Social Security Act or whether the subject under any of the above major headings be existing coverage or service, alternatives to existing coverage or service, or innovative experiments in radical departures from existing coverage or service.

We can draw the above conclusion logically if the specifications of "eligibility for participation" on the part of the provider are properly written. Only those providers capable of rendering quality service should be eligible to begin with. That leaves "cost" standing alone for further consideration.

Continuing that line of logic, it shouldn't make one bit of difference to Congress what amount of profit a for-profit provider makes as long as he is providing a quality service more economically than his not-for-profit counterpart can do. That kind of economy means cost savings to the Federal Government while at the same time, if the for-profit provider should produce a profit, provide additional revenue to the U.S. Treasury because every dollar of before-tax-profit will produce forty-eight cents of income tax for Uncle Sam.

I had suggested to the Ways and Means Committee that an alternative method of payment be made available to for-profit Home Health Agencies. Instead of reimbursement on a cost-plus 9.938% return on equity capital, simply pay us on a fee-for-service basis at our "going rate in the community" so long as our rate is less than that of our not-for-profit counterpart. That move alone would save the Federal Government millions of dollars of auditing costs currently required under Medicare and would save for-profit Home Health Agencies countless hours of administrative time trying to figure out what the $9.938% should be applied against, etc.

On the point of cost-plus reimbursement, I thought it most unusual that both not-for-profit home health agencies in New Orleans could have such similar costs that their billing rates turned out to be identical, so I personally worked up our "justifiable cost basis" in the New Orleans market before my testimony last November. On that basis, and before adding the 9.938% return on equity capital, our billing rate would have to be $5.54 per hour rather than our "going rate in the community" of $4.50 per hour. (I didn't add the 9.938% because, even though I am a CPA, I didn't understand what the 9.938% applies to!)

We don't need that extra $1.04 per hour. We *couldn't get it* from our private customers (who make up 95% of our total sales volume nation-wide). *We shouldn't be allowed to get it* from Uncle Sam!

As I mentioned previously, we will be furnishing additional cost savings data thru the National Council of Health Care Services. If we can be of any further service to you and your committee during your deliberations on health care delivery, please feel free to call upon us at any time.

Respectfully submitted,

EDWARD J. WILSMANN, *President.*

(The following table was subsequently received for the record:)

COMPARISON OF PROPRIETARY AND NONPROFIT HOME HEALTH CARE SERVICES FROM A SELECTED GROUP OF CITIES

City and service	Nonprofit charges	Homemakers, Inc.
St. Paul, Minn.—Homemaker home health aide	$4 per hour (2 or 3 hours only).	$3.15 per hour.
Milwaukee, Wis.—Homemaker home health aide	$5.25 per hour	$3.45 per hour.
Oshkosh, Wis.—Homemaker home health aide	$3 per hour	$2.68 per hour.
Detroit, Mich.—Homemaker home health aide	$4.80 per hour ($38.40 per day).	$3.84 per hour ($30.72 per day).
St. Louis, Mo.—Homemaker home health aide	$5.50 per hour ($13.75 per visit).	$2.85 per hour.
	R.N.[1] at VNA $15.50 per hour.	R.N.[1] $5.75 per hour.
Lansing, Mich.—Homemaker home health aide	$3.25 per hour	$3.55 per hour.

[1] No services provided in Grand Rapids, or Kalamazoo, Mich.

Mr. ROY. I think I would be hard put to defend the quality of care in private nursing homes. Do you think you are capable of defending quality care?

Mr. CALLIHAN. Yes, sir, I would like to invite anyone to visit one of our facilities.

Mr. ROY. I am not speaking of your facilities. I am speaking of facilities nationwide.

Mr. BENNETT. When Dr. Elwood testified 2 or 3 weeks ago, he mentioned a study they did in Minnesota in determining the quality of care. Their conclusion was that regardless of nonprofit or proprietary, there was no difference in the quality of care being provided.

Mr. ROY. On your home health services company, you say you have 125 locations, 20,000 employees. What was your gross income for the last year?

Mr. WILSMANN. Our sales, combining the company's sales with franchise sales, was just slightly over $16 million.

Mr. ROY. What was your net income?

Mr. WILSMANN. We had a loss of slightly over $1 million.

Mr. ROY. What was your capital investment?

Mr. WILSMANN. Something in excess currently of $5 million.

Mr. ROY. I assume you paid no dividends?

Mr. WILSMANN. We had a loss, sir.

Mr. ROY. What has your record been over the number of quarters you have been in existence?

Mr. WILSMANN. We have been operating since April 12, 1965. We have, as yet, to make a profit. Basically, this is because of rapid expansion. We opened 45 offices last year. We plan on opening another 34 to 45 this year.

Anything that might have been made in maintaining a particular level of offices has been plowed back into the business, and, as a result of it, we have ended up loosing to this particular point.

We should turn black for the first time in 1973 when our expansion, as far as owned operations are concerned, will pretty well have glutted the company.

Mr. ROY. What is your record as far as book value of a share of the stock?

Mr. WILSMANN. We are a subsidiary of the Upjohn Co. Our book value of the subsidiary, itself, is definitely in a negative position. We live on borrowed funds from the Upjohn Co.

Mr. ROY. If we support for profit HMO's, would you consider this to be an experimental program? Any Federal aid to HMO's, is this or is this not an experimental program?

Mr. CALLIHAN. I think we would have to term it as much because there are none in existence.

Mr. ROY. Do you feel Federal assistance for the formation of for profit HMO's is an experimental program?

Mr. BENNETT. We have said in our testimony that there should be equal treatment whether it is grants, contracts, loans, loan guarantees. I guess, in effect, we are saying however, loan guarantees might be important such as FHA has done.

Mr. CALLIHAN. Representative Roy, the problem we are trying to overcome is a constant discrimination, historically, against proprietary operators in favor of the nonprofits. We are trying now to overcome that, and hope for some equal treatment.

In experimental programs to determine whether or not we can deliver health care at lesser cost than nonprofit operations can.

Mr. ROY. For-profit HMO's have not existed up until this time, however, nonprofit HMO's have. There has been some reason for this. Therefore, I feel if we financially assist a proven concept, this is one story. If we assist an unproven concept, this is another story. However, I think maybe what you asked in regard to making any preemption of State laws apply to for-profit, as well as nonprofit HMO's would be wise.

Mr. BENNETT. If I may comment, Mr. Chairman. I think the semantics of what is nonprofit is a little hazy at this point.

Mr. ROY. That is the reason I asked for your definition.

Mr. BENNETT. If you talk about even Kaiser, those physicians are on an incentive. The people who built the hospital made a profit, the people who supplied the radiological equipment, and the food and everything that goes into that hospital in that program is nonprofit, but somehow, there is this umbrella which perpetuates itself, and they are nontax paying.

We have cost figures on building a nonprofit hospital that run $60,000 to $70,000 a bed. We can go in for $30,000 a bed. I don't think the system can afford that kind of funds.

Mr. ROY. I will admit we have built some very fancy health care facilities under the nonprofit system. These may or may not be necessary. Probably not necessary.

Mr. ROGERS. I am not sure about this nonprofit business. They all make a profit. Everybody is paid a profit, an incentive.

Mr. BENNETT. They have to make their mortgage payments which come out of profits.

Mr. ROGERS. Certainly. I question that kind of fiction that has been built up.

Mr. CALLIHAN. Amen.

Mr. NELSEN. Hallelujah.

Mr. ROGERS. Mr. Hastings?

Mr. HASTINGS. Thank you, Mr. Chairman. I have had some bad views and good views. First, the good views. I generally agree, proprietary should be included to some degree. I am not sure what that degree is. I know that is consistent with your viewpoint.

Now, bad views. I don't understand the total opposition to the inclusion of any consideration by CHP's. If somebody will clarify that for me.

Mr. CALLIHAN. I can give you an instance where comprehensive health programing is either going to stop or significantly delay a proprietary prepaid health care system in Detroit. A doctor's clinic with 31 members is practicing excellent medicine almost in an HMO environment, now. They are in the process of contracting with the State of Michigan to provide services to 10,000 medical assistance patients in a certain geograhic area.

They have facility on site next to their clinic. They are now building a surgical facility as well. The facility is an ECF hospital kind of combination. In order for them to successfully deliver the right kind of medical care, they must get a hospital license or some kind of modification of a hospital license in order to treat people on site.

Otherwise, they have to ship their people across town. Now, the comprehensive health law for the State of Michigan that is now being passed, says you cannot have a certificate of need unless the areawide comprehensive health planning agency approves you for a hospital.

They have no chance. So, the comprehensive health programing will work against the formation of their HMO. Maybe, unknowingly, you see.

Mr. LIPITZ. We believe the question is: Are you going to experiment? Experimentation requires flexibility. We are not saying that comprehensive health planning does not belong within the HMO's, but if what we are doing with them now is to learn what an HMO can really do, the more difficult we make it to create that experiment, the longer time it will take us to get any information.

Mr. HASTINGS. You say you are not excluding CHP's.

Miss CONNELL. If I may explain. I think the purpose of comprehensive health planning is to eliminate competition as being unnecessary duplication of facilities. Call it what you may, that is eliminating competition.

Also, in general, most CHP agencies are controlled by the present establishment, the local nonprofit hospitals and medical society, and they certainly are not about to disenfranchise themselves, I don't think.

Mr. HASTINGS. Would you advocate that we repeal CHP legislation?

Mr. CALLIHAN. No. What we are recommending in the State of Michigan, Congressman, is that the certificate of need legislation which is tied with CHP, be modified so that, if we are talking about a prepaid system or a prepaid environment, then the laws or the rule for certification be waived for those installations.

If we could get that kind of legislation, it would be most helpful to us.

Mr. HASTINGS. If CHP's were given a consultation role, perhaps in the establishment of any facility subject to, perhaps, appeal to the Secretary of HEW, would you object to this?

Mr. CALLIHAN. So long as it is consultative, and they did not have the final decision.

Mr. HASTINGS. Well, decision subject to appeal to the Secretary does not give them final decision. I am concerned because although you talk about for-profit, which I am in favor of, at the same time, I think we all recognize that, without Federal dollars through medicaid, medicare, health insurance, you are not going to operate very profitably.

The suggestion that the Federal Government or State government are not going to be involved in delivery of health care is not true. We all know that. So, we do have a serious responsibility. Whether competitive medicine is going to be the long range answer or not to the proper delivery of health care, I don't know. Some feel it isn't.

Somebody has to make a decision on where to put another facility. If you are going to put one next door to another, it will be openly free market enterprise, competitive, then I think we probably have a problem in coming up with enough dollars to make both of those institutions remain financially valuable.

So, I am concerned a little bit about what would seem to be your total opposition to the involvement of CHP's.

Mr. BENNETT. We have said in effect, too, though, that as an alternative, Mr. Roy's consultation role of comprehensive health planning would be acceptable.

Mr. HASTINGS. You say it now. You did not say it in your testimony.

Miss CONNELL. I think our position more clearly stated is that in some parts of the health care industry, like the nonprofit hospital industry where competition does not exist, where facilities are reimbursed on a cost-type basis and the negotiations are conducted between the individual hospital and the insurance company, there certainly is a role for comprehensive health planning and restriction of duplication.

In other parts of the health care industry, for instance, the nursing home industry, where competition does exist, where it does provide the consumer with a choice of prices, and so forth, and where the Government is not being asked to underwrite losses, then we don't think the comprehensive health planning belongs.

Mr. HASTINGS. What percentage of the income of the average nursing home is going to be from medicaid and medicare?

Mr. BENNETT. Medicaid is 60 percent.

Mr. HASTINGS. So the suggestion that the Federal Government is not going to be asked to underwrite the law indicates that without that you are not going to operate. We are contemplating, as we all know, a system of national health insurance. Whatever may come out, I have my own views on that.

There is an involvement, certainly, by the Government. I think we certainly have to take a look at your CHP's. Your testimony is helpful in that respect. I would ask you, from your point of view, to be a little more receptive.

Mr. CALLIHAN. I think that is reasonable.

Mr. ROGERS. Can you supply for the record any evidence you may have of average patient cost for specific illnesses or operations regarding proprietary versus the nonprofit? Any statistics would be helpful.

Also, the number of operations, comparing your operations and what may happen outside.

(See letter dated May 22, 1972, from Edward J. Wilsmann, president, Homemakers Home and Health Care Services, Inc., to Chairman Rogers, p. 849.)

Mr. ROGERS. Let me ask you to supply for the record too, your comment on the proposition that if the Federal Government does award grants for profit HMO's, should it exercise a limitation on profits percentagewise? If you could give us a comment on that?

Mr. BENNETT. We will be glad to.

(The information requested was not available to the committee at the time of printing.)

Mr. ROGERS. Thank you very much. Your testimony has been most helpful. The committee is grateful for your appearance today.

Our next witness is Dr. William T. Hart, director, Rochester Mental Health Center.

STATEMENT OF DR. WILLIAM T. HART, DIRECTOR, REGION II, NATIONAL COUNCIL OF COMMUNITY HEALTH CENTERS, AND DIRECTOR, ROCHESTER MENTAL HEALTH CENTER, ROCHESTER, N.Y.

Dr. HART. I believe you have a copy of my testimony.

Mr. ROGERS. Yes, it will be made a part of the record, if you will highlight the specific points that you think should be brought to the committee's attention.

Dr. HART. Mr. Chairman and members of the committee, it is a great pleasure to speak to you today. I am probably presenting more problems than solutions. What I would like to do is to primarily speak about our experience in the development of a mental health center in conjunction with an HMO.

I am the director of the Rochester Mental Health Center, Rochester, N.Y. I am also a psychiatrist. The Rochester Mental Health Center has been operative for over 5 years. It serves 176,000 people in Monroe County, including a quadrant of the city of Rochester. The area in Rochester includes 50 percent of the poor of Monroe County, so that we have had experience with both the poor in the central city and our catchment area which extends out to the rural areas in the towns of Webster and Bondeguoi.

The Center initiated new programs when we started, and an alcoholism clinic joined us, then a child guidance clinic joined us. All other services were started from scratch, including inpatient service. The services we offer include in-patient services, services for the general psychiatric patient, drug abuse services—we have a methadon clinic for heroin addiction—as well as other services, and services for the alcoholic.

I might emphasize that these services are included in the cost figure that I will give you later on in the presentation.

However, I would like to go back to a little of our history to try to support the major point that I would like to make, namely, that HMO's should include mental health services and, more than that, should contract with a community mental health center if it is available to that HMO.

The people's health center, which is a neighborhood health center operates in the inner ghetto section of our catchment area. We began operation approximately 3 years ago. We had been in operation about 2 years at that time. We spoke to the administration there and agreed to deliver mental health services to this neighborhood health center, not specifying at that time the administrative relationship. We didn't know how solid their funding was, or our funding. We were both beaming at this inner city portion of our catchment area to deliver services. However, they left the direction of the mental health services completely to the Mental Health Center. What occurred is as follows:

This neighborhood health center, People's Health Center, serves a population of 12,000, has 12,000 enrollees. They developed health teams to serve segments of this population. These health teams consist of physician, public health nurse, and two or three family health assistants.

We began our work by being available to these health teams that met weekly and in the beginning maybe 10 percent of the conversation of these health teams was concerned with mental health matters. This has grown until now in their weekly meetings about 70 percent of the concerns of the teams are with mental health matters. At the beginning we had many inappropriate referrals to the mental health person on the team but finally we began getting referrals such as the family health assistant who had gone into an apartment and there was a woman there listening all day to the voices coming out of the radiator. At this point we would become quite active and intervene.

Now the relationship of the health center to the Mental Health Center here I think is important, because sometimes patients refuse to be seen by mental health personnel and the care had to be carried out through the physician, or the family health assistant, or the public health nurse who had direct contact with the patient.

Another situation that would occur is that the nonpsychiatric or nonmental health personnel would not want to refer the patient, in which case we had to work with whoever was resisting referral and often would see the patient directly ourselves.

I think the critical item here is that with mental health services in the neighborhood health center there was a heightened awareness on the part of nonpsychiatric personnel to recognize and to treat some of the mental health illnesses that were seen.

Our association with the People's Health Center has continued all these 3 years. At one point in our history—it was about three and a half years ago—the health center decided to deliver mental health services on their own. There were certain irritating constraints that we would place on the personnel. It was the complexity of having two people responsible, but after a long discussion we finally agreed jointly that it was important that the Mental Health Center be involved with the personnel delivering mental health services at the neighborhood health center.

At the present time in our relationship with the People's Health Center there is a new movement, new personnel have come in and there is a new movement to establish independent services. Unless there is a definite fiscal-administrative relationship I think this tendency will continue and eventually the health center will have its own mental health services or have none at all.

The other thing that we have found, as you heard from the previous group, is a tendency to cut out mental health services and drug services, and alcohol services if funds are tight. This is one of the first items that is looked at to drop, one of the first places to cut. I think in terms of people to be served it may be that there are as many mental health problems as all the other problems put together. I suppose the teams are some indication of this, where 70 percent of the weekly discussions of health teams are on mental health problems.

The present situation we are in in dealing with this center is whether we can again convince them of the necessity for the Mental Health Center to be involved with the delivery of the services. At the moment many things are going on that I don't think they are aware of in their relationship to the Mental Health Center that would disappear if they should separate.

This has been our experience with the particular neighborhood health center. In the meantime, several other things have begun happening in the community. One is the establishment of Neighborhood Health Centers, Inc., which is again an OEO funded organization to develop other health centers in Rochester. They are in the process of developing three more.

We are involved with the hospital, our inpatient beds are part of Rochester General Hospital, which is developing one of these mental health centers in this new Neighborsood Health Center.

This highlights an interesting problem, because I think the People's Health Center has developed services to the point that they are not going to be able to support them all. When they come into operation with these other centers there will be some very difficult problems to resolve. It is a sort of tragedy that this is occurring. However, these other centers are developing and we are attempting to develop some style of delivery of services to these groups.

Now there are two other items or groups that are developing services in the county. One is called Genesee Valley Group Health Association. This is a two-member corporation. The two members are Blue Cross and Blue Shield. It proposes to develop essentially on a Kaiser Permanente style.

The final organization is the Medical Society's Foundation. It is called the Monroe Plan, Inc. We approached the Genesee Valley Group Health Association about the delivery of mental health services. They showed some interest. At the time we were doing it the Monroe Plan, apparently not wanting to be left out, approached us and began indicating that they wanted the Mental Health Center to deliver services via their plan, too. So we may have to join that as an individual member. I think the major reason that they were interested is because of the drug and alcohol services that essentially are not delivered by private practice.

Negotiations are on with these two groups. These two groups are probably anywhere from one to two years away from functioning. Whether they will buy our services or not I do not know because it is one more expense that they would just as soon not have. We have no lever to negotiate with them except to try to sell to the administrators and medical directors of these plans the fact that it would be valuable to have our services.

What I would like to speak to you about now is the advantages of the combination of the HMO and the Community Mental Health Center. First, I think if they are completely independent organizations that we will see hostility gradually grow up between the two organizations. You see it in communities now where there is so-called dumping, where patients you don't like are dumped on the other facility. I think there would gradually be more distrust and anger toward the other facility, and the facilities would become totally isolated, and, I think this would lead to a marked deterioration of care.

Now the importance of the delivery of services at the health center I think is what has been stressed with all small organizations; namely, the accessibility. I think mental health care would be much more accessible and we would be able to deliver it in a much more continuous manner, that we would have much greater contact with the patient and be able to do a much better job.

I feel very strongly that, as the Center has grown, we have grown from 18,000 visits in our first year to 42,000 visits last year, it has become much busier and I can see it is going to be very necessary from that standpoint to decentralize some of our care.

Now, the mental health service contribution that would be made to the health center is inpatient services. Of course the health centers cannot all have inpatient services, emergency services. Emergency services are very expensive and I think would have to be done in a central facility.

Training and continuing education are two more. When new personnel come to the mental health center it is necessary to orient them to our style of delivery. The system is different enough that they have to go through a learning process to understand how we are doing things.

Continuing education: Let us asume that a Health Center had three or four personnel, they would be isolated and they would need ongoing exposure to drug techniques and various things that could be talked about at the mental health recruiting. I think it is markedly enhanced by a mental health center.

Special programs: If you look at a drug abuse program, a methadone program, for each of the centers to start one I think would be extremely difficult. There is a very small percentage of your personnel that can deal with this group. The licensing and the difficulties of dispensing I think would be too great. So I think these programs would have to be centralized at the mental health center to serve the patients are enrolled in the neighborhood health center.

In fact, in many of these areas one of the major values of the center would be to be able to sift out personnel and assign them to areas where they are most competent. If the center, the Genesee Valley group I was telling you about, looked toward hiring three people they would have those people all the time and no other people with specialities in alcoholism or the other services.

If the mental health center had the equivalent of three full-time people it could mean eight or nine different people rotating through.

The final point that I think is important is the linkage that the Community Mental Health Center has with other services, the courts, the schools and other agencies in the community. I think that that has been one of the major important thrusts of the Community Mental Health Center that could be passed to the health center.

Finally, again I want to stress that the Mental Health Center is offering a system of delivery that I think is qualitatively different from free mental health services in the Neighborhood Health Center. The flexibility of the people you can put in there, the liaison of enrollees who would move from the health center to treatment at the Mental Health Center, and the wide variety of programs that are available at a Mental Health Center. I think it would be a setback to the development of Mental Health Centers to again separate all these people out in the various health centers.

Now, in terms of cost, we did a study in 1969 of the actual services, mental health services, delivered to the catchment area population. We have a register in Monroe County that notes all psychiatric care given to the population in the county. From that and from our cost figures in 1971—1969 were the most recent statistics we had available to us from the register, but our cost figures for 1971 were from the Center—we found that there was a cost of $11 per year per patient for inpatient services and a cost of $3.35 per person per year for outpatient services. This is adults, but it includes alcohol and drug services.

The inpatient figure is high but there are certain factors operating in Monroe County that I think cause this. One is the availability of beds and the catchment area bed patients get into beds outside of my catchment area that I have no control over. I think this could be reduced very rapidly if there could be some control of the enrolled population, and the outpatient figure I think is a good solid figure, and I think mental health services could be delivered for $10 per person per year with little difficulty.

(Dr. Hart's prepared statement follows:)

STATEMENT OF WILLIAM T. HART, M.D., DIRECTOR, REGION II, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS; AND DIRECTOR, ROCHESTER MENTAL HEALTH CENTER, ROCHESTER, N.Y.

Mr. Chairman, my name is William T. Hart. I am appearing today on behalf of the National Council of Community Mental Health Centers, a nonprofit organization representing approximately 215 community mental health centers, including many of those receiving federal funds. We appreciate this opportunity to testify on HR 5615, HR 11728, and other bills regarding Health Maintenance Organizations.

The National Council is extremely interested in the various proposals pending in Congress at this time relating to the development of HMO's. We are particularly concerned that any new program for health services delivery not overlook the valuable experience gained in the community mental health center program. As this comittee is fully aware, the network of federally-funded community mental health centers have been providing comprehensive mental health services to specified populations for over half a decade. The services provided, either directly or through contract arrangements with other agencies, are designed to meet all of the mental health needs of the catchment area—from preventive care, inpatient and outpatient services, to home care and after care services. These centers, with their linkages between other social service agencies, such as the educational system, the judicial system and other health services in the community, offer the most advanced health delivery system available today.

The experience gained through the CMHC program in delivering comprehensive care is not peculiar to mental health services. We are confident that this expertise would prove invaluable in bringing about a change in the delivery of health services (through the development of HMO's), particularly in the area of linking health and other community services, and with the administrative problems which will arise in any health delivery system.

We would like to address ourselves, in this statement, to three issues:

The inclusion of mental health services in the minimum services required of federally-supported HMO's,

The relationship between HMO's and CMHC's, and

The quesetion of whether an HMO should serve a geographic area, or an enrolled population.

I would also liked to highlight for the committee my own experience at the Rochester Mental Health Center where we are now in the process of establishing linkages with three potential HMO's.

Our concern with the role of mental health services within the HMO structure is, I think, self-evident. Mental health services have traditionally been the step-child of health services, and received less attention as a result. Yet mental illness is one of the major causes of disability, with the result that the cost to the nation in terms of human suffering is substantial. This cost can also be calculated in dollar-terms and according to a study by NIMH American society lost $16.9 billion in productivity in 1968 due to mental illness.

The reason most often given for excluding mental health services is the cost factor. This, is a false argument. A study of our catchment area patient utilization figures from 1969 and mental health center cost figures from 1971 shows that it costs $11 per person per year for the catchment area population to provide hospitalization in short-term acute hospitals, and only $3.37 per person per year for outpatient care. The most striking item in these figures is the high cost of hospitalization, but it must be remembered that this constitutes all psychiatric care to a group that includes 50 percent of the poor in Rochester, N.Y. Also, Rochester has a very high rate of utilization of inpatient psychiatric beds, but with proper financial patterns I think that this can be lowered dramatically. Our estimate of a reasonable figure is $10 per person per year for comprehensive mental health services.

Our experience is also supported in the recent report on *Health Insurance and Psychiatric Care: Utilization and Cost* by the American Psychiatric Association, which I am sure the Committee has seen. This report concludes that the cost of providing mental health services is relatively low and entirely feasible.

We therefore strongly urge the committee to consider requiring mental health services of all federally-funded HMO's. But particularly HMOs should be strongly encouraged to established an arrangement with existing CMHC's in the area whereby the center would provide mental health services to HMO enrollees.

ROCHESTER HMO'S

In Rochester, there are three types of health maintenance organizations being formed, all of which will served people within our catchment area, and I would like briefly to discuss the relationships which are developing between the HMO's and the Rochester Mental Health Center.

The first group is Neighborhood Health Centers of Monroe County, Inc., which has an OEO grant to develop neighborhood health centers within poor and near poor areas. There is a neighborhood center already operative, the People's Health Center, that plans to join Neighborhood Health Centers, Inc. in the very near future. This center was sponsored by the University of Rochester, and is funded by OEO and Medicaid payments. The Rochester Mental Health Center has been delivering mental health services to the people served by this Health Center since it opened about two and a half years ago, (its catchment area lies entirely within ours). This enabled us to gain experience in clinical, administrative and fiscal relationships.

Initially, our relationship with this center was quite informal and at one point about a year ago there was a move to separate their mental health services from the Rochester Mental Health Center entirely and to operate by themselves. After a series of meetings the problems that would arise from this became evident and a bilateral decision was made that both the Health Center and the Mental Health Center had to share control of mental health services within the Health Center. At the present time this is accomplished by ⅔ of the mental health personnel being employed by the Health Center and ⅓ by the Mental Health Center. Now we are working out a relationship that I hope will follow the pattern which I shall discuss later.

The next type of health organization that is arising is a Medical Society Foundation called the Monroe Plan, Inc. Enrollees would be eligible, for a prepaid annual fee, for a range of services delivered by the physicians who are members of the Plan. The physicians would be paid on a fee for services basis.

The third health organization is the Genesee Valley Group Health Association, Inc. and it is being formed by Blue Cross and Blue Shield and will be a closed panel physician group patterned essentially on the Kaiser Permanente Model.

HMO–CMHC RELATIONSHIPS

From our acual clinical experience with the People's Health Center and from our negotiations with the other health centers, a pattern for a relationship has emerged. The pattern is a contract arrangement, where the Health Center contracts with the Mental Health Center for the delivery of services both at the Health Center and the Mental Health Center. This arrangement offers the best care to the consumer.

Based on our experience in Rochester there are requirements for the relationship that should exist between a Health Center and a Mental Health Center.

The first of these is that mental health centers should actually be delivered in the Health Center. This is necessary so that mental health personnel are available to consult to other disciplines. An example of this is the patient who is unwilling to be referred to mental health personnel and must be handled by consultation between the actual care giver and the mental health personnel. Also, it has been our experience that a certain awareness of psychological implications of both physical and mental illness is fostered by the presence of mental health personnel within a Health Center. The presence of mental health personnel also increase accessibility and continuity of care because of geographic proximity to the patient offered by the multiple bases of operation.

