The Federal Government as Venture Capitalist: How Does It Fare?

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IN THE ANNALS OF FEDERAL PROGRAM DEVELOPment, the Office of Health Maintenance Organizations (OHMO) is a unique enterprise. The office is charged with the specific assignment of creating new private businesses that ultimately must succeed or fail by their own capitalistic devices. The very notion that government should so boldly challenge private medicine says a great deal about its dissatisfaction with the status quo, but perhaps of more importance now is a report on how this federal experiment in venture capitalism is faring.

First of all, one must recognize the formidable obstacles that loom before a government agency that strives to crack a private market. These obstacles stem from the complex nature of government itself, its role as a redistribution agent, and its political inclination to be all things to all people (or at least as many as can be accommodated at any one time). Congress posed additional obstacles by its complicated design of the Health Maintenance Organization Act of 1973.

The HMO concept emerged as a government initiative during the Republican administration of Richard M. Nixon. The concept proved politically and ideologically attractive to Nixon's conservative administration because of its reliance upon financial incentives rather than regulation to contain spiraling health-care costs, thus reducing gov-

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ernment's role. But the HMO act, as Birnbaum (1980) points out, became ensnared in inflexible language, delayed rule-making, and bureaucratic wrangling, thus complicating OHMO's role as administrator. Organizationally, OHMO is part of the Public Health Service and currently falls under the Office of the Assistant Secretary for Health, Department of Health and Human Services (HHS).

The challenge of creating new businesses is a tall order for any organization. For an agency like HHS, it was a totally foreign undertaking. Three broad social purposes dominate the works of the department: administering income transfer payments to eligible individuals (aid to families with dependent children and Social Security, for example), financing medical care for eligible elderly and poor people (Medicare and Medicaid), and awarding grants to nonprofit organizations that are engaged in activities deemed worthy of public support (medical schools, for example) but cannot conceivably generate enough revenue on their own to become self-sustaining. Thus the orientation and skills of most HHS employees do not lend themselves readily to venture capitalism.

Karen Davis, deputy assistant secretary for health planning and evaluation, and Howard R. Veit, director of OHMO, characterized OHMO's mandate in a June 11, 1980, memorandum to Dr. Julius B. Richmond, assistant HHS secretary for health and U.S. surgeon general:

> As we considered HMO legislative issues and general program direction, we continually encountered the conflict between the social goals the HMO program was endowed with at its inception and the difficult and complicated task of creating viable, self-sufficient businesses. This conflict is difficult, but not always impossible, to reconcile. In general, OHMO and OHPE [Office of Health Planning and Evaluation] have recommended protecting the social responsibility features of the HMO statutes. You should be aware, however, that the "pro-competition" proponents in OMB [Office of Management and Budget] and the Congress will attempt to weaken these aspects.

Venture capitalism is a form of private investment in which government usually plays no central role except, in select instances, one of oversight through the Securities and Exchange Commission. Venture capitalism involves individuals or organizations that invest their

money in high-risk development opportunities, hoping for a high return on equity. OHMO's development activities characterize some, but not all, features of venture capitalism. OHMO invests public dollars in high-risk situations with a hope that the return for society will be the creation of private organizations that are capable of delivering quality health care at a reasonable price.

A fundamental difference between the federal funding of HMO development and of other HHS health service projects is the matter of self-sufficiency. From the outset, HMOs are expected to work toward the day when they do not depend on federal dollars to operate, except for those that pay for services rendered through Medicare and Medicaid. Virtually all other health service projects funded by HHS are expected to depend entirely on the federal dollar for survival. When federal support is removed, the projects are abandoned, except in those instances when state or local governments are willing to assume the costs.

The task of creating new HMOs has taxed the capabilities of OHMO's small staff. Initially, OHMO felt most comfortable awarding grants to HMO project applicants, but staff lacked the expertise to offer the kind of financial planning and marketing advice so critical to the success of a new prepaid group practice. But there has been progress on this front. OHMO staff is in a better position today to offer technical assistance and also it is using industry experts in financial matters to help new plans. Veit recognizes that the future of the HMO industry hinges in good part on its ability to attract capable managers to the field. Also, the General Accounting Office (GAO), the monitoring arm of Congress, has worked closely with OHMO to increase the management skills of the program and its grantees.

OHMO has evolved in its six years of operation—and countless reorganizations—from essentially a grant-making office to an office that has come to recognize, if not yet totally implement, its complex mandate. In talking with me on March 23, 1980, Veit said:

> OHMO is much more analytical now than before, much tougher in its review of grant applications. But it's difficult in our program to separate the bad risks. It's a painful process to get staff to look with discernment at potential grantees. But we strive to be unrelenting on that score because funding bad grantees today only leads to failures tomorrow.

