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# Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering

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# Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering

*Philip C. Kissam* and Ronald M. Johnson***

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## I. INTRODUCTION

A health maintenance organization (HMO) may be defined as an organization that agrees to provide, directly or by contracts with

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other providers, a specified range of health services to a voluntarily enrolled population in exchange for prepaid per capita payments.[1] The HMO's primary and unique feature is that it is both a health service provider and a health service insurer.[2] As providers with fixed budgets, HMOs have much stronger incentives to control health service costs than the fee-for-service providers who dominate the American medical economy.[3] As insurers with relatively close control over the delivery of insured services, HMOs also should have greater ability to control costs than traditional health service insurers.[4] These facts make HMOs a most promising instrument for re-

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1. INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, HEALTH MAINTENANCE ORGANIZATIONS: TOWARD A FAIR MARKET TEST 2 (1974) [hereinafter cited as IOM REPORT]. This broad definition carries several policy implications that should he noted here for more complete understanding of the term. First, the definition includes profit-making as well as nonprofit entities. Secondly, the definition allows for great flexibility in an HMO's organizational structure. For example, it includes not only prepaid medical group practices with salaried physicians, but also foundations sponsored by medical societies that reimburse private practitioners on a fee-for-service basis. Thirdly, the definition is not limited by reference to specific health care services. Under this definition an HMO might provide only prepaid dental care, prepaid drug services, or prepaid surgical services. Finally, the definition does exclude nonvoluntary enrollees, although prepaid health care practices could be established for nonvoluntary populations. No one to our knowledge has proposed this, and consumer choice of HMOs does seem to be an important device for helping guard against the risk of financially induced underservice by HMOs, *id.* at 53-54, and for obtaining consumer acceptance of this relatively new form of medical practice, *see id.* at 42. Note also that the term "health maintenance organization" itself possibly is misleading in its implication that HMOs are likely to be substantially better than other providers in maintaining the health of patients through preventive rather than remedial medical care. *Id.* at 2. A more generic term such as "prepaid health care practice" would appear to be preferable, but the term HMO has obtained popular acceptance among health care policymakers and on balance its use appears to reduce rather than add to semantic confusion. *Id.*

2. *Id.* at 3.

3. *See* Auger & Goldberg, *Prepaid Health Plans and Moral Hazard*, 22 PUB. POLICY 353 (1974).

4. Traditional health service insurers, Blue Cross, Blue Shield, and commercial carriers, typically reimburse providers from whom a subscriber bas chosen to obtain service or indemnify subscribers for fees paid to a provider chosen by the subscriber. *See* M. ROEMER, R. HETHERINGTON, C. HOPKINS, A. GERST, E. PARSONS & D. LONG, HEALTH INSURANCE EFFECTS: SERVICES, EXPENDITURES, AND ATTITUDES 1 (1972) [hereinafter cited as ROEMER]. These arrangements provide insurers with less legal and administrative control over the delivery of services than may be established by an HMO tbat contracts in advance with professional and institutional providers. Admittedly legal controls over providers can be implemented by establishing conditions for provider reimbursement, but individual insurers may be in a weak bargaining position vis-a-vis providers to obtain such controls and administration of these controls can be cumbersome. Moreover, it is the nonprofit Blues that have tended to use the provider cost reimbursement method, and physicians and hospitals have created and dominated Blue Shield and Blue Cross carriers, respectively. S. LAW, BLUE CROSS WHAT WENT WRONG? 6-13, 18-30 (2d ed. 1976) [hereinafter cited as LAW]. It is not likely that the Blues will turn willingly on their creators and attempt to impose stringent cost controls, at least in health insurance markets where these carriers have established relatively dominant positions.

forming the health care system,[5] although they also raise concern about the possibility of underservice that results in the denial of needed care.[6]

HMOs have existed in this country since 1929.[7] They now serve as the primary health care providers for perhaps as many as ten million Americans,[8] but only in the past decade have the numbers of HMOs and their subscribers expanded appreciably.[9] In this decade policymakers also have developed substantial interest in promoting HMOs as an alternative to fee-for-service medicine, primarily in response to society's *cri de coeur* over rising health care costs.[10]

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5. *See, e.g.*, S. REP. No. 129, 93d Cong., 1st Sess. 1-17 (1973) (reporting on S. 14, the Senate version of the Health Maintenance Organization Act of 1973) [hereinafter cited as SENATE HMO REPORT I]; Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716 (1970) [hereinafter cited as Havighurst, *HMOs*]; Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644 (1972).

6. *See, e.g.*, IOM REPORT, *supra* note 1, at 51-61; Havighurst, *HMOs*, *supra* note 5, at 754-56.

7. HEALTH SERVICES ADMINISTRATION, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH MAINTENANCE ORGANIZATIONS: SUMMARY OF FY 1975 ANNUAL REPORT 1 (1975) [hereinafter cited as HEW ANNUAL REPORT].

8. *See* N.Y. Times, May 17, 1976, at 16, col. 5. *But cf.* note 9 *infra*.

9. *See* HEW ANNUAL REPORT, *supra* note 7, at 5, indicating that from 1965 to 1975 the number of HMOs in operation increased from ahout 20 to more than 175 and the number of HMO enrollees increased from about 1.5 million to 6 million. One national census of HMOs recorded a growth in the number of operational HMOs from 34 prior to 1970 to 181 as of July 1, 1975. R. WETHERVILLE & J. NORDBY, A CENSUS OF HMOS: JULY 1975, at 8 (1975) (available from Interstudy, 123 East Grant Street, Minneapolis, Minn. 55403 [hereinafter cited as HMO CENSUS]. The July 1975 report, however, contains the last HMO census data collected by Interstudy. Letter from Robert E. Schlenker, Senior Health Economist, Interstudy, to Philip Kissam, Oct. 3, 1975. This recent expansion is due apparently to favorable market conditions, including rapidly increasing health care costs and related insurance premiums, and the expectation of HMO organizers that the federal government will provide subsidies and other benefits to promote HMO growth. McNeil & Schlenker, *HMOs, Competition, and Government*, 53 MILBANK MEM. FUND Q. 195, 195-207 (1975).

10. The current interest of policymakers in HMOs seems to have been initiated in 1967 by the report of a National Advisory Commission on Health Manpower that outlined the possibility of significant efficiencies for prepaid group practices. *See* Greenlick, *The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation*, 399 ANNALS 100, 101-02 (1972). This interest has developed notably as part of the political response to dramatically rising health care costs. *See, e.g.*, 117 CONG. REC. 284 (1971) (speech by Senator Kennedy to introduce a bill to create a national system of health care); 117 CONG. REC. 3119, 3119-21 (1971) (message of President Nixon to Congress relative to building a national health strategy). Admittedly rising health care costs seem extraordinary and worrisome. Since 1959, except for the period from August 1971 to April 1974, when mandatory federal price controls applied to the health sector, both hospital service costs and physician fees have increased at substantially higher rates than the prices for other consumer services, and during this period the percentage of GNP devoted to health services increased from 5.2% to 8.3%. PRESIDENT'S COUNCIL ON WAGE AND PRICE STABILITY, THE PROBLEM OF RISING HEALTH CARE COSTS 5-9, 27 (1976). Some of this spending has been for needed additional services and relatively unique cost increases, but much of it apparently must be attributed to the peculiarities of health

New federal[11] and state[12] legislation to promote and regulate HMO development has been enacted and the literature on HMOs has flowered.[13] There remains, however, substantial disagreement about

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economics, which include importantly, the widespread availability of third-party payments for services and the fact that physicians alone often determine the nature and extent of services. *See id.* at 9-21.

11. The major federal HMO legislation consists of the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (Supp. V, 1975), and the 1972 amendments to the Social Security Act that established conditions for HMO participation in the Medicare program on a prepaid basis, 42 U.S.C. § 1395mm (Supp. V, 1975), and authorized states to provide health services to Medicaid enrollees through prepaid contracts with HMOs, 42 U.S.C. § 1396(a)(23) (Supp. V, 1975). This legislation is discussed in the text accompanying notes 232-459 *infra.*

12. We analyze state HMO legislation in a second article, Kissam & Johnson, *State HMO Laws and the Theory of Limited Reformmongering* (to be published in a forthcoming issue of the *Kansas Law Review*). As of June, 1976, at least 25 states had enacted new legislation that expressly authorizes and regulates the operation of HMOs. *See, e.g.,* ARIZ. REV. STAT. ANN. §§ 20-1051 to -1068 (1975) (enacted 1973); ARK. STAT. ANN. §§ 66-5201 to -5228 (Supp. 1975) (enacted 1975); CAL. HEALTH & SAFETY CODE §§ 1340-1399.5 (West Supp. 1976) (enacted 1975); COLO. REV. STAT. ANN. §§ 10-17-101 to -129 (1973) (enacted 1973); FLA. STAT. §§ 641.17-.38 (1972) (enacted 1972); IDAHO CODE §§ 41-3901 to -3931 (Supp. 1975) (enacted 1974); ILL. ANN. STAT. ch. 111 ½, §§ 1401-17 (Supp. 1976) (enacted 1974); IOWA CODE ANN. §§ 514B.1-.32 (Supp. 1976) (enacted 1973); KAN. STAT. ANN. §§ 40-3201 to -3226 (Supp. 1975) (enacted 1974); KY. REV. STAT. ANN. §§ 304.38-010 to -200 (Supp. 1976) (enacted 1974); ME. REV. STAT. ANN. ch. 56, §§ 4201-26 (Supp. 1976) (enacted 1975); MD. ANN. CODE art. 43, §§ 840-58 (Supp. 1975) (enacted 1975); MICH. COMP. LAWS ANN. §§ 325.901-.947 (1975) (enacted 1974); MINN. STAT. ANN. §§ 62D.01-.29 (Supp. 1976) (enacted 1973); NEV. REV. STAT. §§ 695C.010-.350 (1975) (enacted 1973); N.J. STAT. ANN. §§ 26:2J-1 to -30 (Supp. 1976) (enacted 1973); N.D. CENT. CODE §§ 26-38-01 to -35 (Supp. 1975) (enacted 1975); OKLA. STAT. ANN. tit. 63, §§ 2501-10 (Supp. 1975) (enacted 1975); PA. STAT. ANN. tit. 40, §§ 1551-68 (Supp. 1976) (enacted 1972); S.C. CODE ANN. §§ 37-1131 to -1136 (Supp. 1975) (enacted 1974); S.D. COMPILED LAWS ANN. §§ 58-41-1 to -97 (Supp. 1976) (enacted 1974); TENN. CODE ANN. §§ 56-4101 to -4105 (Supp. 1975) (enacted 1971); TEX. INS. CODE art. 20A.01-.33 (Supp. 1975) (enacted 1975); UTAH CODE ANN. §§ 31-42-1 to -32 (1974) (enacted 1973); WASH. REV. CODE ANN. §§ 48. 46.010-.920 (Supp. 1975) (enacted 1975). We have not included New York statutes concerning prepaid health care services because we are in agreement with others, *see* Schneider, *infra* note 13, at 268 n.7, that those statutes are not sufficiently comprehensive to be considered the equivalent of an HMO act. N.Y. INS. LAW § 250 (McKinney Supp. 1975) (enacted 1971); N.Y. PUB. HEALTH LAW §§ 4400-23 (McKinney Supp. 1975) (enacted 1971). For a description of the New York scheme authorizing prepaid practice see Albright & Vestner, *Prepaid Health Care Legislation in New York,* 36 ALBANY L. REV. 488 (1972).

13. It is practical to provide only a sample of the recent literature on HMOs. Major works on HMO laws and legislative policy include: IOM REPORT, *supra* note 1; Havighurst, *HMOs, supra* note 5; Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?,* 1975 UTAH L. REV. 381; Holley & Carlson, *supra* note 5; McNeil & Schlenker, *supra* note 9; Rosoff, *Phase Two of the Federal HMO Development Program: New Directions After a Shaky Start,* 1 AM. J.L. & MED. 209 (1975); Schneider, *Model Consumer Health Maintenance Organization Act and Commentary,* 6 RUTGERS-CAMDEN L.J. 265 (1974); Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects,* 70 NW. U.L. REV. 90 (1975); Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis,* 84 HARV. L. REV. 887 (1971) [hereinafter cited as Harvard HMO Note]. Two recent articles have reviewed medical and economic studies of HMO performance: Donabedian, *An Evaluation of Prepaid Group Practice,* 6 INQUIRY, Sept. 1969, at 3; Roemer & Shonick, *HMO Performance: The Recent*

the appropriate role of HMOs in health care policymaking.[14]

The purpose of this Article is twofold. First, we develop a theory for HMO legislation based on an assessment of past experience with HMOs, current problems with the delivery of health services, and different legislative theories that have been advanced by others. Secondly, we use this theory to help evaluate some major issues faced by legislators and administrators in regulating HMOs and to suggest a number of improvements. A recurring theme throughout this analysis is that policymakers have not considered fully all of the economic and political ramifications of the HMO phenomenon. This has helped produce theoretical conflict about HMO policy and legislation that is incomplete and often muddled.

The first part of this Article summarizes the literature on the empirical performance and theory of HMOs. The second part analyzes legislative theories about HMOs that have been advanced by others and proposes a new one, which borrows from previous theories and to some extent synthesizes them. The third part analyzes federal HMO legislation in the context of this theory, and certain legislative changes are proposed.

## II. HMO Performance and Theory

The major points made about HMOs in the existing literature[15] may be divided into four categories: (1) the favorable economic performance of HMOs in contrast to the fee-for-service sector; (2) certain quality of care advantages of HMOs; (3) the favorable competitive stimulus that HMOs may provide to other providers and insurers; and (4) certain risks that HMOs will provide care of inferior quality, in particular the risk of underservice. A review of these points seems advisable because resolution of several important legislative issues depends in part on one's conception of the fundamental nature of HMOs.

### A. *Favorable Economic Performance*

Available empirical studies suggest consistently that consumers may obtain health services from HMOs at a lower total cost

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*Evidence*, 51 MILBANK MEM. FUND Q. 271 (1973). Another recent study has reviewed much of the economic theory and performance of HMOs. *See* Auger & Goldberg, *supra* note 3.

14. *See, e.g.*, IOM REPORT, *supra* note 1, at 1; Havighurst & Bovbjerg, *supra* note 13, at 386-87.

15. The following discussion is based largely on the following sources: ROEMER, *supra* note 4; Auger & Goldberg, *supra* note 3; Donabedian, *supra* note 13; Havighurst, *HMOs*, *supra* note 5, at 720-24; Holley & Carlson, *supra* note 5, at 649-53; Roemer & Shonick, *supra* note 13; Harvard HMO Note, *supra* note 13, at 921-33.

(insurance premium and out-of-pocket expenditures) than they can obtain similar services from fee-for-service providers when consumers are covered by traditional health insurance plans.[16] The HMOs studied have achieved savings for consumers ranging from about ten percent to thirty percent of the total costs of providing medical care.[17] These savings for HMO subscribers have been realized through substantially lower out-of-pocket expenditures rather than reduced premiums, which tend to be higher than premiums charged by other health insurers.[18] HMO premiums tend to be higher because HMO policies generally cover more services than other policies, particularly more ambulatory services, and require fewer deductibles and coinsurance payments by subscribers.[19] These savings, moreover, have occurred even though the more comprehensive HMO coverage invites more frequent consumer demands for service, and even though HMO subscribers tend to have a higher overall risk of illness and thus need care more frequently than subscribers to other plans.[20] The primary sources of HMO cost savings appear to be reduced hospital utilization and, to a lesser extent, reduced surgery and reduced drug costs.[21] The reduction in drug costs can be substantial,[22] but many HMOs do not offer full coverage of drug

16. *See* ROEMER, *supra* note 4, at 3-8 (reviewing prior comparative studies), 43-49 (cost findings of the reported study); Donabedian, *supra* note 13, at 16-17; Roemer & Shonick, *supra* note 13, at 294-95. The term "traditional health insurance" will be used herein to denote insurance plans that reimburse providers for costs or indemnify subscribers for fees paid. *See* note 4 *supra*.

17. ROEMER, *supra* note 4, at 46 (reporting total expenditures of HMO subscribers to be 11% less than total expenditures of subscribers in commercial health insurance plans and total expenditures of HMO subscribers to be 28% less than total expenditures of subscribers in Blue Cross-Blue Shield plans); Donabedian, *supra* note 13, at 16 Table 5 (summarizing the cost data from four different comparative studies). *See also* REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER 207 (1967) [hereinafter cited as COMM'N REPORT] (estimating 20-30% savings for members of the Kaiser Permanente Plan HMO); Harvard HMO Note, *supra* note 13, at 922 (reporting 33% savings for members of the Group Health Cooperative of Puget Sound HMO).

18. *See, e.g.*, ROEMER, *supra* note 4, at 46.

19. *See* Harvard HMO Note, *supra* note 13, at 905-06. The reasons for more comprehensive coverage by HMOs have not been made entirely clear, but presumably it results from an amalgam of sponsor's philosophies, consumers' market preferences, and the attractiveness to participating physicians of being able to provide a full range of services without worrying about substantial out-of-pocket expenditures for patients. *See, e.g.*, Phelan, Erickson & Fleming, *Group Practice Prepayment: An Approach to Delivering Organized Health Services*, 35 LAW & CONTEMP. PROB. 796, 800-02 (1970) [hereinafter cited as Phelan]; Harvard HMO Note, *supra* note 13.

20. *See* ROEMER, *supra* note 4, at 14-17. HMOs' more comprehensive insurance coverage is one reason why HMOs will tend to attract higher risk individuals. *Id.* at 47.