The second requirement is that not *all* of the care should be delivered within the Health Center. For example, emergency services are very expensive and are most efficiently run in a centralized facility. Specialized programs and programs which are being initiated will have to be operated at the Mental Health Center. Examples of this are alcohol and drug programs and certain group therapy programs. Training of personnel is also an important function of the Mental Health Center that cannot be decentralized. Recruitment of personnel is enhanced by the Mental Health Center's affiliation with the Health Center. The Mental Health Center offers a system of delivery of services that requires some orientation and experience within the system before new personnel can operate effectively. This must be done at the Mental Health Center. Consultation and education to agencies and various groups within the community will need special procedures and specialized personnel. Finally, the system of delivery of care developed by a Mental Health Center is an entity that should not be excluded from the Health Center. The procedures that make a wide range of service available also offer a different quality of service to the community.

The relationship that would best foster these arrangements is one where the Health Center contracts with the Mental Health Center for the delivery of mental health services both within the Health Center and at the Mental Health Center. The Health Center would have the final say through the fiscal mechanism .They could feed back consumer satisfaction or dissatisfaction with the services delivered and could make it incumbent upon the Mental Health Center to deliver a package that was satisfying to the consumer and that was economically feasible.

TRANSITIONAL PROBLEMS

However, in establishing these arrangements there are several transitional problems that need careful thought and planning. The problem of the enrolled population versus the geographical population is one of the more difficult.

The community mental health center is, of course, organized to serve a catchment area population, and by concerning itself with a geographic area can deal with the entire mental health needs of the community. This is especially important in the delivery of preventive services—consultation and education services being a principal thrust of the mental health center concept. Indeed, traditionally all preventive health services (such as the public health service programs) have been delivered on a geographic basis and it is our belief that this is essential for any effective preventive service. Thus the concept of an enrollment process for HMO's does not tie in with our experience in existing programs for effective delivery of preventive services. Yet prevention is cited as one of the primary functions of the new delivery system.

The problem of a contract between the HMO, with its enrolled population, and a center with its geographic base would not be as difficult to solve with regard to other services provided by the mental health center. It is our assumption

that the populations served by an HMO will come primarily from an area close to the organization, and therefore there could be a general area served by the mental health center from which the bulk of the HMO consumers would come. At the present time, certain facilities served by CMHC's draw people from out of the catchment area—schools, family agencies, day-care programs, etc.—and these problems have been resolved on an individual basis.

CONCLUSION

In summary, we would like to stress the following points for the development of a health program of health maintenance organizations:

—An HMO should be required to offer a full range of services including mental health services and these services should be provided by CMHC's where they are available.

—There should be an integrated system for delivering health services to the enrolled population with linkage between all human services in the area.

—The organization should serve a geographic area, for truly preventive services cannot be provided any other means.

—The experience of the community mental health center needs to be taken into account in developing HMO's, for there is much to learn from this effort. One of the most important features of the centers is the *range* of services which they provide. In order to provide these services, the centers have had to develop creative programs, often shifting the traditional roles of professionals in order to get maximum use of manpower.

—Consumer participation should be a requirement in the development of the HMO system.

In this respect, we find the Administration bill, H.R. 5615, falls far short of providing the basis for the development of a sound system of health care delivery. H.R. 11728 is, in our opinion, a far better bill, but it could be significantly strengthened by the recognition of the need for comprehensive mental health services, and for linkages between HMO's and CMHC's such as I have outlined above.

Mr. ROGERS. Thank you very much, Dr. Hart. This has been most helpful testimony.

I think the committee will want to consider, as you say, encouraging mental health services and certainly in cooperation with the existing mental health centers we have already established over the country. We now have how many?

Dr. HART. There are over 500 that are funded and close to 400 that are operating.

Mr. ROGERS. That gives you a great resource to begin on.

I thank you so much for your testimony.

Mr. Nelsen.

Mr. NELSEN. I was interested in one of your statements. I was interested in all of them, in fact, but I want clarification on the OEO operation. As I recall from debates on the floor, it seems that the OEO activities just sort of float around and spring up here and there, are not under any supervision and are not required to meet the same standards of delivery that we require of others.

I wonder if you have any comment.

Dr. HART. Yes. This has been a problem because there is no control, the OEO money bypassed all of the planning agencies directly into this neighborhood health center I was talking about. My negotiations essentially depended on the good will of the administrator and director of the center, and myself. There were no levers of any kind there. It still is very much of a problem.

Mental health services in these centers will depend on whether I can get them to buy it. Just plain selling.

Mr. NELSEN. Thank you.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I have no question. I thank you for your testimony.

I will state that I feel very much as the chairman feels with regard to the mental health services and the use of community mental health centers that are now established.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. Thank you.

I am glad to welcome you here with your testimony. I have no questions.

As Dr. Roy stated, we are interested in the chairman's wishes that mental health centers be included. Certainly we will take a careful look at it.

Mr. ROGERS. Thank you so much for your presence here. It has been most helpful.

Dr. HART. Thank you, Mr. Chairman.

Mr. ROGERS. I am very pleased to have as our next witness a representative of the American Nurses' Association, who is a health expert from my own area. I particularly welcome Mrs. Mabel Johansson, as well as Miss Constance Holleran. I am very pleased to have you here. I am delighted you have been selected to offer the testimony.

STATEMENT OF MABEL S. JOHANSSON IN BEHALF OF AMERICAN NURSES' ASSOCIATION; ACCOMPANIED BY CONSTANCE HOLLERAN, DIRECTOR, GOVERNMENT RELATIONS DEPARTMENT, ANA

Mrs. JOHANSSON. Thank you, Mr. Chairman. I bring you greetings from the home city.

Mr. ROGERS. Thank you.

Mrs. JOHANSSON. Mr. Chairman, I am Mabel S. Johansson, director, Nursing Division, Palm Beach County Health Department, West Palm Beach, Fla. I am accompanied by Constance Holleran, director, Government Relations Department, American Nurses' Association.

The American Nurses' Association, the professional organization of registered nurses in the United States, is committed to the position that health care is a basic right of all people. It further believes that health care should be comprehensive, offering preventive, health maintenance, diagnostic and treatment, restorative and protective services through an integrated delivery system.

With few exceptions, notably the prepaid group practice plans, the system for delivering and financing health care through health insurance, whether provided under public or private mechanisms, has fostered the use of the most expensive facilities and providers. Little emphasis has been placed on the use of ambulatory services—clinics, outpatient departments, home care, the neighborhood health center. Preventive and restorative services have been largely ignored.

It is our conviction that, although vitally important additionl emphasis on public and private financing alone will not guarantee that health care is accessible to all. What is needed is the development of integrated systems to deliver quality comprehensive health care services which are accessible and acceptable to people of all income levels and in all geographic areas of the country.

The health maintenance organization is one approach for structuring the delivery of comprehensive health care into such an orga-

nized system. The legislation you are considering would encourage this development, and we support its intent.

There is widespread criticism of the present delivery system. We believe that integrated systems for delivery of health care services should be developed through areawide health planning mechanisms in which consumers are involved. These planning groups must have authority to do the planning.

For this reason, we believe that there should be some provision in the legislation, such as that in H.R. 11728, which states that the HMO should be "organized to assure members a meaningful policymaking role . . ." In inaugurating a new program, sound planning by those most familiar with local resources and needs is essential. Without input from the individuals who will require health services, there could be dangers of public resistance. A selling job will have to be done to convince people that care received through a health maintenance organization is of high quality, readily available, and less costly. Consumers who have participated in planning for change would be the best salesmen. One of the biggest blocks to joining, other than financial, is likely to be the idea of not having one doctor as a contact point. There should be ways of working this out.

As the delivery system evolves there should be continuing opportunity for consumers to evaluate its effectiveness in meeting their needs. Further, any corporate structure, arrived at through the planning process, for coordinating and delivering health care should have a board composed of consumers and providers. It should not be dominated by any one institution or agency or any one group of professional practitioners.

We support the concept of the health maintenance organization assuming the responsibility for providing comprehensive health services, directly or indirectly, to its clients. H.R. 11728 does include, among other services, those of clinics, outpatient departments, home health services, and extended care facilities. While it may be necessary in many locales for the organization to provide all the services directly, where institutions—hospitals and extended care facilities, home health agencies, and other professional services—are well developed, contractual arrangements could be made in order to avoid duplication, fragmentation, and competition for scarce health personnel. The important issues are coordination and continuity.

If medical schools operate HMO's, as has been suggested by some, there should be safeguards to assure that the purpose of the HMO service to people does not become secondary to the educational purpose of the medical school. We would recommend that schools of the health sciences, rather than medical schools exclusively, establish HMO's to insure interdisciplinary planning and participation in delivery of health care. All health professionals should have opportunity for learning experiences under expert guidance and supervision in whatever structured delivery system is decided upon. Such experience could bring about a more rapid acceptance of the need for a better utilization of the many health professionals, many of whom are now underutilized.

Whatever programs in health maintenance are developed, we believe they should be under public or nonprofit auspices, as provided in H.R. 11728. Profitmaking in the health field is not in the best interest of the

American people already concerned about the ever-increasing costs of health care and who are suspicious of profiteering in the health field.

We are aware that adequate health care services are lacking in many rural and inner-city areas. The thrust of both H.R.11728 and H.R. 5615 is to establish health maintenance organizations in medically underserved areas. We agreed that a major effort must be made to reach out to those who have been denied health care for economic, social geographic reasons. We would hope that this would not result in and perpetuate a separate system for the poor and underprivileged. For too long they have been isolated from quality services. We favor a one class system in which all sectors of the population would be covered and in which services of high quality would be available to all.

In rural areas, during planning for an HMO, there will have to be consideration of incentives to attract health professionals to the area. Financial incentives—loan forgiveness, grants, higher compensation—can have some impact in attracting health manpower to areas of scarce supply. Health workers, like other people, have professional, intellectual, and social needs. Salary differentials, realistic continuing education programs, sabbaticals, and opportunity for consultation with peers should be provided as a means for encouraging redeployment of health professionals. There should be less problem in extending health care services into ghetto areas if proper planning is required as a condition for receiving funds and if the HMO is required to serve a cross section of the population—the affluent, the middle-income group, and the poor. However, it may be necessary to develop an HMO for a homogeneous population because of certain demographic characteristics.

The matter of communication in rural areas is already being dealt with through use of closed circuit television, radio, and telephone. Transportation for those in need of sophisticated and intensive care in a large center can be provided by helicopter, air ambulance, mobile coronary care, and accident care units. Satellite health centers, with affiliation to an urban health center, can be staffed by qualified health professionals other than physicians, but with adequate provision for communication, consultation, and transportation to and from urban centers.

Certainly in some rural areas, a sparse population could not financially support the full range of professional services required for comprehensive health care, but there should be the requirement and the opportunity to secure professional services in and out of a major health center.

The Palm Beach County Health Department is the provider of health care services to a defined population of the medically indigent numbering in the thousands. We do not have the formalized organization of a health maintenance organization, but we do have most of the components of an HMO, including a formalized arrangement with local hospitals. Presently we are in the planning stages of developing a more structured organization which will include a preexisting consumer advisory board.

Nursing is an integrated service functioning in all areas of the health care service. Examples of nurses who are practicing in various areas of health care are:

First; the pediatric nurse associates, working in a team relationship, are providing health care to a large pediatric population. The service is available 24 hours a day, 7 days a week. The nurse is responsible for all continuing well-child supervision and for diagnosis and treatment of minor illnesses. The children are healthy and the mothers are satisfied.

I would like to add that this service has not been misused. Contrary to many statements that have been made that if you provide a free service to people, they misuse it—they have not.

2. The nurse is a member of the mental health outreach team of the comprehensive mental health center, and functions as a cotherapist. Many patients are seen on a continuing basis only by the nurse.

Since this has been instituted there are no waiting lists at the comprehensive mental health center and more people are being seen sooner and emergencies can be seen on the same day.

3. Nurse midwives are providing continuing supervision of the prenatal patients. The patients like the "nurse-doctor" and relate well to her.

4. Nurses in health centers and outreach trailers are providing primary health care service to people, including both diagnosis and treatment and preventive services.

In the delivery of health care more recognition should be given to this primary care role of the nurse. Nurses have been engaged in providing preventive services and in promoting good health practices in communities, schools, industry, the home and in neighborhood health centers, but this role has had less recognition than the role played in crisis-related situations in hospitals. Increasingly they are assuming a primary care role, especially in pediatrics, in maternity care and in the mental health field. We submit that increased involvement by nurses in primary care can result in helping people enter the health care system at a point early enough so that medical science can be of help to them. I think of the nurse as being a patient advocate.

Primary care can be described as being health oriented rather than illness oriented. More and more education for nursing practice concentrates on maintenance of health and prevention of illness. Traditionally, education for medical practice has focused on pathology and the treatment of disease. These are complementary roles and appropriate to achieving the overall societal goals of keeping people well and curing the ill.

We see the nurse expanding her practice in the area of health care in a number of ways: assuming responsibility for monitoring the growth and development of children, providing care throughout normal pregnancies, counseling regarding physical and mental health, and screening and treating minor illnesses, following guidelines established collaboratively by physicians and nurses. One health maintenance organization—Harvard Community Health Plan, Boston, Mass.—reports that of 4,500 visits made to its center, 65 percent were related to upper respiratory problems, minor trauma, muscle pain and need for psychological support. Their experience indicates that 70 percent of these incidents can be handled by the nurse alone without sacrificing quality care and with full patient acceptance and approval.

For individuals with chronic illness, guidance and supervision is essential to maintain a degree of health so they can remain at home. We are pleased to see that H.R. 11728 includes home health services within the comprehensive health services provision. The nurse is the appropriate health professional to provide these services. A striking example of this type of nursing care and what can be accomplished is the case of an 18-year-old diabetic who in an 8-year period was hospitalized 124 times. Later, under nursing supervision, she had no hospitalization over a 7-month period.

The Permanente Medical Group teaches and employs pediatric nurse practitioners in several of its northern California medical centers. They perform primary child health care. This includes taking histories, making a complete physical examination, using basic skills of inspection, palpation, percussion and asuculation with the aid of the stethoscope and an otoscope. They make the judgment whether the child is well or ill and refer the child to a pediatrician or other specialist as needed. They also manage minor illnesses, look for variations on growth patterns and essentials of child nutrition, order immunizations as needed, and perform developmental screening tests at specific ages.[1]

The work of a pediatric nurse practitioner relieves the pediatrician from many demands, freeing him to devote more time to serious illnesses of children.

Mr. Chairman, we believe that preparation and utilization of the nurse practitioner in a primary care role is one important way to extend health services and to use health manpower more effectively. We hope that the committee will give serious consideration to this potential as they continue deliberation of HMO legislation.

Optimal utilization of the nurses' skills and expansion of her functions can have a very positive influence on health care. This is also true of other workers in the health field. We have reached the point in our history where no single profession can meet all the needs for health services of all people in this country.

Attached is a statement of the definition of the term "Nurse Practitioner" developed by the Congress on Nursing Practice of the American Nurses' Association. I respectfully request that it be included in the record of these hearings.

We would also like to include in the record a statement on the Frontier Nursing Service, which describes the nurse practitioner in action.

Mr. ROGERS. Without objection, it will be made part of the record.

Mrs. JOHANSSON. Thank you.

H.R. 11728 proposes that a National Advisory Council on Health Maintenance Organizations be established within the Public Health Service, to advise and assist the Secretary in the development of policy and preparation of regulations relating to HMO's. The Council will also make recommendations with respect to approval of grants, loans, and loans guarantees. The American Nurses' Association recommends that the composition of the Council be multidisciplinary, and that the membership include at least one representative of the major health professions.

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[1] "Pediatric Nurse Practitioner in a Large Group Practice," by Marie Feldman, Kaiser Permanente Reporter, Feb. 11, 1972.

Thank you for this opportunity to present the associations' views on the matter of Health Maintenance Organizations.

(Definition of the term "Nurse Practitioner," and "The Frontier Nursing Service," referred to follow:)

DEFINITION OF THE TERM "NURSE PRACTITIONER"

A nurse practitioner is a licensed professional nurse who provides direct care to individuals, families and other groups in a variety of settings including homes, institutions, offices, industry, schools and other community agencies. The service provided by the nurse practitioner is aimed at the delivery of primary, acute or chronic care which focuses on the achievement, maintenance or restoration of optimal functions in the population. The nurse practitioner engages in independent decision making about the nursing care needs of clients and collaborates with other health professionals, such as physicians, social workers and nutritionists, in making decision about other health care needs. The nurse practitioner plans and institutes health care programs as a member of the health care team.

The acquisiton of knowledge in depth and competence in skill performance in a particular field of practice enables this practitioner to:

1. Assess the physical and psychosocial health-illness status of individuals and families by health developmental history taking and physical examinations.
2. Evaluate and interpret data in order to plan and execute appropriate nursing intervention,
3. Engage in decision making and implementation of therapeutic actions cooperatively with other members of the health care team.

The practitioner institutes and porvides health care to patients within established regimes such as supervising and managing normal pregnancy and delivery, pediatric health supervision and diagnostic screening. The nurse practitioner provides counseling, health teaching and support to individiuals and families.

The nurse practitioner is directly accountable and responsible to the recipient for the quality of care rendered.

THE FRONTIER NURSING SERVICE

One example of a successful health care program developed for a rural area is the Frontier Nursing Service in Leslie County, Kentucky. It was the lack of health care in rural areas that led to establishment of the service which began 47 years ago as an experiment in the use of nurse midwives. With additional training in the care of common health problems and with medical backup, services were extended to the entire family.

At the center of the FNS now is the family nurse. The system for delivery of care is built around the residential nursing clinic which is readily accessible and makes possible the development of a program unique to the area. All families served by the nurse live within an hour's travel time, and the average population served is 200–250 families or 900–1000 individuals.

The majority of illnesses dealt with are minor and can be identified and managed by the family nurse. Serious illnesses can be recognized by these nurses and referred to the physician. Nurses also screen and direct their patients to appropriate health and social agencies. There are six nursing outposts located within an hour's travel of a hospital and health center at Hyden, Kentucky. It has more extensive diagnostic and treatment facilities and a resident physician is available at all times. Hyden clinic is conducted similarily to the nursing outposts with nurses screening all patients and doing preliminary health histories and so on.

Specialty clinics are conducted periodically. Clinics are conducted periodically by spcialists from university or other medical centers. For example, a surgical team from the University of Cincinnati conducts ear, nose and throat clinics twice a year, and they perform such surgery as to sillectomies. This arrangement makes it possible to provide such services to isolated families without prohibitive costs.

Many patients needing specialty services are transported to a regional hospital or medical center. Regional mental health services and other state facilities

also are used. Thus there is no need for costly equipment or for maintaining full-time specialists on the staff.

The community (the consumer) has been very much involved in the planning and maintenance of the service since it was established. It was developed on the basis of stated needs of the people, and no nursing outpost is built without their request.

In addition to health services which are provided or made available through the FNS, there is a strong emphasis on health education. A recent newspaper article (Washington Post, December 28, 1971) pointed out the dramatic decline in the birth rate in the area (where families of 10 and 12 children are not uncommon) since the FNS instituted a program in birth control education.

The Frontier Nursing Service has proved over the years that a workable health program can be made accessible and acceptable and provided at moderate costs to people in a poor, rural area—with the registered nurse as the provider of primary health care.

Mr. ROGERS. Thank you so much, Mrs. Johansson, for a very excellent statement, and Miss Holleran for her presence and support here.

I think it is true that Palm Beach County does have one of the most outstanding health departments in the Nation, and many of the innovative programs have actually been experimented with in Palm Beach County. So I commend you for the work you have done, particularly in the migrant area. It has been most rewarding.

Mr. KYROS. No questions, Mr. Chairman.

I wish to thank Mrs. Johansson for an excellent and comprehensive statement, particularly in regard to our passing the Nurses Training Act. Those hearings are important in seeing what the role of the nurse is, and I think this makes consideration of HMO's more relevant. Thank you.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

I want to join with my colleagues in expressing a thank you. My only daughter is a registered nurse, so I am a little bit partial to any observations that the nurses make.

I want to also comment that that radiant smile of yours would cure almost any person. Thank you very much.

Mr. ROGERS. Thank you so much. We may be in touch with you as the legislation is considered for additional advice.

Mrs. JOHANSSON. Thank you.

Mr. ROGERS. Our next witness is Miss Jane B. Keeler, president of the Council of Home Health Agencies and Community Health, National League of Nursing.

I believe you will be accompanied by others?

STATEMENT OF JANE D. KELLER, PRESIDENT, COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING; ACCOMPANIED BY MRS. LEAH HOENIG, EXECUTIVE DIRECTOR

Miss KEELER. Mrs. Leah Hoenig, director of our council.

Mr. ROGERS. We will make your statement a part of the record, without objection. If you will highlight it for us it will be helpful.

Miss KEELER. Mr. Chairman and members of the committee. My name is Jane D. Keeler and I am the director of Visiting Nurse Association of New Haven, Conn., an accredited community health service. I am also the president of the Council of Home Health Agen-

cies and Community Health Services of the National League for Nursing and it is in that capacity that I appear before you today. The council is the national spokesman for over 1,400 official and voluntary home health and community health agencies throughout the country and includes in its membership the majority of the large community health agencies. These agencies utilize the services of nurses, physical therapists, occupational therapists, physicians, social workers, nutritionists, home health aides, and speech and hearing therapists. I am accompanied by Mrs. Leah Hoenig, the executive director of the council.

It is important to my presentation that the committee understand the context within which I speak. Because of their professions prior to election to the Congress, Congressmen Roy and Carter are probably the members who have the most intimate knowledge of the role and contribution of the home health agency. I may be in error but in all probability the closest association other members of this committee have had with home health care agencies is through a tax contribution to your public health agency or through your favorable response to an appeal to support your local visiting nurse service. What we do is provide health care services outside the walls of hospitals and other health care institutions such as within a patient's home, in schools, in ambulatory health care centers and in other community settings such as senior citizen centers and neighborhood health centers. I am attaching a list of those agencies for whom we speak in the congressional districts represented on this subcommittee.

Perhaps if I tell you a little bit about the agency I direct it will be illustrative. The Visiting Nurse Association of New Haven has been serving residents of New Haven since 1904. In the intervening years we have assumed responsibility for the provision of home health and other community health services in adjacent communities of East Haven, West Haven and Milford, covering a total population of approximately 270,000.

We are the certified home health agency providing home health care under the medicare program. We also provide nursing and other therapeutic patient care services related to illness to all other age groups and participate in the medicaid program in the State of Connecticut. As a basic part of our program in relation to illness, the rehabilitation needs of patients are always assessed and, through physical therapists who are members of our staff as well as through nursing rehabilitation activities, patients with rehabilitation needs receive these services as well as other therapeutic care.

In addition to care related to illness, members of our staff provide health education and guidance services to women who are pregnant, to new mothers, to parents of infants and preschool children, and the nursing component of the school health program in 63 public and parochial schools in the city of New Haven. Health education activities are carried out in the home and in an extensive well-child clinic program which provides basic, preventive health services to infants and preschool children. In the city of New Haven between 4,500 and 5,000 children each year receive their preventive health care through this clinic program. Our staff participates in the health service of an extensive year-round Head Start program working with parents and educators in these programs and in day care centers. We provide

health education and counseling sessions at senior citizen centers and centers in housing projects. In all of our interaction with the individuals and families, staff members are constantly alert to health and social problems which indicate a need for assisting the family to plan to use other health and social resources.

The program we of the VNA of New Haven offer, which I have described, is not unlike that offered by community home health agencies throughout this country.

What I hope you will understand is that our agencies have been concerned over the years with not only care related to illness, but also with preventive health services, health education activities and with assisting families make appropriate use of other health care resources.

I would like for just a moment to give you a little depiction of the extent to which our services are distributed in the neighborhood settings and areas within the geographic area we cover. You have some coding here which indicates that in all of these dark green locations we have schools. The well-child clinics are the orange coding. The Head Start programs are the lighter green. We also provide care in day care centers identified by the lighter yellow. These services are provided in these locations. In addition, our staff worked throughout the neighborhoods in providing health care services to patients and their families in their own homes. I think the point particularly I would like to make with this is that we have been out there for a long period of time and have developed, we feel, a way of working with families in their home settings that should be taken into consideration as we think of the newer patterns of care, particularly those being suggested by the HMO concept.

We want to commend the sponsors of H.R. 11728 and of similar legislation for what we believe to be a serious endeavor to deal in a meaningful way with our Nation's deficient health care system. We implore you to give thorough and careful study to this proposal and to the suggestions that we make because we believe, the grievously unfortunate mistakes of medicare and of medicaid and certain other Federal support programs must be avoided where the stimulus has been to develop services which duplicate components of care which already exist within the community.

As we understand it, this legislation addresses the organization of health care services and does not concern itself with payment mechanisms for health care delivery. My comments shall be within the frame of reference.

As enunciated in H.R. 11728, an HMO would be required to provide "comprehensive health services, directly or indirectly, through a medical group or groups and other health care delivery entities"—as stated on page 3, lines 8–10. The term comprehensive, is defined beginning at line 18 of page 6,

> The term "comprehensive health services" means (A) physician services (including consultant and referral services); (B) inpatient and outpatient hospital services; (C) extended care facility services; (D) home health services; (E) diagnostic laboratory and diagnostic and therapeutic radiologic services; (F) rehabilitation services (including physical therapy); (G) preventive health services; (H) emergency health services; (I) out-of-area emergency health services; and (J) such other personal health services as the Secretary may determine are necessary to insure the protection, maintenance, and support of human health.

Of the 10 categories, I wish to comment specifically on (D), (F), (G), and (J).

In relation to item (D), we urge this committee to assure that all possible emphasis be placed upon the proper and appropriate utilization of home health services. The percentage of persons who prefer an institutional setting, be it hospital, extended care facility, nursing home or another to his or her own home is miniscule.

I think this has been well demonstrated. We have testified to this fact and others certainly support this concept.

Psychological trauma is not an inconsiderable element adversely affecting the health status of the individual. The cost of care provided in a home environment is markedly less than that required in a hospital stay or in an extended care facility. As defined in H.R. 11728, section 1011 F, which encourages and actively provides for its members (i) health education services and (ii) education in the appropriate use of health services," and 1101 (2) (F), and 1101 (2) (F) rehabilitation services, and (G) preventive health services are so inextricably entwined that we are unable to treat these elements separately.

However, once again I would say they are all concepts of patient and family care for which our services have been long noted, been concerned with and have attempted to provide.

Nursing and related services as practiced and provided in home health and community health service agencies are quite different from their counterparts in inpatient care institutions. Individuals when hospitalized are usually undergoing an acute episode of illness, whereas patients cared for in their own homes may be recovering from an acute episode or suffering from a short or long term illness. The care provided in the home includes consideration and attention to the health status of not only the patient but his family. Such care encompasses teaching of desirable health practices, interpretation of the appropriate use of health care resources, early identification of health problems of family members, and referral for medical assessment and care. Rehabilitation is an essential component of care provided to individuals and families by health workers in home health and community health agencies.

We who are involved in the provision of health care services to people outside of institutions, have always believed that the health status of our citizenry will not be improved until the system has shifted its focus from acute episodic care to health services in which the preventive components are strong.

We are gratified to note the specific inclusion of preventive health services in H.R. 11728 as a requirement and we urge again that there be a prohibition against establishment of an HMO duplicating home service where such service already exists. We also urge that NLN–APHA accreditation for community home health services be among the required standards.

Our comment relative to discretionary power of the Secretary as stated in item (J), page 7, is one of caution. We realize that it is not unusual to provide rather wide discretionary powers to the Secretary, HEW, in legislation of this kind. We hope, however, that this committee will observe closely the implementation of this program. There are approximately 20 references in H.R. 11728 to the fact that the Secretary by regulation shall do one thing or another. I am sure you

realize that under the powers of the Secretary, HEW to delegate responsibility, we are discussing some 115,000 to 120,000 employees and, despite the Secretary's personal commitment he must depend upon his staff. It has been our experience in the past that HEW staff may at times not be the most experienced, or knowledgeable in certain areas of health care.

For example, it might be interesting to know how many HMO, or for that matter, how many group health practice experts, persons who have experience in these programs, not those who have read the literature, are on the HSMHA, HMO staff. It is because of less than satisfactory experiences particularly under the medicare and medicaid program to which I referred earlier that we so strongly urge a significant policy role for the National Advisory Council on Health Maintenance Organizations. In addition, representation in appropriate number and experience in the operation of home health agencies should be required on the advisory council.

Health maintenance organizations are intended to affect the methods for delivery of health care. As I noted earlier, the proposal is neither a funding program nor will it to any appreciable degree increase the health manpower which provides services. It is especially important therefore that this legislation will make it clear that the services of existing community agencies should be utilized.

