REPORT
TO THE
MINNESOTA LEGISLATURE
ON
HEALTH MAINTENANCE ORGANIZATIONS

****

By

THE MINNESOTA DEPARTMENT OF HEALTH

Pursuant to Minnesota Statutes §62D.25

CONTENTS

PREFACE

The Health Maintenance Act of 1973 (Minn. Stat., Chap. 62D) was effective July 1, 1973, and operates both to enable and regulate health maintenance organizations (H.M.O.s), formerly known as prepaid group practice plans. This report is being made pursuant to Minn. Stat., §62D.25.

Organizations of this kind have existed to serve the general public in Minnesota for about 35 years. In addition, the railroads had prepaid health care, including hospitals, for employees in Minnesota as early as the 1880's.

In 1955, when Group Health Plan, Inc. was converting from a mutual insurance company to a prepaid service plan, the legal environment was clarified somewhat by an Attorney General's ruling which indicated that nonprofit corporations were not subject to the corporate practice of medicine prohibition, thus allowing the development of that particular plan.

In 1965 the law relating to state employees was written to mandate that employees could choose a prepaid group practice plan as an alternative to conventional health insurance coverage. See: Minn. Stat., §§43.42 and 43.43(e)(2).

In 1967, at the time of the recodification of the insurance laws, prepaid group practice plans were subjected to the insurance liquidation and rehabilitation laws, and were thereby subjected to some regulatory authority. There is one other reference in the statutes, prior to the Health Maintenance Act of 1973, to these plans. The new regulatory laws relating to nonprofit health service plan corporations, enacted in 1971, define "prepaid group practice plans" and exclude them from that regulation.

Therefore, prior to 1973 there were four basic factors that related to H.M.O.s in Minnesota: the history of prepaid medicine in Minnesota, the Attorney General's ruling allowing the incorporation of a nonprofit corporation to render medical service, the governmental support of such plans through the dual choice mandate for state employees, and other statutory acknowledgement of the existence of such plans, including certain regulatory authority vested in the Commissioner of Insurance. Nevertheless, prepaid medical practice was not very widespread and did not serve many people. Among other problems, it was generally felt that the legal climate was too uncertain for a venture as large as the establishment of an H.M.O.

In adopting the Health Maintenance Act of 1973, the Legislature stated certain objectives. Generally speaking, the law is a vehicle to stimulate the exploration of alternative methods of health care delivery which, in turn, might control costs and make

comprehensive services more accessible to the people. In order to accomplish these purposes, the Act reflected a policy to eliminate barriers to the organization, promotion and expansion of H.M.O.s, and to impose regulation on them under the auspices of the State Board of Health. See: Minn. Stat., §62D.01.

Finally, the Board of Health was required to make a report to the Legislature on various matters. Minn. Stat., §62D.25, the relevant statute, provides:

> "REPORT TO THE LEGISLATURE. The Board shall report to the legislature on or before April 1, 1975, as to the following:
>
> (1) The number of applications for certificates of authority which have been filed since the effective date of this act;
>
> (2) The number of certificates of authority granted pursuant to this act;
>
> (3) The number of current enrollees in health maintenance organizations in the State of Minnesota;
>
> (4) The average annual prepayment cost per enrollee in the State of Minnesota;
>
> (5) The conclusions of the board as to the effect of health maintenance organizations on the quality of health care services provided to the people of this state;
>
> (6) The conclusions of the board as to the effects of health maintenance organizations on health care costs and whether any cost savings are being passed on to enrollees in any form; and
>
> (7) Its recommendations as to any changes in this act."

The following is the required report.

NUMBER OF APPLICATIONS FOR CERTIFICATES OF AUTHORITY

The Board has received nine applications for Certificates of Authority as an H.M.O. Minn. Stat., §62D.03, Subd. 2, required operating plans to file applications within 90 days after the effective date of the Act, or by October 1, 1973. On October 1, 1973, seven corporations applied as "operating H.M.O.s," and two others applied for certificates so they could commence operation. These applicants, their location, and their inception date were as follows:

Community Health Center, Inc.
4th St. at 11th Ave.
Two Harbors, Minnesota 55616
Operational since 1928 as a Steel and Railroad Plan.
Operational: November 1, 1944 as a prepaid practice plan.