21. *See* Auger & Goldberg, *supra* note 3, at 383-87; Donabedian, *supra* note 13, at 13-16, 19-20; Roemer & Shonick, *supra* note 13, at 281-85.

22. McCaffree & Newman, *Prepayment of Drug Costs Under a Group Practice Prepay-*

services, particularly outpatient drugs,[23] apparently because of the perceived marketing need to maintain a competitive balance between their relatively high premiums and those of other insurers.[24]

The conclusion that HMOs are substantially more efficient than other providers is subject to several qualifications. First, existing studies have focused on the experience of a few relatively well-established HMOs, such as the Kaiser Permanente Plan[25] and the Health Insurance Plan of Greater New York.[26] New HMOs may not be as successful as existing ones in attracting competent physicians, skilled administrators, and capital resources that are necessary for efficient performance.[27] Secondly, existing studies also have focused primarily on only one of two basic HMO types, the so-called "closed-panel" HMO that reimburses its physicians on a salaried or capitation basis. The other type, the medical care foundation (MCF), reimburses its participating physicians on a fee-for-service basis, although such fees are subject to the total prepayments collected from subscribers.[28] The MCF is of newer vintage than the

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*ment Plan*, 58 AM. J. PUB. HEALTH 1212 (1968), found a cost savings in one HMO's outpatient prescription drug program of 45% compared to nationwide outpatient drug costs, which figure they adjusted downward to 28% to account for taxes paid and profits of retail pharmacies and drugs purchased outside the plan by the HMO's subscribers. They explain this dramatic difference by pointing to the HMO's use of a drug formulary tbat includes prices, its administrative controls over prescriptions including drug utilization reviews, and economies of size of the particular HMO (which had 95,000 members). *See also* Johnson, *Present and Projected Drug System Services in a Highly Developed HMO Structure*, 88 HEALTH SERV. REP. 873 (1973).

23. Johnson, *supra* note 22, at 874; Harvard HMO Note, *supra* note 13, at 905-06.

24. Havighurst, *HMOs, supra* note 5, at 779-80.

25. The Kaiser Permanente Plan today operates HMOs in 5 states, California, Colorado, Ohio, Oregon, and Hawaii, and serves more than 2 million subscribers. Phelan, *supra* note 19, at 807-08. It is clearly the predominant HMO organization in the country, and it has figured prominently in many of the comparative empirical studies. *See* ROEMER, *supra* note 4, at 5-10; Donabedian, *supra* note 13, at 16-17.

26. The Health Insurance Plan of Greater New York serves something less than a million subscribers in the metropolitan New York area and is the second largest HMO organization in the country. Phelan, *supra* note 19, at 806. This HMO also has figured prominently in many of the comparative empirical studies. *See* ROEMER, *supra* note 4, at 3-4; Donabedian, *supra* note 13, at 16-17.

27. Harvard HMO Note, *supra* note 13, at 946-54.

28. The two basic types of HMOs are described and labelled as "closed-panel" and "medical care foundation" by Auger & Goldberg, *supra* note 3, at 358-63. These terms will be used herein, although the term "closed-panel" carries the somewhat misleading implication that the MCF is "open-panel," i.e., an insurance plan that covers services obtained from any qualified physician. The critical difference between the two HMO types lies with their different mechanisms for reimbursing participating physicians as described in the text. *See generally* Egdahl, *Foundations for Medical Care*, 288 NEW ENG. J. MED. 491 (1973). MCFs have been sponsored by county medical societies and are open for participation by all physician members of the county society who agree to accept various controls over their practice (including maximum fees, claims and peer review, and certain risk-sharing). *See* Auger &

closed-panel HMO,[29] and results of the few studies of MCFs' cost effectiveness appear to be less than conclusive.[30] This may be in good part because MCFs continue to provide fee-for-service reimbursement to individual physicians and thus do not fully reverse the financial incentives of participating physicians.[31] A third qualification is that existing studies have assessed the relative quality of HMO and fee-for-service performance only in limited ways, primarily by comparative analyses of medical procedures and patient attitudes.[32] The studies indicate that the quality of HMO services has been at least equivalent to the quality of services furnished under traditional insurance plans,[33] but one cannot be certain that HMOs' cost savings are not achieved at the expense of quality as measured by health outcomes. Finally, HMOs' relative efficiency may not reduce the total costs of medical expenditures for all groups. For example, the aged and the poor apparently have received relatively little service from the HMOs considered in existing studies.[34] These groups commonly are thought to have a relatively high risk of disease,[35] and they may demand substantially increased services if pro-

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Goldberg, *supra* note 3, at 358-63; Egdahl, *supra*, at 491-93. As a result, the MCF subscriber is provided with more of an "open" choice of physicians than subscribers to closed-panel HMOs, but the former subscriber still is insured only for services obtained from physicians who agree to participate in the MCF.

29. The first MCF was formed in San Joaquin County, California, in 1954. Egdahl, *supra* note 28, at 491.

30. *See* Roemer & Shonick, *supra* note 13, at 294-95. *But cf.* Auger & Goldberg, *supra* note 3, at 383-84; Egdahl, *supra* note 30, at 493-94.

31. Auger & Goldberg, *supra* note 3, at 378-80.

32. *See* ROEMER, *supra* note 4, at 41-42, 50-58; Donabedian, *supra* note 13, at 7-10, 20-24; Roemer & Shonick, *supra* note 13, at 304-09. The ideal, but rarely available, measure of quality is of course an assessment of health outcomes, *i.e.*, how healthy are HMO subscribers compared with others? Roemer & Shonick, *supra* note 13, at 302. There have been a few studies comparing health outcomes of HMO subscribers and other groups, but apparently none of these studies have compared the relative costs of service. *See* Donabedian, *supra* note 13, at 23-24.

33. *See* ROEMER, *supra* note 4, at 41-42, 50-58; Donabedian, *supra* note 13, at 7-10, 20-24; Roemer & Shonick, *supra* note 13, at 291-93, 302-09.

34. *See* COMM'N REPORT, *supra* note 17, at 207 (reporting that "indigents and old persons are underrepresented" in the Kaiser Permanente Plan compared to California's population); Greenlick, *supra* note 10, at 108-09 (reporting similar findings for other early HMOs, including the Health Insurance Plan of Greater New York); *cf.* Schneider & Stern, *supra* note 13, at 98-101, 111-12; Harvard HMO Note, *supra* note 13, at 934-36.

35. *See, e.g.*, ROEMER, *supra* note 4, at 14 (a higher risk of disease is associated with age); Schneider & Stern, *supra* note 13, at 99 (a higher risk of disease is associated with poverty). *But see* AMERICAN ENTERPRISE INSTITUTE, NATIONAL HEALTH INSURANCE PROPOSALS: LEGISLATIVE ANALYSIS No. 19, at 9 (1974) [hereinafter cited as AEI ANALYSIS], which suggests that, except for infant mortality, there may be no differentials in health status based upon income.

vided with more comprehensive insurance.[36]

The most persuasive theoretical explanation for HMOs' relative efficiency appears to be simply that their reversed financial incentives encourage provision of less costly care.[37] In fee-for-service medicine there are inherent incentives for physicians and hospitals to increase their incomes by providing unnecessary services, and, perhaps more significantly, by providing services of the highest possible quality without considering whether the extra benefits obtained are commensurate with the extra costs.[38] These incentives are likely to be particularly strong when health insurance reduces the patient's out-of-pocket costs, which reduces the ethical constraint on the provider to consider the immediate financial burden to the patient.[39] With the reversal of economic incentives, HMOs in theory should seek to reduce costs by introducing a relatively large number of changes in traditional patterns of medical practice.[40] One would expect, for example, that HMOs would attempt to institute more effective controls over physician access to hospital beds by limiting the bed supply and instituting procedures such as second consultations and intensive physician peer review to eliminate unnecessary and unnecessarily long inpatient stays.[41] Similarly, one would expect HMOs to make more frequent use of less costly generic drugs, at least when HMO policies cover drugs;[42] to arrange for more efficient delegation of medical acts by physicians to nonphysicians;[43] and to question physicians' adherence to routine practices, such as the ordering of X-rays and laboratory tests, simply to maximize quality of care or minimize perceived risks of malpractice liability.[44]

Existing HMOs appear to have implemented some but by no means all of these expected changes. On the one hand, closed-panel HMOs have reduced substantially hospital utilization by patients

36. *See* Harvard HMO Note, *supra* note 13, at 934-35. *But see* ROEMER, *supra* note 4, at 7-8.

37. *See* Auger & Goldberg, *supra* note 3, at 354-58; Roemer & Shonick, *supra* note 13, at 301-02.

38. Auger & Goldberg, *supra* note 3, at 372; Havighurst, *HMOs, supra* note 5, at 720-22. *See generally* Havighurst & Blumstein, *Coping With Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 9-28 (1975).

39. Auger & Goldberg, *supra* note 3, at 372.

40. Havighurst, *HMOs, supra* note 5, at 720-22.

41. *See generally* Roemer & Shonick, *supra* note 13, at 281-88.

42. Havighurst, *HMOs, supra* note 5, at 721, 779-80; *see* Donabedian, *supra* note 13, at 19-20.

43. *See* Roemer & Shonick, *supra* note 13, at 297.

44. Havighurst, *HMOs, supra* note 5, at 720-22.

without apparent sacrifice in the quality of care.[45] Major reasons for reduced hospital utilization appear to be the ability of closed-panel HMOs to limit their hospital bed-to-population ratios, and the lack of financial incentive of salaried physicians compared with other physicians to prescribe inpatient surgery that is more remunerative than outpatient surgery or no surgery at all.[46] On the other hand, MCF-type HMOs in one available study did not experience any decline in hospital utilization, and the fee-for-service reimbursement of MCF physicians would appear to be a major obstacle to any such reduction by MCFs.[47] Furthermore, many HMO policies may not cover drug costs because of the need to maintain a competitive balance between HMO premiums and those of other insurers.[48] Exclusion of this coverage eliminates much of the incentive for HMOs to reduce patients' drug costs.[49] Finally, there seems to be little evidence that HMOs have implemented expanded delegation of medical acts or other innovative cost-reducing medical practices that relate most intimately to individual physician decisionmaking.[50] One important explanation for this failure may be the fear of HMOs that innovative and cost-effective practices may cause imposition of additional malpractice liability if the customary standard of professional practice for fee-for-service providers is applied to HMOs.[51] Other considerations undoubtedly are the traditional emphasis of individual physicians on providing the highest quality of care possible without consideration of costs[52] and understandable physician resistance and feared consumer resistance to dramatic departures in existing direct care practices. The failure of HMOs to expand medical delegation aggressively appears to be particularly unfortunate in view of substantial opportunities for cost savings

45. Roemer & Shonick, *supra* note 13, at 281-88.

46. *Id.* at 287-88.

47. *Id.* at 285-86.

48. *See* text accompanying notes 24-26 *supra.*

49. Havighurst, *HMOs, supra* note 5, at 779-80; HMOs might still advertise that they generally prescrihe less costly generic drugs (which patients pay for directly) in an effort to obtain subscribers, but this would seem to be a weaker incentive for cost reduction than if drug cost savings accrued directly to HMOs.

50. *See* COMM'N REPORT, *supra* note 17, at 215-16; Roemer & Shonick, *supra* note 13, at 295-302. *But cf.* Lairson, Record & James, *Physician Assistants at Kaiser: Distinctive Patterns of Practice,* 11 INQUIRY, Sept. 1974, at 207 [hereinafter cited as Lairson].

51. *See* Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice,* 1975 DUKE L.J. 1375, who suggests, reasonably we believe, that malpractice law should develop separate customary standards to apply to HMOs and fee-for-service providers in order to take account of HMOs' interest in making cost effective decisions.

52. *See* Havighurst & Blumstein, *supra* note 38, at 20-28.

offered by feasible expanded delegation[53] and the existence of conditions, at least in closed-panel HMOs, that appear conducive for such delegation.[54] In addition to the general explanations for this failure given above, the typical structure of state medical practice laws raises significant questions about the legality of much expanded delegation.[55] Although most states recently have enacted "physician's assistant" and "nurse practitioner" laws to promote and regulate expanded delegation, by and large these laws seem incomplete and overly restrictive.[56] For example, they tend to limit unduly or leave unresolved the scope of authorized expanded delegations,[57] and they tend to limit eligible nonphysicians to persons with relatively comprehensive training[58] who have received approval from state licensing boards that are dominated by organized medicine and organized nursing.[59]

Economies of scale and economies of integration have been suggested as additional theoretical explanations of HMOs' relative efficiency.[60] These economies in theory are equally available to other providers, but the HMOs' need for a minimum number of subscribers to effect risk pooling,[61] their relatively comprehensive coverage of services and unitary organization, and their strong incentive to reduce costs all suggest that HMOs might take particular advantage

53. *See* Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 KAN. L. REV. 1, 7-11 (1975). Note that many ideas about expanded medical delegation are just being recognized as feasible. Moreover, of all innovative medical practices expanded delegation may have the most visible impact upon the consumer, and thus substantial physician and consumer fears about its introduction appear likely.

54. These conditions include the feasibility of close supervision of delegated acts by the physician, a relative lack of concern by him that his income position may be eroded, and, in the case of larger, self-sufficient HMOs, lessened fear of retaliation by competitors. Roemer & Shonick, *supra* note 13, at 297.

55. Kissam, *supra* note 53, at 11-13.

56. *See id.* at 1, 29-59.

57. *Id.* at 44-51. *See* Lairson, *supra* note 50, at 207, 216.

58. Kissam, *supra* note 53, at 37-43.

59. *Id.* at 52-55.

60. *See, e.g.*, Auger & Goldberg, *supra* note 3, at 354-58; Holley & Carlson, *supra* note 5, at 649-50; Roemer & Shonick, *supra* note 13, at 295-302.

61. Auger & Goldberg, *supra* note 3, at 357, report that "[i]ndustry sources indicate that a scale of about 5,000 customers (which would call for about 3 to 5 primary physicians) is sufficient for achieving the economies of risk pooling." Such a minimum scale of operations, while considerable, is not nearly as substantial as some have thought previously. *See, e.g.*, Ellwood, *Restructuring the Health Delivery System—Will the Health Maintenance Strategy Work*, in UNIVERSITY OF CHICAGO CENTER FOR HEALTH ADMINISTRATION STUDIES, HEALTH MAINTENANCE ORGANIZATIONS: A RECONFIGURATION OF THE HEALTH SERVICES SYSTEM 2, 4 (1971), stating that "[a]s a general rule-of-thumb, the minimum feasible size of such organizations is about 20,000 enrollees, and if the HMO owns or controls its own hospital, minimum enrollment is probably closer to 50,000 or, better still, 100,000."

of these economies. Scale economies might be realized by better management controls over physician practices and by more efficient use of medical paraprofessionals and other ancillary personnel.[62] Scale economies for hospital services (when hospitals are operated by HMOs) might be realized in investment, purchasing, and administration.[63] Integration economies might occur because HMOs are often in a position to coordinate such related services as ambulatory and inpatient services, surgeons and operating rooms, and primary and specialist physician services.[64] Although the theoretical hypotheses that HMOs can achieve greater economies of scale and integration than the fee-for-service sector seem attractive, available empirical studies have neither demonstrated nor contradicted these claims.[65] It thus would seem unwise to design legislation in a manner that favors development of relatively large HMOs as a means of ensuring more efficient HMO performance.[66]

The more comprehensive coverage of services under HMO policies, in particular broader coverage of ambulatory services,[67] has been suggested as another cause of HMOs' relative efficiency.[68] Broader insurance coverage of ambulatory services reduces the incentive on both patients and physicians to hospitalize simply in order to obtain insurance benefits.[69] Elimination of this perverse incentive might in theory reduce the total costs of patients' medical care. Empirical studies, however, have shown that increased ambulatory insurance benefits per se have increased rather than decreased hospital utilization rates,[70] presumably because broader ambulatory coverage encourages and results in detection of additional needs for inpatient care. Again, it would appear unwise to design legislation to require comprehensive service coverage by HMOs as a means of ensuring more efficient HMO performance.[71]

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62. Roemer & Shonick, *supra* note 13, at 296-97. The example given by these commentators is that of better control over the pacing of physician visits by individual patients.

63. *See* COMM'N REPORT, *supra* note 17, at 216.

64. Holley & Carlson, *supra* note 5, at 649.

65. *See* Auger & Goldberg, *supra* note 3, at 358; Roemer & Shonick, *supra* note 13, at 301; *cf.* COMM'N REPORT, *supra* note 17, at 216, concluding that economies of scale that may be associated with the large group practices of the Kaiser Permanente Plan do not appear to be a "major explanatory factor" of Kaiser's lower costs.

66. For a discussion of legislation that has been designed to favor relatively large HMOs, see text accompanying notes 429-38 *infra*.

67. *See* note 19 *supra* and accompanying text.

68. *See, e.g.*, SENATE HMO REPORT I, *supra* note 5, at 10; Harvard HMO Note, *supra* note 13, at 923-24.

69. Harvard HMO Note, *supra* note 13, at 923-24.

70. Roemer & Shonick, *supra* note 13, at 283-84, 286.

71. For a discussion of legislation that requires very comprehensive service coverage by HMOs for both cost and quality reasons, see text accompanying notes 254-69 *infra*.