The difficulties of creating a private business usually are a revelation to HMO grantees as well. Many of the grantees represent consumer-based organizations that do not have staffs with the necessary business background to successfully launch a new enterprise. One HMO official described this dilemma in a personal interview April 14, 1980, but did not want to be identified; Veit himself, however, also subscribes to these views:

> We've found that the health-care field is not a field that has attracted a lot of people with corporate skills. HMOs are businesses that generate millions in income and expenses. You can't have a nice guy who is a social worker running that kind of an organization. Most of our grant applications derive from community groups that are striving to change the delivery system a little. OHMO has tried to adjust to this problem by becoming more aggressive itself in seeking out organizations that have some of the necessary skills to create HMOs.

OHMO's mandate is further complicated by the conflicting nature of its several roles. Besides serving as a venture capitalist, OHMO also is charged by law with promoting the HMO concept in the hope of stimulating development through private capital and with regulating federally qualified HMOs. Thus, the OHMO must serve as the prime HMO booster and the major overseer of HMO performance—conflicting assignments that cause no end to strife within the program. A federally qualified plan is an HMO that abides by operational requirements set out in the HMO act, including the offering of a comprehensive package of benefits. In return, the act provides access to the market through a requirement that all employers of 25 or more individuals must offer their employees an opportunity to enroll in a qualified HMO if one is available in the area. HMOs that accept federal funds and become operational must seek federal qualification.

Veit's directorship also is hindered by other realities of the bureaucratic life. Almost one-third of OHMO's full-time employees—62 of 177—work in the ten regional offices of HHS. These staff members, however, report to the respective regional health directors, who, in turn, are responsible to the assistant secretary for health, not to Veit. OHMO, like most government programs, also operates under the vagaries of a political system that is constantly reordering its priorities

—not the kind of environment needed to bolster health maintenance organizations in an uncertain market. Veit (1980) referred to this problem in a speech:

> The impact of the federal program could have been greater if the government's commitment to HMO growth had remained consistently higher during the 1970s. In 1975, there were ample funds appropriated by Congress to start new HMOs. In 1976 and 1977, scarce dollars for new programs together with poor administration by HEW [now HHS] impeded growth. In late 1977, the department began to reorganize the federal program. This, plus increased congressional appropriations in 1978, 1979, and now in 1980, has allowed us to bring many more new HMOs into development.

The foregoing list of obstacles that stand before OHMO is by no means an apology for its performance. Any individual who spends time observing or participating in the life of a government program soon recognizes that things never run as smoothly as one would prefer, the staff is never as capable as it could be, and funds never seem to go far enough. OHMO is certainly no exception to this rule. The marvel, perhaps, is that OHMO has accomplished anything as a tiny outpost favoring marketplace solutions in a department that tilts to regulation.

Performance

One measure of OHMO's performance is the growth of new prepaid health plans in the 1970s, though a cautionary note seems appropriate. Most plans started with federal funds are small. And though they serve as symbols of one direction of reform favored by government—prepaid group and individual practices—their impact on the system thus far has not been dramatic. Zealous rhetorical overkill in the early days of the program, even while Congress was still debating the legislation that led to the 1973 HMO act, far surpassed what could realistically be expected to occur in the relatively short time that has passed since then. The overwhelming number of members enrolled in HMOs today belong to plans started long before the federal government began its romance with prepaid group practice.

Since 1970, the number of HMOs has increased from fewer than 30 to 230. This includes federally qualified plans and plans that have not

sought qualification. Enrollment nationally in prepaid health plans, or HMOs as they have been called since the federal government got in the act, has increased from 2.9 million to almost 9 million, according to OHMO. Since 1974, the federal government has awarded grants of $130 million and committed $175 million in loans. Of the 230 HMOs that now are providing care, 113 are federally qualified, a regulatory stamp of approval affixed by OHMO that was defined earlier. Of the 113 qualified HMOs, 80 have received federal grant and/or loan assistance. Veit (1980) notes that federally assisted HMOs are "for the most part, still small and still striving toward self-sufficiency. Although the federal program has already had a considerable impact on the growth of the field, 85 per cent of all members are in HMOs that have developed privately. The federal government has, however, put in place a number of new programs that represent substantial capacity for future growth."

OHMO, not surprisingly, has encountered failure, too. Any time government intervenes in a private market, it assumes risks that private investors are generally thought to be unwilling to take. OHMO has revoked the qualification of 7 plans,[1] leaving 113 so designated.[2] Thus, the current failure rate is 6.0 percent. The overwhelming cause of failure was inadequate plan management, according to OHMO, but lack of capital and poor location also were factors.