Group Health Association of Northeastern Minnesota
307 First Street North
Virginia, Minnesota 55792
Operational: January, 1973

Group Health Plan, Inc.
2500 Como Avenue
St. Paul, Minnesota 55108
Operational: August, 1957

MedCenter Health Plan
5050 Excelsior Boulevard
St. Louis Park, Minn. 55416
Operational: December, 1972

Minnesota Health Maintenance Network Plan
Blue Cross/Blue Shield of Minn.
3535 Blue Cross Road
St. Paul, Minnesota 55165
Operational: September, 1974
Not operational prior to effective date of the Act

Nicollet-Eitel Family Health Plan
2001 Blaisdell Avenue
Minneapolis, Minnesota 55404
Operational: June, 1973

Ramsey Health Plan
St. Paul Ramsey Hospital
640 Jackson Street
St. Paul, Minnesota 55101
Operational: October, 1972

SHARE
1515 Charles Avenue
St. Paul, Minnesota 55105
Operational since 1882 as Northern Pacific Beneficial Association
Operational: June, 1973 as an H.M.O.

Pilot City Health Center
1349 Penn Avenue North
Minneapolis, Minnesota
Not operational as an H.M.O.

Number of Certificates of
Authority Granted

Certificates Granted to:	Date
1. Community Health Center, Inc. Serving Lake County and portion of Southeastern St. Louis County	December 13, 1973
2. Group Health Association of Northeastern Minnesota Serving Cook, Lake and Northern and Central St. Louis Counties	December 13, 1973
3. Group Health Plan Serving the seven county Twin Cities Metropolitan Area	December 13, 1973
4. MedCenter Health Plan Serving Hennepin County, Anoka County, and portions of Ramsey, Dakota and Carver Counties.	December 13, 1973
5. Minnesota Health Maintenance Network Plan (formerly Blue Cross/Blue Shield of Minn.) Serving the seven county Twin Cities Metropolitan Area, Itasca County, Southern Koochiching County and Central St. Louis County.	December 13, 1973
6. Nicollet-Eitel Family Health Plan Serving the seven county Twin Cities Metropolitan Area	December 13, 1973
7. Ramsey Health Plan Serving Ramsey County, Southern Anoka County, Central Washington County and Northern Dakota County	December 13, 1973
8. SHARE Serving the seven county Twin Cities Metropolitan Area	December 13, 1973

NUMBER OF ENROLLEES IN MINNESOTA

As of January 1, 1975, there were 96,601 enrollees in the eight health maintenance organizations in Minnesota. The table (Exhibit I) shows the enrollment of each of the Minnesota H.M.O.s in six-month increments since January, 1971. The increase from 39,853 in January, 1971 to 96,601 in January, 1975 represents a 170% increase during the four years.

The current total of 96,601 enrollees represents a statewide percentage of 2.5% of the Minnesota population. Within the service area served by Minnesota H.M.O.s,[1] the percentage is 5.1% of the population.

Change in H.M.O. enrollment is shown in Exhibit II. There has been an increase in each six month period since January, 1971. The increases are due to two factors: 1) steady, consistent growth of Group Health Plan, Inc., of St. Paul, and 2) emergence and growth of six new health maintenance organizations in Minnesota. The average six month increase has been 11.3% since January 1971. The average increase has increased to 13.4% each six months since January 1973, when five new H.M.O.s started operation in Minnesota.

Using this trend of 13% growth in H.M.O. enrollment every six months, projections for H.M.O. enrollment up to 1980 is shown on Exhibit III. This shows that enrollment in Minnesota H.M.O.s will be 324,225 in 1980 if the present growth pattern is maintained.