We appreciate this opportunity to present our views on this important legislation.

(The list of agencies referred to follow:)

HOME HEALTH AGENCIES IN THE DISTRICTS REPRESENTED BY MEMBERS OF THE PUBLIC HEALTH AND ENVIRONMENT SUBCOMMITTEE

Congressman Paul Rogers of Florida: Palm Beach Health Department, Nursing Division, and Visiting Nurse Association of Palm Beach County.

Congressman David E. Satterfield III of Virginia: Bureau of Public Health Nursing, State Department of Health, and Institution Visiting Nurse Association.

Congressman Peter N. Kyros of Maine: Portland Visiting Nurse Association and City of Portland Health Department.

Congressman Richardson Preyer of North Carolina: Guilford County Health Department.

Congressman James Symington of Missouri: St. Louis County Health Department.

Congressman William Roy of Kansas: Public Health Nursing Service, Division of Medical Health Service and Topeka-Shawnee County Health Department.

Congressman Ancher Nelsen of Minnesota: Bloomington Health Department and Immanuel Hospital Home Care Service.

Congressman Tim Lee Carter of Kentucky: Clay County Health Department, and Owsley Lee Jackson and Clay County Health Department.

Congressman James F. Hastings of New York: Visiting Nurse Association in Jamestown.

Congressman John G. Schmitz of California: Visiting Nurse Association of Orange County in Tustin.

Miss KEELER. I would like to add one additional comment out of our personal experience in New Haven. At the present moment within the city of New Haven proper we have a neighborhood health center which was funded, has been funded over the last 3 years, through children's bureau and M&IC funds, and now has 314(e) grant money.

Within that same neighborhood, despite the efforts of the neighborhood health center, the degree of health need in that area is so extensive that our agency still is carrying out well-child clinic care. We are still providing all of the home health care services to medicaid and

medicare recipients. We also now have developing a new group prepaid mechanism operating in the area of New Haven with an expectation they will have an enrollment of an approximately 30,000. They have gotten up to about 5,000 in their enrollment so far.

I worked very closely with this group. I serve on the board of directors. I have to tell you I am having extreme difficulty in helping them to understand that it might be more appropriate for them to consider utilizing our services when we get out into the home health services than their planning to orient their staff, staff up and send their people out through this total geographic area.

Mr. ROGERS. In other words, they would do that on a contract basis

Miss KEELER. This is what I have been trying to work out with them. And that is why I strongly urge with respect to H.R. 11728 that existing quality services should not be duplicated.

Mr. ROGERS. Thank you so much, Miss Keeler and Mrs. Hoenig. You have been most helpful to the committee. Your opinions are well taken and they will be considered.

Mr. Kyros.

Mr. KYROS. No questions, but I want to commend the testimony of the witness. We have all had experience with the visiting home nurses when we were young. I am very pleased to hear your testimony.

Miss KEELER. Thank you.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. No questions, thank you.

Mr. ROGERS. We are grateful for your presence and your helpful comments.

Miss KEELER. Thank you.

Mr. ROGERS. Our last witness is Dr. Robert V. Sager, a member of the board of directors of the Physicians Forum, Inc., in New York.

Dr. Sager, the committee welcomes you. We appreciate your presence.

STATEMENT OF DR. ROBERT V. SAGER, MEMBER, BOARD OF DIRECTORS, PHYSICIANS FORUM, INC.

Dr. SAGER. We appreciate this opportunity to appear before the House Subcommittee on Public Health and Environment. My comments, today, will be primarily directed at the Nixon administration HMO proposals.

My name is Robert V. Sager, M.D. I am a member of the board of directors of the Physicians Forum on whose behalf I am testifying today. I am also chairman of the forum's Committee on Health Maintenance Organizations. I am a specialist in internal medicine and have practiced over the past 43 years, initially in private practice. Since returning from World War II, I have been involved in group practice and was one of the founding members of one of the health Insurance Plan of Greater New York's first medical groups, and subsequently, I became an associate director of HIP. Since my retirement from HIP, I have spent some of my time working for the Northeast Neighborhood Comprehensive Health Center (NENA), a community-controlled comprehensive health care center located in New York's lower east side.

The Physicians Forum is a national organization of physicians which has, for more than 30 years, supported every major proposal for

a strong and comprehensive national health insurance system. We supported the Wagner-Murray-Dingell bill in the late 1940's; the Forand bill in the 1950's; and we were the first physician organization to come out in favor of the King-Anderson bill, which, as you know, formed the basis of the medicare portion of Public Law 89–97 passed in 1965. Since that time, the forum has repeatedly called for the extension and improvement of national health insurance in the United States as part of a restructuring of our national health care system.

It is the forum's position that the purpose of a national health insurance program is not simply to pay the Nation's medical bills but rather to reform its anachronistic, fragmented, often dehumanizing, and therefore relatively ineffective medical care system. I would like to insert into the record, at this time, the Physicians Forum statement on a national health system which more fully explains our position, as well as the complete statement on the Nixon administration health maintenance organization proposal. The principles upon which this HMO statement is based can be applied to other HMO bills before this committee.

I would like to say that our remarks are directed mainly toward H.R. 5615. But I would like to make a few remarks about H.R. 11728, a bill introduced by Representative Roy, yourself, and others.

Although we do feel that the bill has weaknesses which should be corrected, I shall restrict myself, at this time, to pointing out a few areas of superiority in it as compared to the administration proposals. Dr. Roy's bill mandates that an HMO provide additional health services making a package that is more nearly comprehensive; the HMO must be a nonprofit organization in order to receive Federal support; consumers be given a meaningful policymaking role; also, education of consumers in appropriate use of health services must be provided, and the medical groups are required to provide regular opportunities for continuing education of their personnel.

There are additional provisions for special project grants for consumer and provider education. The bill is also stronger in its provisions for public accountability and for quality assurance and evaluation (although it does not approach Senator Kennedy's HMO bill, S. 3327, with respect to the latter point).

Mr. ROGERS. I believe they set up a separate organization.

Dr. SAGER. A separate organization which is separately funded and unconnected I believe with HEW. It certainly has the aspects of a commission.

Mr. ROGERS. I was wondering if they would have enough personnel to do adequate checking. Do you think they would? How many would you have to hire to do that?

Dr. SAGER. It would be an immense organization if the HMO's really got going.

Mr. ROGERS. Do you think that would be a practical approach at this date?

Dr. SAGER. Not right now. It could be pari passu to the development of the HMO's.

After analysis of the administration-sponsored Health Maintenance Organization assistance bill—H.R. 5615—and the related National Health Insurance Partnership proposals—H.R. 7741—the physicians forum finds them unacceptable. To use the words of the forum's

statement of December 1971, on current national health insurance proposals, the administration legislative package, in spite of the reference to health maintenance organization, "is inadequate for the support of the nonprofit, salaried, prepaid, group-practice medicine which is needed in the United States." Furthermore, the forum considers the use of the terms "health maintenance organization (HMO)" and "comprehensive health services" in the context of these bills misleading and demogogic.

The forum's principles for a national health system provided the framework for the present analysis. To understand the proposed HMO system of medical care delivery, not only were the bills mentioned above considered, but also statements by officials of the Department of Health, Education, and Welfare, and the actual implementation of HMO planning proposals which was begun, with the specific legislation still to be enacted, by the diversion of funds appropriated for other purposes.

The pertinent Forum principles may be stated as follows:

1. Adequate distribution of facilities and personnel in kind and number so that patient care services are based on demonstrated health needs;

2. Creation of local and regional community-controlled health boards with responsibility for the provision of all personal and environmental health facilities and services;

3. Practice by personal physicians and other health workers on a salaried basis in groups which are based in neighborhood health centers;

4. Peer and consumer review of quality of care provided and continuing education for health workers of all types;

5. Obligatory service for physicians, nurses, and other health workers—who should not have to pay personally for their training—in rural and poverty areas of medical need—for a specified period of time, of course.

6. Payment for all personal health care through an equitably financed national health care fund, to be a mandated trust fund so constituted as to remove it effectively from dependence on annual appropriations by Congress; and

7. Establishment of a National Department of Health with full Cabinet rank.

The aforementioned principles indicate that the Physicians Forum is in favor of a unified and complete system of health services.

The Nixon-HMO Insurance System is fragmented and pluarlistic throughout: the system is broken up among a variety of bills; some of the HMO types have built-in fragmentation of health care; eligibility under the insurance plan is a loopholed and patchwork affair; medical care is not offered to all the people; what is offered retains all the features of our present multiclass system, including, as I note further on, a means test, especially under the insurance bill. Continuity of care is favored but there is no effective mechanism for assuring it. The HMO plan, in itself, is not economically viable. Since loans and grants to assist with operational costs would be limited to 3 years, HMO's in currently undeserved areas could hardly become financially self-sufficient. It is indeed questionable whether an effective and satisfactory chain of HMO's providing first-class medical care could be founded at

all without the concurrent establishment of an equitable, truly national financing mechanism.

Comprehensive services are not mandated and social services are completely omitted (except, it appears, in relation to enforcement of means tests under the insurance bill). Continuity of care is favored but there is no effective mechanism for assuring it.

The emphasis of the HMO plan is more on cost saving than on improved services, which it also appears to favor. The emphasis on cost cutting and competition invites an invasion of for-profit HMO's and encourages nonprofit private HMO's to increase the difference between payments for care (income) and cost of delivery, since net income becomes inversely related to the number of services rendered and there is no mechanism for assuring that a significant amount of the increased income be used for more or better services. In fact, without provisions for adequately monitoring the quality of care and for educating the consumers on what they have a right to expect and giving them a meaningful role in policymaking and surveillance of care, this short-changing of the recipient of care is inevitable.

We must emphasize that an HMO is not necessarily a group. In discussing HMO's government officials are fond of name-dropping "Kaiser-Permanente" and similar successfull group-practice organizations and lauding their virtues to suggest a relationship, but reference to the H.R. 5615 HMO definition reveals that all an HMO is required to do is arrange for services. While pluralism may be a valuable characteristic, in this case it is blown up to monstrous proportions. An HMO may be public at any level, Federal, State, local, regional: nonprofit private, including consumer and neighborhood sponsored groups; medical society foundations which are associations of solo physicians and not groups at all; and Blue Shield and Blue Cross insurance associations; and, finally, profitmaking private organizations under variety of sponsorships, singly or in consortiums; commercial insurance companies, electronic and industrial firms, drug houses, banks, management companies, and so on.

Physicians in these organizations may be full time or part time, paid by salary, partnership share or fee for service. The HMO may give most of the health services directly or contract out for them; they may operate from an institution, an ambulatory health center, a neighborhood health center, a number of scattered centers or, from solo private offices. A glance at the first planning grants to HMO's indicates that almost all of these varieties are at present in gestation and may eventually come to fruition.

The above list makes it clear that there will be several types of HMO's that are not groups; that the unfortunate market effects of fee for service, demonstrated by the medicare experience, will be repeated; that not all HMO's will be neighborhood centered and that in some kinds of HMO's care may be delivered through personal physicians and in others there is little likelihood of this.

Community boards are not provided for even in an advisory capacity; neither are grievance procedures. The only way consumers could conceivably affect quality would be by exercising their market power by mass withdrawals from the HMO; the administration seems to believe it can rely on market relations to bring forth and preserve the best.

As for providing patient care services sufficient to meet demonstrated needs, failure is written into the bill. Not only are the mandatory services not comprehensive—dental care, mental health services including psychiatric care, and drugs, among others, need not be offered—but the quantity of services can be limited by the size of the prepayment package purchased by or for the individual. Furthermore, experience rating is not interdicted, so that people most in need of care can be priced out of the market.

The HMO bill, H.R. 5615, does contain provisions that encourage the development of HMO's in medically underserved areas, both urban and rural. But without adequate financing provisions for continued operation, the encouragement is meaningless. In addition, workable incentives for recruiting and retaining the necessary manpower in such areas are lacking.

I know you are pressed for time.

I thank you very much.

(Testimony resumes on p. 885.)

(The attachments to Dr. Sager's prepared statement follow:)

Financing of Health Services

Our present method of payment for personal health services precludes adequate health care for the people of the United States and supports the two classes of medical care which currently exist. Prevention is not encouraged. Too few incentives for better care exist. Inefficient systems are supported and rewarded.

We therefore propose:

- *Establishment of a national health care fund to pay for all personal health care, including preventive, curative, and rehabilitative services. This is to be a mandated trust fund, so constituted as to remove it effectively from annual appropriations by Congress. It is to be financed by a progressive income tax surcharge for health.*
- *Distribution from the trust fund of all funds for personal health services to be made to the regional and local community-controlled health boards on a per capita basis.*
- *Funding through general tax funds for environmental health services, medical research, health education and construction of health facilities.*
- *Establishment of a national Department of Health with Cabinet status, which would be responsible for the administration of all health services, personal and environmental. The Department of Health is to consult regularly on basic policies with a National Health Board composed of representatives from the regional community-controlled health boards.*

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THE PHYSICIANS FORUM IS A MEMBERSHIP ORGANIZATION

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A National Health System

Proposed by

THE PHYSICIANS FORUM INC.
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The American health care system is failing. Medical care is a commodity to be bought rather than a right for all. The poor are ignored or offered charity; care for other groups is deteriorating. Physicians concentrate in affluent neighborhoods and have largely abandoned rural and ghetto areas. Other health workers receive meager wages and scant respect. A fragmented, institution-dominated system of care is unresponsive to the community and is pervaded with racial, economic and sex discrimination. The war machine is well fed but public health, hospitals, medical education and medical research are starved relative to increasing needs. For the world's most affluent and technologically advanced nation, our health indices are a disgrace.

The American people need and deserve a society that guarantees the right of all to health.

I A HEALTHY LIFE FOR ALL

The physical and mental health of the American people is dependent on the social and economic health of the nation. We recognize that ultimately the health problems of our country can be effectively attacked only with a fundamental restructuring of our society from the present private-profit, special-interest oriented system to one which is structured primarily for the social welfare of all its people.

We therefore propose:

- *The eradication of racism from all phases of American society.*
- *A guaranteed income, set at a level high enough to eliminate poverty.*
- *The abolition of hunger and malnutrition, a national disgrace in this most affluent country.*
- *The planned reconstruction and transformation of our decaying cities to provide better housing which is intelligently deployed in relation to educational, recreational, transportation and employment facilities.*
- *Opportunities for education and vocational development, available to all, with adequate opportunity for advancement commensurate with ability and achievement.*

2 A HEALTHFUL ENVIRONMENT

The industrialization, mechanization and commercialization of our country have produced hazards of grave concern to our health and well-being. Among the by-products is pollution of our physical and social environments. The federal and local governments have abdicated their responsibility; corporate interest has replaced the public welfare.

We therefore propose:

- *Rigid enforcement of existing air-pollution codes and establishment of new ones where needed, with penalties of sufficient magnitude to discourage chronic offenders.*
- *Crash research programs to produce non-pollutant engines and other technological innovations to reduce pollution.*
- *Immediate promulgation and strict enforcement of the highest safety standards for the automobile industry and strict enforcement of laws aimed at the prevention of highway accidents.*
- *Establishment of plants capable of treating and converting solid waste.*
- *Strict control of industrial wastes and hazards with the cost borne by industry.*
- *Establishment of a national consumer code with strong laws protecting the people by insuring truth in advertising, packaging and labeling of foods and drugs.*
- *Renunciation of nuclear, biological, chemical and all weapons of mass destruction; disavowal of war with its intolerable psychological and physical toll on others as well as ourselves.*

3 THE NATIONAL HEALTH CARE SYSTEM

Lack of organization and coordination of the several aspects of health care makes it impossible for people to receive adequate care. Services have been established which meet the needs of professionals, not patients. Until our health resources are appropriately structured and placed under consumer control, they will continue to fail to meet the needs of patients. The following proposals establish the foundation of a new system designed to solve the national health care crisis.

Manpower

Current methods of training health care personnel cannot begin to provide the manpower to meet the nation's immediate needs. Our country is confronted with a health manpower crisis that requires emergency measures now.

We therefore propose:

- *A massive increase in enrollment and training programs in the health professions based on the immediate expansion of existing medical, dental and nursing schools and other facilities, as well as creation of new training resources. Large scale federal financing is needed for both new and expanded facilities and training programs.*
- *Elimination of economic barriers to education and training programs through federal financial support for schools and students.*
- *Creation of new health careers, unrestricted by outmoded requirements, with special emphasis on recruitment of personnel from those sections of the population that have been excluded from the health field because of economic and racial discrimination.*

- *A large increase in the number of physicians and other health care personnel, sufficient to provide adequate services for all, including people in rural and poverty areas.*
- *The use of allied personnel to assume many of the tasks currently performed by physicians. These personnel would function as members of the health care team.*
- *Development of an adequate salary structure for all health workers so that health personnel will not be exploited by institutions or practitioners. The right to unionize should be established for all health workers.*
- *Elimination of separate state licensure requirements and establishment of national criteria for all health workers.*

Facilities and Services

The availability and distribution of health care facilities and services are inadequate in type, quantity and scope, and they do not begin to meet even the most urgent health needs of the nation. Our hospitals and medical centers are being used inappropriately; their services are provided on the basis of ability to pay or the personal interests and convenience of the professionals.

We therefore propose:

- *Creation of local and regional community-controlled health boards with responsibility for the provision of all personal and environmental health facilities and services. Each board should have its members selected by the actual consumers of health services in the area.*
- *Distribution of facilities in kind and number so that patient services are based on health needs. The types of facilities and services should include educational and preventive services, screening programs, neighborhood health centers, acute and chronic hospitals, organized home care, rehabilitation services, skilled nursing homes and all other services required to provide comprehensive care.*
- *Creation of regional networks of health facilities and services, including medical schools, hospitals, neighborhood health centers and other health services, in order to make the full range of services available to all people in the region regardless of where they live. These networks are to be under the direction of the regional community-controlled health boards.*
- *Encouragement of diversity and experimentation with new and different methods of providing care.*
- *Abolition of discrimination because of economic status, color, sex, religion or political affiliation in all facilities and services.*

Health Workers and Health Care

To assure effective and high quality personal health services, we propose:

- *Practice by personal physicians and other health workers in groups which are based in neighborhood health centers.*
- *Payment of physicians, as well as other health workers, by annual salaries commensurate with training, experience and ability.*
- *Peer and consumer review of the quality of care provided and ongoing educational experiences for all health workers, including full time postgraduate education without loss of salary.*
- *Creation of clear avenues of advancement—career ladders—for all health workers.*
- *Obligatory service for specified time periods by physicians, nurses and other health workers in rural, poverty and other deprived communities.*

STATEMENT ON THE NIXON ADMINISTRATION HMO PROPOSAL—THE PHYSICIANS FORUM INC.

After analysis of the Administration-sponsored Health Maintenance Organization Assistance Bills (H.R. 5615 and S. 1182) and the related National Health Insurance Partnership proposals (H.R. 7741 and S. 1623), the Physicians Forum finds them unacceptable. To use the words of the Forum's Statement of December 1971 on Current National Health Insurance Proposals, the Administration legislative package, in spite of the reference to Health Maintenance Organizations, "is inadequate for the support of the non-profit, salaried, prepaid, group-practice medicine which is needed in the United States." Furthermore, the Forum considers the use of the terms "Health Maintenance Organization (HMO)" and "comprehensive health services" in the context of these Bills misleading and demogogic.

The Forum's principles for a National Health System on which its December Statement was based also provided the framework for the present analysis. To understand the proposed HMO system of medical care delivery, not only were the Bills mentioned above considered, but also statements by officials of the Department of Health, Education, and Welfare and the actual implementation of HMO planning proposals which was begun, with the specific legislation still to be enacted, by the diversion of funds appropriated for other purposes. The steps in this analysis with the pertinent Forum principle stated first follows:

1. Adequate distribution of facilities and personnel in kind and number so that patient-care services are based on demonstrated health needs

Definition (abstracted from H.R. 5615): A health maintenance organization (HMO) is defined as a public or private organization which provides, either directly or through arrangements with others, health services to individuals enrolled with such organizations on a per capita (or per family) pre-negotiated prepayment basis; health services are those which a defined population might reasonably require to be maintained in good health, including at a minimum: ambulatory physician care and outpatient preventive medical services, inpatient hospital and physician care and emergency care, the organization to have arrangements for assuring its members prompt and appropriate services meeting quality standards established in accordance with regulations of the Secretary of Health, Education, and Welfare.

The bills encourage the location of HMO's in medically underserved areas, both urban and rural, by financial aid in the form of grants, contracts, loans and loan guarantees; but these are also available for HMO's in more favored areas.

Since the state and local health planning agencies will be expected to investigate an advise on the need for a facility in a proposed area, there is the possibility that their input will have an effect. On the other hand, spokesmen close to the Administration talk of choices among competing HMO's and other forms of health care delivery as a necessary ingredient of the strategy. Whether this can be reconciled with rational planning is open to question.

The Health Manpower Training Act of 1971 contains some provisions that could be favorable to recruitment of physicians into HMO's in underserved areas, primarily those calling for loan forgiveness and scholarships in return for a period of work in such areas. However, past experience with financial "forgiveness" incentives has not been very successful, possibly because of competition from the potential earnings in high income metropolitan areas.

As for providing patient care services sufficient to meet demonstrated needs, failure is written into the HMO Bills. Not only are the mandatory services not comprehensive (dental care, psychiatric care and drugs, among others, need not be offered), but the quantity of services can be limited by the size of the prepayment package purchased by the individual. Even with the concurrent passage of the Nixon National Health Insurance Partnership Act, which provides for an HMO option, this would still be so. It is, in fact, actually mandated in the Act for low income families covered under the Family Health Insurance Plan by limits on the number and kinds of services which are reimbursable. Further, the general emphasis in the Bills on cost-cutting could lead to many distortions and is likely to adversely affect the quality, quantity and types of medical services rendered, whether these are medically indicated or even legally required.

2. Creation of local and regional community-controlled health boards with responsibility for the provision of all personal and environmental health facilities and services

Community boards are not provided for even in an advisory capacity. Relevant grievance procedures contained in the National Health Insurance Partnership Act indicate concern only for overcharges to the consumer and none for the quality of the care delivered. The Act provides for "review" of grievances amounting to more than $100 and for judicial hearings in matters of more than $1000, obviously applying to services not considered by the HMO to be included in the prepayment package, but which the consumer might consider to be covered. No provision relating to environmental conditions is contained in any of the Bills under consideration.

3. Practice by personal physicians and other health workers on a salaried basis in groups which are based in neighborhood health centers

Here we must emphasize that an HMO is not necessarily a group. In discussing HMO's government officials are fond of name-dropping "Kaiser-Permanente" and similar successful group-practice organizations and lauding their virtues to suggest a relationship, but reference to the definition reveals that all an HMO is required to do is "arrange" for services. While pluralism may be a valuable characteristic, in this case it is blown up to monstrous proportions. An HMO may be public at any level, Federal, state, local, regional; non-profit private, including consumer and neighborhood sponsored groups; hospital and medical school organizations, group or non-group; physician groups; medical society foundations which are associations of solo physicians and not groups at all; and Blue Shield and Blue Cross insurance associations; and finally profit-making private organizations under a variety of sponsorships, singly or in consortiums: commercial insurance companies, electronic and industrial firms, drug houses, banks, management companies, and so on. Physicians in these organizations may be full-time or part-time, paid by salary, partnership share or fee-for-service. The HMO may give most of the health services directly or contract out for them, they may operate from an institution, an ambulatory health center, a neighborhood health center, a number of scattered centers or from solo private offices. A glance at the first 52 planning grants to HMO's indicates that almost all of these varieties are at present in gestation and may eventnally come to fruition.

The above list makes it clear that there will be several types of HMO's that are not groups; that salary will not be the only method of remuneration; that not all HMO's will be neighborhood centered and that in some kinds of HMO's care may be delivered through personal physicians and in others there is little likelihood of this.

4. Peer and consumer review of quality of care provided, and continuing education for health workers of all types

Peer review, the effectiveness of which is very uncertain, is provided for under the National Health Insurance Partnership Bill through Professional Standards Review Organizations of local physicians to assess the quality and appropriateness of services. The only way consumers could conceivably affect quality would be by exercising their market power by mass withdrawals from the HMO; the Administration seems to believe it can rely on market relations to bring forth and preserve the best. The Secretary of HEW has the right to inspect, evaluate and regulate which, if vigorously exercised through Federal or state agencies, could be effective in monitoring the quality of services.

As noted previously, manpower legislation already enacted offers loans to health professions students; but there is no specific provision mandating on-the-job, part-time continuing education or education for advancement up the ladder.

5. Obligatory service for physicians, nurses and other health workers—who should not have to pay personally for their training—in rural or poverty areas of medical need

None of these requirements are fully met. As referred to above, loans for health-professions education are available and could be partially redeemed by service in underserved areas. There is no obligation to render a period of service in areas of medical need.

6. Payment for all personal health care through an equitably financed national health fund, to be a mandated trust fund, so constituted as to remove it effectively from dependence on annual appropriations by Congress

The HMO Assistance Bills contain no provisions for financing the prepayments required of enrolled consumers. The methods of financing health care under the National Health Insurance Partnership Act, which, as previously mentioned, could cover HMO services, are almost as various as the types of HMO's and perhaps more multifaceted. For employed workers, both the employer and the employee contribute for the purpose of purchasing private health insurance. Since the employer's contribution is tax-deductible, to that extent the insurance is subsidized from general tax revenues. Deductibles and coinsurance are imposed on the employee in addition to his initial contribution until medical expenses of $5000 in one year are incurred, when family cost-sharing is forgiven for a period of three years. Poor families with children, not covered by a required employer plan, who are in the lowest income class would have their premiums subsidized from general revenues; for the upper income classes among the poor (up to $5,000 income), the subsidies would be reduced by significant deductibles and coinsurance; poor families without children are not covered at all. (Provision for paying HMOs under Medicare for those who elect to obtain their care through them will be possible if H.R. 1 is enacted.) Non-employed people with resources could purchase insurance providing medical care from HMOs.

In sum, the Administration Bills do not provide for unified or equitable financing of health care; deductibles, copayments and coinsurance are widespread; a relatively small proportion of the funds comes directly or indirectly from general tax funds with, of course, no mandated trust fund. A significant proportion of the population is left out of the system (even employed people whose employers must offer them a plan could refuse it) and, lastly, the means test which the Forum has found intolerable must be retained to sort out the poor families into different income classes.

7. Establishment of a National Department of Health with full Cabinet rank

This is not contemplated in the Bills.

To all of the above, additional observations should be made:

1. The Nixon-HMO-Insurance-System is fragmented and pluralistic throughout: the system is broken up among a variety of Bills; some of the HMO types have built-in fragmentation of health care; eligibility under the insurance plan is a loop-holed and patchwork affair; medical care is not offered to all the people; what is offered retains all the features of our present multi-class system.

2. The HMO plan, in itself, is not economically viable. Since loans and grants to assist with operational costs would be limited to three years, HMOs in currently underserved areas could hardly become financially self-sufficient. Also, will private HMOs want to make any cash investment (10% is called for) in a severely depressed area? It is indeed questionable whether an effective and satisfactory chain of HMOs providing first class medical care could be founded at all without the concurrent establishment of an equitable, truly national financing mechanism.

3. Comprehensive services are not mandated and social services are completely omitted (except, it appears, in relation to enforcement of means tests!). Continuity of care is favored but there is no effective mechanism for assuring it.

4. The emphasis of the HMO plan is more on cost-saving than on improved services, which it also appears to favor. The former carries a real threat to the latter. The emphasis on cost-cutting and competition invites an invasion of for-profit HMOs and encourages non-profit private HMOs to increase the difference between payments for care (income) and cost of delivery, since net income becomes inversely related to the number of services rendered and there is no mechanism for assuring that the increased income be used for more or better services. In fact, without provisions for adequately monitoring the quality of care and for educating the consumers on what they have a right to expect and giving them a meaningful role in policy-making and surveillance of care, this short-changing of the recipient of care is inevitable.