### B. *Quality of Care Benefits*

The distinct feature of HMOs, prepayment to a provider, suggests several reasons why HMOs generally might offer higher quality care than that which prevails in fee-for-service medicine. First, HMOs have a strong incentive to reduce unnecessary medical services and some of these services, such as unnecessary surgery[72] and unnecessary drug prescriptions,[73] may be quite harmful to patients. Although the extent of harmful, unnecessary medical care is certainly subject to debate,[74] HMOs have shown an ability to reduce the amount of surgery and cost of drugs[75] that they provide to patients without apparent decline in the overall quality of care. These facts suggest that HMOs may improve substantially the quality of medical care by reducing delivery of unnecessary but harmful services.[76]

Secondly, HMOs are likely to develop relatively strong utilization controls in order to resolve conflicts between the institutional goal of low-cost service and personal goals of individual physicians that tend to increase organizational costs.[77] Internal utilization controls will require much review of physician work by other physi-

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72. For a recent survey of the kinds and estimated amounts of harmful, unnecessary surgery helieved to occur in this country see N.Y. Times, Jan. 27, 1976, at 1, col. 6. Much of the recent literature on the possible extent of unnecessary surgery in the United States is cited in HOUSE SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS, COST AND QUALITY OF HEALTH CARE: UNNECESSARY SURGERY 2 (1976) [hereinafter cited as HOUSE UNNECESSARY SURGERY REPORT].

73. For a survey of the kinds and estimated amounts of harmful, unnecessary drug prescriptions helieved to occur in this country see N.Y. Times, Jan. 28, 1976, at 1, col. 7. Among other things, this article reports an estimate by one researcher that, hased on published data, antibiotics prescribed in hospitals are unnecessary in 22% of all cases. *Id.* at 17, col. 1. It also reports on a confidential survey hy the drug industry showing that in 1973 perhaps more than 7 million Americans suffering merely from a common cold obtained drug prescriptions; in more than half of these cases the prescriptions were for antibiotics that are ineffective for common colds and often have serious side effects. *Id.* at 17, cols. 4-5. *See also* N.Y. Times, April 8, 1976, at 24, col. 3, reporting on a federally funded study in Pennsylvania hospitals, which found that 20% of the antibiotic drugs prescribed may not be justified by present scientific evidence.

74. *See* Lasagna, *Medical-News Report,* N.Y. Times, May 6, 1976, at 37, col. 7; N.Y. Times, Feb. 6, 1976, at 1, col. 1.

75. HOUSE UNNECESSARY SURGERY REPORT, *supra* note 72, at 15; *see* notes 21-24 *supra* and accompanying text.

76. *See* HOUSE UNNECESSARY SURGERY REPORT, *supra* note 72, at 6-7; N.Y. Times, Jan. 27, 1976, at 24, col. 5.

77. Auger & Goldberg, *supra* note 3, at 378-82. This goal conflict between MCFs and their physicians is described in the text accompanying notes 28-31 *supra*. A similar conflict for closed-panel HMOs may exist because salaried physicians or even profit-sharing physicians can have personal goals, such as the desire to work less, to upgrade equipment, or to follow extra cautious procedures, that are also cost inducing. Auger & Goldberg, *supra* note 3, at 378-79.

cians.[78] If utilization review is implemented by HMOs, it seems likely that it would expand naturally into a review of quality with possible improvement in the quality of care rendered.[79] Thirdly, HMO physicians, particularly salaried or profit-sharing physicians of closed-panel HMOs, should have little incentive to refrain from engaging in referrals and consultations, in contrast to fee-for-service physicians who tend to lose income when recommending referrals or obtaining consultations.[80] This feature of HMO practice also may be expected to improve the quality of care, although it has not yet been subjected to empirical comparison with the fee-for-service sector.[81]

Fourthly, it has been argued that, "[t]he fixed price concept for comprehensive services provides a strong financial incentive . . . to place greater emphasis on preventive services to avoid the need for costly, intensive care which can reduce HMO [sic] income."[82] There is some evidence that existing HMOs do provide more preventive care than fee-for-service providers.[83] It should be noted, however, that HMOs' financial incentive to provide preventive care exists only to the extent that early detection and treatment of disease can avoid more costly subsequent care,[84] and empirical evidence of the existence of cost-effective preventive care appears to be lacking.[85] It also should be noted that increased preventive care may not improve the health status of recipients. For example, serious questions may be raised about whether periodic health examina-

78. *Id.* at 380-82. On the infrequent nature of physician peer review in existing group practices, whether pre-paid or not, see Roemer & Shonick, *supra* note 13, at 292.

79. For discussion of how another form of physician peer review designed primarily to control medical costs seems likely to focus on quality improvements as well (perhaps too much so), see Havighurst & Blumstein, *supra* note 38, at 38-68. Formal physician peer review programs have produced dramatic increases in the quality of care in particular instances, but apparently there have been few controlled studies of how effective professional review activities in general are, and what features enhance or restrict this effectiveness. Donabedian, *Promoting Quality Through Evaluating the Process of Patient Care*, 6 MED. CARE 181, 191 (1968). Moreover, information concerning the costs of professional review activities is fragmentary, and therefore the cost effectiveness of much peer review is indeterminate. AMERICAN PUBLIC HEALTH ASS'N, A GUIDE TO MEDICAL CARE ADMINISTRATION-VOL. II: MEDICAL CARE APPRAISAL 121-22 (1969).

80. *See* Havighurst, *HMOs*, *supra* note 5, at 721-22; Harvard HMO Note, *supra* note 13, at 928-29.

81. *See* Roemer & Shonick, *supra* note 13, at 292.

82. SENATE HMO REPORT I, *supra* note 5, at 2.

83. *See* ROEMER, *supra* note 4, at 41; Roemer & Shonick, *supra* note 13, at 293.

84. Havighurst, *HMOs*, *supra* note 5, at 721. Professor Havighurst also notes that implementation of cost-effective preventive care assumes a "long-range perspective" on the part of providers. Uncertainty about pay-offs from such care and a tendency to short-run conservatism will discourage HMOs from providing even cost-effective preventive care. *Id.* at 755 n.104.

85. *See* Holley & Carlson, *supra* note 3, at 651-52, particularly n.37.

tions for adults improve their health or increase their longevity.[86] On the other hand, the provision of substantial prenatal and postnatal care for mother and infant (much of which is preventive care) is associated strongly with reduced infant mortality,[87] and one study suggests that HMO maternal care, with its emphasis on preventive care, will tend to reduce infant mortality rates.[88] Evidence also suggests that increased well-child care, including parental education in child care, can improve the health status of children.[89]

HMOs also may provide better quality care than fee-for-service providers as a consequence of other relatively unique characteristics. HMOs provide more comprehensive insurance coverage than traditional health insurance plans,[90] and closed-panel HMOs tend to provide services through integrated physician groups and facilities.[91] Relatively comprehensive coverage of services should make it easier for consumers to gain access to the entire range of available medical services. HMO subscribers generally incur lower out-of-pocket expenditures for obtaining care, and they seek care from a single source that is able to provide responsible guidance to the most appropriate service.[92] Furthermore, the care provided may be more "continuous" then "episodic" and result in more efficient referrals and use of follow-up procedures to ensure that patients return for appropriate care.[93] The severe fragmentation of fee-for-service medi-

86. *See* AEI ANALYSIS, *supra* note 35, at 10.

87. INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCES, INFANT DEATH: AN ANALYSIS OF MATERNAL RISK AND HEALTH CARE 1-3 (1973); Dott & Fort, *The Effect of Availability and Utilization of Prenatal Care and Hospital Services on Infant Mortality Rates*, 123 AM. J. OBSTET. & GYNECOL. 854, 856-58 (1975). One cannot be certain that increased prenatal care *causes* reduced infant mortality because a variety of other uncontrolled factors may contribute to the favorable outcome. Lane & Kelman, *Assessment of Maternal Health Care Quality: Conceptual and Methodologic Issues*, 13 MED. CARE 791, 792-93 (1975).

88. *See* Shapiro, Jacobziner, Densen & Weiner, *Further Observations on Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice Medical Care Plan*, 50 AM. J. PUB. HEALTH 1304 (1960); Shapiro, Weiner & Densen, *Comparison of Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice, Medical Care Plan*, 48 AM. J. PUB. HEALTH 170 (1958).

89. AEI ANALYSIS, *supra* note 35, at 11-12. *See also* Morris, *The Use of the Well-Baby Clinic to Promote Early Intellectual Development Via Parent Education*, 66 AM. J. PUB. HEALTH 73 (1976).

90. *See* note 17 *supra* and accompanying text.

91. Harvard HMO Note, *supra* note 13, at 903-05.

92. *See* Havighurst, *HMOs, supra* note 5, at 722; Holley & Carlson, *supra* note 5, at 650. For a study suggesting that the health status of elderly persons may be improved by easier access to HMO care see Shapiro, Williams, Yerby, Densen & Rosner, *Patterns of Medical Use by the Indigent Aged under Two Systems of Medical Care*, 57 AM. J. PUB. HEALTH 784 (1967).

93. Harvard HMO Note, *supra* note 13, at 931-32.

cine, and the consequent harm to quality care in terms of access difficulties and uncoordinated services have been well-documented, dramatically if not quantitatively.[94] Both comprehensive coverage and physically integrated services also should make it easier, at least for closed-panel HMOs, to maintain "unitary" or "continuous" medical records for patients.[95] This should help ensure that providers are informed fully of the patient's clinical history,[96] reduce the possibility that patients needing care will drop out of the system,[97] and provide additional incentive for physicians to keep careful records.[98] Finally, the integrated service feature of closed-panel HMOs also may encourage and support other changes in medical practice that are believed to improve quality, including group selection of new physicians, increased time for physicians to undertake continuing education,[99] and more intensive peer review.[100]

### *C. Competitive Stimulus to Others*

Substantial expansion of HMOs may provide reduced cost and quality improvement benefits not only for HMO subscribers but for other health care consumers as well.[101] If HMOs are capable of substantially reducing consumers' total medical expenditures, other health insurers, hospitals, and physicians, in order to retain business, should be more willing to implement and accept effective controls over utilization and rates and to engage in other cost effective practices. There is already evidence that other insurers and providers do respond to economic competition from HMOs, including the mere threat of competition. MCF-type HMOs, which involve physician acceptance of increased controls over their practice,[102] apparently have developed largely in response to closed-panel HMO de-

94. *See, e.g.*, B. EHRENREICH & J. EHRENREICH, THE AMERICAN HEALTH EMPIRE 4-9 (1970); *cf.* Harvard HMO Note, *supra* note 13, at 900.

95. Unitary medical records generally are utilized by closed-panel HMOs. Harvard HMO Note, *supra* note 13, at 929.

96. Holley & Carlson, *supra* note 5, at 650.

97. Harvard HMO Note, *supra* note 13, at 929.

98. *Id.* The extra incentive exists because attending physicians will know that other associated physicians may review the record.

99. *Id.* at 928. As to the difficulties of evaluating the impact of current continuing education programs on the quality of care, see Lewis & Hassanein, *Continuing Medical Education—An Epidemiologic Evaluation*, 282 NEW ENG. J. MED. 254 (1970). These commentators suggest that effective continuing education programs (and effective evaluation of them) cannot be developed until medical care largely has been reorganized into group practices, which can provide physicians time for obtaining continuing education. *Id.* at 257-59.

100. Harvard HMO Note, *supra* note 13, at 928. *See also* note 79 *supra*.

101. *See* Havighurst, *HMOs, supra* note 5, at 743-47.

102. *See* note 28 *supra* and accompanying text.

velopment in the same or neighboring areas.[103] Also traditional health insurers have begun to sponsor a significant number of new HMOs,[104] another apparent response to the competitive threat of HMOs.

The competitive benefits from substantial HMO expansion may not be limited to general cost competition among insurers and providers. Arguably, certain HMO practices will have favorable demonstration effects upon both consumers and providers in the fee-for-service sector that encourage the introduction of both quality improvements and specific efficiencies throughout the medical economy. For example, as a relatively large number of health care consumers become exposed and accustomed to such HMO practices as more comprehensive insurance coverage,[105] reduced drug utilization,[106] and increased use of paraprofessionals,[107] they may begin to demand or at least accept more willingly such practices from other providers. Similarly, physicians may be encouraged to introduce some of these practices given the example set by their professional colleagues working for HMOs.

The rebuttal to claims of this nature is that the health care market has failed and realistically cannot be made to work.[108] Professor Havighurst's answer seems persuasive on this point.[109] The health care market has failed in large measure because of the medical profession's success in repressing market forces such as price competition and the freedom of physicians to delegate medical functions.[110] If this is true, effective HMO legislation that frees HMOs from such constraints may be all that is needed to make the market work. Moreover, claims of health care market failure often focus exclusively on the lack of competition between physicians and bar-

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103. Egdahl, *supra* note 28, at 491; Havighurst, *HMOs, supra* note 5, at 769-70; McNeil & Schlenker, *supra* note 9, at 202. This phenomenon of competitive response seems to be particularly true in California, where much HMO development has taken place. As of July 1, 1975, 70 of 181 operating HMOs in the United States were located in California, and 17 of 34 operating MCF-type HMOs were located there. HMO CENSUS, *supra* note 9, at 8-10. Almost all of the MCF development nationwide has occurred since 1972. *Id.* at 10-11.

104. As of April 1975, the Blues together were sponsors of 17% of all operational HMOs and other insurance companies were sponsors of an additional 12%. *Id.* at 14. Most of this development has occurred since 1970. McNeil & Schlenker, *supra* note 9, at 202.

105. *See* text accompanying note 19 *supra*.

106. *See* text accompanying notes 21-24 *supra*.

107. *See* note 43 *supra* and accompanying text. *But cf.* text accompanying notes 50-59 *supra*.

108. *See, e.g.*, Schneider, *supra* note 13, at 275.

109. Havighurst, *HMOs, supra* note 5, at 739-42.

110. *Id.* at 739-40. As to the medical profession's continuing ability to constrain the freedom of physicians to delegate medical functions, see Kissam, *supra* note 53.

riers to entry in the health professions.[111] This ignores the fact that much of HMOs' competitive influence will occur in health insurance markets, in which some degree of competition already exists.[112]

### D. *Potential Disadvantages*

Commentators have noted several potential problems with the HMO concept that are relevant to the establishment of sound HMO legislation. The most obvious and perhaps most troublesome problem is that HMOs' reversed financial incentive might result in the denial of appropriate care in some circumstances.[113] In some instances it will be cheaper to let a patient die instead of providing expensive life-maintaining treatment, and there may be opportunities to provide less expensive but less effective treatment that causes harm to the patient.[114] More frequently, HMOs' economizing efforts may curtail available physician or hospital resources to the extent that patients' effective access to services is limited, inadequate treatment plans are formulated, and needed hospital stays are unduly denied, postponed, or shortened.[115] There are a number of strong constraints on HMOs other than possible legislative safeguards that minimize the risks of underservice. Injured patients may bring malpractice suits against HMO physicians and probably against the HMO as well.[116] Although some harms from undue economizing by HMOs may escape the notice of potential malpractice plaintiffs,[117] there is evidence that existing HMOs do maintain appropriate con-

111. *See, e.g.*, Schneider, *supra* note 13, at 275.

112. *See* LAW, *supra* note 4, at 11-12; Hanson, *The Private Insurance Industry and State Insurance Regulatory Activities as Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation*, 6 U. TOL. L. REV. 677, 691-95, 698 (1975).

113. Auger & Goldherg, *supra* note 3, at 388-90; Havighurst, *HMOs*, *supra* note 5, at 722-24, 754-56; Roemer & Shonick, *supra* note 13, at 309-11.

114. Havighurst, *HMOs*, *supra* note 5, at 754.

115. Auger & Goldberg, *supra* note 3, at 389-90. These latter situations are likely to be more frequent because they result from organizational decisions that are less subject to the ethical constraints on individual physicians.

116. *See generally* Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U.L. REV. 69 (1975). No MCF and only a few closed-panel HMOs directly employ their physicians; these organizations instead enter into independent contracts with either participating physicians (MCF) or physician groups (most closed-panel HMOs) for the provision of medical services. On this basis these HMOs themselves may not be liable for acts of negligence by their participating physicians. *See id.* at 70 n.5, 72-73. Curran and Moseley point out, however, that evolving doctrines of malpractice law and the nature of HMOs (which in some sense hold themselves out to subscrihers as providing medical care) may result appropriately in direct liability for all HMOs. *Id.* at 73-77. In any event, individual participating physicians should have adequate incentive from fear of malpractice suits to oppose any undue economizing by the HMO. *See id.* at 83.

117. Havighurst, *HMOs*, *supra* note 5, at 755-56.

cern about the possibility of malpractice litigation and have established internal standards and procedures to guard against such incidents.[118] Other constraints against underservice are market competition for subscribers between HMOs and other insurers, the possibility of outside evaluations by trade unions or employers who contract with HMOs for group insurance, and the ethical standards of HMO physicians.[119]

The clinic form of service by closed-panel HMOs may engender an impersonal atmosphere that so disrupts the professional relationship of trust between patient and physician that the quality of care suffers.[120] This relationship seems important to the quality of health care because of consumers' relative lack of knowledge about medical practices, even though the precise role of this relationship in promoting quality has not been well documented.[121] It is true that the major complaint of closed-panel HMO subscribers has been dissatisfaction with the impersonal nature of clinic services, but the technical quality of care apparently has not suffered, and some evidence exists that overall satisfaction of closed-panel HMO subscribers is increasing.[122] HMOs should have adequate incentives to minimize the impersonal nature of their operations in order to compete for subscribers and to minimize malpractice complaints. Furthermore, consumers may adjust psychologically to certain inevitable impersonalities of clinic medicine with the passage of time and increasing availability of HMOs.[123]

HMOs, by reason of their relatively unique structure and role in the medical marketplace, conceivably might promote different kinds of medical care for different classes, to the disadvantage of blue collar groups, the poor, and the elderly.[124] It is argued that many HMOs might recruit exclusively either among blue collar groups or among the elderly and poor, and that the HMO incentive to economize would have particularly deleterious effects on the con-

118. *See* Curran & Moseley, *supra* note 116, at 84-86. *See also* text accompanying notes 50-52 *supra*.