Exhibit IV shows the total enrollment by State, July 1973 and July 1974. That chart also shows the percentage increase in H.M.O. enrollment during that time period and the percentage of total State population enrolled in July, 1974. Minnesota ranks ninth both in the total number of people enrolled in the H.M.O.s and the percentage of total population enrolled.

Exhibit V shows a total of 177 operational H.M.O.s in the United States as of October 1, 1974. Seventy-seven (44%) of the H.M.O.s are located in the state of California. Minnesota has 8 H.M.O.s, which puts it in first place among the remaining states. Illinois has seven H.M.O.s and New York and Pennsylvania each have six H.M.O.s. Nine other states have either four or five H.M.O.s as of October 1, 1974.

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[1] According to the 1970 census, the population of the service areas of Minnesota H.M.O.s is 1,915,663. This area includes the counties of Anoka, Carver, Cook, Dakota (excluding the Hastings area), Hennepin, Lake, Itasca, Ramsey, Scott, St. Louis (excluding the Duluth area) and Washington (excluding the Stillwater area).

Even though Minnesota ranks second in number of operational H.M.O.s, there is a relatively small percentage of the total population involved at this time. Most of the Minnesota H.M.O.s have not enrolled as many individuals as they have capacity to serve; however, if more employers can be persuaded to offer their employees an H.M.O. option to the traditional health insurance benefits, the percentage of the population served by H.M.O.s will increase substantially.

As indicated above, only about half of the citizens of Minnesota live in areas served by an H.M.O. In fact, with the exception of the Iron Range and North Shore areas, there are no comprehensive prepaid services available to people outside the Twin Cities Metropolitan Area.

Similarly, the availability of H.M.O.s to people in low income and inner-city areas is marginal. Some counties (Lake, St. Louis, and Ramsey) have offered H.M.O.s to Title XIX (Medicaid) aid recipients, but only a small number are actually enrolled at the present time.

The State development grant program, involving ten grant projects, has been used to study the extension of prepaid services in these areas, and positive results have been achieved. The needs that must be met in rural and inner city areas have been better identified, as well as the problems that are peculiar to these settings, and in some instances service has been (or soon will be) made available to people htat previously did not have good access to care. The number of people thus served is relatively small, but in time the grant program could extend prepaid care to thousands of citizens who presently have limited access to health care services or, at least, to prepaid services.

As suggested above, the primary sources of health care financing are through government programs or employment benefits, and if more employers, especially the larger employers, were to offer an H.M.O. option as a part of their health care benefits, many more people would have access to this system. A federal law has been passed to require all Fair Labor Standards Act employers of 25 or more employees to offer a "federally certified" H.M.O. as an option to employees. However, the federal program is so vague and is moving so slowly, that in recent months it has operated to actually discourage H.M.O. growth because employers are not willing to adopt any program until they see how the federal requirement will effect them.

EXHIBIT I

ENROLLMENT IN MINNESOTA HMOs SINCE 1971

Organization	January, 1971	July, 1971	January, 1972	July, 1972	January, 1973	July, 1973	January, 1974	July, 1974	January, 1975
Community Health Center Two Harbors	3857	3774	3691	3648	3605	3695	3785	3745	3991
Group Health Association of Northeastern Minnesota Virginia/Grand Marias/Cook					30	500	1549	1678	8702
Group Health Plan St. Paul/Minneapolis	35,996	37,862	42,879	46,365	52,230	55,051	59,173	63,108	66,638
MedCenter Health Plan St. Louis Park					1000	4017	5506	6710	8108
Minnesota Health Maintenance Network Plan Minneapolis/Grand Rapids/ Virginia									1725
Nicolett-Eitel Family Health Plan Minneapolis						117	639	1309	1953
Ramsey Health Plan St. Paul					1715	1829	1945	2122	2184
SHARE St. Paul						3000	2853	2870	3300
TOTAL	39,853	41,636	46,570	50,013	58,580	68,209	75,450	81,529	96,601