We conclude as we started: The Nixon-HMO fragmented system is unacceptable. The few positive facets of the Bills, such as the possibility of experimentation in new forms of health-care delivery and the apparent encouragement of group practice as well as the emphasis on increase of care in underserved areas, are overwhelmed by the great inadequacies described above. Even if the best of all possible HMOs were to emerge, the Nixon legislative proposals

would remain tantalizing and frustrating, for there would be insufficient economic support to keep them alive. The medical market-place, which has brought health care to its present crisis, would be retained, and the more expensive and less comprehensive medical care would continue to drive out the more efficient and more comprehensive, leaving the great majority of the population without the benefit of the services really necessary to support health maintenance in the true sense of the term.

Mr. ROGERS. Thank you, Dr. Sager, for being present and letting us have the benefit of your thinking.

The committee will go over your statement very carefully with the ideas you have advanced. We are grateful to you for presenting it. It has been most helpful.

Mr. Kyros.

Mr. KYROS. Dr. Sager, what, in your opinion, would be adequate financing provisions for continuing operations?

Dr. SAGER. Neither I nor we are experts in finance, but we had considered that a large proportion of the fund should come from general taxation and a certain small amount might come from funds such as social security types of taxes. We favor the greatest amount possible being funded through progressive taxation.

Mr. KYROS. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you so much.

I believe this concludes the number of witnesses today.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12:20 p.m., the committee was adjourned, to reconvene at 10 a.m. Wednesday, May 10, 1972.)

HEALTH MAINTENANCE ORGANIZATIONS

WEDNESDAY, MAY 10, 1972

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order please.

We are continuing hearings on proposed legislation for health maintenance organizations. Our first witness this morning will be the Health Insurance Association of America, located in Washington, Mr. Richard H. Hoffman, who is vice president and associate actuary, the Equitable Life Assurance Society of the United States, and Mr. Harry Sutton, director of health care programs, the Prudential Insurance Co. of America.

The committee welcomes you gentlemen. We will be pleased to receive your testimony.

STATEMENT OF RICHARD H. HOFFMAN, CHAIRMAN, SUBCOMMITTEE ON HEALTH MAINTENANCE ORGANIZATIONS, HEALTH INSURANCE ASSOCIATION OF AMERICA; ACCOMPANIED BY HARRY SUTTON, MEMBER, SUBCOMMITTEE ON HEALTH MAINTENANCE ORGANIZATIONS

Mr. HOFFMAN. Thank you, sir.

Mr. Chairman and members of the committee, I am Richard H. Hoffman, vice president and associate actuary, the Equitable Life Assurance Society of the United States. With me is Harry Sutton, director of health care programs, the Prudential Insurance Co. of America. We are appearing on behalf of the Health Insurance Association of America, which has a membership of over 300 insurance companies that write approximately 80 percent of the health insurance written by insurance companies in the United States.

Mr. Sutton speaks as a member of the Health Insurance Association of America's Subcommittee on Health Maintenance Organizations, of which I am chairman. Mr. Sutton has been instrumental in exploring new approaches to delivery and financing of health care for the Prudential, as have I, as chairman of the Equitable's Committee on Health Care Developments.

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We welcome the opportunity the committee has afforded us to discuss our experience with the health maintenance organization concept and to present our views on the legislative proposals pending before you, especially H.R. 11728, which Representative Roy has introduced in cooperation with your distinguished chairman and other members of this committee.

INSURERS ARE ON RECORD

You gentlemen are well aware that the HMO idea is not new to us. In point of fact, the leading health insurers of this Nation have been on record for some time on this topic, and as we have testified before, many of us are deeply involved in the development of HMO's, for we have felt an obligation to test out any ideas in our areas of competence which seem to hold promise of getting at the pressing task of improving the Nation's health care delivery systems. Companies which have become involved find it to be a sobering experience, but also find that they are gaining valuable insights into the practical organizational, management, and financing aspects of the various health maintenance and ambulatory care approaches.

Mr. Chairman, in testimony last December 1 before the Subcommittee on Health of the Senate Labor and Public Welfare Committee we described our experience and outlined eight lessons insurance companies have learned. An updated summary of this experience is attached as an appendix.

Our experience led us to say in our December testimony that "insurance companies have taken a considerable and active interest in this HMO concept because it seems to us that it is potentially an important means of bringing about improvements in health care delivery, encouraging more efficient use of available manpower, improving access to care, and stimulating the effective use of less costly forms of care." [1]

In spite of the potential, we doubt if anyone really feels that an HMO approach, however defined, will by itself solve all of the Nation's health care problems. Our experience as health insurers over many decades, and our more recent specific explorations into many facets of health care delivery, have brought us to the acute realization that there is no one-way approach to better health care.

The need is for the development of a multifaceted delivery system which can work to stimulate innovation, produce better health services, and lower costs. It should include all varieties of health maintenance and ambulatory care services, including prepaid group practices, medical foundations, and fee for service practice.

Paralleling a pluralistic and evolving health care delivery system must be a pluralistic financing and insurance system that utilizes the full resources of the Nation, private as well as governmental. The social need is so great that it makes no sense for the nation to hobble its efforts by not using all available competencies and resources. It does make sense, on the other hand, to build on present strengths and to work at the problem on a full and fair cooperative basis.

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[1] Statement of the Health Insurance Association of America on health maintenance organizations presented before the Subcommittee on Health of the Senate Labor and Public Welfare Committee, December 1, 1971.

BROAD STRATEGY NEEDED

We believe that a broad and comprehensive strategy should be developed that deals with the full spectrum of problems in the health care field. At a minimum, that strategy should include:

1. Aggressive encouragement of ambulatory and primary care services, including group practice, medical foundations, and other forms of HMO's.
2. Incentives to increase and motivate manpower—not only physicians, but allied personnel as well.
3. Effective support of comprehensive community health planning, with strong consumer participation.
4. Comprehensive health insurance available to everyone, regardless of economic or social status or geographic location.

These, it should be noted, are the principal building blocks of the proposed National Healthcare Act (H.R. 4349 and S. 1490) supported by the Health Insurance Association of America.

HMO'S NEED FEDERAL LEGISLATION

Clearly in developing this strategy for better health for all, the HMO concept ranks high although as we mentioned earlier it can only play a part, although a significant part.

The record shows that development of effective forms of health care delivery is difficult. Experience has demonstrated this is particularly so with prepaid group practice largely because it requires new lifestyles for both providers and users. Furthermore, there are problems in finding and preparing skilled managers and administrators, and in attracting—and holding—medical staff. Marketing is not easy, for the presumed advantages of organized group services are not always as readily apparent to consumers as to the organizers.

More often than not these difficulties, and especially the assembling of a sufficient number of interested enrollees to form a viable group, cause extensive delays in reaching the financial break-even point. Finally, there are construction needs which require financing and amortization. So, however one looks at it, this is a costly and risky business—and it is a business albeit a social business—that necessarily must balance income with outgo.

Consequently, we believe that in the public interest the overall strategy concerning HMO's should start with a clear commitment to stimulate their growth. To do so, we believe it will be essential for government to provide financial assistance, and to keep open opportunities for participation by the private sector. Federal legislation also is needed to remove existing barriers in State law.

Federal legislation, we believe, should be carefully constructed to encourage the growth of HMO's, and to give them a fair chance to compete within the entire health care system in the interest of improving access, enhancing quality, and reducting costs of health care.

Federal legislation should be flexible, but not inhibiting, permitting variations in the structure of HMO's subject to minimum requirements. This should primarily relate to output and encourage all types of responsible organizations to become involved.

Let me underscore that term, "responsible organizations" because we must all face the hard reality that any activity like health that in-

volves public and private expenditures of over $200 million a day is subject to possible abuse by misguided and/or opportunistic people.

Clear statements of purpose and expectation, standards of performance, and defined processes of accountability are essential and, in our view, should be applicable to any sponsor or participant group regardless of its source of funds or formal organizational structure.

FORMS OF FEDERAL FINANCIAL ASSISTANCE

The HMO development process can be thought of in four stages each of which require some form of Federal financial assistance: (1) planning agency approval and feasibility studies; (2) initial organization and plan development; (3) getting underway—the "start up" period to the break-even point; (4) facilities design and construction.

1. PLANNING AGENCY APPROVAL AND FEASIBILITY STUDIES

We propose that any Federal financial assistance for the development of HMO's in a community should require prior approval by the appropriate comprehensive health planning agencies (areawide and State). This, we feel, will help assure a greater degree of community support and provider and consumer involvement from the outset.

In view of the critical necessity of encouraging immediate action to create HMO's, modest grants and/or contracts should be available to potential sponsors for necessary feasibility studies.

2. DEVELOPMENTAL SUPPORT

Initial organization and plan development should be encouraged by federally guaranteed loans. Such loans should require matching funding by sponsors of approximately 20 percent. This would provide significant leverage for Federal tax dollars and it would also provide greater incentives to the sponsors for more efficient management of the developmental process and for ultimate success of the HMO. By making the sponsor share the risk, financial stability will be encouraged. Furthermore, the developmental process should not be financed without insistence by the Secretary of HEW on defined outcomes within a definite time schedule.

Projects in poverty and underserved areas should also be eligible for grants and/or contracts.

In making Federal assistance available it would be shortsighted in terms of the goal of encouraging maximum HMO development to limit eligibility to nonprofit entities. To do so would severely retard the HMO movement and there is no evidence that it would in any way enhance efficiency or preclude the possibility of abuse. For this reason, there should be no distinction between so-called profit and not-for-profit projects—that is, taxpaying and non-tax-paying entities.

Clark C. Havinghurst, professor of law at Duke University, has noted that "one consequence of the predominantly nonprofit orientation of the (health) industry has been to free decisionmakers to maximize just about any value they choose, including in too many cases the gratification of administrators' empire-building impulses or physi-

cians' convenience and income derivable from utilization of plant purchased with Government or charitable funds." [1]

In short, the real test is not whether the HMO has utilized private funds in its formation or whether the HMO is a taxpaying and nontax-paying entity. The real test is the availability and quality of care that the consumer gets for his dollar. Furthermore, the same amount of Government funds will accomplish more if used to attract the maximum private resources to this immensely complex task.

3. STARTUP COSTS

The critical period for any new health care delivery system involving a group practice concept is the first 2 or 3 years, when more or less full-scale organization and staffing is required, but the enrolled population is still below an optimum level. This "startup" period necessitates financial underpinning to help get these infant organizations on their feet.

We believe this can best be provided through guaranteed loans along the same lines and for the same reasons we have outlined for the developmental period. In the case of projects in poverty or underserved areas the matching requirements of 20 percent could be modified by the Secretary.

To promote these three stages of HMO development effectively, we believe the Congress should authorize for the next 5 years at least $50 to $75 million per year for grants, contracts, and guaranteed loans.

4. FACILITIES CONSTRUCTION

Many HMO's will need to be housed in special facilities, most accurately described as ambulatory care centers. Thus, HMO needs should be considered as part of the larger issue of ambulatory health care center development. Here is where a basis change is needed in the physical plant of the Nation's delivery system, for it has been graphically shown that the development of ambulatory alternatives to high-cost hospital care can dramatically cut the cost of medical care. In 1 year, for instance, the Surgi-Center in Phoenix, Ariz., saved that community more than $400,000.

But an ambulatory care center (as defined in "The National Healthcare Act," H.R. 4349) is a brick and mortar medical care delivery facility with a potential for bringing its benefits to the consumer and taxpayer whether or not it is operated on a fee-for-service basis or in conjunction with an HMO.

We have recommended, therefore, that Congress make available $200 million a year for the next 5 years for the construction of ambulatory care facilities, and for conversion of existing in-patient and other facilities. The funds should be made available regardless of whether the facility is used on a fee-for-services or HMO basis in order to foster healthy competition.

However, we suggest that perhaps 40 percent of these funds be ear-

[1] Clark C. Havinghurst, "Health Maintenance Organizations and the Market for Health Services," Law and Contemporary Problems, Duke University, autumn 1970, vol. 35, issue No. 4, p. 752.

marked for HMO ambulatory care facilities. Thus an HMO could be eligible for funds both from the HMO incentive program discussed above and for the construction of an ambulatory care facility.

ELIGIBLE HMOS

In our view an HMO is distinguished from traditional forms of organization by two major characteristics:

First, the providers are so organized (typically on a group practice basis) as to be able to assume meaningful responsibility for delivering coordinated comprehensive care to the consumer in an efficient and convenient manner; and

Second, the providers have financial and other meaningful incentives to achieve balanced utilization of health care facilities and services in the interest of meeting the health needs of the participating population.

For purposes of determining eligibility for Federal assistance, we would propose the following HMO definition:

A health maintenance organization is a prepaid health care system, comprised either of a single organization or of a cooperating group of legally constituted organizations, which has as its objective the provision of health care services to a defined population on an essentially prepaid basis, and which effectively encompasses all of the following functions:

1. Marketing of the services of the system to prospective participants, and enrolling them on a voluntary basis for a predetermined period of time, generally 1 year.

2. Assumption of responsibility for providing or arranging for the provision to the enrollees of coordinated, reasonably comprehensive, quality health care services, including at least those classifications of physicians' sevices and hospital services which are generally available in the community.

3. Financing all, or all but an incidental portion, of such health care services by means of fixed periodic charges paid by or on behalf of enrolled participants.

4. Assumption of the financial risk as to adequacy of such fixed periodic charges in relation to the cost and utilization rate of all health care services provided to the enrolled participants. The providers of professional services, whether a separate cooperating organization or a subdivision of the organization, should either participate to a significant degree in bearing or sharing such risks or should operate under an incentive compensation program which relates compensation for professional services effectively to the success of the HMO in achieving its objectives.

Item 2 of the term, "reasonably comprehensive services," needs to be spelled out more explicitly. It should comprise an acceptable range of services relevant to the needs of the enrolled population, but without unrealistically mandating an exhaustive list.

Initially the benefit-services pattern should include physician services (other than esoteric procedures such as heart transplants), inpatient and outpatient hospital services, diagnostic X-ray and laboratory tests, therapeutic radiologic services, some preventive and maintenance health services, including health education of enrollees, and

emergency medical care out of the service area. To mandate minimum standards richer than these would increase the cost to the consumer so as to seriously jeopardize the ability of the HMO to compete for participants.

To allow the broadest possible program of benefits, modest cost-sharing should be permitted, although it should not be made mandatory. One specific, if relatively small, way of cost-sharing is by use of registration charges at the time a member receives services. This can be very modest—a dollar or two for the most part. Such charges are desirable as a means of reducing annual capitation premiums to the enrollee by placing some responsibility on the patient in the utilization of health services.

QUALITY SURVEILLANCE

Quality care must be the basic objective of any health care system. Therefore, there must be built into the HMO a process for continual monitoring and review to assure enrollees and the community that high quality care is being delivered.

From the point of initial exploration of feasibility of an HMO, the quality surveillance idea should be in mind. Definite proposals for its inclusion in the basic operating plan should be a requirement for approval by the Comprehensive Health Planning Agency and HEW. Continuing effective existence and operation should be a condition for governmental funding such as medicare, medicaid, FEHBA and for private insurance payments.

In the present state of the art it would appear that high quality care can best be assured by requiring that an HMO have either, within its framework or through an agreement with an outside independent review organization, an active review committee. It should be composed not only of physicians and allied health personnel of the HMO, but of disinterested physicians and allied health personnel, and assisted by representatives of the HMO's enrollees and insurance carriers.

This review mechanism should effectively determine whether the services rendered are (a) of good quality from the standpoint of professional practice; (b) appropriate and needed for the proper treatment of the patient; and (c) provided only as long as necessary within HMO and institutional settings. Standards for both ambulatory and inpatient care would have to be developed, and it is most important that the orientation be toward preventing under- as well as over-utilization. The HMO management should take effective and prompt action with respect to the committee's findings and should be responsible for maintaining the continuing education of staff.

We are also very aware from our own experience as well as observation that the success of an HMO depends on the satisfaction and hence the loyalty of the enrollees themselves. The matter of what is "satisfactory" health care is highly subjective, and evaluations necessarily differ sharply from person to person. Therefore, the matter of enrollee satisfaction or dissatisfaction is a primary and continuing test for an HMO.

We realize that the evaluation of performance and effectiveness, whether by peer review or outcomes assessment, is a complex subject

which reqiures further study with the aim of developing appropriate quality evaluation standards and techniques. To this end, we suggest the Council of Health Policy Advisors that has been proposed in the National Healthcare Act, H.R. 4349, assume as part of its general functions and duties the responsibility of conducting the necessary research to determine what kinds of measures are possible and how they can be applied to produce meaningful information for public accountability.

OPERATIONAL FLEXIBILITY

I assume, we all agree, that once an HMO has begun operations there must be assurance that it will remain competitive with other delivery systems; otherwise, it will not be able to survive.

Therefore, a federally subsidized HMO should not be required, as some have proposed, to charge the same capitation to everyone. It should have the option to do so, but it also should be in a position to at least develop capitations separately for the aged medicare enrollees, for medicaid recipients, for members of employed groups, and for others. HMO's must compete for participants within the present system where these distinctions are made.

Furthermore, an HMO should not be required to enroll applicants who are not already eligible for similar health care coverage, without some form of underwriting or limitation of benefits for preexisting conditions. Otherwise, the cost of care to the other members of the plan who prudently joined before an imminent sickness could be significantly increased because of those who wait to be sick before joining.

Another point to mention is the provision of H.R. 11728 which would have the HMO assume the full financial risk for the first $5,000 of services renedered to a member per year. We feel that any HMO legislation should not contain so specific a restriction. An HMO should be free to decide for itself the extent of its financial capabilities so long as it participates significantly in the risk.

COMMUNITY PARTICIPATION AND HEALTH EDUCATION

A vital dimension of the emerging health care system of the Nation is participation of consumers. The needs and desires of potential enrollees must be recognized in the development of HMO's.

The community should be consulted with respect to HMO development at the outset. As represented by the Comprehensive Health Planning Agency with its balanced participation of consumers and providers, the community should share in initial decisions to explore and develop HMO's and other delivery systems. This sharing should take the form of local and State level review and evaluation, and advice to HEW as to the desirability of grants, contracts, and loan-guarantees from the viewpoint of community needs and priorities.

In addition, an organized and continuing program of health education of subscribers and patients should be a basic element in any ambulatory care or HMO system. This requires that consumer health education should be built into the professional and on-the-job training of all personnel so that in day-to-day practice they can apply educational concepts as a part of the team approach to health care.

Beyond—or perhaps before—the internal HMO health education program takes hold, potential subscribers need the benefit of effective informational and educational efforts to help them make informed decisions regarding their use of community resources—to select the best form of health care for their personal and family needs, whether it be one or another HMO, ambulatory care center, private physician, or other resource. In addition, a comprehensive community effort at health education of the public should be undertaken, joined in by HMO's.

INSOLVENCY PROTECTION

In an infant industry like this, an above-average risk of failure of a plan will exist, particularly in the case of newly formed HMO's. People who have relied on the HMO for their health care must be protected against the adverse effects of such a contingency.

To guard against such failures it is important that HMO's be soundly conceived, well financed, and backed up by sufficient reserves to carry them through difficult operating periods, which most likely will occur within the early years. The involvement of an insurance carrier in an HMO arrangement could provide this backing. However, there will undoubtedly be some failures and to provide maximum protection to the participants we have two proposals.

First, the HMO should have adequate financial resources at all times to provide services that have been contractually committed even though they may not have actually been provided or paid for as of a given date. HMO's should also be required to hold a contingency reserve in an amount equal to 1½ months' capitation payments. These amounts should be held in approved investments, with the insurance commissioner of the State in which the HMO is domiciled responsible for seeing that these requirements are carried out. Should the funds of an HMO be insufficient to provide the required reserves, the insurance commissioner must be notified immediately and he would be responsible for determining whether the HMO should be declared insolvent. Alternatively, the HMO could purchase a performance bond providing the equivalent financial protection. On either basis, sufficient funds would exist to provide promised services to all participants contracted for up to the date that insolvency is declared.

The second proposal is that the HMO should be required to arrange with an insurance carrier to assume coverage of its subscribers automatically should the HMO terminate.

STATE LEGAL BARRIERS

It will not be enough to encourage development of health maintenance delivery systems by financial means, by involvement of consumers and providers, and by health education of the public. It will be very necessary also to remove artificial barriers to innovative means of delivering health services that differ from the conventional.

It is our understanding that in 20 or more States there are a variety of laws and procedures which unduly restrict sponsorship, organization and management of HMO's. To achieve needed flexibility and to allow the free flow of resources into this area, these restrictions should be overriden. There is no longer any substantive reason that only

unincorporated individuals, associations, or partnerships should provide health care services, or that the use of allied health personnel should be unduly restricted by outdated laws. There is no reason that physicians should constitute all or a majority of the governing body of an HMO. There is no reason why sponsorship should be limited to non-tax-paying organizations. Such laws merely foreclose the utilization of available and needed resources and hamper the development of the "right of choice" for the consumer.

PAYING FOR THE HEALTH CARE SERVICES OF THE POOR

Most people obtain health insurance through their place of employment, receiving the benefit of a substantial contribution toward the cost from their employer. However, there are the poor who are not employed and would not be covered by such plans, yet it is our strong feeling that every American has the right of access to quality health care without regard to economic or health or geographic status.

We have proposed, therefore, that the same minimum standards of ambulatory and inpatient health care be applicable to the poor as to the balance of the population. This can be achieved as outlined in the National Healthcare Act (H.R. 4349), by means of Federal and State subsidies for low-income persons without perpetuating second-class health citizenship.

Under H.R. 4349 eligibility for subsidies would be determined on the basis of income as reported for Federal income tax purposes. Premium costs would be subsidized by the combination of Federal and State funds on a sliding scale in accordance with the person's level of income. Those with little or no income would have the full premium paid from Government funds. This program, which would be administered on a State-by-State "pool" basis, would be underwritten by all insurance carriers. The program would provide both conventional insurance coverage and an option to join an HMO. Thus, the poor would first be provided with the means to obtain health care coverage, and then would be free to choose the health care delivery alternative in which they wished to participate.

On this basis HMO's would be able to compete in the marketplace for persons in all sectors of the population. They could accept a proportional share of the low-income population, but without jeopardizing their total operation. Protection against the cost of health care could be made and without overburdening one delivery alternative or the other with the cost necessary to finance the poor. If given a fair chance on equal terms and without any competitive advantages or disadvantages with respect to other alternatives, we are certain that HMO's and the group practice concept will show their mettle.

THE HEALTH MAINTENANCE OPTION

Consistent with the basic principle of free choice of delivery alternatives, health insurance contracts should provide a health maintenance option, that is, a choice between conventional health insurance benefit plans and HMO benefit plans, whether they are provided through the place of employment or through a Government program.

Insurance plans should be required to offer this option within each contract, where feasible.

Under the health maintenance option approach, the insurance carrier would receive the premium for the coverage from the policyholder and pay to the HMO its capitation charge for its services. To assure the lowest possible cost for individuals receiving health care from an HMO, State insurance premium taxes should not be payable on the capitation amount paid by insurers to HMO's. This would increase the attractiveness of the health maintenance option and promote participation in HMO's.

CONCLUSION

Mr. Chairman, I hope our foregoing comments have made it clear that we are in basic agreement with the overall goals and objectives of H.R. 11728. We have indicated some areas of difference, although most are matters of emphasis and priority.

We appreciate very much your courtesy in hearing us out, and we want to assure you of our willingness to discuss with you any or all aspects of this complex situation. And to sum up, I would like to repeat what we said in testimony last December.[1]

Private insurers believe that the Health Maintenance Organization concept can provide a significant contribution to the solution of the health care delivery and financing problems in the United States. As we have reported, insurance companies are devoting extensive resources toward development of better and more innovative health delivery and fiancing systems. Our experience demonstrates that we can contribute constructively in this nationwide effort and that, indeed, our participation is needed in the public interest.

We are convinced that if the nation is to move ahead toward maximum development in this field, all possible resources of interest, expertise, and financing must be employed to the full. This is not a matter in which professionals alone, nor consumers alone, nor government alone, nor insurers alone, can successfully carry full responsibility—in the most profound sense it must be a cooperative partnership effort. It is not in the public interest to discourage, either inferentially or overtly, any responsible and accountable potential participant in this effort. It is a massive task. Every responsible party should be given full opportunity to participate if reasonable results are to be assured.

Thank you, Mr. Chairman.

(Appendix A referred to follows:)

APPENDIX A

SUMMARY OF ACTIVITIES OF INSURANCE COMPANIES IN HMO DEVELOPMENT, AND EIGHT LESSONS FROM EXPERIENCE

Following is a brief "progress report" of what some insurance companies have been doing recently to stimulate development of HMO's without waiting for specific legislation, with some of the major conclusions to be drawn from the experience.

CURRENT PROJECTS

In the new city of Columbia, Maryland, the Connecticut General Life Insurance Company, in 1969, was instrumental in the formation of the Columbia Medical Plan in conjunction with the Johns Hopkins Institutions. Connecticut General agreed to advance most of the developmental costs and to assume 100 percent of the Plan's operating losses for the first five years and 90 percent of the Plan's losses thereafter.

[1] Statement of the Health Insurance Association of America on Health Maintenance Organizations, presented before the Subcommittee on Health of the Senate Labor and Public Welfare Committee, Dec. 1, 1971.

The Committee will be interested to know that thus far Connecticut General's "investment" in the Plan has amounted to $700,000. In addition, Connecticut General is providing 100 percent mortgage financing for a $6 million hospital facility which is being built in Columbia.

To aid in its future HMO development activities, Connecticut General has now formed a subsidiary. It also is in the advanced planning stages of an HMO development in Phoenix, Arizona, which is presently scheduled to commence operations in the mid-to-late 1972.

In Boston, there is the Harvard Community Health Plan. Ten insurance companies—Aetna Life & Casualty, Connecticut General. The Equitable Society, John Hancock, Liberty Mutual, Massachusetts Mutual, The Metropolitan, The Prudential, The Travelers, and Union Mutual (as well as Blue Cross)—are participating in the marketing of the Harvard Plan, and these companies also provided considerable input in the formative developmental stages of this Plan.

Washington University School of Medicine in St. Louis is the site of a demonstration project whereby an ambulatory care center has been expanded to provide more comprehensive outpatient treatment and hopefully, to reduce the need for costly hospitalization. This project has been financed by a five-year, $500,000 grant from the Metropolitan Life Insurance Company. Metropolitan also has amended applicable health insurance policies to include a Health Maintenance Option. In addition, The University and the company have set up procedures to facilitate study of potential savings to enrollees who use the University's HMO facilities. Metropolitan is also participating in the Columbia, Maryland Plan.

The Equitable Life Assurance Society is active in HMO development in several areas of the nation. In Washington, D.C., the Society provided, in 1967, the initial impetus and technical counsel that helped start The National Medical Association Foundation on its way toward creating innovative HMO-type health services, especially for black citizens of the inner cities. In Washington, Equitable provided $2.6 million in mortgage financing for construction by the NMA Foundation of a unique community health center combined with an intermediate care and rehabilitation facility. This is due to be operational this year.

Also in Washington, Equitable has provided a mortgage commitment of $2.1 million to the Community-Group Health Foundation to build a permanent facility for health care services to an underserved, low-economic area of the Nation's Capital.

In Detroit, Equitable also advanced $800,000 to finance the now-in-operation group practice center created by black physician-members of the NMA. In New Haven, Equitable put forward $1.5 million in the form of a mortgage commitment to build the primary facility for the New Haven Community Health Plan. This now is operational, and the mortgage has been taken up by a local bank Equitable also now is a participant in the Columbia, Maryland Plan.

More than a year ago, Equitable responded to requests from local physicians and community leaders in Boise, Idaho, to develop a prepaid group practice plan on a broad community basis. After extensive explorations, Equitable offered to provide staff and start-up funding for an HMO approach. Subsequently, an HEW "experimental systems contract with HMO components" was awarded under which Equitable has the prime responsibility for the development of an HMO for Treasure Valley, involving rural as well as urban areas. All elements in the Boise community are involved—physicians, hospitals, the Regional Medical Program, the comprehensive planning agencies, Boise State College, business and labor, and the local, state, and federal governments.

In Minneapolis-St. Paul, Equitable served as a catalyst in stimulating a cooperative effort in conjunction with other carriers, hospitals, physicians, major business firms, and other interested groups in the community to develop a city-wide HMO system that will feature a variety of delivery mechanisms. This project is now in developmental stages, with costs being borne by the sponsoring firms, insurers, and foundations.

In Wisconsin, the Employers Mutual of Wausau has started a plan through which the Medical Society will enter into an HMO type arrangement to provide services for the employees of the insurance company. As this plan gains experience, it is anticipated it will expand to include the entire community of Wassau, Wisconsin.