119. Auger & Goldberg, *supra* note 3, at 390-91; Havighurst, *HMOs, supra* note 5, at 756.

120. Klarman, *Analysis of the HMO Proposal—Its Assumptions, Implications, and Prospects*, in UNIVERSITY OF CHICAGO CENTER FOR HEALTH ADMINISTRATION STUDIES, HEALTH MAINTENANCE ORGANIZATIONS: A RECONFIGURATION OF THE HEALTH SERVICES SYSTEM 24, 33 (1971).

121. *Id.*

122. *See* Donabedian, *supra* note 13, at 7-8; Roemer & Shonick, *supra* note 13, at 304-07.

123. Roemer & Shonick, *supra* note 13, at 307.

124. *See* Havighurst, *HMOs, supra* note 5, at 723, 751; Schneider & Stern, *supra* note 13, at 97-101.

ditions and quality of care provided by these HMOs. On the one hand, truly nonprofit HMOs[125] may not recruit aggressively among either the middle class or the poor.[126] These HMOs seem likely to be sponsored by labor unions, employers, substantial consumer groups, and university medical centers.[127] They may be dominated by persons "beholden to the organized medical profession"[128] and shy away from middle class recruitment that would offend fee-for-service providers. They also may avoid recruitment of the elderly and poor because of alleged higher risk characteristics of these groups, preferences of their basic constituents, and physical location. These HMOs would tend to offer especially low premiums to attract employers and union leaders who contract for employee groups. Even if these HMOs provide care that is technically sufficient, the result of low premiums may be over-crowded and less than comfortable conditions, to which a "second-class image" would be attached by both subscribers and others.[129] This image presumably would insult subscribers and create potential obstacles to consumer acceptance of HMOs in general. This problem would not seem to be a serious one, however, unless employee subscribers to these HMOs do not have an effective choice of insurance plans, or if the second-class image is not in fact insulting to subscribers but damaging to consumer acceptance of HMOs in general. On the other hand, profitmaking HMOs may find that their most substantial market opportunities lie in inner city areas where they face little direct competition from established providers.[130] Potential subscribers are likely to be the poor and elderly, whose health benefits are financed by the Medicare[131] and Medicaid[132] programs. These persons often have few, if any, alternatives for medical care,[133] and they may have

125. HMOs, particularly physician-sponsored ones, may be nonprofit in form because of legal or tax reasons, but return "profits" to physicians in the form of salaries or profit-sharing agreements. Havighurst, *HMOs, supra* note 5, at 750.

126. *Id.* at 751.

127. *Id.* at 749.

128. *Id.* at 751.

129. *Id.*

130. *Id.* at 745.

131. Title XVIII of the Social Security Act, 42 U.S.C. § 1395 (1970). A brief description of the Medicare program of health insurance for the elderly may be found in STAFF OF HOUSE COMM. ON WAYS AND MEANS, 93D CONG., 2D SESS., NATIONAL HEALTH INSURANCE RESOURCE BOOK 429-33 (1974) [hereinafter cited as RESOURCE BOOK].

132. Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1970). For a summary of the Medicaid program of health care benefits for the poor see Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations,* 8 CLEARINGHOUSE REV. 7 (1974).

133. Havighurst, *HMOs, supra* note 5, at 729.

less ability than the average consumer to negotiate their way through a complex medical delivery system[134] or to question the quality of care that is provided. The poor and elderly thus may be particularly subject to harm from overeconomizing by "poor people's" HMOs, and there is evidence in California that this has happened.[135]

Finally, the American Public Health Association[136] and several commentators[137] have expressed concern that HMOs are likely to limit their enrollee population to low-risk individuals by using experience rating (with higher rates for higher risk groups) and by refusing to sell insurance at any price to high-risk individuals. To the extent that HMOs engage in these practices, they merely are following other health insurers in an attempt to remain competitive.[138] This concern is founded upon the premise that HMOs should be used as vehicles for reforming health care financing, a premise which will be discussed subsequently.[139]

## III. LEGISLATIVE THEORIES

Professor Havighurst has suggested that HMO supporters fall into two camps.[140] Members of the two camps, whom we refer to as "quality utopians" and "fair market theorists," have distinctly different ideas about the use of HMOs as a vehicle of health care reform and, consequently, about the nature of desirable HMO legislation.[141] In this Part we analyze these approaches and suggest a third, intermediate strategy as a more effective way of employing HMOs as a policy instrument. We begin this analysis, however, by outlining some important elements that are common to all theories.

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134. *See* ROEMER, *supra* note 4, at 31-32.

135. Schneider & Stern, *supra* note 13, at 100 n.52, 126-38.

136. American Public Health Association, *Health Maintenance Organizations: A Policy Paper*, 61 AM. J. PUB. HEALTH 2524, 2528-36 (1971).

137. *See, e.g.*, Roemer & Shonick, *supra* note 13, at 309-10; Schneider & Stern, *supra* note 13, at 98-99.

138. *See* Havighurst, *HMOs*, *supra* note 5, at 788.

139. *See* text accompanying notes 174-99 & 295-306 *infra*.

140. Havighurst & Bovbjerg, *supra* note 13, at 386-87.

141. *Id.* Some major statements of the two positions are identified in notes 174 & 201 *infra*. For purposes of illustration, we use in general the 1973 report on HMOs of the United States Senate Committee on Labor and Public Welfare, SENATE HMO REPORT I, *supra* note 5, as the leading statement of the quality utopians' position, and the 1974 report on HMOs of the Institute of Medicine's Committee to Develop a Policy Statement on Health Maintenance Organizations, IOM REPORT, *supra* note 1, as a leading statement of the fair market theorists' approach.

### A. *Common Elements in All Theories*

All HMO supporters apparently would agree to four general propositions about the nature of desirable HMO legislation. A first proposition is that HMO legislation should preempt or amend certain state laws that unnecessarily restrict HMO development, either inadvertently or in the interest of fee-for-service providers.[142] These restrictions include the effective prohibition of nonprofit HMOs, other than those sponsored by medical societies, through application of Blue Shield enabling laws. These laws typically require any nonprofit medical service insurance plan to obtain county medical society approval, to include a certain percentage of local physicians as members, or to be open to all physicians who desire to join.[143] All HMOs, particularly profitmaking ones, may be prohibited by application of the hoary, but occasionally viable, common law rule against the corporate practice of medicine.[144] Even if HMOs can be organized, their development also may be hampered by application of initial capital and reserve requirements established by health insurance laws[145] and by legal prohibitions against medical advertising.[146]

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142. *See* IOM REPORT, *supra* note 1, at 19-24, 43; SENATE HMO REPORT I, *supra* note 5, at 26-29. *See generally* Holley & Carlson, *supra* note 5, at 653-58; Harvard HMO Note, *supra* note 13, at 960-76. As noted above at least 25 states in recent years have established HMO enabling acts, *see* note 12 *supra* and accompanying text, and these acts by and large remove the legal restrictions against HMOs that are descrihed in the text immediately below. Furthermore, a numher of HMOs have established themselves successfully in states that have not had HMO enabling acts. *See* McNeil & Schlenker, *supra* note 9, at 198-200; Harvard HMO Note, *supra* note 13, at 964-69. Of the 181 operating HMOs as of July 1, 1975, reported hy the HMO CENSUS, *supra* note 9, at 8, 25 were operating in states without HMO enabling acts. Nonetheless, under the traditional state health insurance and medical practice laws that remain in many states, HMO entry may be deterred by uncertainty about the legal authority of HMOs to operate, potential litigation resulting therefrom, and possibly substantial costs involved in negotiating administrative waivers. *See, e.g.*, note 144 *infra*.

143. Holley & Carlson, *supra* note 5, at 654-55; Harvard HMO Note, *supra* note 13, at 962-63. These commentators also note several cases in which state courts have found constitutional defects in Blue Shield enabling laws and allowed HMOs and other prepaid health insurance plans to operate.

144. Holley & Carlson, *supra* note 5, at 657-58. This rule usually has been applied to profitmaking entities, *id.* at 657, but for a recent application of the rule against a nonprofit HMO, see Garcia v. Texas State Bd. of Medical Exam'rs, 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd mem.*, 421 U.S. 995 (1975). The rationale given for this rule is that quality of care may suffer if employment of physicians by corporations either shields physicians from the "rigors of competition" or diverts their loyalty from the patient to the organization. Holley & Carlson, *supra* note 5, at 657. The rule seems outdated in view of the widespread use of malpractice insurance, which also shields physicians from any "rigors of competition" that there may be, and in view of increasing employment of physicians by hospitals.

145. Holley & Carlson, *supra* note 5, at 656-57; Harvard HMO Note, *supra* note 13, at 969-74. For discussion of the generally inappropriate nature of these requirements see text accompanying notes 172 & 173 *infra*.

146. Holley & Carlson, *supra* note 5, at 658. These commentators also point to state

A second proposition is that HMOs deserve positive governmental assistance to help overcome relatively unique market barriers that have obstructed and may obstruct HMO development.[147] This assistance is of two kinds: developmental subsidies for HMOs in the form of grants, loans, and loan guarantees;[148] and legislative rules that promote HMO access to a variety of health insurance markets.[149] The argument for developmental subsidies is predicated on the existence of several types of development costs that HMOs face to a greater extent than other providers or insurers, and on the existence of other market imperfections that may limit the amount of private capital invested in HMOs. The development of viable HMOs must overcome substantial consumer inertia[150] and physician hesitation[151] to participate in this different form of practice. HMOs also require relatively unique and scarce managerial resources,[152] and substantial amounts of initial capital for planning costs, operating deficits while subscriber enrollments are built up, and new outpatient facilities if not hospitals.[153] The most substantial source of private capital to meet these needs appears to be existing health insurance companies, but these institutions may be loath to finance truly competitive HMOs that take away business.[154] The level of private investment in HMOs also may be socially insufficient because it cannot recapture the external economic benefits that may result from the competitive stimulus of HMOs on other providers and insurers.[155]

Legislative rules to promote HMO access to group markets include mandates upon employers and government health insurance programs to provide, when HMOs are available, "an HMO option"

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legal restrictions on the delegation of medical acts as another unnecessary restraint on HMO development. *Id.* at 659-60. Such restrictions, however, affect all providers, not merely HMOs, and there is apparently no general agreement on the need to free HMOs from such restraints. *See, e.g.*, IOM REPORT, *supra* note 1, at 29 (recommending only that "consideration" be given to reforming state medical acts on this point, and apparently recommending that this be done with regard to all physicians or all institutions or none at all).

147. *See* SENATE HMO REPORT I, *supra* note 5, at 18-19; IOM REPORT, *supra* note 1, at 32-42; Schneider, *supra* note 13, at 283-95.

148. *See* SENATE HMO REPORT I, *supra* note 5, at 18-19; IOM REPORT, *supra* note 1, at 32-35.

149. *See* IOM REPORT, *supra* note 1, at 38-42; Schneider, *supra* note 13, at 283-95.

150. *See* Donabedian, *supra* note 13, at 4-7.

151. Harvard HMO Note, *supra* note 13, at 946-48.

152. *Id.* at 953-54.

153. IOM REPORT, *supra* note 1, at 32-35.

154. *See* Schneider, *supra* note 13, at 301; Harvard HMO Note, *supra* note 13, at 950.

155. IOM REPORT, *supra* note 1, at 34. These external benefits of HMOs are described in the text accompanying notes 101-10 *supra*.

in any health benefit plan offered to employees or beneficiaries.[156] They also include guarantees that HMOs contracting with government health insurance programs will be reimbursed on an adequate basis and that beneficiaries of these programs will have adequate incentives to enroll in HMOs.[157] The argument for these kinds of rules is predicated on the existence of considerable resistance to HMO insurance by both private and public employers (and perhaps union leaders as well), the potential for unfair practices by competing insurers, and the general failure of government programs to provide adequate reimbursement schemes for HMOs. HMOs have faced considerable obstacles in entering employee group health insurance markets.[158] Simple inertia among employers and union leaders is undoubtedly one element.[159] Another apparent cause is resistance by employers, who fear additional administrative costs if HMO insurance is offered as an option and additional pressure from employees for the employer to pay additional amounts needed to cover HMOs' generally higher premiums.[160] Similarly, union leaders may desire to avoid interjecting the new issue of higher HMO premiums (to be paid by employer or employee) at the bargaining table.[161] A third likely cause is the entrenched position of competing insurers. Their management may enjoy close personal relationships with both employers and union leaders.[162] Furthermore, when faced with HMO competition, these companies may be in a position to offer below-cost premiums or refuse to renew coverage for employees choosing the HMO option.[163]

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156. *See* IOM REPORT, *supra* note 1, at 38-42; Schneider, *supra* note 13, at 283-95.

157. *See* Schneider & Stern, *supra* note 13, at 113-14, 116-21.

158. Schneider, *supra* note 13, at 286-87. One possible significant exception to this statement is the market for health insurance for federal government employees. *See id.* at 289 n.61.

159. The inertia factor is probably compounded when an HMO proposes to insure only employees of one plant in a multi-plant firm or only those employees of one plant who reside in a particular geographic area.

160. Schneider, *supra* note 13, at 286. Some HMOs insist that employees be offered the option of choosing between the HMO and traditional insurance plans, and in any event such an option seems attractive as a device for countering potential consumer dissatisfaction. *Id.* at 285.

161. Conversation among Philip Kissam, Professor Joseph Harkins of Kansas University Medical Center, and Mr. Allen Meadors, formerly a Vice President of Kansas Blue Cross, in Lawrence, Kansas, Mar. 11, 1976.

162. Schneider, *supra* note 13, at 286-87 n.55.

163. *See id.* These practices may violate state insurance laws or antitrust laws, although the MCCARRAN-FERGUSON ACT, 15 U.S.C. § 1011 (1970), limits the application of federal antitrust laws to agreements or acts of boycott, coercion, or intimidation by insurers, *id.* § 1013(b), and otherwise to the business of insurance only "to the extent that such business is not regulated by State law," *id.* § 1012(b).

HMOs are confronted with a different set of obstacles in attempting to serve beneficiaries of government health insurance programs. HMOs have participated in Medicare and Medicaid since the inception of these programs in 1966,[164] but until recently they have participated largely on a cost reimbursement rather than prepaid basis.[165] Cost reimbursement eliminates HMOs' special incentive to economize and also limits their interest in serving Medicare and Medicaid beneficiaries. This occurs because of the substantial administrative costs involved in obtaining cost reimbursements under these programs[166] and the absence of any opportunity to retain cost savings. Even with prepayment, however, HMOs may face difficulties in obtaining adequate levels of government payment.[167] Governments acting as third-party payers have an obvious interest in retaining HMO cost savings for themselves instead of allowing savings to accrue to HMOs and their subscribers.[168]

A third proposition to which all HMO supporters apparently agree is that HMO legislation must provide suitable safeguards against the risk of underservice, notwithstanding the considerable sanctions against underservice that already exist.[169] Opinions differ about the full range of appropriate safeguards,[170] but a consensus appears at a minimum to include regulations providing for licensure of HMOs, government monitoring of statistical reports, subscriber grievance procedures monitored by a government body, disclosure requirements for marketing of insurance policies, and a guaranteed option for subscribers to withdraw from HMOs at periodic intervals.[171] The final common element among HMO legislative theories is that HMO legislation must protect HMO subscribers from any unexpected loss of insurance coverage due to an HMO's financial

164. Schneider & Stern, *supra* note 13, at 111.

165. Havighurst & Bovbjerg, *supra* note 13, at 383 n.9. One reason for HMOs' limited participation on a prepayment basis in Medicare and Medicaid has been inadequate statutory authorization, a problem now cured by amendments that are discussed in the text accompanying notes 407-59 *infra*.

166. *See, e.g.*, Schneider & Stern, *supra* note 13, at 117 n.134.

167. *See id.* at 113-21.

168. *See* text accompanying notes 429-38 *infra*.

169. *See* SENATE HMO REPORT I, *supra* note 5, at 31-34; IOM REPORT, *supra* note 1, at 55-61; text accompanying notes 116-18 *supra*.

170. *Compare* Schneider, *supra* note 13, at 273 (consumer participation in HMO governance is "essential" to consumer accountability, which is needed to counter HMOs' incentive for underservice), *with* IOM REPORT, *supra* note 1, at 48 (consumer participation in HMO governance "is not an essential characteristic of a good HMO").

171. *See* SENATE HMO REPORT I, *supra* note 5, at 16-17, 34-45; IOM REPORT, *supra* note 1, at 55-61.

difficulties.[172] Because HMOs provide many of their benefits in kind rather than cash, however, it generally is recognized that regulation of HMOs' financial condition should be more flexible than the conservative capital and reserve requirements that are applied to other health insurers.[173]

We turn next to an analysis of the basic differences between the two camps of HMO supporters and their legislative theories. These differences focus around two related questions: (1) the nature of a "qualified HMO," that is, the kind of HMO that should be promoted by federal or state legislation; and (2) the scope of benefits to be conferred upon qualified HMOs. As a result of these differences, the two camps propose markedly different kinds of HMO legislation.