Another relevant measure of OHMO's performance is the failure rate on loans advanced to qualified HMOs to subsidize their operations until they become self-sustaining (Department of Health, Education, and Welfare, 1979). As of January 1, 1980, the Department of Health, Education, and Welfare (HEW) had extended $157 million in

[1] Sound Health Association, Takoma, Washington; Central Essex HMO, Orange County, New Jersey; Health Alliance of Northern California, Los Gatos, California; ChoiceCare Health Services Inc., Fort Collins, Colorado; Gem Health Association, Boise, Idaho; Group Health Plan of New Jersey, Hudson County, New Jersey; and HMO Concepts, Anaheim, California. After they failed as separate entities, Sound Health Association was taken over by Group Health of Puget Sound and Group Health Plan of New Jersey by Health Insurance Plan of Greater New York.

[2] Regarding nonqualified plans, an informal list prepared by OHMO's division of development estimates that 60 plans have failed since records were first kept in 1970. Judith M. Mears, a lawyer for the Kaiser Foundation Health Plan who conducted a survey on failures, concluded, on the basis of a 1979 census, that a total of 174 nonqualified plans existed between 1970 and 1979. Thus, she estimated a failure rate of 34 percent for nonqualified HMOs in the 1970s.

loans and loan guarantees to qualified plans. Of that total, $6.9 million remains outstanding from the qualified HMOs that ceased operations in 1979. That amounts to a 4.4 percent loan default rate for qualified HMOs in 1979.[3]

While Mears found it possible to calculate a fairly accurate rate of both federally qualified and nonqualified HMOs, she concluded that the data necessary to compute a failure rate for small businesses or service businesses are not being collected by any private or governmental entity. The rate that business people and personnel in federal agencies attribute to the Small Business Administration (SBA) is that one of every two small businesses goes out of business within the first two years of operation, but the SBA does not use this statistic in any of its official material.

One question Congress undoubtedly will ponder in early 1981 when it considers extension of the Health Maintenance Organization Act is how to judge a failure. Can the termination of an operational HMO be judged a total failure, given the knowledge that it is a risky venture? Were there valuable lessons learned that justify the public investment? Should the federal government reduce its potential for loss by investing only in HMOs that look like sure winners?[4]

One thing OHMO has learned through the failures is that the demise of an HMO is accorded far more publicity than is the bankruptcy of most small businesses. In a story from Fort Collins, Col-

[3] Mears, in her survey, found that a loan default rate of 4.4 percent falls about in the middle of a list of default rates for selected federal loan programs: farm ownership, 0.1 percent; rural housing, 0.2 percent; farm operating loans, 1.0 percent; farm emergency loans, 1.0 percent; Hill-Burton loans, 1.7 percent; FHA hospital loans, 1.7 percent; health professions student loans, 2.0 percent; FHA Title II (group practice facilities and physicians' offices), 3.5 percent; Small Business Administration loans, 3.8 percent; all HUD loans, 5.4 percent; nursing student loans, 5.4 percent; economic development loans, 7.1 percent; Federal Housing Administration nursing home loans, 9.6 percent; guaranteed student loans, 11.5 percent; direct student loans, 17.4 percent; Federal Housing Administration Section 235 program loans, 19.5 percent.

[4] OHMO's current development strategy calls for placing first priority on cities where health care costs are considered above the national average. OHMO places in this category the following areas: Boston-Lawrence-Haverhill-Lowell, Massachusetts; New York City and environs; Buffalo, New York; Newark, New Jersey; Philadelphia and Pittsburgh, Pennsylvania; Washington, D.C.; Baltimore, Maryland; Atlanta, Georgia; Miami, Tampa, St. Petersburg, Florida; Chicago, Illinois; Detroit, Michigan; Cleveland, Ohio; Milwaukee, Wisconsin; Houston and Dallas, Texas; St. Louis, Missouri; and Denver, Colorado.

orado, headlined "Health Maintenance Organization Collapses as Its Doctors Drop Out," the *New York Times* reported on January 2, 1980:

> Insured medical care for 30,000 people in northeastern Colorado is ending today because almost all the area doctors abandoned the local health maintenance organization. The doctors' decision to withdraw from ChoiceCare Health Services, Inc., left subscribers scrambling for coverage, federal officials fuming and creditors holding a debt of more than $1 million.

In Veit's view, the program has not been operating long enough to accurately calculate what its failure rate ultimately will be:

> The ultimate success of the program depends on the number of [HMO] programs that are both financially viable and deliver high-quality care. Determining success rates requires many years given the long development period for an HMO. Our experience shows that it takes three or four years to become operational, and an additional four to five years to reach the break-even point. Thus, it takes seven to nine years of development before we can talk definitively about success. (Veit, 1980)

On a more pessimistic note, Veit told a newspaper interviewer, "It's a miracle that more haven't failed. Like any business, an HMO that isn't run effectively will fail. In the coming years, we anticipate 5–10 failures a year" (*American Medical News,* 1980).