For the past two years, the Prudential Insurance Company, in conjunction with the local medical center, is providing manpower and services in the development of an HMO to serve the 70,000 residents of Hunterdon County, a semi-rural New

Jersey community. The proposed Hunterdon County Health Plan will be managed by a community sponsored nonprofit organization, and is expected to begin enrolling subscribers in 1972. A Prudential task force also is now available to provide developmental assistance for other groups interested in establishing HMO's.

A number of other companies are in early stages of development of several types of Health Maintenance Organizations. For example, Aetna Life and Casualty is assisting several existing fee-for-service group practice clinics in various parts of the country to establish Health Maintenance Organizations. CNA/insurance has developed an HMO plan in Chicago and is in the process of enrolling participants. Liberty Mutual is playing a decisive role in the development of the Mathew Thornton Health Plan in Nashua, New Hampshire. And in California, the Pacific Mutual Life Insurance Company is participating in the early development stages of three HMO's, two of which involve new communities, and the third is country-wide and being promoted by the County Medical Society.

The John Hancock Mutual Life Insurance Company is working with one very large employer to select an appropriate location for the development of a group practice plan. They hope to have a development underway in the relatively near future.

The Kaiser Foundation Health Plans have had extensive financing from private sources. Beginning in 1962, for instance, insurance companies provided about $43 million for capital financing of the Kaiser Operations. In 1971 this was increased by $62 million to a total of over $105 million. The participating companies are Aetna Life and Casualty, Connecticut General, The Equitable Society, John Hancock, The Metropolitan, New York Life, and Northwestern Mutual.

LESSONS FROM EXPERIENCE

Insurance companies have learned a good bit from these developmental activities. It is clear that even with the best of good will, with full commitment, and with adequate resources, the development of Health Maintenance Organizations is a difficult and demanding process. Here are some of the important things:

First, there is *time*. It requires a considerable period of time—counted in years—before an HMO can be successfully planned, established and become operationally self-sufficient. The three basic components of an HMO—the consumers, the providers, and the financing mechanisms must be brought together into what is essentially a collaborative relationship. Creation of constructive interrelationships, whichever of the three components may be the primary organizing force, is a time consuming undertaking.

Second, there is *financing*. There must be assurance of adequate financial resources for planning, for facility construction, for operational deficits—the so-called "start-up" costs—and for protection against unforeseen losses in ongoing regular operations.

Insurance company experience clearly indicates that at this time the government must be one of the sources of initial capital. Just as clearly, it is a problem as to how such subsidies can be applied equitably.

Third, there is the matter of assembling the needed *managerial and administrative skills* to operate these complex systems with their legal, fiscal, professional, and community relations problems. Persons with these sensitive skills are still in extremely scarce supply, and it is apparent that serious efforts must be mounted to recruit and train personnel who can provide these resources for HMO's.

Fourth, the *benefit-services* pattern must be reasonably comprehensive and relevant to the needs of the enrolled population. It should include preventive and maintenance services, and give assurance of continuity of care. Arrangements are necessary for the provision of emergency care that might be needed outside the HMO's geographic area of operation. Also, certain supplementary benefits in addition to those provided under the group practice might be required.

Fifth, *enrollment of consumers* is, of course, basic. Insurance company experience indicates that if HMO's are to succeed, a very effective system of marketing will be required. The advantages of HMO's simply are not self-evident to the consumer who has had no experience with them. Consumers will have to be persuaded to try the HMO, and then they must experience the quality of service that is promised. This marketing is not easy and to accomplish it will call for every marketing talent and resource available. In order to speed up the process, HMO's should permit all insurance carriers to market the plan and to offer the "Health Maintenance Option."

The weight of experience thus far indicates that the principal immediate source of enrollment—in addition to public assistance categories—is employed groups and their families.

Sixth, and crucial, is *professional involvement.* Obviously, the necessary health professionals who are committed to the HMO concept must be ready to participate as and when the various aspects of the services become operational or expand. Health professionals who are open to new ways of practice must be attracted to this rather different approach to delivery of health services. This makes it particularly important that they should help to shape the pattern of services.

Both professionally and administratively there was many ways to design an organization for the delivery of health services. For example, they can be thought of in terms of the relative degree of organization and centralization of health manpower and facilities. They can be looked at in terms of professional scope of commitment to the enrolled population—i.e., whether enrollees are served on an exclusive full-time basis or part-time basis; whether the HMO provides all services; whether certain specialist services are obtained outside of the system; or whether existing facilities can be modified or expanded rather than having to always build from scratch. Experience indicates that this need for flexibility should be clearly recognized if we are to get action economically in a reasonable time span.

Seventh, experience indicates that a *Health Maintenance Option*—a multiple, free-choice approach—is essential. Insurance companies are convinced that the very existence of a Health Maintenance Option will provide a strong incentive to create and develop HMO's. For the HMO, the option helps to assure enrollment, particularly at the outset.

For the consumer, the existence of a Health Maintenance Option within the standard insurance contract makes it easy for him to select an HMO if he so wishes, but it also gives him the freedom to choose other means for obtaining his health care, or to shift from one to the other if he becomes dissatisfied.

Finally, there is the importance of *community participation.* Clearly, every effort should be made to provide a voice for the community and the consumer to be served in the planning, development, and ongoing functions of any HMO.

Furthermore, plans should not be restricted to one segment of the population of a community. HMO's should anticipate community-wide enrollment—the unemployed, the employed, the seasonally employed, and retirees. In no instance should the development of an HMO create a two-class system of health care.

It has become apparent also, that the typical sponsor of a new HMO requires assistance to deal with the problems relating to financing, risk-taking, management and administration, design of benefit patterns, and marketing and enrollment. These are areas for which insurance personnel are uniquely fitted by training and experience. These are the functions which have been performed for decades—and performed well—by insurance companies in administering group health insurance programs.

Mr. ROGERS. Thank you very much, Mr. Hoffman, for a comprehensive statement on the position of the Health Insurance Association. The attitudes and viewpoints you have expressed will be helpful to the committee.

Let me ask, in the law should we require minimum benefits to be offered by HMO's?

Mr. HOFFMAN. Yes, we think there ought to be minimum standards present in the law, but they should be minimum, "minimum standards," so to speak. They should be comprehensive enough to assure a broad range of benefits as outlined in the statement, but not so comprehensive as to price the HMO's out of the market. We could have a Cadillac product that nobody wanted to buy.

Mr. ROGERS. In other words, the physician services, I think you said, hospital services, emergency care——

Mr. HOFFMAN. Tests.

Mr. ROGERS. Radiological and laboratory tests?

Mr. HOFFMAN. Preventive services and maintenance services.

Mr. ROGERS. To what extent preventive and maintenance services? Should they have so many doctors office visits, should they have so many home visits, so many examinations? What do you recommend?

Mr. HOFFMAN. We think that there should be unlimited office visits, but perhaps with a registration charge.

Mr. ROGERS. $1 or $2?

Mr. HOFFMAN. $2 or $3. Home visits as well, with a larger charge for that kind of service.

Mr. ROGERS. How much would you recommend there?

Mr. HOFFMAN. I think $5 to $10.

Mr. ROGERS. For a home visit?

Mr. HOFFMAN. Well, it is very costly, as everyone appreciates to have physicians travel.

Mr. ROGERS. It is to discourage home visits, but allow them if necessary?

Mr. HOFFMAN. Allow them if necessary. There is probably a number that strikes a proper balance. This probably needs to be tested.

Mr. ROGERS. I think if you have additional ideas on that, it will be helpful to have specifics in all of these areas in order to help the committee. What about castastrophic illness?

Mr. HOFFMAN. The benefit program should certainly provide for catastrophic illness.

Mr. ROGERS. It should provide?

Mr. HOFFMAN. In some cases, the HMO might have to contract out for the catastrophic services, like kidney dialysis or transplants or that type of procedure.

Mr. ROGERS. Certainly mental health?

Mr. HOFFMAN. Mental health in hospital care should be a part of the required services. As far as ambulatory mental health is concerned, I think we have to be careful of that. On the one hand, although it is desirable to provide a significant degree of mental health care; on the other hand, we know it can be very, very expensive. I think this should be kept in mind.

Mr. ROGERS. Dental care?

Mr. HOFFMAN. Dental care, we feel, should be optional at this time. Again, if dental care were a requirement, the price would have to be increased so much as to make it unattractive to a large number of people to whom you want to offer the option.

Mr. ROGERS. Health education: What should we require on health education?

Mr. HOFFMAN. On health education, we think people should be helped to understand how to use the health care system and HMO's better. They should be given instructions as to how to maintain health.

Mr. ROGERS. Let me ask you this: Would your industry object, or what would be the feeling if we were to also require all health policies to have these same minimum benefits?

Mr. HOFFMAN. This is the position that we have taken in the National Health Care Act. So we would heartily support such an idea.

Mr. ROGERS. You think this is a reasonable approach?

Mr. HOFFMAN. We believe that all health policies and HMO's should be subject to the same minimum standards. In fact, I might expand on that a little bit and say in almost every respect, not only minimum benefits but other requirements like quality surveillance and so on, we should be applying the same responsibilities and tests to both the conventional system, the HMO system, or any other system, and in that way improve the entire system of health care delivery. At the same time, HMO's could be a strong factor in such a program.

Mr. ROGERS. Because in carrying out your thoughts this committee may introduce legislation to go ahead and do exactly that, and I think we can do it in these hearings with HMO's. So that goal that the industry supports, too, could be accomplished very quickly.

Mr. HOFFMAN. On that basis, I would heartily recommend that the minimum standard benefits included in the National Health Care Act be seriously considered by your committee. If they were adopted, then I would say the minimum standard benefits for HMO's ought to be the same.

Mr. ROGERS. I think it would be helpful for people to have a choice, because at least they would be covered by minimum benefits; and then the competitive system could bring in additional benefits, I presume.

Mr. HOFFMAN. That is correct.

Mr. ROGERS. I think it would be helpful if you would submit to us—I know you have given us general outlines, but as specifically as you can—any suggestions you may have as far as they would apply to the insurance industry.

Mr. HOFFMAN. We will be very happy to do so.

(The following information was received for the record:)

MINIMUM STANDARD BENEFITS OF A COMPREHENSIVE NATIONAL HEALTH INSURANCE PROGRAM

We are in favor of minimum standard benefits as part of a comprehensive national health insurance program that deals with both the delivery and financing aspects of the nation's health care problems. We believe that the best approach would be the one outlined in the National Health Care Act, H.R. 4349, which uses tax incentives to encourage the adoption of such minimum standards on a phased-in basis[1] to allow sufficient time for the development of manpower and facilities needed to provide the services being insured. The minimum standards we recommend are:

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[1] Priority I benefits would become effective 12 to 18 months after enactment of the bill. Priority II benefits would phase-in three years after Priority I benefits come into effect, and Priority III benefits would phase-in three years after Priority II benefits come into effect. The President could defer phase-in of Priority II or Priority III benefits by Executive order if services and facilities required to supply the benefits are not available.

Benefit	Copayment	Priority
1. Charges made by a licensed physician for professional services rendered—		
(a) At a physician's office (by the physician or, at his direction, by his staff of nurses (R.N.) and allied health professionals)—		
(i) For diagnosis and treatment of 1 or more conditions (except pregnancy) other than by surgery or radiation therapy—	$2 per day per physician's office	I
(A) On the first 3 days of such care per year per individual	do	II
(B) On the next 3 days of such care per year per individual	50 percent	III
(C) On any additional day of such care per year per individual:	$2 per day per physician's office	III
Mental conditions	do	I
All other conditions (except pregnancy)		
(ii) For 1 or more surgical procedures for treatment of conditions (other than pregnancy) including any charge for anesthesia or the rendering thereof, for casts, dressings, or other surgical supplies, and for dressings or other surgical supplies, and for postoperative visits—all days of such care per year per individual.	$2 per day per physician's office	I
(iii) For radiation therapy for treatment of conditions (other than pregnancy) by X-ray or radioactive materials including charges for such materials—all days of such care per year per individual.	None	I
(iv) For diagnostic X-rays, laboratory tests, electrocardiograms and other diagnostic tests required in connection with care described in (i), (ii), (iii) above and (b) below.	do	II
(v) For counseling on birth control and for fitting of contraceptive devices		
(vi) For pregnancy—see item 9 below		
(vii) For periodic health examinations, including immunizations—	None	I
(A) for infants under age 5 (well-baby care)—during first 6 months following birth—first 6 such exams	do	II
During next 18 months—first 6 such exams	do	III
During next 3 years—first 3 such exams	do	III
(B) for individuals ages 5 through 39—1 such exam every 5 years	do	III
(C) for individuals ages 40 and over—1 such exam every 2 years	20 percent	II
(viii) For physical therapy	do	III
(ix) For speech therapy		
(x) For eye examinations—see item 5 below		
(b) At the individual's home or elsewhere (other than at a hospital, extended-care facility, or the physician's office) by the physician for diagnosis and treatment of—	50 percent	III
(i) Mental conditions	$5 per day per physician	III
(ii) All other conditions (except pregnancy)		
(c) At a hospital, by the physician for the diagnosis and treatment of 1 or more conditions other than pregnancy:	$2 per day (applicable only to the charges of attending physician).	I
(i) During first 30 days of the confinement	$5 per day per physician	II
(ii) During 31st through 120th days of the confinement	$5 per day per physician	III
(iii) During 121st through 300th day of the confinement		I
(iv) In any day of the confinement for which no hospital benefit is payable under item 6(a) below		
(d) At an extended-care facility by the physician for the diagnosis and treatment of 1 or more conditions other than pregnancy:	$2 per day (applicable only to the charges of the attending physician).	
(i) During first 60 days of confinement		
(ii) During 61st through 120th days of the confinement	$5 per day per physician	I
(iii) During 121st through 180th days of the confinement		
(iv) On any day of the confinement for which no extended care benefits is payable under item 7(a) below	None	
2. Charges by a qualified independent laboratory for laboratory examinations prescribed by a licensed physician pursuant to his rendering the services described in item 1 (a) (i), (ii), (iii) and item 1(b) above.		

Benefit	Copayment	Priority
3. Charges by a licensed dentist for professional services rendered either by the dentist or at his direction by his office staff of allied health professionals for—		
(a) Annual oral examination (including prophylaxis and dental X-rays)—		
(i) Individuals under age 19	do	II
(ii) All others	do	III
(b) Amalgam fillings, extractions, dentures for—		
(i) Individuals under age 19	20 percent	II
(ii) All others	do	III
(c) Other dental care (except orthodontia)	50 percent	III
4. Charges for the following when prescribed by a licensed physician:		
(a) Drugs requiring a prescription, and insulin, digitalis, and such other life-preserving nonlegend drugs as are specified by the Secretary of Health, Education, and Welfare.	$1 per prescription	II
(b) Contraceptives for birth control	None	II
(c) Prosthetic appliances	20 percent	II
(d) Services of physical therapist	do	II
(e) Services of speech therapist	do	III
5. (a) Charges for eye examinations by a licensed physician or optometrist for—		
(i) Individual under age 19—no more than 1 examination per year	None	III
(ii) Individual age 19 and over—no more than 1 examination every 3 years	50 percent	III
(b) Charges for eyeglasses prescribed by a licensed physician or optometrist:		
(i) Individual under age 19—no more than one set of frames and lenses every year	None	III
(ii) Individual age 19 and over—no more than one set of frames and lenses every 3 years	50 percent	III
6. (a) Charges by a hospital for ward or semiprivate accomodations and for ancillary services used while the individual is confined as an inpatient for one or more conditions other than pregnancy:		
(i) First 30 days of the confinement	$10 first day and $5 per day thereafter	I
(ii) 31st through 120th days of the confinement	$5 per day	II
(iii) 121st through 300th days of the confinement	do	III
(b) Charges by a hospital for services rendered by it on a non-inpatient basis	Same as for equivalent services under item 1(a).	
7. (a) Charges by an extended-care facility for ward or semiprivate accommodation and for ancillary services used while the individual is confined as an inpatient for one or more conditions other than pregnancy:		
(i) First 60 days of the confinement	$2.50 per day	I
(ii) 61st through 120th days of the confinement	do	II
(iii) 121st through 180th days of the confinement	do	III
(b) Charges by an extended-care facility for services rendered by it on a non-inpatient basis	Same as for equivalent services under item 1(a).	
8. Charges by a home health agency for home health services rendered by it under a plan except for services rendered in connection with pregnancy:		
(i) First 90 days of the plan	$2.50 per day of services rendered.	I
(ii) 91st through 180th days of the plan	do	II
(iii) 181st through 270th days of the plan	do	III
9. Pregnancy—Charges for any of the services rendered to in items (1), (2), (6), (7), and (8) above when such services are rendered in connection with a pregnancy and any complications thereof during the period commending with the date of inception of the pregnancy and ending with the 90th day following termination of the pregnancy.		

Mr. ROGERS. What would you say the overall assets and resources of your industry be, the 300 that you estimate?

Mr. HOFFMAN. When you ask that, do you mean the total assets of the companies?

Mr. ROGERS. Yes.

Mr. HOFFMAN. Because many of the companies are life insurance companies; and although we have significant assets in the life insurance business, they are not very large in the health insurance business.

Mr. ROGERS. I presume that Prudential, for instance, does both. This is what I was thinking.

Mr. HOFFMAN. You are thinking in terms of company assets?

Mr. ROGERS. Yes.

Mr. HOFFMAN. I don't have a figure offhand, but it certainly must be well over a hundred billion dollars. May we submit that for the record?

Mr. ROGERS. Certainly.

(The following information was received for the record:)

ASSETS OF MEMBER COMPANIES FOR 1970

The total assets of member companies of 1970 (the last year for which data is available) came to about $210 billion. The vast majority of these assets arise from the life and pension business of our companies and represent funds accumulated to pay benefits and cash redemption values to the life and pension policyholders. Funds set aside for present and future benefits to the policyholders of our member companies, for which they are contractually committed, amount to about 93% of the above assets.

Mr. ROGERS. Now, how much of those resources would you estimate are being spent on research for improvement of health care or for improving living conditions of the American people? What would you estimate would be your percentage?

Mr. HOFFMAN. It would be very difficult for me to estimate because I am not familiar with what companies other than my own are doing. I know in our case, a high-level committee of the Equitable has been studying how we could improve the health care delivery system and how we could develop the HMO's. Over the past 3 years, we have spent, I would say, over a half million dollars.

Mr. ROGERS. I wonder if you would let us know. I think it would be helpful to put it into perspective, what is being done by the insurance industry with respect to health, health education, health research, health programs, to improve the life of the American people as far as their health is concerned. I know when we got into this problem with the automobile industry, for instance, once they looked at it, they felt much more could be done by the industry itself in research and in some leadership. When people are paying for life insurance, it seems to me that a very active role should be played by an industry where resources are considerable. I was anxious to look at that and see.

Mr. HOFFMAN. We will try to get a figure. We certainly agree such research is important.

(The following information was received for the record:)

SOCIAL RESPONSIBILITY IN HEALTH AREA OF THE INSURANCE INDUSTRY

Insurance companies have long since ceased to regard themselves solely as "conduits for the flow of money." This was dramatized, most recently, by a Conference on Corporate Social Responsibility attended by nearly 100 heads of

insurance companies. The executives at that time voted to expand social concerns into a number of areas, health among them.

One specific result of the Conference was the establishment of a Clearinghouse on Corporate Social Responsibility. The Clearinghouse will assist companies to better fulfill their social responsibilities in health, housing, job training, environment, and corporate giving.

With reference to the health area, this action reflects the growing involvement by health insurers in programs that go beyond the financing of health care to improving the organization and delivery of services—through recognizing that the single greatest contribution of insurers to the better health of Americans remains removal of financial barriers to these services.

Our statement clearly illustrates the active interest of insurance companies in experimental HMO programs. In addition, it is significant to note that more than $262 million out of the total commitment of nearly $2 billion under the urban investment program of the life insurance business has been for health facilities in low-income urban areas—such as health centers, hospital additions, nursing homes, professional buildings, rehabilitation clinics, and the like. The overall purpose of this program has been to channel investment funds into the restoration and improvement of the cities.

In all, insurance company investments in health care and related facilities totaled $2.3 billion as of July 1970 with an additional $546 million in outstanding commitments.

In 1970, the Institute of Life Insurance and the Health Insurance Association of America surveyed 649 life and health insurance companies to determine, in part, their contributions to health facilities and services. Some 336 responding companies reported a total of $1.6 million in contributions to medical schools and scholarships for the period 1965–1969, and an estimated $500,000 in 1970.

Also, the Life Insurance Medical Research Fund, over a period of 25 years had contributed over $26 million for research grants and fellowship awards.

A substantial number of companies contribute to voluntary health agencies in such categories as heart disease, cancer, diabetes, cystic fibrosis, mental illness, epilepsy, eye disease, alcoholism, cerebral palsy, and others.

Companies also provide developmental grants to national organizations for fellowships and medical teaching and research programs, including the National Fund for Medical Education, the National Fund for Graduate Nursing Education, and the Education, Research Foundation of the American Medical Association, the National Fund for Dental Education, and the National Medical Fellowships, the latter two giving special attention to minorities.

A number of companies contribute directly to local medical centers or other community health institutions for specific research and teaching projects.

The foregoing statistics do not reflect the substantial commitment of the insurance business in terms of the manpower and related funds devoted to its ongoing innovative activities which cover such areas as comprehensive health planning, health care cost control and quality assurance programs, licensure laws as they pertain to the health professions, health care foundations, and health maintenance organizations, all of which are in the public interest. Industrywide information as to the dollar value of such commitment it not available. However, it is significant to note that the HIAA has allocated for its current fiscal year approximately 40% of its budget in these areas.

Mr. HOFFMAN. I think I should point out that any costs of performing that type of activity, unfortunately, has to be passed on to our policyholders.

Mr. ROGERS. Well, you do have considerable profit.

Mr. HOFFMAN. Not in the health insurance business.

Mr. ROGERS. I think in the overall. Some of it is life and some of it is health. As I recall, there are significant investments in real estate that bring in large profits that are not necessarily geared to health insurance. I am sure it would increase the assets of the company.

Mr. HOFFMAN. Let me point out that in the case of my company and Mr. Sutton's company, we are mutual life insurance companies and we have no profits.

Mr. ROGERS. No profit at all?

Mr. HOFFMAN. We have no stockholders. The company is effectively owned by its policyholders. As a matter of fact most of these assets we were referring to earlier are really their money which we are holding in the form of reserves for their future benefit.

Mr. ROGERS. You do not hold any reserves for increased salaries or increased buildings or increased investments? You don't do any of that? It is all just paid out to the shareholder?

Mr. HOFFMAN. In our operation we pay any excess of what policyholders have paid us in premiums over the cost of their insurance coverage back to them in the form of a dividend. Now, we do keep small amounts that we put into special reserves, contingency reserves and surplus, to guard against unforeseen contingencies.

Mr. ROGERS. Do you make investments in real estate or businesses?

Mr. HOFFMAN. We certainly do. The return on that is passed, most of it, on to the policyholders.

Mr. ROGERS. I think it may be well for us to get into a little bit of this.

Mr. SUTTON. For example, in our company between 90 percent and 100 percent of our total gain from operations is paid out in dividends each year, and it is substantial, nearly $850 million a year.

Mr. ROGERS. I think it would be good to spread this on the record.

Mr. SUTTON. I might mention, too, we have looked at some of these figures in our own company. While it may sound small in relation to our assets, we have spent several million dollars a year on various types of research, comprehensive health planning, grants to United Fund Organizations, and just plain grants. I think tens of millions of dollars a year are invested in health facilities of one kind or another including HMOs.

Mr. ROGERS. This could be so, and I would like the committee to know what is being done and whether it is commensurate with what should be done. So if we could get those figures supplied for the record, I think it would be helpful.

(See "Social responsibility in health area of the insurance industry," p. 905.)

Mr. ROGERS. Dr. Roy?

Mr. ROY. Thank you, Mr. Chairman.

What percentage of Americans have some kind of health insurance?

Mr. HOFFMAN. According to our figures, it is over 90 percent.

Mr. ROY. What percentage of the health care dollar is paid for by third party carriers, by third party payers?

Mr. HOFFMAN. That is a complicated question because in answering it we need to take into account in the total health bill expenses like construction and so on, which cannot be covered by insurance policies. We have to take account of items which are included in the total national health bill, which are obviously not insurable, like toothpaste and aspirin and the like. If you do all that I believe that the figure is over 50 percent. I would like to verify that.

Mr. ROY. I have been doing you an injustice. I had some figures out of, I believe HEW, that indicate 38 cents out of each dollar is paid by Government, 38 cents out-of-pocket, and 24 cents by third party carriers. Do you think this is probably incorrect?

Mr. HOFFMAN. Excuse me. I was counting what the Government paid as part of the insurance coverage.

Mr. ROY. Thirty-eight plus 24 comes to 62 percent.

Mr. HOFFMAN. Again, if we may submit the figures, because we have that all worked out.

Mr. ROY. Could those figures be submitted, Mr. Chairman?

Mr. ROGERS. Yes.

(The following information was received for the record:)

TOTAL NATIONAL HEALTH EXPENDITURES BY GOVERNMENT AND THE PRIVATE SECTOR FOR PERSONAL HEALTH CARE, HEALTH RESEARCH AND CONSTRUCTION

During fiscal year 1970–71, U.S. national health expenditures totaled $75 billion of which $47 billion (62%) was spent by the private sector and $28 billion (38%) by government at various levels. Total expenditures included monies expended by government and the private sector for both personal health care ($69 billion) as well as for health research and construction ($6 billion).

Of the $47 billion spent by the private sector for health care in 1970–71, $41 billion was spent by consumers for personal health care. The remainder was spent, privately, for health research and construction and for health services provided through in-plant hospital-medical facilities.

Private health insurance benefits during fiscal year 1970–71 totaled $16.6 billion or 41% of consumer expenditures for personal health care. This proportion was an almost four-fold increase over the 11% of consumer expenditures for personal health care which was reimbursed by private health insurance twenty years ago.

During 1970–71, 73% of consumer expenditures for hospital care was reimbursed by private health insurance, and 48% of expenditures for physicians' services was reimbursed. The comparable percentages, twenty years ago, were, respectively, 32% and 11%. The foregoing relationships of private health insurance benefits to total consumer spending for personal health care are of some interest but do not adequately portray the effectiveness of private health insurance in reimbursing expenditures encountered by insured persons for items of health care which they have chosen to insure. Thus, recent studies of the Health Insurance Association of America indicate that under group policies, approximately 80% of the charges incurred by insured persons, for the kinds of expenses which they have chosen to insure, are reimbursed. Over half of all such claimants are reimbursed for at least 90% of the charges, and about three out of four collect at least 70%. These proportions vary from 86% for the cost of hospital care to 77% of the cost for surgery to 61% of the cost for prescription drugs.

At best, private health insurance is a low-profit business. In recent years, our profits in the aggregate on group health business have been nonexistent and have averaged only a little over two percent on individual health care business.

Group marketing and administrative costs, according to a recent study of the Association, averaged only eight percent of premiums, exclusive of the 2.1% paid in State premium taxes. This is an overall average made up of group plans with less than 25 lives and jumbo cases involving 500 or more employees. For the plan which covers Federal employees, administrative costs have averaged less than four percent of premiums including a modest profit.

Mr. HOFFMAN. As far as the amount of insurance benefits paid in comparison to the health costs of an insured individual, for which he has bought insurance, the number is over 80 percent.

Mr. ROY. So your retention of the health insurance dollar is something less than 20 percent?

Mr. HOFFMAN. No. I was talking about benefits we pay compared to the individual's health cost, that is the bills that he must pay, not compared to the premium. It is how much the person's expenses are when he goes to the hospital and gets his bills from the doctor and so on, in contrast to what we pay. That is in the order of over 80 percent.

Mr. ROY. I am lost as to the discrepancy in the figures.

How many cents out of each health care premium dollar is retained by the company for administration or for profits?

Mr. HOFFMAN. In the group insurance field, which I am most familiar with, if you leave out premium taxes, it averages under 10 cents out of every dollar.

Mr. ROY. Could you point out to us any presently operating for profit HMO's?

Mr. HOFFMAN. I believe there is one on the west coast, Dr. Upjohn's HMO. I have not had a report on that but I gather they are beginning to start a successful operation.