### *B. The Quality Utopians*

Many supporters of HMOs perceive them as a policy instrument for implementing a broad set of reforms in American health care.[174] This approach places substantial reliance on governmental regulation in order to ensure development only of those HMOs that can carry out the desired reforms. These reforms, not necessarily in order of importance, are the need to provide more economical health care, the need to provide a variety of quality improvements in health care, and the need to redistribute health resources to relatively needy persons, including attempts to eliminate "dual-track" medicine.[175] The perceived need to provide more economical services is common to all legislative theories and need not be discussed here. The proposed quality improvements include requirements that qualified HMOs provide comprehensive insurance coverage, with particular emphasis on screening and preventive care services, continuous medical care to any patient under the direction of one re-

172. *See* SENATE HMO REPORT I, *supra* note 5, at 56-57; IOM REPORT, *supra* note 1, at 23-24.

173. *See* IOM REPORT, *supra* note 1, at 23-24; Harvard HMO Note, *supra* note 13, at 969-74. *But cf.* IOM REPORT, *supra* note 1, at 68 (a dissenting opinion claiming that the efficacy of alternatives to reserve requirements is not clear and deserves study).

174. *See, e.g.*, SENATE HMO REPORT I, *supra* note 5, at 7-28; W. ROY, THE PROPOSED HEALTH MAINTENANCE ORGANIZATION ACT OF 1972, at 13-19 (1972); American Public Health Association, *Health Maintenance Organizations*, 61 AM. J. PUB. HEALTH 2528 (1971); Schneider, *supra* note 13. We do not suggest that these and other quality utopians have a common position on all issues. For example, Roy and Schneider appear to adopt more realistic positions than others on various issues. *See, e.g.*, note 185 *infra* and accompanying text.

175. *See* SENATE HMO REPORT I, *supra* note 5, at 2, 7-18. For a description of the existing dual-track of medical care in this country and its alleged prohlems see Schneider, *supra* note 13, at 318-26.

sponsible professional and by use of unitary medical records, consumer participation in HMO governance to ensure more accessible and convenient care, substantially increased patient health education services, and increased continuing education for health professionals.[176] The proposed distributional reforms include requirements that HMOs use community rather than experience rating to establish premiums, and hold open enrollment periods during which subscribers are accepted without regard to health status.[177] In order to help eliminate dual-track medicine, it also is proposed that HMOs limit enrollment of subscribers from low income areas to a given percentage[178] and that HMOs affirmatively recruit low income and elderly subscribers within such limits.[179] In the words of Professor Havighurst, a commentator from the other side, quality utopians value HMOs "as a model health care system, providing a large population with comprehensive services of good quality and plowing savings from efficiency in resource use back into improved accessibility, better care, and more extensive services."[180]

The quality utopians' desire to promote only model HMOs appears to contain two major, related difficulties. First, many desirable qualities of model HMOs are likely to require substantial resources in addition to those available to existing HMOs.[181] These additional resources can be obtained in three ways: by increasing HMO premiums and cost-sharing provisions, which seems likely to price many HMOs out of the health insurance market;[182] by continuing government subsidies, which simply may never be available;[183] and, to a limited extent, by "plowing back" into services those savings achieved by more efficient resource use, which certainly will limit HMO development by reducing the attractiveness of HMOs to investors and some consumers. Thus the consequence of requiring all HMOs to implement a multiple set of health care

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176. *See* SENATE HMO REPORT I, *supra* note 5, at 7-18.
177. *See id.* at 29-30.
178. *Id.* at 17-18.
179. Schneider, *supra* note 13, at 321-26.
180. Havighurst & Bovbjerg, *supra* note 13, at 386.
181. *See* text accompanying notes 254-306 *infra*.
182. *See, e.g.*, McNeil & Schlenker, *supra* note 9, at 216-17.
183. Quality utopians at times have premised their legislative proposals on the assumption or hope that a relatively generous national health insurance program would be enacted shortly, which would provide HMOs with additional resources. *See, e.g.*, SENATE HMO REPORT I, *supra* note 5, at 29. The political wisdom and likelihood of this happening is beyond the scope of this Article, although it may be noted that the political climate in 1976 does not appear to bode well for such a program. As to questions about the wisdom of such a program, *see generally* AEI ANALYSIS, *supra* note 35. Similarly, state legislatures cannot be expected realistically to provide HMOs with additional resources. Schneider, *supra* note 13, at 276-77.

reforms may be to retard HMO development severely. The quality utopians answer this argument in two ways: first, that development of model HMOs is an experimental process, which understandably should take a relatively long period of time;[184] and secondly, that regulators (legislators and administrators) should balance the cost impact of various model HMO requirements against the need of HMOs for economic viability, and impose only relatively high priority requirements to the extent practicable.[185] These answers, however, lead to a second set of objections to the theory of exclusive or predominant development of model HMOs.

Model HMOs rightfully may be viewed as an experiment, in view of the remarkably little evidence available to determine whether the quality and distributional reforms to be implemented by model HMOs will improve health outcomes substantially.[186] There may be justification for substantial subsidies to develop a relatively few, closely monitored model HMOs to help answer this question, but it does not follow that nonmodel HMOs are undeserving of legislative action to remove barriers to their expansion. Nonmodel HMOs have demonstrated a capacity to reduce costs substantially without sacrificing quality, and HMO theory suggests that wider benefits may be obtained by substantial expansion of such HMOs.[187] A governmental policy designed to promote only model HMOs, however, can guarantee merely health care of the

184. *See* IOM REPORT, *supra* note 1, at 7; N.Y. Times, May 17, 1976, at 16, col. 5 (remarks of Dr. Philip Caper, a member of Senator Kennedy's staff). The American Medical Association has taken this position with respect to all HMOs, but this position is perhaps more a delaying tactic than support for the quality utopians' approach. *See* Rosoff, *supra* note 13, at 213.

185. *See* Schneider, *supra* note 13, at 275-76.

186. *See, e.g.*, SENATE HMO REPORT I, *supra* note 5, at 10-17. For a review of the literature and a generally inconclusive answer to the question whether increased health insurance in general has a favorable effect on health, see AEI ANALYSIS, *supra* note 35, at 9-12. There is evidence that increased maternity and well-child care and increased health services for the elderly may have a favorable impact upon health status, *see* text accompanying notes 87-89 *supra*, and we suggest above that expanded insurance coverage of drugs by HMOs might help limit harmful effects from unnecessary prescriptions. *See* notes 72-76 *supra* and accompanying text. The quality utopians, however, propose that qualified HMOs be subject to much more comprehensive and costly requirements. *See* text accompanying notes 176-79 *supra*. Social values other than improved health outcomes, such as more dignified and considerate treatment of individuals, may be desired from HMO development. *See, e.g.*, Schneider, *supra* note 13, at 273-74 n.20. In view of the very real problem of allocative inefficiency in American health care, *see* Havighurst & Blumstein, *supra* note 38, at 9-20, and the self-defeating nature of the quality utopians' proposals for HMOs, *see* text accompanying note 199 *infra*, it does not seem wise to expect HMOs alone to carry the burden of implementing tbese and other values.

187. *See* text accompanying notes 101-07 *supra*.

"nicest possible kind"[188] to a relatively few subscribers, or to a larger number if substantial subsidies are provided. Since our health care system already appears to consume too many resources,[189] this result does not seem to justify legislative inattention to, or continuing restriction of, nonmodel HMOs. Alternatively, model HMOs might be promoted exclusively by the compromise method of balancing the cost impact of various model HMO requirements against HMOs' need for economic viability. This approach suffers from the failure of the quality utopians to suggest criteria by which some model HMO requirements are to be considered more important than others and worth the extra cost. Some guidance on this issue seems necessary if regulation by a balancing method is to maximize social gains from HMO development.[190]

Notwithstanding these objections, the quality utopians' legislative theory suggests a potentially siguificant insight into the nature of health care policymaking in the United States. Their desire to attach general health care reforms to newly developing HMOs may constitute an implicit recognition that such reforms realistically cannot be obtained in a more direct manner, by regulation of all providers and by substantially increased public funding. If direct reforms are unrealistic, because of political opposition or lack of administrative feasibility, the regulation of HMOs to implement reforms indirectly would seem to have substantial virtue. Professor Hirschman, a Harvard economist, has pointed approvingly to the use of a similar "reformmongering" insight by economic planners in less developed countries.[191] He argues that many severe social problems may not receive governmental attention because the victims of these problems lack effective access to policymakers.[192] In this environment reformers may succeed in bringing a "non-visible" problem to policymakers' attention and in obtaining a reform solution by either of two indirect methods. First, reformers can argue that solution of the non-visible problem is necessary for solution of another problem that already has policymakers' attention, but has

188. Havighurst, *State Regulation of HMO's: Arranging for a "Fair Market Test"*, in SUBCOMM. ON RURAL DEVELOPMENT OF THE SENATE COMM. ON AGRICULTURE AND FORESTRY, 93D CONG., 2D SESS., RURAL HEALTH CARE DELIVERY: PROCEEDINGS OF A NATIONAL CONFERENCE ON RURAL HEALTH MAINTENANCE ORGANIZATIONS, LOUISVILLE, KENTUCKY, JULY 8-10, 1974, at 90, (Comm. Print 1974) [hereinafter cited as Havighurst, *State Regulation of HMOs*].

189. *See* Havighurst & Blumstein, *supra* note 38, at 9-28; note 10 *supra.*

190. We suggest such criteria in the text accompanying notes 218 & 219 *infra.*

191. A. HIRSCHMAN, JOURNEYS TOWARD PROGRESS: STUDIES OF ECONOMIC POLICY-MAKING IN LATIN AMERICA 227-97 (1973) [hereinafter cited as HIRSCHMAN].

192. *Id.* at 229-31.

stubbornly resisted treatment.[193] Secondly, reformers may focus policymakers' attention on a non-visible problem in a more general manner, by arguing that solution of the problem is now possible for the first time if wider use is made of a newly available policy instrument.[194]

The current state of health care policymaking in this country seems similar to that of economic policymaking in less developed countries, and the quality utopians may be viewed as using both of Professor Hirschman's reformmongering techniques in an attempt to achieve quality and distributional reforms by HMO regulation. As is the case generally in less-developed countries, sustained governmental health care policymaking in this country is of relatively recent origin,[195] and occurs in a political environment dominated by powerful elites that are resistant to change.[196] Moreover, many of the bad effects of inferior quality and poorly distributed health care resources are experienced by victims in widely disparate circumstances, a situation that is not conducive to commanding the attention of policymakers.[197] These considerations as well as society's related inexperience in measuring and treating health policy problems, may cause important issues to remain non-visible to governmental decisionmakers. The quality utopians have made at least implicit use of both reformmongering techniques. At times they have justified imposition of very comprehensive insurance requirements on HMOs as a means of ensuring that HMOs reduce health care costs.[198] This may be seen as an attempt to solve a non-visible problem (untreated health problems stemming from inadequate insurance coverage) by arguing that its solution is necessary to treat a very visible problem, rising health care costs. More significantly, the quality utopians' attachment of numerous quality and distributional reforms to HMOs may be viewed as an argument that solutions to several non-visible problems have become possible for the first time by wider use of a newly available policy instrument, the HMO.

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193. *Id.* at 231-32.

194. *Id.* at 233-35.

195. *See* Chapman & Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROB. 334 (1970).

196. *See, e.g.*, R. HARRIS, A SACRED TRUST (1969); LAW, *supra* note 4; Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW & CONTEMP.PROB. 267 (1970); *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 938 (1954).

197. *See* HIRSCHMAN, *supra* note 191, at 229.

198. SENATE HMO REPORT I, *supra* note 5, at 10. This argument is discussed in the text accompanying notes 67-71 *supra*.

The legislative approach of the quality utopians towards HMOs may be seen as an attempt to use reformmongering techniques in a comprehensive manner. The essential problem with this approach, it seems to us, does not lie with use of the techniques per se, but rather with the overly broad scope of their application. This approach promises to be self-defeating since little HMO expansion is likely to occur under governmental regulation of the sort proposed by the quality utopians.[199] The theory outlined below[200] attempts to avoid this problem by focusing only on certain specific desirable reforms that can be attached to HMOs without significantly retarding their development.

### C. *The Fair Market Theorists*

The second group of HMO supporters[201] contends that HMO legislation should have only one basic goal. This is the removal of legal, institutional, and other obstacles to HMO development in order to give HMOs a "fair market test" to see if they can provide an increased degree of price and quality competition in the market for health services.[202] This approach views HMOs as a policy instrument uniquely designed to address the problem of rising costs and inefficiencies in our health care system. Although proponents of this theory recoguize that HMO development also may improve resource distribution and the quality of health care, they argue that governmental regulation of HMOs to address these problems should be avoided in order to increase HMO development.[203] Any such improvements resulting from HMOs, they argue, should come from a decision by consumers to pay for these improvements. In the view of these theorists, HMO legislation should be limited to removing all legal and market obstacles to HMO development and to providing minimum necessary safeguards against inadequate quality and financial insolvency. The legislation should not impose other requirements on HMOs, because to do so would tend to increase HMOs' costs and reduce their potential for promoting cost-effective performance in the American medical economy.[204]

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199. *See* text accompanying notes 254-315 *infra.*

200. *See* text accompanying notes 218-31 *infra.*

201. *See* IOM REPORT, *supra* note 1; Ellwood, *supra* note 61; Havighurst, *HMOs, supra* note 5; McNeil & Schlenker, *supra* note 9.

202. IOM REPORT, *supra* note 1, at 3-5. A detailed statement of the theory underlying this approach is provided in Havighurst, *HMOs, supra* note 5, at 743-47. Professor Havighurst was a member of the committee that prepared the IOM REPORT.

203. *See* Havighurst & Bovbjerg, *supra* note 13, at 387.

204. IOM REPORT, *supra* note 1, at 4-5, 13-29.

The great strength of this approach lies with its use of economic market theory to suggest potential benefits from substantial expansion of nonmodel HMOs and to suggest useful means for promoting such expansion. Fair market theorists have made at least four kinds of major contributions to the debate over desirable HMO legislation. First, they have emphasized the potential external benefits (improved behavior by HMO competitors) that may be obtained if HMOs develop into a substantial sector of the American medical economy.[205] The recognition of such benefits supports the idea that nonmodel as well as model HMOs should be promoted by legislative action. Secondly, these observers have emphasized that statutes requiring HMOs to provide comprehensive insurance coverage and assume full financial risk of their coverage can defeat market development of new and smaller HMOs by imposition of additional costs.[206] Mandatory comprehensive coverage may increase HMO premiums that are already relatively high, which increases the risk of entry for new HMOs. The development of new and smaller HMOs on a permanent basis also may be viable only if HMOs can protect against risk by obtaining substantial reinsurance. The merit in expanding opportunities for new HMOs seems clear unless one accepts the quality utopians' experimental approach. In addition, smaller HMOs may be the only effective form of HMO organization in rural areas,[207] and these HMOs may provide certain quality benefits that larger HMOs do not, such as a greater range of specialist services and more personalized care.[208]

Thirdly, fair market theorists, more than other HMO supporters, seem to be acutely aware of general legal restrictions on medical care that may unfairly obstruct HMO development. The fair market theorists have recommended that any governmental HMO policy should attempt to broaden physicians' legal power to delegate medical acts because any undue restriction on medical delegation will have a particularly harmful effect on HMOs that have the organizational structure and incentive to pursue efficiencies in this area.[209] They also have demonstrated the potentially negative effects on HMO development and performance that may result from Profes-

205. *See, e.g.*, Havighurst, *HMOs*, *supra* note 5, at 743-47.

206. *See, e.g.*, IOM REPORT, *supra* note 1, at 44-46.

207. Havighurst, *State Regulation of HMOs*, *supra* note 188, at 92-93.

208. Havighurst, *HMOs*, *supra* note 5, at 746-47. The greater range of specialists would result from the fact that smaller HMOs would have to purchase specialists' services outside their organization more frequently than larger HMOs. *Id.*

209. IOM REPORT, *supra* note 1, at 28-29.

sional Standards Review Organization regulation[210] and certificate-of-need regulation of new health facilities,[211] and they have recommended that HMOs be exempted from or given special consideration under these regulatory schemes that have been designed primarily to control costs in the fee-for-service sector.[212]

Fourthly, these theorists have suggested an apparently ingenious market solution to the problems of (1) ensuring fair and adequate payments by government insurance programs to HMOs[213] and (2) guarding against the particular risk of HMOs underserving the poor.[214] They argue that if HMO enrollment of government program beneficiaries is limited sharply, for example to fifty percent, then the government program should pay the HMO the same premium it charges its other enrollees, without attempting to base the governmental rate on actual costs or otherwise attempting to capture HMO savings.[215] The HMO's need to keep its premium rate down and maintain its quality at an adequate level in order to attract at least fifty percent of its enrollees from the private market would assure that the government is paying a fair rate for services of adequate quality. One possible problem with this solution is that HMOs (particularly urban ones) serving any substantial number of elderly and poor beneficiaries of government health programs may find it impossible to obtain fifty percent membership from other populations because of locational or image factors.[216] Unless reasonable waivers from the fifty percent government beneficiary limitation are available, this proposal could work unfairly to deny the benefits of HMOs to the urban poor.[217]

Notwithstanding these significant contributions, the fair market test theory does appear to contain one major weakness. It fails to recognize any place in HMO legislation for use of the reformmongering technique to achieve desirable health care reforms other than general efficiencies. We argue in the next section that government regulation of HMOs can be used in a limited fashion

210. Havighurst & Bovbjerg, *supra* note 13. This issue is discussed in the text accompanying notes 281-86 *infra*.

211. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1204-15 (1973) [hereinafter cited as Havighurst, *Certificate of Need Regulation*]. This issue is discussed in the text accompanying notes 371-87 *infra*.

212. *See* IOM REPORT, *supra* note 1, at 25-28, 31-32; Havighurst & Bovbjerg, *supra* note 13, at 411-211.