EXHIBIT II
GROWTH OF HMO ENROLLMENT

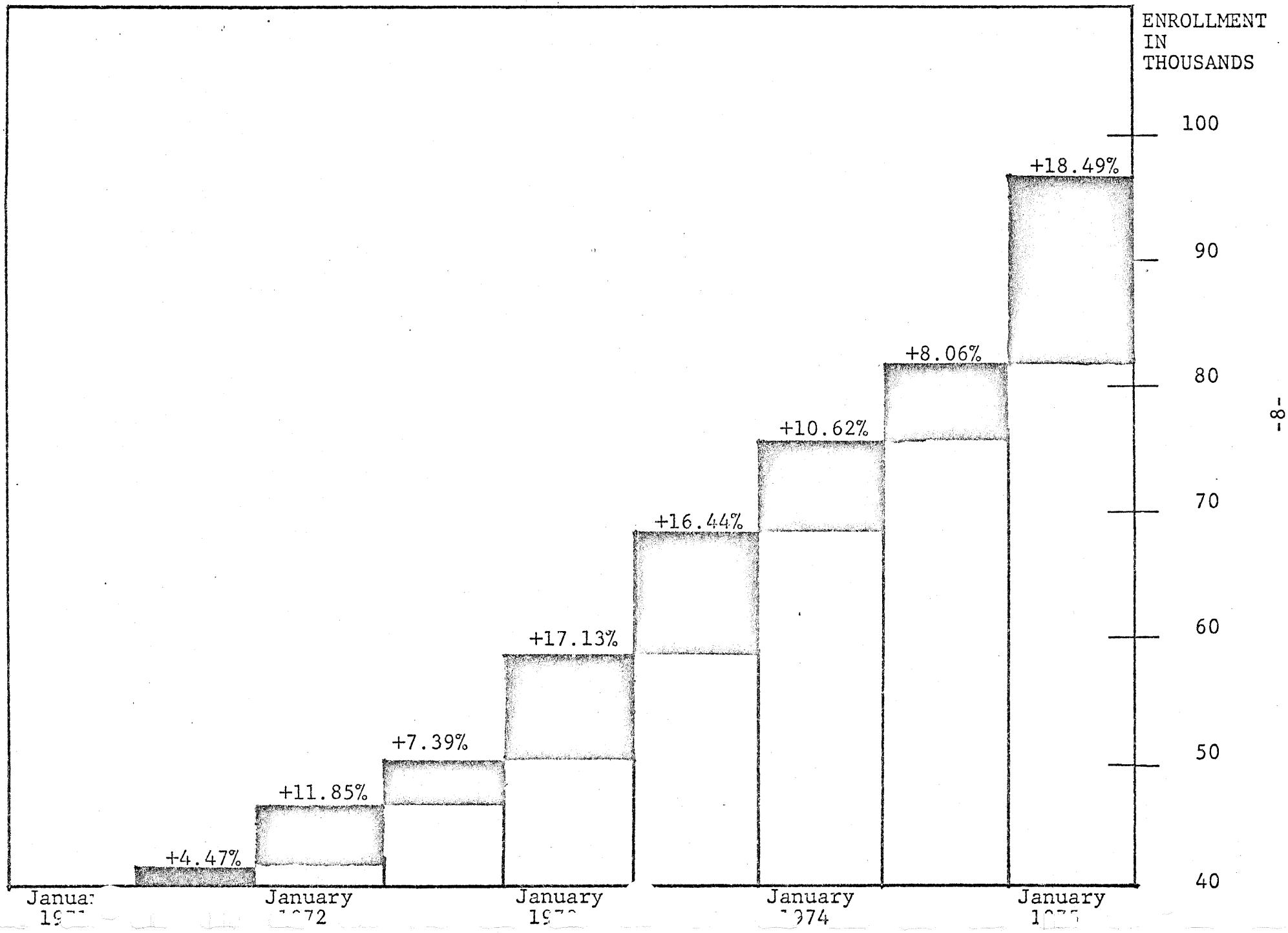

EXHIBIT III

Actual and Projected Enrollment
Increase Using 26%
Growth Per Year

Date	Actual H.M.O. Enrollment	Projected H.M.O. Enrollment	Percent of Total Population Enrolled in HMO's
January, 1973	58,580		1.54
July, 1973	68,209		1.79
January, 1974	75,450		1.99
July, 1974	81,529		2.15
January, 1975	96,601		2.54
July, 1975		107,929	2.84
January, 1976		121,960	3.20
July, 1976		137,815	3.62
January, 1977		155,731	4.09
July, 1977		175,976	4.63
January, 1978		198,853	5.23
July, 1978		224,904	5.90
January, 1979		253,916	6.67
July, 1979		286,925	7.54
January, 1980		324,225	8.52

EXHIBIT IV

Enrollment by State, July 1973 and July 1974

State	July 1973 Enrollment	July 1974 Enrollment	Percent Increase	Percent of Total Population Enrolled in 1974
California	2,536,959	2,732,069	7.7%	13.8%
New York	n/a	774,708	--	4.3%
Washington	193,433	214,726	11.0%	6.4%
Oregon	199,494	212,950	6.7%	10.3%
Hawaii	99,253	111,273	12.1%	14.8%
Ohio	91, 735	110,883	20.9%	1.0%
Dist. of Columbia	88,596	99,655	12.5%	13.3%
Michigan	78,000	92,862	19.1%	1.0%
Minnesota	68, 209	81,529	19.5%	2.1%
Colorado	46,248	61,310	32.6%	2.8%
Arizona	25,797	47,752	85.1%	2.7%
Illinois	25,699	40,245	56.6%	0.4%
Pennsylvania	11,819	38,295	224.0%	0.3%
Wisconsin	21,585	24,040	11.4%	0.6%

Data obtained from "A Census of H.M.O.s, October, 1974", prepared by H.M.O. Empirical and Policy Studies Group of the Health Policy Division, InterStudy, Minneapolis.

EXHIBIT V

Number of H.M.O.s by State, October 1, 1974

State	Number of Operational H.M.O.s.[1]
California	77
Minnesota	8
Illinois	7
Pennsylvania	6