Mr. ROY. Do you know how long that has been in operation?

Mr. HOFFMAN. I think since the end of last year.

Mr. ROY. Could you comment on the general role of profitmaking institutions in the health care industry? Nursing homes, and so on?

Mr. HOFFMAN. We think in the hospital field that profitmaking institutions are able to provide better services at lower cost than nonprofits in many cases. We see no evidence that one form is better than the other.

Our position is that all forms should be permitted. I think that we should not rule out any approach at this stage of the game when so little is known about HMO's. It is a brandnew concept, and we think that legislation should not be so restrictive as to eliminate any sector of the economy from trying to improve the health care delivery system.

Mr. ROY. Would you say that the concept of the health maintenance organization is a proven or unproven concept?

Mr. HOFFMAN. I would say it is proven in the areas in which it has been tried out—in new communities and rapidly growing communities. I don't believe it has been proven in any sense of the word as being a panacea for all of the health care problems.

Mr. ROY. I don't think anyone is looking at it in that sense.

Mr. HOFFMAN. We think it can be very helpful in many situations but I think we still have to learn in which situations and under what circumstances it can be of greatest value.

Mr. ROY. Would you say that the nonprofit HMO is presently a proven concept?

Mr. HOFFMAN. I don't think either one is.

Mr. ROY. Certainly the for-profit HMO is not a proven concept. We have had one running only since the last year. Would you agree with that?

Mr. HOFFMAN. It has only been recently that there has been sufficient interest in the HMO concept for profitmaking HMO's to be considered.

Mr. ROY. Why?

Mr. HOFFMAN. I would think that the major reason is that it has only been recognized recently that strong changes in the health delivery system are necessary. I think that a business organization would have looked at the situation and felt that most people would prefer to stay with the existing fee-for-service system—by people I mean consumers—and there would not be much of a desire on their part to participate in a HMO.

Mr. ROY. The nonprofit HMO's have been in existence for 30 years and it has been said they take care of over 6 million people. Should not one anticipate, if there is profit to be derived from this particular concept, that the for-profit HMO's would have been in there during the last 30 years also?

Mr. HOFFMAN. I think with the exception of one or two of the HMO's, and which were developed under relatively unusual circumstances, by that I mean in areas of rapidly growing population, that there has been no strong interest on the part of the consumer in the HMO approach.

Mr. ROY. What are the present incentives for private insurance companies to develop HMO's?

Mr. HOFFMAN. Because the companies recognize a need for a change in the health delivery system. We believe that this is one major way in which that might be accomplished.

Mr. ROY. If they develop for profit HMO's what is the necessary return on capital?

Mr. HOFFMAN. I would say the normal return that we get generally in our investments.

Mr. ROY. Which is what?

Mr. HOFFMAN. It depends on the market.

Mr. ROY. Can you give me a range of figures?

Mr. HOFFMAN. At the present time, I would say it is in the area of 7 or 8 percent. If the interest rates drop generally, then the normal return would drop commensurately.

Mr. ROY. Do you have any indication that there is this kind of profit available within the HMO prototype concept?

Mr. HOFFMAN. What I am referring to specifically is the return on capital investment; for example, if we were to put our money into developmental costs and start-up costs and even into facilities, we would need to get a return commensurate with normal returns, otherwise we would be penalizing our policyholders who have given us money to purchase life insurance and who expect a reasonable return on the reserves from their life insurance or pensions.

Mr. ROY. Do you have any reason to feel that for profit HMO's could bring about efficiencies that are not present in the nonprofit HMO prototypes?

Mr. HOFFMAN. Yes; I believe that for profit HMO's will have more incentive to do a better economic job in the operation and I would also say that I believe that it is important that nonprofit HMO's be competing with them, so that we will have a comparison of the two. If there are advantages to the nonprofit approach, then the profit HMO's would have to meet their competition in these respects.

Mr. ROY. Could you specify what the for profit HMO might be able to do such as the Kaiser Permanente group, or other groups similar to that, that it is not presently doing to maximize savings or profits?

Mr. HOFFMAN. For profit HMO's would bring to it better management, better administration, and I am not criticizing Kaiser in the least, but I think it is the incentives and the type of managers that have have been developed under the profit system which could add considerably to the effectiveness and productivity of a HMO.

Mr. ROY. This has not occurred during the time that there have been HMO prototypes.

Mr. HOFFMAN. No; but I am sure it will if legislation permits it.

Mr. SUTTON. If I could add a word, I think it would be wrong to state that there have not been obstacles toward the formation of any HMO. I think there have been particularly biases against for-profit in the medical care field. For example, the Blue Cross, Blue Shield organ-

izations are nonprofit. Many of the State statutes relate to providing medical services through nonprofit entities. Even medical societies lean toward nonprofit organizations. Hence there is really a built in bias in some respects against for-profit entities in this field. It is only in the last 10 years or so that there has been a big advance movement in the for-profit hospital chains which have grown quite large and big growth in the nursing care and nursing homes.

Mr. HOFFMAN. I would also like to add that at Equitable we have not even decided in our own minds whether we should, in developing a HMO, have it operate on a profit or nonprofit basis. Our position is, however, that we think profit ought to be permitted. The two HMO developments that we have been exploring we have designed in such a way they will probably end up as nonprofit operations.

Mr. ROY. Let me state that I think certainly for-profit HMO's should be permitted. I think the critical question is how much should they be assisted. Do you think they can find their way in the marketplace without governmental assistance perhaps other than preempting State laws which are presently blocking a number of HMO's?

Mr. HOFFMAN. They probably could. But I would think that we would want to promote them to the maximum extent. I think assistance like guaranteed loans would be helpful to encourage more profit-making organizations to undertake such development and those that do, to do more.

For example, in the case of the Equitable, being that this is a relatively untried area, we feel, as a responsibility to our other policyholders again that we should not risk too much in the way of funds on their behalf. Therefore, if we had guaranteed loans we would be free to undertake more HMO developments than otherwise. I certainly think that guaranteed loans would be very helpful to encourage profitmaking HMO's. In the case of grants and so on, I can understand your position.

Our recommendation is that grants be provided only for feasibility studies and those are modest amounts. That again is simply to encourage all types of organizations to undertake HMO developments.

Mr. ROY. I haven't seen any private money really flowing in this area. I wonder what would be critical to implement private money flowing into the area. I hope that which is critical is not indeed an unwise action by the Government with regard to finances.

Mr. HOFFMAN. No. I would say that private money certainly as far as insurance carriers are concerned will flow into it. I think that can be enhanced by guaranteed loans and small feasibility grants.

Mr. ROY. Do you have any idea how many HMO's we might see developed at the end of the decade by Blue Cross, Blue Shield and HIAA?

Mr. HOFFMAN. That is real crystal ball gazing. I would be hopeful that our companies would be able to create, say—I am just pulling numbers out of the air here—maybe 10 or so in the next couple of years, and then gradually increase that to 25 in a few more years or something along that order.

Mr. ROY. Could the HMO's bear full risk for all services except maybe catastrophic illnesses out of their emergency reserves?

Mr. HOFFMAN. I think this is a difficult question.

I think again the legislation should be flexible in this respect. The answer should be judged in terms of the HMO, itself, and where it is going to operate and how it is going to operate. For example, in rural areas perhaps the foundation HMO is the best approach. That needs to be tried out. I don't think foundations can take all of the risks. In such cases, I think there ought to be some flexibility and that there are other like situations.

Mr. ROY. Would the reduction of risk probably equal reduction of incentive?

Mr. HOFFMAN. The minimum risk that an HMO should take should be on the physician services, I think.

Mr. ROY. I hear rather consistent testimony as to the standard benefits package. Should we perhaps require HMO's to be able to provide a broader range of services in order that these options, mental health, dental care, and so on, would be open to HMO members?

Mr. HOFFMAN. If they were options I would certainly agree. Maybe you might want to require some of them to be options. But to require them to be in every package will simply make it unattractive to the prospective participant.

Mr. ROY. Thank you.

I think your testimony is excellent. I very much appreciate the endorsement of the HMO concept by the Health Insurance Association of America and your excellent cooperation.

Mr. HOFFMAN. Thank you. We appreciate giving it.

Mr. ROGERS. Would you let us know for the record how many HMO's you think we should sponsor in effect by the figures you have recommended? You might break down those you think should be started, planning figures, development figures, for HMO's that you think will be realistic. Supply that for the record.

(The following information was received for the record:)

NUMBER OF HMO'S PER YEAR THAT GOVERNMENT SHOULD SPONSOR

We have suggested an annual appropriation of $50 to $75 million for grants, contracts, and guaranteed loans to finance the stages of: (a) feasibility studies, (b) plan development, and (c) start-up period and about $80 million for the construction of ambulatory care centers. We would estimate that 40 to 60 HMO's per year would ultimately be produced by these funds.

We hasten to point out, however, that this is an extremely tenuous estimate, principally because there is little prior experience on the rates of failure for each stage of development. The rate of failure is particularly important under our recommended approach since most of the required funds are for guaranteed loans, where a cost to the federal government arises only in the event that an HMO should fail.

In arriving at our figure, we have assumed that half of the projects that are awarded feasibility grants would decide to undertake the plan development stage and receive the necessary federal support. We further assume that half of these would become operational and that one of five which becomes operational would fail during the start-up period, with significant operating deficits to be covered by the federal guaranteed loans. We also take into account that perhaps one-third of the HMO's would be poverty area projects, which are eligible for somewhat greater federal support.

Of the $50 to $75 million, we estimate that about 15 percent will be needed for feasibility grants, about 35 percent for developmental costs, and the balance of 50 percent for guaranteeing start-up costs.

It should be borne in mind that since several years are required for an HMO to be studied, planned and put into operation, a lesser number will emerge during the first several years of the program.

Mr. ROGERS. Also let us know any studies you have done as to the cost factor and whether it would be affected by HMO delivery. Have you done any studies like that?

Mr. HOFFMAN. We have not performed any such studies. I think our knowledge is the same as what the committee has, for example, the Kaiser results under the Federal employees plan. We will check but I don't know of any studies of our own.

Mr. ROGERS. If you have any such studies I think they would be helpful.

I share the feeling that your testimony has been excellent and most helpful. Thank you for being here today.

Mr. HOFFMAN. Thank you very much.

Mr. ROGERS. Our next witness is Dr. Robert M. Heyssel, associate dean for health care programs, Johns Hopkins University School of Medicine, on behalf of the Association of American Medical Colleges.

I am delighted to welcome you, Doctor. I understand you will be accompanied by Dr. John A. D. Cooper, president of the AAMC, and Dr. William H. Stewart, who is chancellor of the medical center in New Orleans, Louisiana State University School of Medicine, former Surgeon General and an old friend of the committee. We are glad to see you back in Washington. Since you left here you have not been coming back very much. I can't say I blame you for that. But we are glad this drew you back at least this time, Bill.

Dr. STEWART. Thank you, Mr. Chairman.

I think this is the first time I have been back before a committee since I left. I would like to take the opportunity to congratulate you and this committee on the work you have done on behalf of educating the health professions in the country. It is deeply appreciated.

Mr. ROGERS. And, of course, we are delighted to see Dr. Cooper, who has been helpful to the committee in many instances in the past. Doctor, we welcome you.

Your statement will be made a part of the record, and any statements you care to submit we will be glad to receive.

STATEMENT OF PANEL REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES:

DR. ROBERT M. HEYSSEL, ASSOCIATE DEAN FOR HEALTH CARE PROGRAMS, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, BALTIMORE, MD., AND CHAIRMAN, HEALTH SERVICES ADVISORY COMMITTEE, AAMC;

DR. WILLIAM H. STEWART, CHANCELLOR OF MEDICAL CENTER (NEW ORLEANS), LOUISIANA STATE UNIVERSITY SCHOOL OF MEDICINE;

DR. JOHN A. COOPER, PRESIDENT, AAMC; AND

DR. ROBERT KALINOWSKI, DIRECTOR, DIVISION OF HEALTH SERVICES, AAMC

Dr. HEYSSEL. I am personally pleased to be here this morning, and the Association of American Medical Colleges is grateful for the opportunity to give its views on this legislation.

Dr. Stewart also is here as a representative of the Association of

Academic Health Centers, as well as in his role in the AAMC as chancellor of the Louisiana State University Medical Center.

Rather than read the statement submitted to you, I would like to make less formal comments on behalf of the AAMC.

Our interest in this legislation is threefold. We agree that health care is a right of all the people and should be equally available to everyone; that the present organization of medical care in the United States is inadequate to provide health care to everyone on an equitable basis; and that if reorganization of health services is necessary to achieve that goal, then the financing of health care and the education of health personnel must be considered at the same time as the reorganization of services.

As academic medical centers, we provide practically all of the predoctoral physicians' education in the country and through our affiliated teaching hospitals, community as well as university, the majority of the postgraduate physicians' education and a major part of the education of the so-called health professions.

It is important and perhaps mandatory that if HMO's are to be the principal means of reorganization of health services, then academic health centers and medical schools be involved and the educational experiences of the next generation of physicians and other health personnel be related to these new institutions of medical care.

Academic health centers have been involved, as you know, in a variety of earlier kinds of experimental delivery systems such as OEO neighborhood health centers, children and youth projects and, more recently, in the developemnt of HMO's, really before the name was coined or popularized. Examples are the Harvard Community Health Plan in Boston, the three Yale programs in New Haven, and the Johns Hopkins programs in East Baltimore and in the new city of Columbia.

I might comment that well over 40 academic medical centers have indicated interest in HMO's and some are actively engaged in program planning at the moment, Washington University in St. Louis being an example of an institution which has been running a small pilot program for several years and now has plans to expand it.

Academic health centers have, particularly in urban areas, struggled for many years with the operations of large out-patient departments which are chronically underfunded and chronically the bleeding sores of the center and often of the communities they serve.

I think we do know what the current health system is and what it is not, and what it does not do. We know how well it serves the people, where it fails and some of the reasons for failure.

We want to be part of the effort to change that and are prepared to extend our present commitment to that end.

To enable us to do so requires the kind of legislation embodied in the bills before the House at the moment, with some modification and recognition of added needs.

Some general comments. First, we believe it important to recognize the necessity of dual choice, that is the right of an individual to enroll either in an HMO or to opt for the services, benefits, and kinds of insurance coverage now prevalent. We would urge, that if the Congress wishes the HMO concept to grow, then it enact legislation that requires dual option be mandated for all employed recipients of

medical health benefits, as well as mandated for Government-financed health benefits recipients.

Secondly, we believe HMO's should not be required to meet standards which are not applied to other providers. We do agree with the concept of quality assurance and the necessity for standards applicable to all HMO's. A Presidential Commission on Quality Health Care, as outlined in our testimony, plus an advisory panel, also appointed by the President, to look at issues of quality assurance and to come up with standards for quality of care we think are necessary.

I would like to comment that I think on the system side of an HMO it is possible now to get information which tells about the operation of the HMO in terms of numbers of visits, what kinds of visits those are, how many contacts there were in different areas, what the preventive services are that are given, how many people these are made available to, and so forth. The issue, however, of quality of care of individual patients and individual episodes of illness is a difficult one to deal with. Peer review is one way to do it. There are others such as measurements of the processes of medical care and outcome measurements. These approaches are experimental. It will take some time to develop them properly. So, we agree with the need for a commission which would examine this with expert advice.

Third, we would hope that HMO's would not become yet another categorical program but would have the broad range which allows them to preempt other categorical programs which may exist, such as children and youth programs, medicaid, medicare, OEO, et cetera, where it is necessary for their growth.

Fourth, we would hope that there is recognition of the differing needs and therefore the differing costs in communities and that even the benefits may be varied to meet certain local priority needs. As an example, the needs of an inner city community, are really quite different than, say, suburban areas or many rural areas. It may require, and it certainly does require, I believe, a different cost structure on the capitation side to meet some of those needs, many of which are social and economic as opposed to being purely in the area of medical care.

Finally, education for the people enrolled concerning care and their role and responsibility in maintained health should be an important part of the activities of the HMO.

To turn to more specific comments with regard to comprehensiveness of benefits:

Basically, we feel, at the moment, at least, in view of the marketplace and the reality of cost, that physicians' services in and out of hospital, health education, diagnostic lab and X-ray, rehabilitation, preventive services (to be defined), emergency services in-area and provision for payment for out-of-area emergency services and catastrophic coverage should be included in the package.

We feel that other elements would increase the cost at the moment beyond what is possible to market or for people to meet.

With regard to the issue of mandated open enrollment on an annual basis, this, I think, has some problems in it. The HMO, if it is required to have an open enrollment period, is very likely to enroll a population over time which is actuarially unsound and quite different from its competition.

I think if open enrollment is required, then it should really be mandated for all sectors offering health services and health insurance to the population and not simply for the HMO. If it is required of the HMO, then supplemental payments would have to be made, taking into account the quite differing populations that might become enrolled in the HMO.

With regard to the requirements for a certain proportion, either a ceiling or floor, of the recipients being enrolled from medically underserved areas, we agree with the great need for health services in the inner cities of America and in rural areas.

HMO's are certainly one way to do it.

On the other side of the coin, the problems of enrolling a representative sample of a metropolitan area in any given single delivery point are enormous. One would need a fairly narrow corridor running from the inner city out some place in the suburbs in order to do this.

I think that the requirement should be that no one be excluded from enrollment in the HMO for any reason if they live within the service area of the health maintenance organization.

Finally, we would hope, also, that there would be preemption of state laws which inhibit the growth of HMO's.

I think those are the main points we would like to cover at this time.

Mr. ROGERS. Thank you very much.

Dr. Stewart, did you have a statement or comment?

STATEMENT OF DR. WILLIAM H. STEWART

Dr. STEWART. I would like to, if I may, Mr. Chairman, emphasize the desire to have flexibility in the definition of an HMO.

I must shade my remarks with what we have in Louisiana, because that is what I have been working with in the last three years. At the present time, the trick of HMO's seems to be to put together a set of benefits and services in a package which can be marketed to a group of people so that you get 30,000 or more subscribers in a few years, break even financially and also provide quality medical care.

So far, we have not been able to find that kind of package in Louisiana that we could sell to the people. There is no group that we can find that will generate 30,000 subscribers who could afford to buy the package that we would have to offer to meet the definition of an HMO.

Therefore, I think you have to have some flexibility in this definition of an HMO so that it can fit a variety of situations. Perhaps there should be step increases or a sort of pre-HMO condition that you begin with. But if the benefits are too broad, I think it will be difficult to implement HMO's in areas where the income is lower than the national average and where you don't have either an industrial complex, where you have a group of people who have a fair amount of health insurance or any other kinds of groups that you can get hold of, and also where the public programs, medicaid, particularly, are minimal in their implementation.

The other thing I would like to say is that in the backup hospitalization or the relationship of hospitalization to the effects of HMO's, if you do not own a hospital or have sufficient control of a hospital, then you are more or less at the mercy of the hospital when you are

bargaining for this relationship until you have become of sufficient size that you have bargaining power in a sense in relationship to a hospital.

It may be that it is difficult to reach this savings aspect of HMO's in relation to hospitalization. Until you reach that size or until there is a relationship of control between HMO and hospital which allows one to have this flow of services where it is most likely needed, I think this is an area of HMO which has not been emphasized as much as it needs to be as it is being developed.

One other thing I would like to say is that as far as we see the situation in Louisiana, the interrelationship of the development of HMO's to the development of health insurance in the company is intimate. It is impossible to see how the people would have the funds to buy the kinds of services we think would be good health service without some kind of flow of funds into national health insurance of a type that would provide them the purchasing power to buy this service.

Therefore, I can't see how they can be separated. They have to be somehow related.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much.

Dr. Cooper.

STATEMENT OF DR. JOHN A. D. COOPER

Dr. COOPER. May I make a short statement on one other specific provision in the grants for planning and feasibility studies which we think should be considered by the committee.

The utilization of funds is limited to 1 year. In discussions we have had with a number of individuals involved in initiation of HMO's—they felt this would be too short a period. They hoped it could be extended to at least 2 years, and, if possible 3. It is very important that adequate planning and feasibility studies be done before the HMO is launched or we may end up with a number that are not fiscally viable.

We would urge that this period be extended.

(Testimony resumes on p. 925.)

(The prepared statement of the AAMC follows:)

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the subcommittee: The Association of American Medical Colleges welcomes this opportunity to appear before the subcommittee during its consideration of legislation to improve the health care delivery system by, among other things, encouraging the establishment of health maintenance organizations.

Formed in 1876 to work for reforms in medical colleges, the Association has broadened its activities over the years, so that today it represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 108 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 52 learned academic soceties whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all of the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It is concerned with the delivery of health care, directly

through the facilities of teaching hospitals, and indirectly through the development of improved community health services. It is concerned with innovation and experimentation in all of these fields. The Association and its membership thus have a deep and direct involvement in the legislation this subcommittee is now reviewing.

THE NEED FOR ACTION

The number and variety of the currently pending legislative proposals directed toward new modes of health care delivery provide ample evidence of the broad, grass-roots agreement on the need for urgent national action to improve a health care system which is not meeting society's expectations.

Such wide-spread agreement is encouraging. But the Association is constrained to emphasize a basic point. The ultimate solution to the problem of more adequate health care will not be achieved through the enactment of yet another separate, categorical program of federal assistance. The ultimate solution requires the development of a clear, coherent, and comprehensive national health policy supported by stable financing. This policy should set forth the objectives to be sought, delineate the public and private roles, and provide the program strategy that will assure the availability of effective health services to all the people of the nation.

Without a coherent and comprehensive program strategy and a clear assignment of responsibility, neither a new set of national goals nor new financing mechanisms, alone, will solve the widely acknowledged problems of uneven distribution of health care personnel and resources, both in terms of geographic location and in terms of medical specialty; the ineffective utilization of physicians, nurses and other health personnel; the overemphasis on treatment of sickness rather than on maintenance of health; and the counterproductive fragmentation of health care, symptomized in separate and competing services for veterans, the military, the elderly, the poor, the blind and so on. A direct confrontation of these problems in implementing a national health policy is central to their resolution.

There are a number of factors which will bear on achieving the goals. Competing economic pressures may limit the rate at which a full and comprehensive health care program can be instituted. There are also finite limits to the rate at which health personnel, facilities and other health resources can be made available and organized to provide comprenhensive care.

ROLE OF THE HEALTH CENTER

The Association of American Medical Colleges believes the nation's academic health centers can make a significant contribution in the development of more effective health care services, such as health maintenance organizations. Engagement with the problems of medical care and health services in the community setting has become an essential part of the education of health personnel. By virtue of their special expertise, investigative capability and access to other university resources, academic health centers can contribute innovative approaches and concepts. The teaching hospitals and clinics of an academic health center are vital resources and can be made to serve as an integral component of the framework of community or regional health services. The role of the academic health center in HMO development will be a varied one—educator, sponsor, catalyst, affiliate for tertiary services—depending on the institution and the region involved. What is certain for the academic health center is that it will have a role and that the role will be an important one.

One of the most important aspects of the role of the academic health center in HMO development will be in providing the educational framework for the production of personnel for HMOs and other primary care service. If the HMO, with its emphasis on comprehensive health and preventive care, services to defined populations and prospective budgeting of costs through prepayment, is to emerge as one of the prominent organizations for delivery of health care in the future, it is essential that HMOs become one of the settings in which medical students, interns and residents, along with members of other health professions and occupations receive a significant part of their clinical training. Full participation of the academic health center in HMO development is important in influencing the attitude, interest and involvement of physicians in this form of health service delivery.

The concern of academic health centers in improved health care delivery has already been demonstrated by their participation in a variety of innovative programs, particularly those developed by the Office of Economic Opportunity,

those supported under the Comprehensive Health Planning Act and the full range of comprehensive child care programs of the Children's Bureau. Medical schools and teaching hospitals now participate in over half the comprehensive health services projects of OEO. The emphasis in these programs has been upon organized arrangements for providing comprehensive medical care and services to defined populations. An additional feature has been expanding interest in experiments with capitation payments through title XIX and employee health benefit programs.

Academic health centers provide ambulatory and acute hospital services to all segments of the population including the poor and near-poor. The health maintenance organization concept affords an approach that will permit the academic health center to continue its concern for serving all socio-economic groups in one system of care, and to do so in a manner that is acceptable and responsive to the health care needs of patients and has potential for positive impact upon their health status. HMO development should not be concentrated in urban areas only. There are large rural and migrant populations which have only limited access to primary health care. Academic health centers located in these areas have opportunities to participate in rural HMOs that could provide comprehensive health service, help redistribute health manpower and resources, and could create continuity among primary, secondary and tertiary care.

A recent Association survey shows that a number of academic health centers are already active in HMO development. Among the most outstanding of the new health care programs developed to provide prepaid health care to defined populations are three sponsored by medical schools, the Johns Hopkins programs in East Baltimore and Columbia, Maryland, the Harvard Community Health Plan, and the three programs associated with Yale University. Other actademic health centers are now involved in planning and development of HMO programs.

GENERAL ASSOCIATION VIEWPOINT

At the outset of this statement, the Association wishes to stress its strong support for the objectives and the general approach of the various legislative proposals before the subcommittee. They all provide federal support for the development of prepaid, comprehensive health services to defined populations in a framework that emphasizes preventive rather than curative action. This, we believe, is an arrangement that offers considerable potential for advancing the general health condition of the nation.

The Association particularly concurs in the legislation's effort to approach the development of a rational framework for the delivery of health services as a matter of prime importance, rather than allowing it to emerge merely as a derivative of the development of a national health care financing mechanism. At the same time, it is essential that there be a coupling of the objectives sought in health services delivery and the capabilities of both the financing mechanism and the available health care resources.

The more detailed comments of the Association which follow are a consequence of sober assessments of the needed changes in the current health scene and the task of making such changes. As a result of these assessments, the Association will necessarily be critical of some of the provisions of some of the legislative proposals. Such criticisms are made, however, in a spirit of contributing positively to a major reordering of the American health care system. In the Association's view, it is wiser and more likely of success to begin a deliberate and carefully thought-through process of changing the health care system than to attempt to transform, in a single stroke, the complex and deeply entrenched pattern of providing health care in America.

HEALTH MAINTENANCE ORGANIZATIONS

THE HMO IN CONTEXT

The health delivery concept now commonly known as the health maintenance organization has grown out of the nation's 40-year experience with prepaid group practice. Prepaid group practice was initiated during the 1930s in a small, Elk City, Oklahoma, clinic and underwent its first large-scale implementation in the West Coast development of the Kaiser Foundation Health Plan.

Broadly defined, prepaid group practice is a health care delivery system, accepting the responsibility for organizing, financing and delivering health services for a defined population. Operating principles which set apart prepaid group

practice from other health care plans, such as Blue Cross-Blue Shield, for example, include prepayment by subscribers for health services on the basis of fixed periodic payments; responsibility for organizing and delivering health services to a defined population; provision of a set of comprehensive, plan-provided benefits normally including a predetermined period of hospitalization; complete physician services, and laboratory, diagnostic and X-ray services; use of physicians in multi-specialty group practice; and compensation of physicians by a means other than fee-for-service.

Because the Kaiser-Permanente Medical Care Program is so frequently thought of as the model for prepaid group practice, its organizational pattern is commonly regarded as the only possible one. Actually a number of organizational patterns are possible. Kaiser-Permante is perhaps the best known of the hospital-based plans, owning its own hospitals in which members receive care. Among non-hospital-based plans, which must supplement their programs with Blue Cross or similar insurance or contract directly with outside hospitals, the best known are probably the Group Health Association of Washington, D.C., and Health Insurance Plan of Greater New York. Variations on these patterns include physician-run plans, such as the Ross-Loos Medical Group of Los Angeles, for-profit plans, and academic health center plans, such as the Harvard Community Health Plan, Yale's Community Health Care Center Plan, and Johns Hopkins' Columbia Hospital Clinic Foundation.

Prepaid group practice has developed in settings offering the consumer an option between prepaid group practice and other health delivery methods. Such an option should be retained in the development of health maintenance organizations.

HOUSE LEGISLATION

There are three principal pieces of legislation designed to support development of health maintenance organizations.