213. This problem is described in the text accompanying notes 164-68 *supra*.

214. This problem is described in the text accompanying notes 128-35 *supra*.

215. Havighurst, *HMOs, supra* note 5, at 729-32.

216. *See* Schneider & Stern, *supra* note 13, at 106-09, particularly n.78.

217. *Id.*

to achieve certain of these reforms, and we also argue that this can be done without much, if any, sacrifice of HMO expansion.

### D. *A Theory of Limited Reformmongering*

Based on the foregoing analysis of HMOs and conflicting legislative theories, we submit that the most effective HMO legislation can be obtained by carefully limited use of the reformmongering technique noted above,[218] and otherwise general use of fair market test principles. This approach is admittedly similar to the fair market test in that it places major emphasis on the use of HMOs to introduce greater competition and efficiency into American health care. It also focuses, however, on the use of HMOs to achieve other specific health care reforms that seem highly desirable, are not likely to be achieved by operation of market forces or by direct governmental regulation, and seem attainable indirectly by their attachment to HMOs through governmental regulation.

The reformmongering technique may be of substantial value as an alternative to doing nothing about needed reforms if it is used under three limiting conditions that are designed to ensure that substantial social benefits may be obtained from HMO regulation at relatively little risk of retarding HMO development. The first condition is the existence of some evidence that the particular regulation may provide a substantial "pay-off" in terms of improved health outcomes or efficiencies of a specific kind. The second condition is that the reform is not likely to be achieved generally by HMOs in the absence of regulation. The third condition is the existence of evidence that the regulation will not jeopardize substantially the competitive position of HMOs vis-a-vis other providers and insurers.

At least three types of HMO regnlation appear to satisfy the above conditions. First, it seems desirable to establish regulations that positively encourage HMOs to make maximum use of medical delegations by physicians to nonphysicians. Evidence suggests that much expanded medical delegation can improve efficiency and reduce costs substantially without sacrificing quality.[219] In theory, the

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218. *See* text accompanying notes 191-98 *supra*.

219. *See* Kissam, *supra* note 53, at 3-11. One economic study found that current use of physician's assistants in physicians' offices may increase physician productivity from 40% to 74%, depending upon the extent of delegation by the physician. Smith, Miller & Golloday, *An Analysis of the Optimal Use of Inputs in the Production of Medical Services*, 7 J. HUM. RES. 208, 218-23 (1972). A second less rigorous economic evaluation of nurse practitioners found some economic benefit for physicians employing nurse practitioners instead of professional nurses in their office practices. Yankauer, Tripp, Andrews & Connelly, *The Costs of*

economizing incentive of HMOs should lead them to make such use of nonphysicians, but in fact HMOs apparently have not done so because of both professional and consumer hesitation about this new form of medical practice, as well as existing legal restrictions.[220] Successful implementation of expanded delegation would reduce rather than increase HMOs' costs, and some quality of care benefits might result as well.[221] It can be argued that forcing HMOs into expanded medical delegation may increase their impersonal, clinical atmosphere and jeopardize their competitive position vis-a-vis fee-for-service providers. To guard against this, patient and professional education in the advantages of expanded delegation should be provided, a step that should not be overly costly. Furthermore, the regulatory scheme need not force HMOs into quantifiable amounts of expanded delegation; instead it can require merely that HMOs and their consumers engage in a self-education and discovery process. Accordingly, HMO legislation not only should ensure that HMOs are free from any undue restrictions against expanded delegation in state licensure laws,[222] but also should encourage expanded delegation by requiring HMOs to make maximum feasible medical use of nonphysicians,[223] to report annually on their progress towards this goal, and to provide appropriate education of professionals and consumers that is designed to implement the goal.

Secondly, under the limited reformmongering theory HMO legislation should require that HMO insurance policies cover all drug costs incurred in relation to other covered services.[224] We already have noted that drug coverage by HMOs can reduce drug costs

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*Training and the Income Generation Potential of Pediatric Nurse Practitioners*, 49 PEDIATRICS 878, 882-84 (1972).

220. *See* text accompanying notes 50-59 *supra.*

221. Some studies of expanded medical delegation have found that increased personal attention to patients provided by paraprofessionals may improve the quality of care in terms of better patient understanding of the treatment, higher retention rates, and fewer missed appointments. *See, e.g.*, Bessman, *Comparison of Medical Care in Nurse Clinician and Physician Clinics in Medical School Affiliated Hospitals*, 27 J. CHRON. DIS. 115 (1974); Lewis, Resnik, Schmidt & Waxman, *Activities, Events and Outcomes in Ambulatory Patient Care*, 280 NEW ENG. J. MED. 645 (1969); Runyan, *The Memphis Chronic Disease Program: Comparisons in Outcome and the Nurse's Extended Role*, 231 J.A.M.A. 264 (1975).

222. This proposal is part of the fair market test theory. *See* text accompanying note 209 *supra.*

223. Without quantification, this proposed statutory goal is necessarily vague. It is designed merely to insure that regulatory agencies and HMOs engage in periodic negotiations that by themselves may stimulate more recalcitrant HMOs in the direction of expanded delegation.

224. Professor Havighurst deserves credit for tbis suggestion, Havighurst, *HMOs, supra* note 5, at 779-81, although it clearly is inconsistent with the fair market test that he has helped to develop.

substantially[225] and may yield substantial quality benefits by avoiding unnecessary prescriptions.[226] HMOs may and do refrain from offering full or even much drug coverage in order to keep their premiums down.[227] This suggests that requiring full drug coverage by HMOs, but not by all insurers, may seriously jeopardize HMOs' competitive position. Most drug costs, however, probably are incurred whether or not they are covered by insurance,[228] and many consumers are undoubtedly well aware of out-of-pocket drug costs.[229] These facts suggest that a minimal educational effort by HMOs should be sufficient to overcome any consumer resistance to higher premiums resulting from expanded drug coverage.

Thirdly, under this theory HMO legislation should require those HMOs that provide primary medical care to cover complete prenatal and postnatal medical care for mother and child and well-child care in the same manner that they cover other primary care services. We make this proposal somewhat less confidently than the previous two because of an absence of data about the extent to which these services are currently consumed in the fee-for-service sector and covered by traditional health insurance plans. If these services are not consumed or covered in substantial amounts, this requirement could raise HMO premiums substantially in a manner that could not be explained to consumers as easily as higher premiums caused by full drug coverage. Nonetheless, there is evidence that this kind of care can have a substantially favorable impact on health outcomes.[230] Moreover, if HMOs provide such services their economizing incentive may cause them to increase the education of mothers in child care, an apparently significant variable in child health.[231] Perhaps the best way to implement this regulation is to require such care, but provide for an administrative waiver of the requirement upon a showing that the HMO's economic viability would be jeopardized.

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225. *See* note 22 *supra* and accompanying text.

226. *See* notes 72-76 *supra* and accompanying text.

227. *See* text accompanying notes 23-24 *supra*.

228. This would seem to be true because of the relatively small amount paid for drugs each time, and the fact that prescriptions result only after the consumer has already committed himself to medical care.

229. Consider, for example, the medical deductions part of Form 1040 under the Internal Revenue Code.

230. *See* text accompanying notes 87-89 *supra*.

231. *See* AEI ANALYSIS, *supra* note 35, at 11-12.

## IV. FEDERAL HMO LEGISLATION

Since 1972 the federal government has enacted three laws designed specifically to promote and regulate HMOs: the Health Maintenance Organization Act of 1973[232] (Federal HMO Act); an amendment to the Medicare law establishing conditions for HMO participation in the Medicare program on a prepaid basis[233] (Medicare HMO Provision); and an amendment to the Medicaid law providing express authority for state Medicaid agencies to contract with HMOs on a prepaid basis[234] (Medicaid HMO Provision). As of September 13, 1976, a congressional conference committee had resolved differences between Senate and House Bills that would amend all three laws, and had filed its report with the Senate and House[235] (the 1976 HMO Amendments). In this Part we analyze these laws and proposed laws from our position as "limited reformmongerers"[236] and we raise questions about the desirability of several important provisions.

Two preliminary observations should be made about the relationship between federal and state HMO legislation. First, existing federal laws regulate by establishing qualifying conditions that HMO's must satisfy in order to obtain certain benefits. This legislation does not attempt to regulate all HMOs, nor does it preempt all state regulation of qualified HMOs. Moreover, the restrictive nature of current federal HMO legislation makes it unlikely that most HMOs will be willing and able to qualify for its benefits, although this situation will be changed to some extent by the 1976 HMO Amendments. In any event, the basic structure of federal HMO legislation appears to leave substantial scope for state promotion and regulation of HMOs.

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232. 42 U.S.C. § 300e (Supp. V, 1975).

233. 42 U.S.C. § 1395mm (Supp. V, 1975).

234. 42 U.S.C. § 1396a(a)(23) (Supp. V, 1975).

235. COMMITTEE OF CONFERENCE, CONFERENCE REPORT, HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1976, H.R. 9019, H.R. REP. No. 1513, 94th Cong., 2d Sess. (1976) [hereinafter cited as CONFERENCE REPORT].

236. Because of the newness of federal and state HMO legislation and the correspondingly limited experience thereunder, we do not aspire to the somewhat grander title of "Master Reformmongerer" that Professor Hirschman has bestowed on two Latin American economic planners. HIRSCHMAN, *supra* note 191, at the acknowledgement page. Nonetheless, it seems important to make judgments about the nature of desirable HMO legislation at this time. Present decisions will help determine the pattern of and perhaps unreasonably limit HMO development in the future because of political inertia and the growth of vested interests in existing regulatory schemes. *Cf.* Ackerman, *Regulating Slum Housing Markets on Behalf of the Poor: Of Housing Codes, Housing Subsidies, and Income Redistribution Policy*, 80 YALE L.J. 1093, 1100-01 (1971).

Secondly, on a theoretical level one should come to terms with the question of appropriate federal-state relationships in the regulation of HMOs.[237] At one extreme, the federal role might be limited to providing "seed" money and other government assistance only for model HMOs of the type called for by the quality utopians. This would have the political advantage of preserving the states' traditional interest in health regulation. This approach also might have the advantage of permitting experimentation with different forms of regulation, although in fact much state HMO legislation is patterned after a single model.[238] At the other extreme, the federal government might try to preempt states entirely from HMO regulation on the policy grounds that all HMOs deserve benefits that can be provided only by federal law or resources[239] and that the greater political power of HMO opponents at the state level will make much state HMO legislation unduly restrictive.[240] These considerations appear to be persuasive reasons for an extensive, although not exclusive, federal role in promoting HMOs.[241] A concurrent role for state

237. *See generally* Holley & Carlson, *supra* note 5, at 668-81.

238. *See* Schneider & Stern, *supra* note 13, at 123. A model act prepared by the National Association of Insurance Commissioners has been the template for more than half of the state HMO acts listed in note 12 *supra*. For a brief description of this act see Hanson, *supra* note 112, at 703-08.

239. There are at least 3 types of benefits that HMOs may not be able to obtain from state legislation because of legal or political considerations. First, state legislation cannot relieve HMOs from unduly restrictive federal laws that regulate all medical care. We argue below that there are 2 such laws from which HMOs deserve relief. *See* text accompanying notes 281-86 & 371-87 *infra*. Secondly, only 2 states have mandated that private employers offer an HMO option as part of any health benefits plan offered to employees, MICH. COMP. LAWS ANN. § 325.943 (1975); WASH. REV. CODE ANN. § 48.46.180 (Supp. 1975), and states may be preempted from mandating such an option for organized employees because of the inconsistency between such a requirement and the federal policy of promoting collective bargaining under the National Labor Relations Act. *See* Teamsters Local 24 v. Oliver, 358 U.S. 283, 295-97 (1959), *aff'd on rehearing*, 362 U.S. 605 (1960). Thirdly, only one state has provided for developmental subsidies as part of its HMO act, MINN. STAT. ANN. § 62D.27(2) (Supp. 1976), and states are not likely to provide many resources for this function. Schneider, *supra* note 13, at 276-77. The federal government might provide these benefits and still recognize concurrent state regulation, but to do so would jeopardize its investment in HMOs if state legislation is overly restrictive.

240. *See generally* Kissam & Johnson, *State HMO Laws and the Theory of Limited Reformmongering* (to be published in a forthcoming issue of the *Kansas Law Review*). Although existing state HMO legislation is more liberal than the Federal HMO Act in several respects, the new state laws do contain a number of similar restrictive features such as open enrollment requirements and prohibitions against HMO advertising referring to quality of care issues. The state laws also tend to impose rate regulation on HMOs, and they do very little to promote HMOs by providing positive forms of government assistance, *see* note 239 *supra*. Moreover, only about half of the states have enacted HMO laws, and in other states HMOs may face substantial problems under traditional state health insurance and medical practice laws. *See* notes 142-46 *supra* and accompanying text.

241. Holley & Carlson, *supra* note 5, at 668-77, recommended exclusive federal regula-

regulation seems appropriate, particularly if it is limited to controlling HMOs' financial conditions, marketing practices, and quality of care, and is made subject to federal review. This approach might be politically advantageous in obtaining broad support for effective federal laws. It also would permit reliance on state governments' considerable expertise in regulating the financial conditions of health insurance companies and on the closer political relationship between state agencies and the public.

A strategy that recognizes concurrent state regulation also might encourage more state governments to promote HMO access to state and local government employees.[242] This area of HMO regu-

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tion of HMOs, but their argument was made prior to the enactment of the new state HMO legislation and was grounded at least in part on the difficult legal environment created for HMOs by traditional state health insurance and medical practice laws. *See id.* at 677-81. Exclusive federal regulation, or indeed any federal preemption of state laws applying to HMOs, will raise questions about the constitutional power of the federal government to override state legislation in the health area. *Id.*, Havighurst, *HMOs, supra* note 5, at 781-84. At least 3 arguments of varying persuasive effect may be made to establish this power. First, Congress has the power to regulate insurance transactions that extend beyond state lines, United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944), and traditional health insurers would seem to be sufficiently engaged in interstate transactions to be subject to this power. Commercial health insurers typically do business in states as foreign companies in the same manner as commercial fire insurers were doing business in *South-Eastern Underwriters Ass'n. Compare* KAN. STAT. ANN. § 40-1210 (1973), *with* 322 U.S. at 541-42. State Blue Cross and Blue Shield carriers have more localized operations, but local plans are members of national organizations that perform commercial services for the local plans including, importantly, the solicitation and maintenance of national accounts from multi-state unions and companies. *See* LAW, *supra* note 4, at 20-21. Admittedly, HMOs' insurance transactions will he intrastate in character, but they should have a significant effect on other insurers. *See* text accompanying notes 101-12 *supra*. Thus a persuasive argument may be made that preemption of any state laws that retard HMO development is justified by the federal interest in promoting HMOs as an indirect device for regulating health insurance markets. *See* Havighurst, *HMOs, supra* note 5, at 783-84. Secondly, HMO development may have a significant impact on the interstate flow of drugs. *See id.* at 778-80; text accompanying notes 22 & 72-76 *supra*. If so, preemption of state laws that inhibit HMOs could be justified as an attempt to regulate the prices and quality of interstate drug traffic indirectly by promoting more efficient use of drugs through HMOs. Finally, federal preemption might be justified under Congress' power to tax and spend in furtherance of the general welfare, *see* Helvering v. Davis, 301 U.S. 619 (1937); Steward Mach. Co. v. Davis, 301 U.S. 548 (1937), by argning that preemption of restrictive state laws is necessary for ensuring that HMOs make efficient use of other benefits they receive from the federal government, such as developmental subsidies and improved access to employee markets. *Cf.* Havighurst, *HMOs, supra* note 5, at 783. The insurance argument seems the most persuasive but it will be weakened in any particular case to the extent that a court categorizes HMOs as providers rather than insurers. Such categorization would be inappropriate, we believe, in view of the sui generis nature of HMOs as both providers and insurers. *See* text accompanying notes 2-4 *supra*.

242. Only 5 states have mandated an HMO option of some form for their public employees. IOWA CODE ANN. § 514B.21 (Supp. 1976); N.J. STAT. ANN. § 26.2J-29 (Supp. 1976); PA. STAT. ANN. tit. 40, § 1568 (Supp. 1976); UTAH CODE ANN. § 31-42-32 (1974); WASH. REV. CODE ANN. § 48.46.180 (Supp. 1976).

lation is one in which the federal government may be constitutionally unable to act after *National League of Cities v. Usery*,[243] in which the Supreme Court held that the commerce power does not authorize application of the minimum wage and overtime provisions of the Fair Labor Standards Act to most operations of state and local governments.[244] It is not clear that this decision would forbid a federal mandate to state and local governments to include, at no extra cost, an HMO option in any health benefits plan offered to employees, but the decision clearly does raise some question about the constitutionality of such a mandate.[245] In any event, *National League of Cities* had an immediate although incidental effect on HMO law. By declaring the federal minimum wage law inapplicable to most state and local government operations, this decision effectively exempted state and local governments from the Federal HMO Act's requirement that employers subject to the minimum wage provisions of the Fair Labor Standards Act must, under certain conditions, offer an HMO option to their employees as part of any health benefits plan.[246]

243. 96 S. Ct. 2465 (1976).

244. *Id.* at 2472, 2476.