New York	6
Arizona	5
Florida	5
Michigan	5
Washington	5
Colorado	4
Kentucky	4
Massachusetts	4
Missouri	4
Wisconsin	4

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[1] Data obtained from "A Census of H.M.O.s, October, 1974" prepared by H.M.O. Empirical and Policy Studies Group of the Health Policy Division, InterStudy, Minneapolis, Minnesota.

COST TO ENROLLEES

The Board of Health maintains records of the prepayment costs which enrollees pay to enroll in the various health maintenance organizations. Exhibit VI shows the prepayment rates of each H.M.O. during 1973, 1974, and the current rate for 1975. The chart also shows the percent increase during each year and the average annual increase for the two years.

At the present time the rate for a basic single H.M.O. plan ranges from $19.25 to $26.67 with the average of $22.47. This is an average annual prepayment cost of $269.64 per year.

The rates for family H.M.O. contracts are calculated in two different methods. One method is to have a composite family rate, regardless of family size. According to this method the rates range from $60.75 to $71.50. The second method for calculating family rates is to have one rate for a family of two and a second rate for families of three or more. For families of two the rates range from $38.50 to $47.50, with an average of $44.37. For families of three or more the rates range from $55.00 to $69.75, with an average of $64.31.

The average annual percent increase in H.M.O. contract rates during 1973 and 1974 has ranged from a low of 1.4% to a high of 15.3%. The average percentage increase has been 8.9% per year.