—HR 4170, introduced by Harley O. Staggers, chairman of the Interstate and Foreign Commerce Committee, is known as the Physician Manpower Support and Services Act. Title II of the bill is to encourage and assist academic health centers in the establishment of HMOs. The assistance is to consist of grants and loan guarantees for planning and feasibility studies, for initial development costs. for construction and renovation, for initial working capital and to offset anticipated initial operating deficits. The bill also creates a reinsurance fund, financed from HMO-member premiums, to offset losses due to abnormal deviations in requirements for health services. To receive assistance under the bill, an HMO would be required to provide "a wide range of health services" which "shall include at a minimum: inpatient hospitalizaton, physician services in office and hospital, and preventive care as well as diagnostic laboratory and x-ray services." .

—HR 5615, also introduced by Chairman Staggers as the Administration bill, is known as the Health Maintenance Organization Assistance Act. The bill is to encourage the establishment and utilization of HMOs, particularly in medically underserved areas. Assistance is not restricted solely to academic health centers. The assistance is to be provided through a combination of grants, contracts, direct loans and loan guarantees for planning, for initial operating costs and for construction. Priority assistance is to be given applications for providing new or expanded health services in medically underserved areas. The bill also allows health services for first Americans to be provided through health maintenance organizations. To receive assistance under the bill, an HMO would be required to provide "all those health services which a defined population might reasonably require in order to be maintained in good health, including as a minimum emergency care, inpatient hospital and physician care, ambulatory physician care and outpatient preventive medical services.

—HR 11728, introduced by William R. Roy and others, is known as the Health Maintenance Organization Act. The bill is to provide assistance and encouragement for the establishment and expansion of health maintenance organizations. Through a combination of grants, direct loans and loan guarantees and interest subsidies, health maintenance organizations would be eligible for assistance to help meet planning costs, development costs, certain construction costs and initial operating costs. In addition, assistance would be provided for special projects, management training and clinical training. Other provisions would require an evaluation of the HMO assistance programs, establish a National Advisory Council on Health Maintenance Organizations and preempt restrictive state laws. To receive assistance under the bill, an HMO would be

required to provide the following comprehensive health services: physician services (including consultant and referral services), inpatient and outpatient hospital services, extended care facility services, home health services, diagnostic laboratory and diagnostic and therapeutic radiologic services, rehabilitation services (including physical therapy), preventive health services, emergency health services, out-of-area emergency health services, and additional services at the discretion of the HEW Secretary.

ASSOCIATION COMMENTS

The Association of American Medical Colleges supports the concept that access to adequate health maintenance and care is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system. The system must be a national one, with adequate provision for varying regional requirements. Universal entitlement should be based on financing from both public and private sources, either through insurance or prepaid group practice plans. Control of the system and fixing of national health goals and priorities require appropriate balance between public and provider inputs. Any system must assure simple and understandable access to primary care and prompt referral, in accord with individual patient needs, to progressively more sophisticated facilities and personnel. It must provide for, and emphasize, preventive as well as curative care on an ambulatory basis. The system should optimize quality of care and economy and should utilize incentives as an aid in cost control and in developing a more effective and responsive national mechanism for the delivery of health services. It must include a method for evaluating the overall operation and performance of providers.

Following are specific Association comments on what appear to be the key policy questions contained in the legislation.

Comprehensive benefits.—There can be no compromise with the goal of developing a national system capable of providing a full range of comprehensive health care services to all the people of the nation. This is the only adequate response to the high priority that every socioeconomic level of society places on health. At the same time, it would be sad indeed if the Congressional action to achieve this goal specified the essential package of services which must be immediately available in order to qualify for federal support in such terms that few organizations could command the resources to provide them and only a few persons or groups of persons could afford to purchase the package. The inevitable result would be the stillbirth of federally supported health maintenance organizations. To avoid such a situation, the Association suggests a more flexible definition of what shall constitute a health maintenance organization. Thus, to qualify as an HMO, an organization would be required to embody the following characteristics:

1. The organization or group of cooperating organizations constituting the HMO shall constitute a comprehensive health-care delivery system with clearly identifiable points of responsibility for all managerial, administrative and service functions.

2. It shall assume responsibility for providing or effectively arranging for reasonably comprehensive health care services including at least physician services (including consultant and referral services); inpatient and outpatient hospital services; members' health education services and education in the appropriate use of health services; diagnostic laboratory and diagnostic and therapeutic radiologic services; rehabilitation services (including physical therapy); preventive health services; emergency health service; out-of-area emergency health services; and such other personal health services as the new Secretary may determine are necessary to insure the protection, maintenance and support of human health, including health-center transportation and special services for the poor.

3. It shall receive compensation for such services to its enrolled participants primarily on the basis of a predetermined actuarially sound, periodic rate; however, it may also serve non-enrolled beneficiaries on a fee-for-service basis and may require modest copayments as agreed upon in advance to supplement its periodic rate with respect to certain services to enrollees.

4. It shall be responsible for providing all covered services for a contract period within the revenue provided through the predetermined rate and copayment method of reimbursement, under arrangements whereby the organization bears, and the cooperating units within the organization share, financial responsibility

for the appropriate and effective utilization of health care resources to meet the health care needs of the enrollees.

Open enrollment.—The issue of open enrollment in health maintenance organizations presents a hard choice between idealism and pragmatism. Unquestionably, the goal should be to accept periodically individuals in the order in which they apply, regardless of their health status or the requirements for providing their health services. Some universal financing mechanism, however, is essential to the achievement of such goal. There is no universal financial entitlement at the present time, of course; and unless all carriers provide it, mandatory open enrollment for federally underwritten HMOs would place them in a fiscally untenable position. This would be so because mandatory open enrollment imposed on HMOs but not on other health care arrangements would tend to generate a character of HMO membership that was actuarially unsound in the face of any conceivable financing arrangements. This becomes apparent when one considers the relative attractiveness of HMO membership to a large family with chronic, high-cost, health care needs. Multiply the financial impact of this family's enrollment by any sizable number of similar families living in, or moving to, the same HMO service area, and the potentially disastrous financial picture for the HMO comes into clearer focus.

To deal with this situation within the realities of present financing mechanisms, the Association recommends development of some appropriate legislative provisions to encourage HMO enrollment of high-risk populations, perhaps through some form of additional, special reimbursement. At the same time, the Association strongly urges replacement of the mandatory open enrollment provisions by suitable language emphasizing a progressive HMO enrollment policy aimed at producing an HMO membership whose demographic composition was representative of the geographic area being served.

Medically underserved areas.—The Association supports without reservation the emphasis in the legislation to extend health services to underserved areas. The Association hopes there is a clear understanding that special levels of health staffing and health care promotion will be required for the successful development and operation of HMOs in such areas. All the same, the Association is concerned that well-intentioned efforts to include representation of broad socioeconomic groups in health maintenance organizations do not result in unintended adverse side-effects. It would be unfortunate, for example, for a legislatively mandated percentage of membership from medically underserved areas to prevent a health maintenance organization from offering membership to neighboring residents. Rigid requirements for enrollment from medically underserved areas—whether conceived of as a floor or as a ceiling—could, in the view of the Association, be counterproductive. They could lead, for example, to grotesque gerrymandering of HMO service areas. They could lead to actuarially unsound enrollments. In place of such rigid limits, the Association recommends development of language that would permit the HEW Secretary to determine on a case-by-case basis that federally supported health maintenance organizations contained a reasonably representative proportion of enrollees from medically underserved areas.

Preemption of state laws.—Because of its overriding interest in the development of health maintenance organizations, the Association is particularly concerned by the exstence in many states of legal barriers to HMO development. These barriers take the form of laws that restrict group practice, the corporate practice of medicine, advertising and other practices. The Association supports enactment of legislative proposals for the federal government to preempt such restrictive state laws and to assist states in amending their existing laws.

Clinical, management training.—The education of health personnel must be closely related to the system for providing health services. As the HMO concept diminishes the traditional process of dealing with illness only when it occurs, and generates a new emphasis on maintaining health, health personnel must be trained in the context of this changed approach. In fact, as future physicians and practicing health personnel, they must become thoroughly involved as students in the principles and techniques of preventive care for this shift in emphasis to occur. Thus it is important for medical students, interns, residents and other health professionals to have their clinical training within a framework which provides for the delivery of comprehensive, primary health care in a setting that stresses preventive care and the use of a variety of health personnel in a team approach. When this happens, there are certain additional educational costs incurred, which must be met. The Association urges enactment

of federal assistance for the purpose of covering these additional HMO expenses associated with the clinical training of health personnel, so that such costs are not borne by HMO enrollees. Since health personnel may receive a portion of their clinical training in a variety of HMO settings, the Association suggests that clinical training grants to cover these costs be equally avalable for accredited programs in all teaching HMOs.

Recognizing the difficult problems surrounding the start of an HMO and the great sophistication HMOs require in the areas of management control, marketing, contract negotiation, capital budgeting and financing, the Association urges enactment of federal assistance for training programs in HMO management and administration.

Quality of care.—Since pending legislation proposes to provide significant federal support for the development of the health maintenance organization concept of health service, and since that concept stresses new patterns in health care delivery, it is essential to assure that these new organizations provide the highest quality of care. Nationwide uniformity of standards is imperative for the development of national confidence in this new form of health care delivery. To meet these needs, the Association supports establishment of a mechanism within the federal government to set norms and standards for the delivery of health services. Standards of excellence in the provision of health care must be set and maintained.

For this purpose the Association urges enactment of the following federal mechanism for setting quality-of-care standards:

1. Creation of a five-member, Presidentially appointed Commission on Quality Health Care.

2. Creation of a 12-member, Presidentially appointed National Advisory Council on Quality Health Care, comprised of suitable experienced and broadly representative members from the health professions, the academic health community, business, labor and other consumer interests, which shall advise and assist the Quality Health Care Commission.

3. Authority for the Commission, with the approval of the Advisory Council, to develop and establish within two years appropriate quality health care standards and to prescribe necessary quality control systems.

4. Authority for the HEW Secretary to administer the resulting federal health care quality standards system and to provide technical assistance to health care providers in the development of quality control programs.

5. Transfer to the Commission of the National Center for Health Statistics and other appropriate functions as determined by the President.

These suggestions are not greatly different from some of the provisions of some of the legislative proposals currently pending before the Congress.

The Association is uncertain whether the Commission—as a policymaking body—should be established as an independent agency, separate from the Department of Health, Education and Welfare, or as a Department agency. There seem to be reasonable arguments for and against both approaches. The advantages of independence revolve around the problems of conflict of interest when the same federal agency is responsible for promoting and regulating a certain service. The disadvantages of independence revolve around the problems of further fragmentation of the federal health structure when a major, new, federal health agency is established outside the framework of the principal federal health establishment. Perhaps strong public participation through the Advisory Council in the actions of the Commission would offset the inherent conflict-of-interest situation if the Commission were located in the Department. The location of another major regulatory agency, the Food and Drug Administration, within the Department obviously provides some precedent for locating another regulatory agency within the Department.

The Association is clear in its decision to recommend administration of the federal health care quality standards system by the HEW Secretary. Only in this way can creation of yet another massive federal administrative bureaucracy be avoided. The necessary administrative organization already exists within the Department of Health, Education and Welfare. The Association is convinced that it should be utilized.

Initial HMO financing.—Health maintenance organizations represent an innovation of great potential and considerable complexity. Financing for these programs should be at a level and for a duration sufficient to assure flexibility for experimentation in the full range of settings in which an HMO may exist. The programs should be fully funded for the duration of their planning, develop

mental and early operational phase, specifically until enrollment is at a level that provides sufficient premium income to finance operations. There should be a single source of federal funding for these programs. Frustrating efforts to obtain financing and participation from numerous federal and state programs are a strong deterrent to participation in HMO development. The time, effort and complexity involved in such a fragmented approach will discourage many potential HMO sponsors from becoming involved in HMO development.

Both the time period and the budget for start-up must be realistic. In some instances two to three years may be sufficient but other longer periods may frequently be justified. One-year availability of funds is clearly inadequate. There is little in the way of real experience as to how long the start-up period should be. Numerous authorities have pointed out the difficulties that are involved in marketing and enrollment in communities where there is no experience with prepayment or an absence of large definitive groups that can be enrolled. Intense marketing activity may be required long after the first enrollees have received care from the program.

In relation to capital finance, two types of support are required. Funds for construction and renovation are necessary because existing facilities are unlikely to meet needs for the organization of services required in an HMO. FHA mortgage and guaranteed loan provisions are associated with substantial negotiations and delay, and at the end point mortgage or loan dollars may only be available at very high interest rates. There is also need for initial working capital. In HMOs established to date, enrollment has lagged to such a degree that HMOs required outlays far in excess of what they took in in premiums for a considerable period. The full range of services, however, must be available to the first enrollees in the program. Therefore, the HMO requires support for a sufficient period to assure enrollment to a break-even point.

Health care financing.—Perhaps the most serious issue in the ongoing operation of health maintenance organizations is the matching of premium income to the cost of providing health care services. Inherent in the concept of a health maintenance organization is the provision of a comprehensive package of health services. Although reasonable persons may differ over the makeup of a comprehensive health care package, the implicit corollary of any package is that it can be supported through premium income, either from enrollees or from third-party payers. A commonly regarded source of such financial support is a program of national health insurance geared to provide reimbursement for the services provided by a health maintenance organization. Again, as with the financing of initial HMO development, there should be a single source of funding for the federal share of joint public-private health care financing. Such a national health care financing system would eliminate the present frustration of attempting to reconcile varying packages of services for which reimbursement is provided, varying funding cycles, varying—and sometimes conflicting—guidelines, and varying funding levels.

Thus, it seems clear that an essential interrelationship must exist between the legislative development of a national health insurance system and a national health delivery ssytem. Since the present realities of the legislative process dictate that separate committees consider these matters, two courses of action appear possible. One is to allow the services subject to reimbursement through national health insurance to become the services required of a health maintenance organization. This in effect permits the financing to determine the program. The other course of action is to develop an imaginative, progressive, comprehensive health delivery system and to rely on the will of the people to urge enactment of an appropriate financing mechanism. This would follow the current practice of legislation authorizing a federal program, followed by subsequent legislation relating to the funding for the program. The record of the current practice in providing sufficient funding levels is not encouraging, however.

Faced with these equally unpalatable choices, the Association wishes to suggest a third alternative. We suggest the development of a system of mutual working relationships between the legislative committees charged with developing a national health insurance program and the legislative committees charged with developing health care delivery systems. These relationships could take the form possibly of select committees in each chamber comprised of members of the appropriate standing committees, or of a joint committee comprised of members of the appropriate standing committees of both chambers. At least there should be an agreement of multiple referral for legislative provisions dealing with health care financing and health care delivery. Such an arrangement—in whatever form

it developed—would permit those concerned more directly with health legislation to work closely with their colleagues concerned with health care financing to develop a coordinated program to meet the health needs. Under such an arrangement, a national health program would not be the product of financing considerations alone, and the substantive health committees could gain the understanding and support of those with the charge of providing federal support for health care through the Social Security system or a national health insurance plan.

Dr. HEYSSEL. I would like to enlarge on something that Dr. Stewart was speaking to.

Mr. ROGERS. Certainly.

Dr. HEYSSEL. I think—I don't think we are quite as badly off in Baltimore as you are in Louisiana—a premium of $50 to $60 per family per month is about average for the kinds of services we outlined. The only people who will really be entitled at those rates are those who happen to work in industries which have a large enough fringe benefit payment, or the upper middle class or, in the State of Maryland, medicaid recipients. This would leave out about 30 percent of the population who would not be entitled under current insurance payments either from employers or from governmental sources. So that I would agree that if the concept is to grow, then some form of national entitlement for these groups for benefits as outlined here would be necessary, unless HMO's are going to be for the very wealthy and the very poor and the middle class working groups.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I have heard it said that any time a medical school is going to provide services it is going to cost a great deal more than if they are provided by some group other than a medical school, because somehow the education costs appear to be added into the service costs.

Would you comment on this?

Dr. HEYSSEL. We have three medical schools involved at the moment in the development of HMO's. We have been very careful to set them aside organizationally from the academic enterprise. So that the financing of the HMO's is not involved in any way with the financing of the medical school.

However, if teaching programs and research into health services go on in those HMO's, which is really our reason for doing in most instances, then this will cost more. Some provision will have to be made to meet those costs. The exact percentage or amount of dollars I don't really know.

The number that has been thrown around is 25 percent, approximately. There would have to be an add-on.

I might add that currently, as you know, the cost of postgraduate education is borne by third party insurance payers primarily. In an HMO with 30,000 subscribers it is not appropriate to put all the training load on that small number of people. I think other means of financing the educational enterprise will have to be found.

Mr. ROY. If we are to carry on health education within the HMO setting I presume it would be carried on by an HMO which is part of a medical school or carried on by an independent HMO. If we are to carry it on by an independent HMO and if we are to provide funds, shall we provide those funds to the HMO or should we provide them to the medical school as a sort of pass-through mechanism, which would

then pay the health maintenance organization for any educational function which they perform?

Dr. HEYSSEL. I think the money should go to the medical school to purchase, in a sense, the educational environment and the educators in that HMO.

I would comment on one other thing. Setting up an HMO as part of a medical school is perhaps too restrictive. Harvard, Yale, and Johns Hopkins are very much in control of their HMO's but they are not managed through the usual academic enterprise, that is, through the dean's office, as an example. They are set aside as separate corporate entities, and the physician groups are separate groups from the faculty payment mechanism.

Mr. ROY. In other words, medical schools are presently sponsoring HMO's.

Dr. HEYSSEL. They are sponsoring HMO's. I think they have their names and reputations on the line, but they don't have their fiscal lives on the line for these institutions; nor is the HMO supporting the academic enterprise. I think there are organizational ways to do this which clearly make a separation.

Mr. ROY. Do you think the health maintenance organization is a proven concept?

Dr. HEYSSEL. Yes. I think there are enough people enrolled in enough areas, that they are diverse enough, that growth has been striking enough where the option as been offered to people, and that the performance to date makes me believe they are a proven enterprise.

Mr. ROY. Do you think the for-profit HMO's have proven themselves?

Dr. HEYSSEL. I don't know one that is operational at the moment.

Dr. COOPER. May I make a statement on the for-profit HMO's which I think is important for this committee if it is going to include them? They should be required to assume the same burden of distribution of patients that a nonprofit HMO does. We are concerned that they may not provide the same distribution of services to the same distribution of patients and thus in essence siphon off the patients that are more desirable. So, if for-profit HMO's are included in any bill, we think that the legislation should require the same distribution of patient load and burden of disease and enrollee economic level for for-profit HMO's as for the not-for-profit HMO's.

Mr. ROY. I am working with admitted prejudice against for-profit operation because I have had experience with them. I would be very happy to have you gentlemen comment, either reinforce my prejudice or diminish my prejudice.

Do you have any comment on what has been the experience in for-profit institutions in the delivery of health care?

Dr. HEYSSEL. I think that the proprietary hospitals have, on many occasions, stayed out of areas that were expensive, as an example, the provision of emergency services and other special kinds of services, which undoubtedly has enhanced their ability to show a profit, and have left the most expensive services to other institutions. I endorse the point Dr. Cooper is making that, if for-profit HMO's are developed, then they should be required to serve the same population with

the same kinds of services and be held to the same standards as not-for-profit HMO's.

Mr. ROY. Do you really think we can develop the ability to prevent skimming? We have built between our two general hospitals in Topeka, Kans., another structure which would like a hospital license. They say, "We can take that postsurgical patient from the fourth and seventh day and do it much less expensively." They can do it much less expensively, because the expenses are in the first to the fourth day. I can't help but wonder if we add the two up, in other words, acute hospital costs are bound to go up if they are caring only for the first to fourth day, if we are not increasing the total cost of the 8-day surgical patient.

Do you think that we can develop methods to prevent skimming?

My other question, of course, which is a question for the committee, whether we really want to put the effort in to provide methods to prevent skimming?

Dr. HEYSSEL. Since an HMO has a defined population and, therefore, a denominator against which you can really measure the services delivered to a population, it is possible to get statistics that relate to a whole series of services provided, the number of physician visits, the percentage of the population visited. It is possible to get notions of consumer satisfaction, not only by enrollment performance of the HMO, but in terms of asking people whether the services they were promised in their contactual relationship with the HMO are, in fact, being delivered. I think it is possible to look at that aspect of it and also to be certain that a for-profit HMO would not exclude certain segments of the population because it might have an undue burden of disease, et cetera, or might be thought to be undesirable for other reasons. So I think it is probably easier to prevent skimming in an HMO kind of arrangement than it might be in other segments of the health care industry at the moment.

Mr. ROY. Is it possible, then, to prevent skimming within the organization? I suppose you really address that with the same answer.

Dr. STEWART. I am not sure I completely agree with that. It seems to me that if we really have dual choice in the system, which I think is highly desirable, and the degree of marketing which is necessary, then it seems to me it is difficult to prevent the skimming within that kind of competitive situation. I think we have the lesser-of-two-evils kind of thing.

Mr. ROY. We are coming face to face with another problem. Almost each witness has expressed it. It is impossible to provide health service to a population which cannot pay. These populations exist in many places in our society. We can have the potential to put HMO's in place in these underserved areas where these populations exist if we come up with some type of subsidization for those who cannot meet these costs.

This has politial problems, I am sure, and it has many other policy problems. The medical schools I think especially may be physically located within these areas. Should we make an attempt in this bill to put the HMO's in these underserved areas by some type of subsidy or should we go the other route and admit that these HMO's are going to serve the same populations that presently have the ability tc acquire medical care? However, gaining from cost containment, perhaps quality experience, we can then wait for the payment mechanism

and assume then that there will be some possibility of putting HMO's into the underserved areas? Also perhaps you can address yourself to what is going to happen to the underserved area when the payment mechanism becomes available and there are not service facilities in place. Would you like to comment on this rather long statement-question?

Dr. HEYSSEL. First, it is almost impossible for any group to move into the underserviced inner ghetto and systematically exclude 30 percent to 40 percent of the population. I think subsidies for HMO's which are going to deliver medical care to underserved areas really should be made. As a practical matter, in East Baltimore that is essentially what we have. We have a grant under section 314(e) of the Public Health Service Act which actually pays the premium for some proportion of the enrolled population, the others being paid for by title XIX, medicaid. I think that short of some sort of universal entitlement, a subsidy should be made available for the premiums of those people who cannot otherwise meet the cost and who do not qualify for HMO's operating in underserved areas. Otherwise, I think HMO's would get started and would, in fact, become a program for the middle class and for the upper working class of the country, with the underserved areas being left to shift as they may, as they are at the moment.

Dr. COOPER. May I add one quick point to that? I think that in addition a subsidy is required because an HMO in a medically underserved area has a much greater responsibility to promote health than on in a community which is more accustomed to receiving health care. It does no good to establish an HMO in an underprivileged area and just open the doors for those who happen to come in. You really have to promote health. I think this has been clearly demonstrated in the Portland experience of Kaiser-Permanente. The subsidy has to include not only the payment for those services that cannot be covered by the regular premium, but to permit the HMO in this area to carry on the kind of health promotion program that is required to bring people in deprived areas into the system.

Mr. ROY. I have a dozen questions as to what we might expect or might not realistically expect from the medical schools but time has not permitted me to ask them.

I appreciate your testimony.

Mr. ROGERS. As I understand it you are not anticipating that everyone will belong to an HMO?

Dr. HEYSSEL. No

Mr. ROGERS. Are you anticipating that its main thrust is to those in the poverty area or underserved area?

Dr. HEYSSEL. No.

Mr. ROGERS. Should they be required to serve a certain number of them or should it simply reflect the population of the area in which they exist?

Dr. HEYSSEL. It should reflect the population of the area in which they exist.

Mr. ROGERS. Currently, how do those who cannot pay get served?

Dr. STEWART. In Louisiana we have a State charity system, and the Louisiana Medical School is responsible for the care of 600,000 people. It is subsidized by the State and medicaid and medicare.

Mr. ROGERS. So I think this is pretty much accepted. If those who cannot pay are to get help even in the present setup of HMO's, those people must have some way of getting into the system by payment.

Dr. STEWART. That is correct.

Mr. ROGERS. I was thinking of going to this national health insurance. I am not sure it is a necessary requirement. I don't think everybody will get into an HMO. Suppose they can get their care. For instance, the Governmentw ith medicaid can get people taken care of in an HMO, like one told us in California, for 27 percent less. Maybe it is not going to cost as much.

Dr. STEWART. I think that without some health insurance aid at the present time none of those 600,000 people could be included in an HMO. Now I have the feeling that HMO's provide a quality of medical care which is not attainable under the present system.

Mr. ROGERS. You feel it will be an improvement?

Dr. STEWART. It improves the quality of care. It improves access because it moves it out to the area where the people live rather than their having to come in and seek something that is given to them. But this depends on whether the present effort in HMO's is to try to develop an example of a system as we come along with our national health insurance, which is going to take considerable debate, or whether the present effort is to try to provide an entitlement for all kinds of people at the moment through the HMO. I would think it is more of the former at the present time in the effort. I would hope, Mr. Chairman, even in the absence of the development of national health insurance or anything that takes its place over the next few years, that some experimental HMO's in these underprivileged areas would be tried out and that there be provisions for ways of subsidizing those which may be somewhat different from what would be done if you were dealing with a middle-class community.

Mr. ROGERS. I think that is a good suggestion. Thank you so much for your testimony. The committee is grateful to each of you for being here.

Dr. HEYSSEL. Thank you.

Mr. ROGERS. Members have to be on the floor at 12. Will it be convenient, Blue Shield and Blue Cross, to come back at 1:30?

I understand they will be back at 1:30 and are agreeable to it. Under those circumstances, the committee will stand adjourned until 1:30 this afternoon.

(Whereupon, at 11:55 a.m. the committee was recessed, to reconvene at 1:30 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 1:30 p.m., Hon. Paul G. Rogers (chairman) presiding.)

Mr. ROGERS. The subcommittee will come to order, please, continuing hearings on proposed legislation for health maintenance organizations.

I am very pleased to have as our next witness Mr. Walter J. McNerney, president of the Blue Cross Association. We will be pleased to have you come to the table and any of your associates whom you desire to have with you.

We will make your statement a part of the record, and we will be pleased to receive any comments you desire to make.

STATEMENTS OF A PANEL REPRESENTING BLUE CROSS ASSOCIATION:

WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION;

LEO E. SUYCOTT, PRESIDENT, WISCONSIN BLUE CROSS PLAN, AND PRESIDENT, ASSOCIATED HOSPITAL SERVICE, INC., MILWAUKEE, WIS.; AND

DAVID W. STEWART, MANAGING DIRECTOR, ROCHESTER BLUE CROSS PLAN, AND MANAGING DIRECTOR, ROCHESTER HOSPITAL SERVICE CORP., ROCHESTER, N.Y.

Mr. McNERNEY. I am pleased to be here in behalf of the Blue Cross system, which now serves approximately 100 million Americans through its public and its private programs.

If I may submit the statement that I have in front of me for the record, I would like now to paraphrase it, and then ask David Stewart, managing director of Rochester Blue Cross, and Leo Suycott, president of Wisconsin Blue Cross, to follow.

Mr. ROGERS. Certainly, that will be excellent.

Mr. McNERNEY. I will focus on system policy toward HMO's and the involvement of the system in it. They, in turn, will put more emphasis on the practical issues that are faced in implementing HMO programs. Each has a program in his area.

In essence, Blue Cross supports both the HMO concept and its development. We applaud the new emphasis being put on it by the public, by members of the profession, and by the Government. We have spent a great deal of time, money, and energy within Blue Cross on HMO development.

Mr. Chairman, there are now within the Blue Cross system some 13 operational HMO's. In addition, four plans are marketing HMO's and anticipate the start of service delivery within 6 months. Eleven plans are developing HMO's and are in the process of designing the operating capacity to implement the program successfully. Fifteen additional plans are in various stages of planning; 12 are in the exploratory phase.

Our corporate goal is to have 30 HMO's operative by the end of 1972. The detailed descriptions of those that are operative and those in the planning stage are in the appendixes. Our long-term goal is 280 HMO's by 1980, which would give us an opportunity to afford most of our subscribers a choice between competing methods of financing and delivery.

If I could simply summarize, I would say that, in general, Blue Cross prefers a reasonably flexible approach to HMO's, with important principles defined in the law without the imposition of undue strictures. In the framework of that general feeling, we would like to sound two cautionary notes:

First, I am sure that this committee is familiar with data which indicates that enrollees use a significantly lesser number of hospital days in the HMO-type environment. It is important to note, however, that these data are based on limited populations, not always cross-sectional; and they must be projected to the broader population with

great care. As systems grow in size, they change in their characteristics. We have an appendix that deals with this issue.