245. *National League of Cities* was decided by a 5-4 vote. The Court's apparent rationale was that states' power to determine wages is essential to the separate and independent existence of tbe states within a federal system, *see id.* at 2471, and that the minimum wage and overtime requirements imposed by Congress would impair states' ability to function effectively within that system, *see id.* at 2472-74. Moreover, in his concurring opinion Justice Blackmun interpreted the Court's position as calling for a balancing of the federal interest in regulation under the commerce clause with the states' interest in functioning independently. *Id.* at 2476 (Blackmun, J., concurring). Certainly any decision by an employer about health benefits to be offered to employees is an integral part of the larger decision about employee compensation, and thus *National League of Cities* carries the implication that a federal mandate of an HMO option upon state and local governments would be impermissible under the commerce clause. On the other hand, mandating that state and local governments offer an HMO option to their employees need not increase government costs, *see* text accompanying note 333 *infra*, and therefore would not seem to impair states' ability to "function effectively" within the federal system. Furthermore, an analogy may be drawn to some extent between the mandate of an HMO option, which need not increase government costs, and in the long run might reduce them, and federal imposition of maximum wage controls on state and local governments, which was upbeld in Fry v. United States, 421 U.S. 542 (1975), and explicitly distinguished in National League of Cities, 96 S. Ct. at 2472-75, on grounds that the decision to impose federal wage controls included consideration of the federal government's need to address the "extremely serious" national problem of infiation and the fact that maximum wage controls would "reduce the pressures upon state budgets rather than increase them." *Id.*

246. *See* text accompanying notes 331-47 *infra*. Notwithstanding the constitutional question raised by *National League of Cities*, the 1976 HMO Amendments attempt to remedy that decision's side effect and avoid its implications. *See* text accompanying notes 352-55 *infra*.

### A. *The Federal HMO Act*

This Act establishes a large number of qualifying conditions[247] and provides three kinds of benefits for a qualified HMO: preemption of certain state laws that may restrict HMO development,[248] certain developmental subsidies,[249] and improved access to the market in group health insurance plans.[250] The Act's qualifying conditions are intended to ensure that federally certified HMOs provide high quality care in an efficient manner and carry out certain distributional reforms.[251] These conditions clearly are designed to implement the quality utopians' approach to HMOs, and many of these conditions appear overly restrictive,[252] although as noted below the 1976 HMO Amendments would make some liberalizing changes in these conditions. To be sure, the quality utopians' original proposals provided for substantial federal subsidies that might have allowed qualified HMOs to meet these conditions without pricing themselves out of health insurance markets. In the ensuing political process, however, the money largely was taken out and the qualifying conditions remained.[253]

#### (1) Quality Improvement and Quality Control Conditions

The Act and regulations thereunder establish three quality of care conditions that appear likely to impose unwarranted costs and unduly restrict HMO development under the Act. First, the policies of a qualified HMO must cover a broad range of services, including many that are not covered by existing HMOs.[254] A qualified HMO

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247. 42 U.S.C. §§ 300e, 300e-1 (Supp. V, 1975).

248. *Id.* § 300e-10.

249. *Id.* §§ 300e-2 to -8.

250. *Id.* § 300e-9.

251. *See* SENATE HMO REPORT I, *supra* note 5, at 2-18.

252. For other discussions of the extremely stringent nature of the Act's qualifying conditions, see IOM REPORT, *supra* note 1; McNeil & Schlenker, *supra* note 9, at 202-07; Schneider & Stern, *supra* note 13, at 103-05. Evidence of the Act's restrictive nature is provided by the low number of existing HMOs that have qualified to date. As of July 1, 1975, only 5 very new HMOs with a total enrollment of 5,591 persons had qualified, HEW ANNUAL REPORT, *supra* note 7, at 3-4, and as of July 1, 1976, a total of only 18 HMOs had qualified. Telephone interview with Peter Kirsch, Public Health Advisor, HMO Program, Public Health Service, HEW, West Hyattsville, Md., July 22, 1976 [hereinafter cited as Kirsch interview].

253. The political history of the Act and the events causing this combination of strict requirements and few subsidies are summarized by Rosoff, *supra* note 13, at 212-14.

254. The breadth of the Act's insurance coverage requirements and consequent expansion of coverage and extra costs that are involved are one of 2 major reasons given by many existing HMOs for their unwillingness or inability to qualify under the Act. McNeil & Schlenker, *supra* note 9, at 216-17; *see* N.Y. Times, Feb. 14, 1974, at 30, col. 3; Wall Street J., Feb. 11, 1975, at 1, col. 1.

must offer a "basic health service" policy,[255] and basic health services are defined to include not only physician, hospital inpatient, and hospital outpatient services, but also short-term mental evaluations and crisis intervention, treatment and referrals for the abuse of or addiction to alcohol and drugs, home health services, and preventive services (including family planning, preventive child dental care, and children's eye examinations).[256] In addition, a qualified HMO may charge its subscribers only "nominal" copayments for the provision of specific services as authorized by regulation.[257] The Act's regulations limit HMO copayments to no more than fifty percent of the cost of any specific service and, in the aggregate, to no more than twenty percent of the total cost of providing all basic health services.[258] Furthermore, no copayment may be charged any subscriber after his or her copayments in any year equal fifty percent of the annual premium.[259]

A qualified HMO also must provide subscribers with the opportunity to purchase certain "supplemental health services" to the extent that "required health manpower are available in the area served by the organization," and these services may be offered on either a prepaid or fee-for-service basis.[260] Supplemental services include intermediate and long-term (nursing home) care, long-term physical medicine and rehabilitative care, and vision, dental, and mental health services not covered by the basic policy.[261] One significant supplemental service is "prescription drugs prescribed in the course of the provision . . . of a basic health service or [supplemental] service."[262] This somewhat ambiguous provision (does "prescribed" include drugs that are "dispensed" to inpatients) is clarified by the Act's regulations, which provide that drugs and medicines for inpatient care must be covered by the basic policy,[263] but that other drugs, including those incidental to basic ambulatory services, only need be offered as a supplemental service.[264]

These very comprehensive coverage requirements seem to be

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255. 42 U.S.C. § 300e(b)(1) (Supp. V, 1975).

256. *Id.* § 300e-1(1).

257. *Id.* § 300e(b)(1)(D).

258. 42 C.F.R. § 110.105(a)(4)(i) (1975).

259. *Id.* § 110.105(a)(4)(ii). This regulation bas been criticized by existing HMOs as unauthorized by the Act or its legislative history and as likely to add substantial costs to HMO operations. Rosoff, *supra* note 13, at 224-25.

260. 42 U.S.C. § 300e(b) (Supp. V, 1975).

261. *Id.* § 300e-1(2).

262. *Id.* § 300e-1(2)(F).

263. 42 C.F.R. § 110.102(a)(2), (b)(4) (1975).

264. *Id.* § 110.103(a)(vi).

based on two largely unexamined premises. The first is that consumers will improve their health status substantially if they obtain expanded insurance coverage in the form contemplated by the Act. The second is that provision of such comprehensive services will help reduce total medical expenditures by encouraging greater use of less expensive outpatient and preventive services.[265] There appears to be little evidence to support either of these propositions in full.[266] The unfortunate effect of the Act's sweeping coverage requirements will be to limit the number of HMOs that qualify, without obtaining commensurate benefits in terms of substantially improved quality or reduced costs. The 1976 HMO Amendments go part way towards meeting this objection by changing preventive child dental care from a basic to supplemental service,[267] and by repealing the requirement that HMOs must offer supplemental services.[268] Although these changes would remove one quite costly service from the required basic policy,[269] and relieve HMOs of the burden of having to provide the numerous supplemental services, they still would not provide maximum competitive flexibility for HMOs desiring to qualify for federal benefits. Moreover, the repeal of the requirement that HMOs must offer supplemental services, which include outpatient drug services, substantially weakens one of the few attractive features of the Act's coverage requirements.

These requirements attempt to implement two desirable reforms in a somewhat halting fashion. We have argued that HMOs should be required to provide full maternity and well-child care and full drug coverage on a prepaid basis because attachment of such conditions to the HMO may be the only practical way to implement these reforms on a general basis.[270] The Act's requirement that a broad range of physician, outpatient, and preventive services be covered by the basic policy appears to ensure that full prenatal and post-natal care for new mothers and well-child care for infants will be provided by qualified HMOs.[271] The Act also requires that inpatient drugs be covered and that coverage of other drugs be offered

265. *See* SENATE HMO REPORT I, *supra* note 5, at 10-14.

266. *See* text accompanying notes 70-71 & 186 *supra*.

267. CONFERENCE REPORT, *supra* note 235, at 3-4, §§ 104(a)(1)-(b)(1).

268. *Id.* at 1-2, § 101(b).

269. *See* S. REP. No. 844, 94th Cong., 2d Sess. 7, 14 (1976). [hereinafter cited as SENATE HMO REPORT II].

270. *See* text accompanying notes 224-31 *supra*.

271. *See* 42 U.S.C. § 300e-1(1) (Supp. V, 1975); 42 C.F.R. § 110.102(a) (1975). The 1976 HMO Amendments would include well-child care explicitly within the definition of basic preventive services. CONFERENCE REPORT, *supra* note 235, at 3-4, § 104(a)(1).

to subscribers on an optional basis.[272] Although it would be preferable if all drugs incidental to any basic service were covered by the basic policy and therefore covered on a prepaid basis, the Act at least requires a qualified HMO to offer consumers the opportunity to purchase all their drugs from the cost-conscious HMO. The 1976 HMO Amendments make supplemental services optional at the choice of the HMO,[273] and would leave qualified HMOs free to ignore a substantial part of a patient's drug coverage.

Secondly, the Federal HMO Act also attempts to ensure quality care by mandating two forms of consumer participation in the operation of qualified HMOs. Subscribers must constitute at least one-third of the HMO's policymaking body,[274] and the HMO must provide "meaningful procedures" for hearing and resolving consumer grievances.[275] These provisions are intended to make HMOs responsive to consumer needs for nontechnical aspects of medical care, such as convenience of service, range of available benefits, and the nature of copayment requirements.[276] Notwithstanding their common purpose, the two provisions deserve separate analysis because of potentially different effects. On the one hand, mandatory consumer participation in HMO governance may deter nonconsumer-oriented institutions from establishing HMOs that qualify for the Act's benefits.[277] These institutions, in particular insurance companies, physicians, and profitmaking entities in general, are likely to be the most available source of private capital for new HMOs,[278] and therefore this requirement may significantly retard the development of qualified HMOs. Moreover, it is not clear why market competition between HMOs and other health insurers would not supply the same kind of responsiveness to nontechnical consumer demands that mandatory consumer governance is intended to provide.[279] On the other hand, mandatory grievance procedures seem likely to have

272. *See* notes 261-64 *supra* and accompanying text.

273. CONFERENCE REPORT, *supra* note 235, at 1-2, § 101(b).

274. 42 U.S.C. § 300e(c)(6) (Supp. V, 1975).

275. *Id.* § 300e(c)(7).

276. SENATE HMO REPORT I, *supra* note 5, at 16-17. *See generally* Schneider, *supra* note 13, at 272-74 n.20.

277. *See generally* Schneider, *supra* note 13, at 298-99.

278. Havighurst, *HMOs*, *supra* note 5, at 749-51; Schneider, *supra* note 13, at 299-301.

279. *See* IOM REPORT, *supra* note 1, at 48. Schneider argues that competition in "the health care market" cannot be relied upon to enforce consumer interests because of many existing market imperfections. Schneider, *supra* note 13, at 275. The imperfections he describes, however, are those of provider markets, not markets for health insurance, *see id.*, and in other parts of his article he places reliance upon increased competition among health insurers as a means of promoting HMOs, *see, e.g., id.* at 284-90. *See also* text accompanying notes 108-12 *supra*.

less of an adverse impact upon creation or expansion of HMOs. Also, they might serve as a useful deterrent to underservice and other forms of inferior quality care,[280] even though many of these questions may be of a technical nature. If consumers and providers are aware of a forum in which consumer grievances may be discussed, providers should have additional incentive to practice quality medicine and be more open with consumers in order to avoid complaints.

Thirdly, the Act requires that qualified HMOs establish an "ongoing quality assurance program" in accordance with HEW regulations.[281] This seems to be a reasonable delegation of the responsibility to guard against the risk of underservice by qualified HMOs, but the regulations implement this provision in a potentially adverse way. An HMO's quality assurance program must be designed in a manner that is "likely to meet the standards established" by Professional Standards Review Organizations (PSROs).[282] These organizations are physician organizations designated by HEW to monitor federally funded health services, including those furnished by HMOs, for the purpose of controlling costs and ensuring adequate quality.[283] As the fair market theorists have demonstrated, PSRO regulation of HMOs for cost control purposes is irrelevant

280. *See* IOM REPORT, *supra* note 1, at 60.

281. 42 U.S.C. § 300e(c)(8) (Supp. V, 1975).

282. 42 C.F.R. § 110.108(j)(4) (1975).

283. The PSRO law, 42 U.S.C. § 1320c (Supp. V, 1975), was designed primarily to control the federal health services hudget that is believed to be substantially inflated by the lack of effective cost constraints on fee-for-service providers. Havighurst & Blumstein, *supra* note 40, at 38-41. The law establishes regional organizations of physicians, the membership of which must include a "substantial proportion" of all physicians in the area, 42 U.S.C. § 1320c-1(b)(1)(A)(iii) (Supp. V, 1975), and must be "voluntary and open" to all licensed physicians practicing in the area. *Id.* § 1320c-1(b)(1)(A)(v). These PSROs are generally mandated to monitor all federally funded health services to ensure that these services are medically necessary, provided in the most economical manner, and of sufficient quality to meet "professionally recognized standards of health care," *id.* § 1320c-4(a)(1). They also are authorized to monitor these services by such methods as case-by-case review, *id.* § 1320c-4(a)(2), the maintenance and review of provider and patient "profiles of care and services," *id.* § 1320c-4(a)(4), and the establishment of "professionally developed norms of care, diagnosis, and treatment hased upon typical patterns of practice" in the PSRO's region. *Id.* § 1320c-5(a). Notwithstanding the statute's primary focus on controlling costs, the professional bias of physicians toward providing the highest possible quality care, Havighurst & Blumstein, *supra* note 38, at 20-30, HEW's postenactment interpretation of the laws, *id.* at 41-45, and the fact that PSROs themselves will have no incentive to reduce health care costs other than a most general statutory mandate, *id.* at 53, all appear to guarantee that PSROs generally will emphasize quality of care regulation and place little emphasis on cost controls. This type of regulation in the hands of HMOs' competitors seems very likely to raise substantial barriers to cost effective performance by HMOs. *See* Havighurst & Bovbjerg, *supra* note 13, at 389-411. *See generally* Havighurst & Blumstein, *supra* note 38.

because of HMOs' already strong incentive to economize.[284] More significantly, PSRO regulation of HMOs for quality control purposes is likely to raise HMO costs unduly because PSRO organizations will be dominated by competing fee-for-service physicians and because PSROs are likely to establish standards that emphasize the highest quality care possible without considering appropriate quality/cost trade-offs that are essential to an HMO's effective performance.[285] It may be argued that PSRO review of HMOs is precisely the mechanism needed to guard against the possibility of underservice. This iguores, however, the confused and incomplete state of medical knowledge about how quality may be measured, and also ignores the important fact that PSROs will be dominated by competitors of HMOs. Thus HEW's extension of PSRO standards to qualified HMOs generally seems ill-advised; it would be more appropriate for HEW to establish its own HMO quality regulation program.[286]

The Federal HMO Act and its regulations establish other quality control conditions that appear less objectionable in terms of potential costs and may help HMOs improve or maintain their quality of care. HMO services must be provided "in a manner which assures continuity."[287] The regulations define this to mean that HMOs must provide each enrollee with a health professional who has primary responsibility for "coordinating the member's health care," and that HMOs must develop an adequate system for patient recordkeeping.[288] We already have noted reasons for believing that these practices may improve health care.[289] HMOs also must provide or arrange for continuing education of its health professional staff.[290] Although the effectiveness of continuing education is unproven[291] and the costs of this program could be substantial, this requirement conceivably could help improve HMOs' quality if HMOs experience difficulty in recruiting physicians and therefore obtain relatively poorly qualified ones. The regulations merely restate the statutory provision and, sensibly, do not attempt to quantify the amount of continuing education that must be provided.[292]

284. Havighurst & Bovbjerg, *supra* note 13, at 393-98.
285. *Id.* at 389-411; *see* note 283 *supra*.
286. Havighurst & Bovbjerg, *supra* note 13, at 411-17.
287. 42 U.S.C. § 300e(b)(4) (Supp. V, 1975).
288. 42 C.F.R. § 110.107(c)(2) (1975).
289. *See* text accompanying notes 92-98 *supra*.
290. 42 U.S.C. § 300e(c)(10) (Supp. V, 1975).
291. *See* note 99 *supra*.
292. *See* 42 C.F.R. § 110.108(1) (1975).

Finally, HMOs must compile, evaluate, and report to HEW statistics relating to service utilization by its members.[293] Utilization statistics, which can be compared with service utilization patterns of populations that are comparable to the HMO's members, would seem to be particularly useful for detecting at least gross cases of overeconomizing and underservice by HMOs.[294]

(2) Distributional Reform Conditions

The Federal HMO Act establishes several conditions to ensure that qualified HMOs engage in distributional reforms, that is, activities that redistribute resources from certain groups of subscribers to others. Initially, the Act requires that qualified HMOs fix prepayments for basic health services and any prepayments for supplemental services on a community rating system.[295] The Act also requires that qualified HMOs conduct annual open enrollment periods of at least thirty days, during which individual subscribers must be accepted in the order in which they apply without regard to their health status or health care needs.[296] An open enrollment period may be waived by HEW for reasons of economic viability,[297] limited capacity,[298] or impairment of an HMO's capacity to satisfy the Act's subscriber population requirements that are described below.[299] The 1976 HMO Amendments would make two significant changes in these requirements. Imposition of the community rating requirement would be delayed for four years after qualification under the Act for any HMO that was providing services prior to qualification.[300] More significantly, the 1976 HMO Amendments would amend the open enrollment requirement substantially, retaining

293. 42 U.S.C. § 300e(c)(11)(B) (Supp. V, 1975).