EXHIBIT VI: Prepayment Cost to Enrollees and Percent Increases

Organization	Type of Contract	1973	1974	Current 1975	% Increase From 1973 to 1974	% Increase From 1974 to 1975	Annual Average % Increase
Community Health Center Two Harbors	Comprehensive Plan						
	Single	$14.50	$16.50	$19.25	13.8%	16.7%	15.3%
	Family of Two	$29.00	$32.00	$38.50	10.3%	20.3%	15.2%
	Family of Three or More	$42.00	$46.00	$55.00	9.5%	19.6%	14.6%
Group Health Association Virginia/Cook	Community Rate, Virginia/Cook						
	Single	$25.90	$26.67	$26.67	3.0%	--	1.5%
	Family	$63.68	$65.50	$65.50	2.8%	--	1.4%
Grand Marais	Community Rate Grand Marais						
	Single	$21.00	$25.00	$25.00	19.0%	--	9.5%
	Family	$57.00	$61.00	$61.00	7.0%	--	3.5%
Group Health Plan	Standard Group Plan						
	Single	$19.40	$19.95	$21.90	2.8%	9.8%	6.3%
	Family	$52.50	$54.95	$60.75	4.7%	10.6%	7.7%
MedCenter Health Plan St. Louis Park	Group Contract						
	Single	$19.00	$19.75	$22.50	3.9%	13.9%	8.9%
	Family of Two	$41.00	$43.50	$47.00	6.1%	8.0%	7.1%
	Family of Three or More	$61.00	$63.50	$68.00	4.1%	7.1%	5.2%
Minn. Hlth. Maintenance etwork Plan Virginia	Group Contract, Iron Range						
	Single	--	--	$21.01		--	
	Family	--	--	$63.48		--	
Minneapolis	Group Contract, Twin Cities						
	Single	--	--	$21.41		--	
	Family	--	--	$63.48		--	
Nicollet-Eitel Family Health Plan Minneapolis	Group Contract Two Level						
	Single	$18.47	$18.47	$23.75	0	28.6%	14.3%
	Family	$56.11	$56.11	$64.90	0	15.7%	7.8%
	Group Contract Three Level						
	Single	$18.47	$18.47	$23.75	0	28.6%	14.3%
	Family of Two	$41.82	$41.82	$47.50	0	13.6%	6.8%
	Family of Three	$62.04	$62.04	$69.75	0	12.3%	6.1%
Ramsey Health Plan St. Paul	Standard Group Contract						
	Single	$21.59	$23.53	$25.80	9.0%	9.6%	9.3%
	Family	$59.80	$65.18	$71.50	9.0%	10.0%	9.5%
SHARE St. Paul	Standard Group Contract						
	Single	--	--	$19.50			--
	Family of Two	--	--	$44.50			--
	Family of Three or More	--	--	$64.50			--
	Non-group Contract						
	Single	--	--	$25.47			--
	Family	--	--	$70.00			--

EFFECT ON QUALITY OF HEALTH CARE SERVICES

At the present "state of the art" of health care quality evaluation, there are few objective indicators for the evaluation of the quality of health care services in terms of the results enjoyed (or suffered) by the patients ("outcome" indicators). We currently must rely upon the more mechanical indicators, the type of personnel and facilities utilized by the health maintenance organization, and the utilization (process) data for H.M.O. services, and the subjective, informal evaluation by enrollees and programs involving internal peer review by H.M.O. providers (which are in their early stages of development).

The utilization of Minnesota health maintenance organizations during 1973 and 1974 is shown on Exhibit VII. The data shown includes the bed days per 1,000 enrollees, discharges per 1,000 provider encounters per enrollee.

Conspicuously absent is any substantial uniform data, even in terms of input or process measures, for the existing (fee-for-service) system. Therefore, it is impossible to make a comparative analysis of H.M.O.s and arrive at a meaningful conclu-on quality of care.

However, we do have some subjective impressions that may be somewhat helpful. These thoughts relate to the eight existing certified H.M.O.s in Minnesota, and should be considered in that context. First, with the process used in the various plans to select the providers that will serve the enrollees, the H.M.O.s seem to screen out the poorer providers, (with quality determined by input standards or subjective reputation). For instance, H.M.O.s have selected clinics or individuals that have been identified as having established good reputations in the community, or the plans have set certain eligibility requirements which assure well trained people (such as requiring board certification of board eligibility as a standard in hiring physicians).