One of the more interesting results of federal HMO development is the evolution of a particular model—the individual practice association, or IPA as it is known in industry parlance. When Congress designed the HMO act, it lumped under the HMO definition a form of practice in which member doctors remain in their individual offices but are compensated on a prepaid basis. IPAs are formed by solo fee-for-service practitioners as a defensive measure, in fear of the economic consequences of the creation of a prepaid group practice in their area. IPAs generally are closely affiliated with the local medical society. Private physicians have taken advantage of the availability of federal funds to create IPAs. Strumpf (1980) found that the growth of IPAs from fewer than 5 before enactment of the HMO law to 89 today stemmed largely from federal funds, in the case of 42 plans, and from support by the Blue Cross and Blue Shield Association, in 15 other instances. He said:

> When development is viewed from this competitive perspective, we find that 55 currently operational IPAs developed after a PGP [prepaid group practice] was established [in the same service community].[5]

Fee-for-service physician response to the federal HMO initiative has led to the development of more new plans than has the response from the business community, despite the increasing expressions of concern by businessmen about the rising cost of medical care (Demkovich, 1980). Those corporations that have become involved in the HMO movement have done so not by sponsoring their own HMOs but rather by encouraging their employees to enroll in already operating plans.

InterStudy (1979) made this point in reporting to the Health Care Financing Administration its progress under a grant for "Stimulation of Alternative Health Care Delivery System Development": "One of the original intents of the project, actual corporate development of an ADS [alternative delivery system], was found to be an impractical alternative for most firms."

The National Association of Employers on Health Maintenance Organizations (Employee Benefit Plan Review, 1979) reported a similar conclusion in its Survey of National Corporations:

> There appears to be little interest among respondents to develop their own HMOs—even though this group would have access to the necessary capital—and of the survey respondents only 4.6 percent have developed a company HMO, and 93.4 percent indicated no interest in developing one.

The Future

Congress enacted legislation in 1973 that sought to promote HMOs, but the act was so laden with costly requirements that new organizations developed under it found competing against traditional insurers

[5] IPAs require physicians conditioned to fee-for-service patterns to change their practice modes in order to live within the fixed budget that prepayment dictates. The Physicians Health Plan of Minnesota, an IPA organized by the Hennepin County Medical Society, published a fascinating account entitled, "A Case Study of Utilization Controls in an IPA," which details how one organization coped with the challenge. The study was prepared for OHMO under Contract No. 342804.

almost an impossible task. In two subsequent sets of amendments approved in 1976 and 1978, Congress removed some of these requirements and relaxed others in the hope of stimulating more HMO development. New provisions also were added, reflecting the critical need to train HMO managers and bolster OHMO's capacity to provide technical assistance to developing plans.

These amendments included minor changes in the mandated benefit package, relaxation of the open-enrollment requirement, higher ceilings for grant awards, extension of the loan eligibility period, establishment of an HMO management training program and a technical assistance authority. Other amendments included a new requirement for employers to arrange for HMO payroll deductions and authority for HMOs to seek payment from workmen's compensation and other insurance for enrolled members who had double coverage.

The HMO act expires September 30, 1981, and the administration now is preparing its recommendations for extension of the law. The Carter administration has been resolute in its commitment to HMO development and there is no reason to believe that the president will change course on this question, despite a view held by his Office of Management and Budget that the HMO concept has demonstrated its effectiveness and now it is time for the private sector to assume responsibility for further plan development.

The major legislative issues involved in the extension are similar to the kinds of questions debated in 1976 and 1978. Should more flexibility be included in the mandated benefit package so that HMOs can compete more effectively? Should the development authorities be streamlined so that financial assistance flows without major disruption to HMO projects? A new thrust also will impact on the 1981 debate. A small but growing number of members of Congress believe a medical marketplace virtually free of federal sanctions would be the most favorable environment in which competition could thrive. These members may strive to remove requirements such as community rating in the hope of making HMOs more competitive. Most of the HMO industry would resist such a move because of the importance of community rating as a major distinguishing characteristic of prepaid group practice, because of its value in helping to achieve financial stability, and because it provides high-risk groups better access to HMOs.

In sum, government must recognize that it has created a unique program. OHMO is charged with using tax dollars to develop new

private businesses, a mandate that places the office in a role uncharacteristic of a government agency. But in carrying out this assignment, OHMO cannot in all instances be a hard-nosed entrepreneur looking for the best risk because another dimension of its mandate is to increase access to care to the most vulnerable segments of American society. Balancing these mandates in a responsible manner will be a demanding assignment even under the best of circumstances.

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