The second cautionary note is that the HMO is but one part of the total delivery and financing system. Its success inevitably will depend, in significant part, on the viability of the total structure.

In the next sections of our statement, we deal with specific implementation issues: Benefits, marketing, risk sharing, financing from public programs, community versus experience rating, payments with HMO's, whether they should build their own hospitals, the profit and nonprofit issue, the quality of care issue, Federal funding, and whether they should be required to operate in poverty areas and, if so, to what degree.

The statements are there, and we shall be glad to answer questions in regard to them. I would like now to move quickly to our conclusions:

The HMO concept is now over 2 years old and has broad verbal support. Greater commitment, we feel, is needed from both the public and private sectors.

Issues surrounding the commitment are well known and have been long debated, and we hope fervently that this committee will make some decisions and report a bill to Congress. It is time to get going.

In summary, a few points bear either repeating or elaboration. First, we must recognize that all of us want to measure HMO's by a number of criteria which are, in part, contradictory. We want them to provide comprehensive care, at lower cost. We want to regulate them carefully to insure quality, yet give them flexibility to innovate. We want to implement them quickly, yet some want to rule out the for-profit development and spend as little as possible for startup money. We need decisions now, but as we make them, we should not pretend that we know all the answers. We should make some judgments, take some risk, based on public interest and start; then make changes as we go along, based on experience rather than endless speculation.

Uncertainty should not lead to hesitation, especially because we feel the potential gains outweigh the risk. Action by the Congress and the executive branch now are essential, we feel, to get things moving.

The second point of summary is that in moving ahead we feel that Congress should focus on the national goals of the EMO movement. The Secretary of HEW and the agency administering the program would then be charged with specifying given result areas such as enrollment cost and data requirements. With these goals and guidelines established, the HMO's should be reasonably free to achieve them according to their own means.

In the HMO setting, we feel we should be less concerned about precise internal arrangements among the participating parties, particularly with reference to rules, processes, and standards taken from existing systems that we are trying to change; and more concerned about creating an alternate system and having it work effectively in the market. Under no circumstances, we have stated, should HMO's become a catchall for everybody's favorite reform remedy.

The third general point in conclusion: If we are to be able to evaluate progress in the years ahead, a relatively uniform data base will be essential to HMO's and alternative systems. We feel that the HEW requirements inevitably involved here should be consistent with HMO management requirement and not a needless added burden. That is,

there should be some minimum data, but not as an excessive burden to management.

Fourth, because of the shortage of capital for new building and startup cost, we must make maximum use of existing facilities and have the wit to build around some of the inherent variations rather than to try to impose a stereo typed pattern on the communities.

Fifth, an innovative and controlling force in development should be the exercise of consumer option in a situation hopefully free of current restrictions on the HMO pattern. Too much rigidity in designing HMO's makes it difficult to capitalize on assets and relies too heavily on theoretical gains at the expense of benefits realized by consumers.

Next, the HMO concept can be oversold to its detriment, based on the valuable but limited experience we have had to date. Our objective should be to give it ample opportunity on a broad scale, then let it sell itself.

Finally, I would like to come to what I think is a key point. Too little attention has been paid, we think, in the discussion of HMO's, about the enormous contribution that could be made by carriers' prepayment programs, especially such as Blue Cross. For example, in talking about HMO development, here is what a carrier can bring to the program:

Access to markets where HMO's can be offered on a dual or multichoice basis;

Skills to educate markets regarding HMO potential and enrollment service through widespread field offices;

Ability to calculate and administer rates;

Resources to help establish HMO's, capitalizing on existing staff and modest investments;

Experience requisite to negotiations with institutional and professional providers on reimbursement, utilization review, and other relevant matters;

Capacity to absorb early inordinate risks, especially in the early days of the HMO;

EDP and other systems capacity to provide key evaluation data and institute utilization review programs on an area basis;

Ability to supplement HMO benefits with other benefits as required; and

Machinery through which out-of-area benefits can be paid on a service basis and transfers from one HMO to another, or to an alternative program, can be effected without cessation in coverage.

Blue Cross is committed and; involved. We have the wherewithal to make a major contribution. We stand ready to work with new programs the Congress may propose, and we shall continue to extend our own programs.

(Testimony resumes on p. 985.)

(Mr. McNerney's prepared statement and attachments follow:)

STATEMENT OF WALTER J. MCNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION

I am Walter J. McNerney, President of the Blue Cross Association, the national coordinating body for the Blue Cross System. I am here representing 74 nonprofit Blue Cross Plans which serve nearly 100 million Americans under public and private programs.

With me is David W. Stewart, Managing Director of Rochester Hospital Service Corporation, and Leo E. Suycott, President of Associated Hospital Service, Inc., of Milwaukee, Wisconsin.

I will discuss Blue Cross' policy toward, and involvement in, Health Maintenance Organizations and selected public policy issues from a systemwide point of view. My two colleagues, both of whom have been leaders in HMO development in their areas, will report on the practical issues that must be faced in the implementation of HMOs.

I. BLUE CROSS POLICY

For many years, Blue Cross has participated in group enrollment situations where the employee had a choice of prepaid group practice or more traditional benefits. Some Plans, in fact, have marketed prepaid group practice medical benefits in conjunction with Blue Cross institutional benefits for over 20 years. The HMO concept grew out of some of these earlier options. It has our support. We applaud the new emphasis put on HMOs by the public, by many in the health professions, and by government.

Attached as exhibit I is a policy statement passed by the BCA Board of Governors in August, 1971. The statement reads in part:

"Recognizing that the basic concepts are not yet well developed and will long be subject to varying interpretation, Blue Cross supports the HMO concept as a promising alternative form for delivery of health services in much the same vein as it has previously supported and been actively involved with development of prepaid group practice programs. In line with this commitment, Blue Cross has helped to establish new prepaid group practice plans and has provided these new systems with critical access to large markets by offering the public the program benefits on a dual or multiple choice basis in open competition with more traditional insurance and delivery systems".

BLUE CROSS DEVELOPMENTS WITH HMO'S

Blue Cross has devoted a great deal of time, money, and energy to HMO development.

We now have ten Plans with thirteen operational HMOs.

In addition, four Plans are marketing HMO programs and anticipate the start of service delivery within six months.

Eleven Blue Cross Plans are developing HMOs and are in the process of designing the operating capacity to implement the programs successfully.

Fifteen additional Plans are in various stages of planning HMOs and twelve Plans are in the exploratory phase discussing the idea with provider and consumer groups.

Our goal is 30 operational HMOs by the end of 1972.

Attached as Exhibit II is a report on Blue Cross involvement in Alternative Delivery Systems which includes brief descriptions of local developments. Exhibits III and IV describe briefly Blue Cross roles in various HMOs.

The Blue Cross Association has conducted a number of educational conferences to familiarize Plan personnel with HMO operations. These programs drew upon the expertise of speakers from Kaiser, HIP, GHAA, and other existing group practice organizations. Also, we are conducting a number of problem-oriented conferences to discuss specific areas associated with HMO developments, e.g., an actuarial meeting to discuss rating of HMO benefits.

We are convinced that carriers and Blue Cross, in particular, have a critically important role to play in HMO development. Blue Cross has the administrative skills needed to handle programs of such complexity; it has contracts with thousands of hospitals and a population in the private market of 75 million enrolled in 625,000 groups.

Blue Cross sees the HMO not as the total answer to all delivery problems, but as an important option for consumers. Our long-term goal is 280 HMOs by 1980 offering virtually all of our subscribers a choice between competing methods of financing and delivery. The exercise of this choice promises to be one of the most effective, innovative forces acting on the health delivery and financing systems in the years ahead. It will have the distinct merit of emanating from the grass roots close to the substantive problems involved, and reasonably free of the type of stereotyped solutions that are more apt to be imposed from afar.

II. GENERAL ISSUES

As we begin to formulate national public policy and legislative language for HMOs, we must keep in mind how complex and variegated this country and its health system are. Consumer attitudes and preferences vary widely as do the

structure and traditions of the delivery system. For example, the number of hospital beds per 1,000 population varies on the order of two to one from one state to another, while the physician ratio varies by as much as four to one. Hospitals and other institutions operate under a variety of auspices, including federal, state, and local government, those operated for-profit, hospitals owned by religious groups, etc. Prepaid group practice has strong roots in some states and weak ones in others.

Federal HMO strategy must accept and deal with this variety and not expect that change will occur easily, uniformly, or quickly.

An important strategic question becomes how stringently legislation should define HMOs. Should the Congress be flexible and permit or encourage variations; or should it define benefits precisely, attempt to regulate quality explicitly, rule out for-profit organizations, etc?

On one side of the question lies the risk of fostering an illusion of change while the health system continues in the old ways; and on the other, the danger of saddling HMOs with responsibilities substantially in excess of what is required of other elements of the system, and, in the process, slow progress, reduce the number of potential participants, and incur excessive costs.

In general, Blue Cross prefers a reasonably flexible approach to HMOs. Important principles should be defined in the law without the imposition of undue strictures. Focus should be on improvement of productivity and access. And, sufficient base data should be required so that the effectiveness of various formats can be evaluated over time.

Our hope is that the internal dynamics of HMOs will lead to lower costs, more preventive medicine, less reliance on acute services, and a system that is easier for the consumer to understand and use. The ultimate test will be consumer satisfaction and selection.

In the framework of General Issues, two notes of caution should be sounded. First, I am sure this committee is familiar with data that indicate that enrollees use a significantly lesser number of hospital days. It is important to note that these data are based on limited populations, not always cross-sectional, and that they must be projected to broader population with great care. As systems grow, their characteristics can change; advantages can be lost as well as gained. A commentary on these points from the March, 1972, issue of *Inquiry* is attached as Exhibit V.

This particular note of caution should not be interpreted as a vote against a strong push for and selective subsidy of HMOs. HMOs are not only of theoretical worth. Nine million people are enrolled in prepaid group practices, one form of HMOs. Also, we have subsidized the prevailing system for years with billions of dollars of Hill-Burton funds, tax deductions, regional medical programs, and others, while various antecedents of HMOs have been penalized by professional and legislative discrimination. In fact, we have a heritage of shortsightedness to overcome.

Second, the HMO is but one part of the total delivery and financing system. Its success will depend, in significant part, on the viability of the total structure. At some point, the HMO must be integrated into the larger concept of national health insurance. In this context, there remain major unresolved issues directly impinging on HMO development.

III. FINANCING ISSUES

There are a host of implementation issues involved in structuring HMO legislation. I will comment briefly on those with which Blue Cross has relevant experience. Also, I will emphasize the essential role Blue Cross and other carriers can play in starting HMOs and in sustaining them in the market. It is important that legislation recognize and make provision for carrier capacities and participation.

A. BENEFITS

Most communities now recognize that comprehensive health benefits are a desirable goal for HMOs and other delivery systems. But, the initial requirements for HMOs should not be overly idealistic. The resultant costs could be too far out of line with alternate systems. Also, some communities could not produce comprehensive services initially, without extraordinary subsidy.

A limited scope of basic benefits, with strong emphasis on primary care and health education, would permit HMOs to structure themselves around available resources. Individual HMOs could offer several benefit options on a building-

block basis at different prices, permitting subscribers choices based on their own perceptions of need and ability to pay.

The benefits designed in H.R. 11728 in Section 1101 (2) are, perhaps, too extensive. While the inclusion of extended care, rehabilitation, and other benefits is desirable in the long run, a lesser package will probably result in the development of HMOs in core communities initially.

Out-of-area benefits for emergencies and other special circumstances are vital for a mobile American population. Blue Crossoperates an extensive system to provide out-of-area benefits and transfer of coverage for persons moving permanently. Here, the carrier can play an important role in an HMO concept.

B. MARKETING

The HMO concept cannot grow at an accelerated rate without access to markets. No one has proposed that any given delivery system be compulsory—nor is it likely to happen. Blue Cross and other carriers have large field forces in active contact with corporate groups and extensive experience in account education and service.

The fledgling HMO cannot hope to create this kind of marketing capacity in a reasonable amount of time, if ever. Without it, enrollment will lag and losses in the early years could be substantial. An affiliation with a major carrier, such as Blue Cross, can solve or mitigate many of these problems.

In the market, periodic open enrollment should be required. There is an associated risk that this would lead to a disproportionate number of poor risks enrolled in HMOs. However, this can be helped by a carrier able to merge the experience with other groups in some manner.

C. RISK SHARING

H.R. 11728 requires providers to accept all risks up to $5,000 per case. We would suggest that this be modified to permit carriers to share in taking risks at all levels. This will have several salutary effects. It will decrease the likelihood of bankruptcy and the need to make extensive provisions for insolvency in the law. Also, smaller provider groups will be more likely to belong to HMOs when the risk taking required of them is within reason.

Carriers, given this equity, will be encouraged to sell HMO coverage aggressively. A sharing of risks between carrier and provider is desirable to serve as an incentive to provider and carrier alike.

D. FINANCING FROM PUBLIC PROGRAMS

One of the ways to stimulate HMO development is to make provision for their support from present federal programs. For example, Medicaid, in given states, has some 225,000 welfare recipients enrolled in various HMOs, such as HIP, Kaiser, and Group Health Cooperative of Puget Sound. A capitation rate is paid to the HMO, based upon the actuarial equivalent of the health benefits enunciated in the state legislative enactment which authorized the Medicaid program.

Presently, the Medicare legislation does not make this possible. Some organizations, such as Kaiser, provide their regular HMO-type benefits to Medicare eligibles on a negotiated, cost-plus basis. H.R. 1 (if enacted in its present form) would change this and provide for payment to the HMO of 95 to 100% of the cost of benefits provided to other Medicare eligibles in a common geographical area. Present state leigslation prohibiting Medicaid capitation should be overridden or changed.

E. COMMUNITY VERSUS EXPERIENCE RATING

Blue Cross has been through this complex issue many times. It is important to note that there is no "pure" way to rate equitably. For example, when Blue Cross community rated most of its enrollment (i.e., before commercial carriers caused Blue Cross to modify this principle by experience rating), areas where costs were lower subsidized areas where costs were higher. While governments extoll community rating, they are the first to demand experience rating for their employees (state and national). As long as carriers are permitted to experience rate, HMOs will require the same opportunity in order to compete.

Carriers have much to offer here also. For example, if Blue Cross were to implement a network of HMOs to cover a given geographic area—say, a large

city served by 8 to 10 HMOs—it could come up with a composite rate among the HMOs and market this to large employers which have employees spread throughout the area. The rate could be based on the total experience of those enrolled or some modification of it.

F. PAYMENTS WITHIN HMOS

This is another area where we need to resist the temptation to envelop HMOs in excessive rules and regulations; a variety of methods of reimbursement to hospitals and other providers should be tolerated, even encouraged. This area is currently the topic of much debate and experimentation. It is in the public interest that this search for better methods continue.

In the long run, it is unlikely we will find "one best way". Experience among nations, as well as in the U.S., has taught us that any given method of payment can be validated only by contrast with another. If there is a universal principle involved, it is that any reimbursement system should encourage provider risk assumption. Blue Cross and other carriers have extensive experience in reimbursement and can play an important role in assistance.

The question is often asked, "Should fee-for-service payments be permitted in HMOs?"

We should avoid a false polarization here between salary and fee-for-service; there are a variety of ways to reimburse physicians, as there are other services. To achieve high performance, perhaps we can learn from other enterprises. Service and hard-goods organizations alike use a variety of schemes—straight salary, commissions, productivity bonuses, etc.—to determine income. Elements of the two approaches can be combined and adapted to the individual situation to stimulate performance. The Kaiser Plan and the Group Health Cooperative of Puget Sound permit up to 10% of physicians' income to be from fee-for-service. In newly founded HMOs, more flexibility might be an essential transitional device.

We should keep in mind constantly that an essential merit of HMOs is their primary emphasis on ends, not means, and on active management, not imitation.

G. SHOULD HMOS BUILD THEIR OWN HOSPITALS?

While new hospital beds may be needed on rare occasions, maximum use of existing facilities should be encouraged. In too many areas, we have an oversupply of beds and new ones will represent costly duplication. Funds for capital are in short supply in both the public and private sectors throughout the world. Spending HMO money on facilities on a broad scale could be expensive and add to current problems of overlap and fragmentation.

In any event, HMOs must fall within the purview of state and areawide planning agencies as a guard against duplication of resources. This assumes that these agencies are community-oriented and controlled. In some areas of the country, one sees a vast interest bias against HMO development. This, among other points, underscores the need for strategies parallel to HMO development within a larger framework.

Investment in facilities or construction for HMOs should emphasize ambulatory care and other underdeveloped services. We endorse Section 1104 of H.R. 11728 in this regard.

H. PROFIT-NON-PROFIT

Blue Cross believes deeply in the non-profit operation in the health field. But, non-profit organizations have not moved quickly into all rapidly expanding communities where, in some instances, proprietary organizations have. And, with the shortage of capital we face, access to all money markets will be needed. In some areas, for-profit enterprises have attracted capital more quickly than non-profit developers.

For-profit organizations should be permitted to participate, but energetically required to meet community standards. Open enrollment, quality standards, public disclosure of financial and operating data, provisions against conflict of interest, control of equity return, and planning agency sanction can do much to insure accountability. Section 1101(1) should be changed to permit for-profit HMO developments.

I. QUALITY OF CARE

This is a difficult issue; the medical process is complex and evaluation of quality requires subjective as well as objective judgments.

Importantly, HMOs should not be subject to unique standards not applicable to other delivery modes. This could lead to unwarranted discrimination. In this regard, we should keep in mind that group practice has effective quality control inherent in it. Physicians working closely together have ample opportunity to review their colleagues' work and establish pathways to obtain consultations on difficult cases. Also, HMOs are subjected to the same controls largely as the rest of the system, e.g., professional licensure, institutional licensure and accreditation, and consumer choice.

With all of the above, it would be well to have part of the quality assurance program stipulate the need for a mechanism in HMOs that focuses on results. For example, of so many hypertension patients, how many died, returned to work, etc.? Too much current evaluation in most delivery systems is geared to input under the assumption that given methods or formats automatically produce desirable results. Such a stipulation would assist the evaluation materially contemplated in Section 1110(a).

We support Section 1110(a) of H.R. 11728 which would provide direct subsidies for evaluation. And, we support Section 1101(1)(G) requiring HMOs to have an "ongoing quality assurance program", and Section 1101(1)(H) requiring that data on cost and utilization be compiled and published. In essence, we need to evaluate the investments made in HMOs as we do in all systems.

Data stipulated should not require extensive record-keeping or expensive computing that would burden the HMO. Rather, these data should be essential to the HMO for management purposes and, for the most part, be available in the normal course of events. Their disclosure to the public on a periodic basis will considerably enhance consumer option and serve as an effective internal discipline.

J. FEDERAL FUNDING

H.R. 11728 proposes a variety of grants, loans, and loan guarantees to support various facets of HMO development. We support all of them. Federal money, judiciously placed, can and does speed developments.

The agency charged with administering this program should evaluate alternative methods carefully to see which provides the most leverage.

K. REQUIRED SERVICE TO POVERTY AREAS PER SE

By many, the HMO concept is seen, in one form or another, as an effective answer to the access and use problems of low-income urban and rural areas. In these areas, purchasing power, health facilities, and programs are often absent or weak. The HMO cannot solve all the problems. For the HMO to work in these circumstances, there must be:

1. Adequate public payment programs (Medicaid, Medicare, FHIP, etc.).
2. Adequate grants and loans to meet specific government objectives—for capital and start-up purposes.

It is unlikely that manpower will be attracted to selected urban and rural areas unless there are strong system and program ties established to a central unit of broad scope and sophistication. Through such a satellite arrangement, quality can be protected, even with new and innovative uses of substitute skills, and highly trained professionals can be given the stimulation, mobility, and tools they require.

IV. CONCLUSIONS

I have stated Blue Cross' record and its views on a number of issues associated with HMOs. The HMO concept per se is now over two years old; it has broad verbal support. Blue Cross and others in the private sector are attempting to get programs under way. Government has made selective investments. Greater commitment from both the public and private sectors is needed.

The issues surrounding commitment are well-known and have been long-debated. I hope that this commitee will make decisions and report a bill to Congress.

In summary, a few general points bear repeating or elaboration.

A. We must recognize that all of us want to measure HMOs by a number of criteria—which are, in part, contradictory. We want them to provide comprehensive care—at lower cost. We want to regulate them carefully to insure quality—yet give them flexibility to innovate. We want to implement them quickly—yet some want to rule out for-profit development and spend as little as possible for start-up money.

We need decisions now, but, as we make them, we should not pretend that we know all the answers. We should make some judgments and take some risks,

based on the public interest and what promises to work, and start. And, make changes as we go along, based on experience rather than endless speculation. Uncertainty should not lead to hesitation, especially because potential gains outweigh the risks. Action by the Congress and the Executive Branch are essential to set more forces in motion.

B. In moving ahead, Congress should focus on the national goals for the HMO movement.

The secretary of HEW and the agency administering the HMO program would then be charged with specifying given result areas, such as enrollment, costs, and data requirements. With these goals and guidelines established, the HMO should be free to use reasonable means to achieve them.

In the HMO setting, we should be less concerned about precise internal arrangements among participants, particularly with reference to rules, processes, and standards taken from existing systems that we are trying to change; we should be more concerned about:

Creating an alternate delivery system characterized by a specified payment for reasonably comprehensive services in virtually every area of this country within some target date.

That this system should begin to develop effective incentives and controls and improve access to care.

That innovations in the use of manpower, health education, etc. emerge in the process.

It is difficult to describe the health care system in performance terms, but we need to learn. Under no circumstances should HMO's become a catch-all for everybody's favorite reform remedy.

C. If we are to be able to evaluate progress in the years ahead, a relatively uniform data base will be essential to HMOs and alternative systems. HEW requirements, in this regard, should be consistent with HMO management requirements and not be a needless, added burden.

D. Because of the shortage of capital for new building and start-up costs, we must make maximum use of existing facilities and have the wit to build around some of the inherent variations—rather than try to impose a stereotyped pattern on all communities.

E. We should keep in mind that a major innovative and control force involved in HMO development will be the exercise of consumer option in a situation prospectively free of current restrictions on the HMO pattern. Too much rigidity in designing HMOs makes it difficult to capitalize on current assets and relies too heavily on theoretical gains at the expense of benefits realized by consumers.

F. The HMO concept can be oversold to its detriment, based on the valuable, but limited, experience we have had to date. Our objective should be to give it ample opportunity on a broad scale. Then, let it sell itself.

G. Finally, in the debate over HMOs to date, too little attention has been given to the enormous contribution carriers, such as Blue Cross, can bring to HMO development. For example:

Access to markets where HMOs can be offered on a dual or multi-choice basis.

Skills to educate markets regarding HMO potential and service to those enrolled through widespread field offices.

Ability to calculate and administer rates.

Resources to help establish new HMOs, capitalizing on existing staff and modest investments.

Experience requisite to negotiations with institutional and professional providers on reimbursement, utilization review, and other relevant matters.

Capacity to absorb early inordinate risks, especially in the early days of the HMO.

EDP and other system capacity to provide key evaluation data and institute utilization review programs on an area basis.

Ability to supplement HMO benefits with other benefits as required.

Machinery through which out-of-area benefits can be paid on a service basis and transfers from one HMO to another, or to an alternative scheme, can be effected without cessation in coverage.

Blue Cross is committed and involved. We have the wherewithal to make a major contribution. We stand ready to work with new programs the Congress may propose; and we will continue to extend our own programs.

Exhibit I

BLUE CROSS ASSOCIATION

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 329-6000

October 29, 1971

TO: Chief Plan Executives

FROM: Antone G. Sirgsen, Senior Vice President, Research and Development

SUBJECT: POLICY STATEMENT ON HEALTH MAINTENANCE ORGANIZATIONS

HMO discussion continues to dominate the current health scene and impacts upon proposed NHI legislation, Administration postures, and HEW strategy. In its assessment of the efficiency and effectiveness of modes of health care delivery and financing, the Blue Cross Association supports the HMO concept as a viable alternative form for delivery of health services in much the same way it supported and developed prepaid group practice programs. Blue Cross Plans will continue to develop prepaid programs and offer them on a dual or multiple choice basis.

At the Board of Governors Meeting, August 22, 1971, the Blue Cross Association adopted the attached HMO policy statement. The statement includes a broad HMO definition and lists a nine-point set of guidelines for Plan assistance in the development of HMOs. The thrust of the Blue Cross position emphasizes the need for Plan involvement in HMO development. It states however, that the effectiveness of the HMO will depend upon its ability to offer alternative systems and not simply to confine change to components, such as financing mechanisms and organizational flexibility. Such change may create the illusion of change, when in reality the delivery system continues to function in its traditional fashion.

As the HMO concept develops into national policy and proposed legislation is drafted into law, we will continue to assist Plans and provide them with technical expertise, position papers, resource and informational materials to meet this new challenge.

Distribution: Chief Plan Executives -- 250
Prepaid Group Practice Coordinators -- 12
Research and Development -- 7
Provider Relations -- 22
Enrollment Managers -- 4
National Account Representatives -- 6
Chief Marketing Executives -- 18

HEALTH MAINTENANCE ORGANIZATIONS

A Policy Statement by
Blue Cross Association

August 12, 1971

In the quest for improved access to and greater productivity in the delivery of health services, a great deal of interest has centered on Health Maintenance Organizations (HMOs) in recent months. While lacking in precise definition, the HMO is generally characterized as an organized health care delivery system which promotes early detection and continuity of care by an arrangement which holds a single organization responsible for assuring delivery of an agreed set of institutional and physician services to an enrolled population for a stipulated period of time in exchange for a fixed and periodic payment.

There is great latitude in terms of what types of organizations or quasi-organizations may qualify as HMOs; the HMO is not limited to a particular organizational delivery form, provider reimbursement mechanism, enrollee payment or financing source. Rather, it is a concept designating performance criteria to which a variety of systems may adhere insofar as each integrates (1) an overarching point of fiscal, legal and administrative accountability with (2) a planned and coordinated service delivery system comprised of institutional and individual providers, (3) a review, evaluation and control mechanism, (4) an enrollment mechanism, and (5) a consumer payment mechanism.

Recognizing that the basic concepts are not yet well developed and will long be subject to varying interpretation, Blue Cross

supports the HMO concept as a promising alternative form for delivery of health services in much the same vein as it has previously supported and been actively involved with development of prepaid group practice programs. In line with this commitment, Blue Cross has helped to establish new prepaid group practice plans and has provided these new systems with critical access to large markets by offering the public the program benefits on a dual or multiple choice basis in open competition with more traditional insurance and delivery systems.

In a similar manner, Blue Cross will promote the growth of HMOs by stimulating their expansion through the marketing mechanism and by establishing new programs in which Plans themselves will operate HMOs. To support these developments, Blue Cross will support the removal of artificial restrictions such as anti-group practice, anti-corporate practice of medicine, and certain other licensure laws.

HMOs will be expensive to launch. Substantial federal grants and loans will be needed. In many areas, an approach geared to building and elaborating on existing resources will be required in order to permit greater development with the limited capital and start-up funds which will be available.

When assisting HMO development, Blue Cross will be guided by the following policies:

1. An HMO should be required to provide and make accessible to its enrollees full comprehensive care (beyond the connotation of pending legislation) with strong emphasis

on primary care and health education. It should use its potential to influence social and cultural forces which impact on health.

2. HMO development should fully utilize consumer involvement in the planning and organization of delivery of services.
3. HMOs should be within the purview of planning agencies to prevent the creation of duplicate capacity and to ensure that community, program and facility needs are best served. A variety of organizational forms and methods of governance should develop. But to introduce these new schemes to the existing autonomous and heterogenous health care systems clearly requires realistic coordination and regulation of health care delivery on a community or regional basis.
4. Evaluation should be an inherent part of every HMO. At this stage of preliminary development, divergent systems are presented with the unique opportunity to establish a fact and data base that will permit careful and realistic assessment of the effect of such factors as changed manpower usage, alternative payment, reimbursement and delivery methods. This opportunity should not be lost in a short-sighted effort at hasty implementation.

The efficacy of the HMO option has yet to be systematically analyzed and correlated with performance criteria; however, comparison and results can only be derived from systematic analysis of functioning systems. Evaluation and development must occur simultaneously over time.