Secondly, pursuant to our regulations, the physicians practicing in H.M.O.s must participate in peer review programs. These are developing at the present time, and operate to keep the physicians aware of problems in serving the H.M.O. members and alert to the best methods of solving their health problems.

Third, the members (consumers) have formal avenues for input (board membership, advisory boards and complaint systems) and like peer review for the providers, this brings matters to the

attention of the providers and management that are perceived by the patients as problems or short-comings of the system.

As indicated, there is no conclusive data on results in either the prepaid system or the fee-for-service system, so no valid conclusion can be formed. However, it can at least be said that there is absolutely no evidence of any lesser quality in the prepaid system, and there are approaches being used in the H.M.O.s that might lead to improved results in terms of better care and, thus, better health.

EXHIBIT VII Utilization of H.M.O.s during 1973 and 1974

Or Organization	Bed Days Per 1000 Enrollees 1973	1974	Discharges Per 1000 Enrollees 1973	1974	Average Length of Stay 1973	1974	Outpatient Provider Encounters 1973	1974
Community Health Center[1] Two Harbors	804	819	103	102	7.5	8.0	3.9	3.8
Group Health Association Virginia, Grand Marais Cook	706	690	148	150	4.8	4.6	5.9	4.5
Group Health Plan St. Paul, Minneapolis	489	492	82	84	5.8	5.9	3.7	3.5
MedCenter Health Plan St. Louis Park	330	349	79	82	4.2	4.3	4.4	4.2
Minn. Health Maintenance Network Plan Minneapolis, Virginia Grand Rapids	--	n/a	--	n/a	--	n/a	--	n/a
Nicollet-Eitel Family Health Plan Minneapolis	271	505	48	116	5.6	4.4	2.3	4.1
Ramsey Health Plan St. Paul	631	775	138	147	4.6	5.3	4.9	7.4
SHARE St. Paul	775	560	86	83	9.0	6.7	2.8	3.7
Average	572	598	98	101	5.9	5.7	4.0	4.2

[1] Utilization Data for Comprehensive Plan only, excludes "Over 65" Plan.

COST SAVINGS TO CONSUMERS

There is some evidence of economy to the consumer in the H.M.O. setting. Once again, however, it is not possible to form firm conclusions about this system because there is inadequate data to compare with.

In monitoring the operations of the H.M.O.s in Minnesota we have observed certain elements that help the consumer in the price he pays. First, H.M.O.s are generally in a strong bargaining position from the point of view of savings to providers on administrative costs, and this keeps down the cost of services to the H.M.O. Secondly, with some hospitals and pharmacies, the enrollees represent a substantial source of revenue that otherwise would not be generated, so the costs to the H.M.O. can sometimes reflect this bargaining position.

Since we do not have good data on costs in the other system, we cannot reach conclusions as to whether there are savings, or whether they are passed on to the consumer, but there are many examples that indicate that savings do exist and that they inure to the benefit of the enrollees.

First, you will note that the average annual rate for an individual health maintenance contract is $270.00 at the present time. This may or may not include complete vision care, and does not include services covered by federal programs (Medicare or veterans benefits for instance), or services covered by workmen's compensation coverage. Furthermore, the services purchased are largely personal health services, (as opposed to nonpersonal, which includes construction of facilities, research, disease control) and therefore this amount does not accurately reflect total per capita health care costs for the H.M.O. enrollees.

Nonetheless, this compares to a national total per capita expenditure for health in fiscal year 1974 of $485.00, and a national per capita expenditure for personal health care of $452.00. CAUTION: the exclusion of most older people skews the Minnesota H.M.O. data substantially and, therefore, this can only serve as a background for further study.

The rate of increase in cost is a second vehicle for comparison and is slightly more reliable. Our total national health care expenditures for fiscal years 1973 and 1974 were at 7.7% of the G.N.P. and totalled $94,235,000,000 in 1973 and $104,239,000,000 in 1974. Of these amounts, $87,805,000,000 and $97,183,000,000 were the expenditures for personal health care in 1973 and 1974 respectively. This represents a 10.7% increase in personal health care costs from one fiscal year to the next.

Of course, during 1974 the wage and price controls in the health industry were removed, so much of the increase relates to a "catch-up" effect that is not present in other fields and that may not prevail in other years. With this warning, note that the preliminary figures for the first nine months of calendar year 1974 show an annualized increase of 14.3%, including an 18% increase in hospital rates and 14.0% increase in physicians fees.

In Minnesota, hospital cases paid in 1974 by Blue Cross and Blue Shield of Minnesota showed a 9.5% increase.

These figures are to be compared to the increase in prepayments in Minnesota H.M.O.'s from 1973 to the present of from 1.4% to 15.3%, and an average increase of 8.9%.

Our final cost comparison relates to the monthly prepaid amounts for family contracts in H.M.O.s as compared to the related amounts in various kinds of group insurance programs. This is as follows:

Program	Monthly Family Rate
Lowest H.M.O. Family Rate	$55.00
Average H.M.O. Family Rate	$64.31
Highest H.M.O. Family Rate	$69.75
Large Groups (State Employees)	$54.92
Group with Benefits for Ambulatory Care	$75.00
Medium group - 50 people	$50.00
Small group - 10 to 15 people	$62.00

Considering the difference in benefits in the H.M.O.s, which generally have greater benefits, especially in the more costly areas of "first dollar" ambulatory coverage, (more costly in terms of the prepaid amount or premiums), this again would indicate that services purchased through the H.M.O. cost less in the aggregate than similar services purchased through the fee-for-service system. The other data would indicate that H.M.O.'s have controlled the rate of increase in costs more effectively than the other system.

On the other hand, press reports indicate that Group Health Co-op of Puget Sound is now installing an approximately 20% increase in its rates.

One real cost savings is in administrative cost, particularly in the relationship between the financing mechanism and the provider.

Another real reduction in cost is a lesser use of the hospital setting for the delivery of service, which comes from more ambulatory treatment and shorter lengths of stay.

Other areas provide savings to H.M.O.s and their enrollees, but do not flow from actual efficiencies in rendering care. These savings are from the H.M.O.'s bargaining power in buying goods and services, which sometimes allows the H.M.O. to avoid sharing the providers' bad debt expenses and in some cases, various elements of "overhead" or basic operating costs.

To repeat, then, there is no accurate comparative data, but some savings appear to exist in the H.M.O.s, and the savings seem to be passed on to the consumer.

National cost data and projections are from: Worthington, Nancy L., "National Health Care Expenditures, 1929-74," and "Current Operating Statistics," Social Security Bulletin, Vol. 38, No. 2, February, 1975, DHEW Publication No. (SSA)75-11700.

RECOMMENDED LEGISLATION

We have the following proposals:

1. Require claim reserves for items on which the H.M.O. pays money claims. This relates to the 1974 amendment which allowed the H.M.O.'s to "self insure" or insure certain of their enrollees' health care costs (as opposed to direct service benefits) and would remove an element of risk of financial trouble without substantially increasing costs or initial capital requirements.

2. Allow H.M.O.s to pass the financial risk for the provision of care to the providers of care (pay providers on a fixed capitation basis). This is being done now and is desirable, but it is technically improper. This would remove the technical problem.

3. Require large employers, in addition to the State, to offer the H.M.O. option to employees. This is recommended to maintain growth, so that the presence of the alternative system has some impact on health care delivery. As a part of this, we also urge a mandate of conversion rights for enrollees equal to those for insured people in a given group, and marketing regulations in the dual choice setting.

4. Renewal of the grant program for H.M.O. development with a $150,000.00 appropriation and amendments to the statutes to make the program more flexible.

5. Expand the powers of H.M.O.s (§62D.05) to allow the sale of other prepaid services, i.e., dental or medical services only, to allow H.M.O.'s to compete with independent providers offering these programs and to encourage the development of prepaid services through a single system.

6. Finally, if the types of conclusions called for in §62D.25 are important and are still needed, we recommend funding for a comparative study of both the prepaid system and the fee-for-service system.