294. IOM REPORT, *supra* note 1, at 58-59.

295. 42 U.S.C. § 300e(b)(1)-(2) (Supp. V, 1975). A community rate is in essence a single rate for all subscribers that eliminates rate differentials based on varying health status and cost experience of different groups. The Act does allow HMO rates to reflect different administrative costs of collecting payments from different groups, *id.*, § 300e-1(a)(A), and it also allows HMOs to charge different rates for subscribers wbose premiums are paid by Medicare and Medicaid. *Id.*, § 300e-1(8)(B).

296. *Id.* § 300e(c)(4).

297. *Id.* § 300e(c)(4)(A). A waiver of open enrollment may be granted if the HMO would otherwise obtain a disproportionate number of high-risk subscribers sufficient to jeopardize its "economic viability." Regulations define the concept of economic viability to include, but not be limited to, "an increase in rates which would make the [HMO] noncompetitive in its area." 42 C.F.R. § 110.108(d)(1) (1975).

298. 42 C.F.R. § 110.108(d)(1) (1975).

299. *Id.* § 110.108(d)(2). The Act's subscriber population requirements are discussed in the text accompanying notes 307-15 *infra*.

300. CONFERENCE REPORT, *supra* note 235, at 4, § 105(a).

only a quite limited form of this requirement for relatively mature and growing HMOs.[301]

The purpose of community rating and open enrollment requirements is to preclude qualified HMOs from employing "experience rating" for different groups and "skimming practices" that result in higher rates or total unavailability of health insurance for relatively high-risk individuals.[302] The provision of adequate health services for high-risk individuals who are unable to afford them certainly seems to be an appropriate social goal. From the standpoint of economic welfare theory, the most efficient way to do this is to provide direct subsidies to such individuals. The alternative use of community rating and open enrollments to achieve this goal in effect taxes low-risk subscribers to subsidize high-risk persons; this may cause low-risk subscribers to purchase less health insurance than they should and high-risk subscribers to purchase too much.[303] Nonetheless, if adequate public subsidization of health services for high-risk individuals is not politically feasible, the indirect approach of attaching this reform to HMOs may appear desirable. The major problem with this use of the reformmongering technique is that both requirements (particularly if taken together) appear likely to diminish substantially the competitive position of qualified HMOs vis-a-vis other health insurers, who remain free to employ experience rating and skimming practices. One HMO experienced fifty percent higher costs for subscribers joining during open enrollment,[304] and others have experienced utilization increases of thirty-five to 140 percent from such subscribers.[305] Such data suggest strongly that community rating and open enrollment requirements together will price HMOs out of the health insurance market.[306] A

301. *Id.* at 3, § 103. The open enrollment requirement would apply only to an HMO (1) that has been in existence 5 years, or has an enrollment of 50,000 subscribers, and (2) that has not incurred a financial deficit in its most recent fiscal year. Furthermore, such an HMO could close its open enrollment after taking 3% of its net increase in enrollment during the preceding year exclusive of increases under existing group contracts.

302. SENATE HMO REPORT I, *supra* note 5, at 6; *see* text accompanying notes 136-39 *supra*.

303. *See* Pauly, *The Welfare Economics of Community Rating*, 37 J. RISK INS. 407 (1970).

304. McNeil & Schlenker, *supra* note 9, at 217-18.

305. SENATE HMO REPORT II, *supra* note 269, at 9.

306. These requirements are the second reason given by existing HMOs for their unwillingness or inability to qualify under the Federal HMO Act. *See id.* at 6; McNeil & Schlenker, *supra* note 9, at 217-18; Schneider & Stern, *supra* note 13, at 104 n.65. *But cf.* SENATE HMO REPORT II, *supra* note 269, at 31-32, where Senators Kennedy, Nelson, and Hathaway cite the Marshfield Clinic HMO's 5-year experience witb open enrollment to support opposition to any weakening of the Act's open enrollment requirement. This HMO estimates tbat its

community rating requirement alone would appear less objectionable, but it still might prevent HMOs from competing for particular employee groups by offering experience rates that are closer to those offered by other insurers. An open enrollment requirement alone also would appear less objectionable, since HMOs could employ special open enrollment rates to cover the costs of serving this group of enrollees. Either requirement alone, however, would largely defeat the cross-subsidization purpose of the two requirements taken together. Finally, the proposed amendment to limit the open enrollment requirement to relatively mature and expanding HMOs would seem to penalize unfairly those HMOs and their subscribers. Moreover, under this amendment the ability and incentive of relatively successful HMOs to continue expanding would be diminished, and these HMOs may be the best source of future HMO development.

The Act also requires qualified HMOs to enroll persons who are "broadly representative" of the population within the area it services,[307] although HMOs serving nonrural areas are limited to no more than seventy-five percent membership from "medically underserved populations."[308] The representative population provision originally was intended as a weaker alternative to the open enrollment requirement,[309] although both provisions remained in the Act. This provision has not been further defined by regulation,[310] and it would seem to be somewhat superfluous in conjunction with the open enrollment provision and subject to similar objections. Nonetheless, it might serve as a useful moral and regulatory adjuration for some qualified HMOs to seek out Medicare and Medicaid beneficiaries in their areas. The real effectiveness of this search, however, will depend on the adequacy of HMO payments under these programs, a problem discussed in a later section.[311] The limitation on

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premium for all subscrihers increased only 8% above what it would have been without open enrollment. The Senators call tbis a "small increase," but it is unclear why an 8% increase in an annual insurance premium of several hundred dollars may not substantially disadvantage a truly competitive HMO.

307. 42 U.S.C. § 300e(c)(3) (Supp. V, 1975).

308. *Id.* Medically underserved populations may he either populations of areas with a shortage of health services or population groups with a shortage of services. These populations are to be designated by HEW after consultation with official state health planning agencies. *Id.* § 300e-1(7). Regulations provide that these designations will be made on an ad hoc basis in connection with applications by HMOs for qualifications. 42 C.F.R. § 110.203(g) (1975).

309. *See* S. Rep. No. 621, 93d Cong., 1st Sess. 37 (1973).

310. *See* 42 C.F.R. § 110.108(c) (1975).

311. *See* text accompanying notes 407-59 *infra*. Any attempt by HEW to use the representative population requirement to force qualified HMOs to enroll Medicare and Medicaid beneficiaries despite inadequate payments to HMOs for such services would be subject to the same objections raised above about the open enrollment requirement.

enrollments from medically underserved populations is designed to encourage nonrural HMOs serving low income areas to recruit a substantial proportion of their subscribers from other areas.[312] This requirement may be viewed as an attempt to guard against underservice by "poor people's" HMOs by ensuring that a substantial number of nonpoor are enrolled in any qualified HMO.[313] This limitation may not be waived by HEW,[314] and as noted earlier the absence of a waiver provision may work to the disadvantage of the urban poor if HMOs in their areas are unable to obtain twenty-five percent membership from other areas or population groups.[315]

(3) Cost Reform Conditions

The Federal HMO Act establishes two significant qualifying conditions that are designed to ensure cost effective performance by HMOs.[316] The first of these seems unnecessary and restrictive; the second seems desirable, but has been implemented by HEW in a weak fashion. First, a qualified HMO must assume almost all the financial risk involved in providing basic health services.[317] Thus, for example, an HMO that desires to assume financial risk only for ambulatory or primary care services, while reinsuring its subscribers for other covered services,[318] cannot qualify under the Federal HMO Act. The purpose of the financial risk requirement is to ensure that qualified HMOs face the fullest possible financial incentive to keep costs down.[319] While reinsurance may lift some immediate incentive from HMOs to reduce costs,[320] it is not clear why HMOs in competitive markets would not have incentive to reduce costs of reinsured services in order to keep the costs of reinsurance policies at a minimum. These HMOs would have a similar incentive to narrow the

312. SENATE HMO REPORT I, *supra* note 5, at 18.

313. *See* text accompanying notes 213-17 *supra*.

314. *See* 42 U.S.C. § 300e(c)(3) (Supp. V, 1975).

315. *See* text accompanying notes 216 & 217 *supra*.

316. The Act's comprehensive coverage requirements may be viewed as a third condition designed to ensure cost effective performance, but it does not seem likely to achieve that purpose. *See* text accompanying notes 67-71 *supra*.

317. 42 U.S.C. § 300e(c)(2) (Supp. V, 1975). Exceptions are allowed only for reinsurance of (1) the cost of providing services to any subscriber in excess of $5,000 in any year, (2) the cost of basic health services obtained by subscribers elsewhere because of emergencies or other "medical necessities" (for example, out-of-town travel or work), and (3) not more than 90% of losses in excess of 15% of annual income. *Id.*

318. For discussion of the myriad forms such HMOs might take and the role of reinsurance in supporting these HMOs see Havighurst, *HMOs, supra* note 5, at 746-47, 790.

319. SENATE HMO REPORT I, *supra* note 5, at 14.

320. With reinsurance of costs for certain services, an HMO becomes in effect a consumer or a provider, or both, of fee-for-service medicine for those services.

range of reinsured services because of the relatively high cost of reinsurance.[321] The unfortunate effect of the Act's financial risk requirement is to reduce the possibility that new and smaller HMOs can qualify.[322] Since the ostensible general purpose of the Act is to promote HMO growth, it seems particularly unfortunate that new HMOs cannot use substantial reinsurance to protect against risk, at least during their initial years of operation.[323] Furthermore, although small HMOs with substantial reinsurance may not be as cost effective as larger HMOs because of relatively high reinsurance costs, smaller HMOs may offer higher quality care for which consumers are willing to pay.[324] If so, smaller HMOs would provide the quality improvements and competitive stimulus to fee-for-service providers that are expected from HMOs generally.

Secondly, the Act mandates that qualified closed-panel HMOs

> utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of . . . services. . . .[325]

MCF-type HMOs are subject to a similar but weaker mandate to utilize such personnel "to the extent feasible."[326] These provisions appear to be an invitation to HEW to issue regulations that positively encourage HMOs to make maximum feasible use of expanded medical delegation. Such regulations might include required submission of staffing patterns, annual reports on progress towards expanded delegations, and professional and consumer education on the use of physician's assistants and nurse practitioners. For the reasons given above,[327] we think that such use of the reformmongering technique in HMO legislation is highly desirable. Unfortunately HEW's regulations merely restate the very general language of the statutory provisions.[328] The opportunity to use the HMO as a vehicle for promoting expanded medical delegation in the American medical economy apparently has not been seized.[329]

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321. IOM REPORT, *supra* note 1, at 46.

322. *Id.* at 45-46. Existing HMOs apparently have not complained much about this requirement, *see* note 254 *supra*, but well-established HMOs tend to have the capacity to satisfy this requirement.

323. For a discussion of the business risks involved in starting new HMOs see Harvard HMO Note, *supra* note 13, at 949-54.

324. *See* text accompanying notes 207-08 *supra*.

325. 42 U.S.C. § 300e-1(4)(C)(iv) (Supp. V, 1975).

326. *Id.* § 300e-1(5)(B)(i).

327. *See* text accompanying notes 219-23 *supra*.

328. 42 C.F.R. §§ 110.101(i)(3)(iv), (j)(ii)(A) (1975).

329. HEW might "goad" HMOs on expanded medical delegation in the course of ap-

(4) Benefits for Qualified HMOs

The Federal HMO Act offers qualified HMOs the three general kinds of government assistance to which all or most HMO theorists apparently would agree: improved access to group insurance markets; preemption of certain unfairly restrictive state laws; and developmental subsidies. The Act and HEW's regulations thereunder may be criticized for not going far enough in each of these areas, but even so, the Act's benefits may be sufficient to attract HMOs despite the apparently substantial extra costs involved in meeting the qualifying conditions.[330]

The Act requires that any employer who is subject to the minimum wage requirements of the Fair Labor Standards Act (or would be but for a specific exemption in section 13(a) of that Act[331]), who employs at least twenty-five employees, and who offers health insurance as a fringe benefit to its employees shall offer "to its employees . . . the option of membership in qualified health maintenance organizations which are engaged in the provision of basic and supplemental health services in the areas in which such employees reside."[332] No employer is required to pay more for health benefits by reason of offering the HMO option,[333] and the employer's obligation commences only after an HMO has been qualified by HEW[334] and has requested inclusion in the employer's health benefits plan.[335] Two major issues of statutory interpretation and political controversy have surrounded HEW's implementation of the mandatory HMO option requirement.[336] One issue is whether the Act requires employers to offer employees the HMO option if the employees' collective bargaining agent has first rejected the offer in negotia-

proving individual applications for qualification. The explicit reference to "regulations of the Secretary" in the Act's provision regarding use of ancillary health personnel, however, would seem to make this an unwise if not illegal practice.

330. *See* Schneider & Stern, *supra* note 13, at 104-05. The most significant henefit is apparently the Act's mandate to many employers to offer employees the option of insurance coverage by a qualified HMO. *See id.*; McNeil & Schlenker, *supra* note 9, at 216-17. The Act's other benefits may be less important because new state HMO laws are doing away with the legal restrictions at which the federal act is aimed, and because developmental subsidies have not been made available in substantial amounts. *See* note 396 *infra* and accompanying text.

331. Section 13(a) of the Fair Labor Standards Act, 29 U.S.C. § 213(a) (Supp. V, 1975), exempts a broad variety of employees, such as professionals and certain retail and agricultural employees, from the minimum wage and overtime provisions of the Act.

332. 42 U.S.C. § 300e-9(a) (Supp. V, 1975).

333. *Id.* § 300e-9(c).

334. *Id.* § 300e-9(d).

335. 40 Fed. Reg. 50212 (1975).

336. *See* 40 Fed. Reg. 6602-03 (1975); 40 Fed. Reg. 50212 (1975); Rosoff, *supra* note 13, at 229-34.

tions with the employer.[337] A literal reading of the provision, which requires that the option be offered to "employees,"[338] seems to require that such an offer be made. Furthermore, the Act's legislative history reveals that Congress did intend the mandatory HMO option to have a dual purpose—improving HMOs' access to health insurance markets and "providing individuals with additional alternatives from which to choose for their care."[339] It appears, nonetheless, that Congress did not consider the role of collective bargaining agents in this process,[340] which raises the question of the need to balance the policy of promoting collective bargaining under the National Labor Relations Act[341] with the Federal HMO Act's policy of promoting HMO expansion. The final regulations, which were adopted after considerable debate and exchange of views among federal agencies and the private sector,[342] provide that employers need offer the HMO option only to the collective bargaining agent of any organized employees, and that the agent may refuse the option on behalf of the employees.[343] The 1976 HMO Amendments would ratify this decision,[344] and this accommodation of the two conflicting federal policies is most likely a politically necessary one.[345] This resolution, nonetheless, seems unfortunate in view of the incentives that both employers and union leaders may have to avoid offering an HMO option to employees.[346] Furthermore, one may question whether the alternative disposition, direct offer of the HMO option to all covered employees, would seriously damage the overall federal policy of promoting collective bargaining, which seems quite well established indeed.

The second issue is whether the HMO option provision applies to the federal government, which together with state and local gov-

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337. *See* 40 Fed. Reg. 50212 (1975).

338. 42 U.S.C. § 300e-9(a) (Supp. V, 1975).

339. H.R. REP. No. 451, 93d Cong., 1st Sess. 39 (1973).

340. *See id.* at 38-39.

341. 29 U.S.C. § 151 (1970).

342. *See* 40 Fed. Reg. 50212 (1975).

343. *See id.* at 50215. HEW's proposed regulations would have required employers to offer the HMO option directly to employees, including those represented by collective bargaining agents. 40 Fed. Reg. 6602-03 (1975).

344. H.R. REP. No. 9019, 94th Cong., 2d Sess. § 9(a)(2) (1976); SENATE HMO REPORT II, *supra* note 269, at 54.

345. The report of the Senate Committee on Labor and Public Welfare on the 1976 HMO Amendments explains the proposed amendment to ratify HEW's final regulation simply as a clarification of congressional intent not to modify the rights of unions to bargain collectively on behalf of their members with respect to health benefits. SENATE HMO REPORT II, *supra* note 269, at 11.

346. These incentives are discussed in the text accompanying notes 159-61 *supra*.

ernments became subject to the Fair Labor Standards Act by amendment[347] subsequent to enactment of the Federal HMO Act. *National League of Cities* removed most state and local government employers from coverage under the Fair Labor Standards Act's minimum wage requirements, and therefore from coverage under the Federal HMO Act's option provision. The question remains, however, whether the failure of the Federal HMO Act to use the phrase "as amended" in referring to the Fair Labor Standards Act prohibits application of the HMO option provision to the federal government, and any other employers who may come under the Fair Labor Standards Act by subsequent amendment.[348] HEW assumed that the failure to use the broader reference was merely a "technical oversight"[349] and promulgated regulations that apply the mandatory HMO option to the federal government and other such employers.[350] The 1976 HMO Amendments would ratify this regulation,[351] and it certainly is appropriate that the federal government as an employer undertake an obligation that it expects of most private employers.

The 1976 HMO Amendments also would deny certain federal grants under the Public Health Service Act to any state that does not arrange for inclusion of an HMO option (for federally qualified HMOs) in health benefit plans offered to state and local government employees.[352] The federal grants to which the HMO option would be made a condition are those for public health services, communicable and other disease control programs, family planning services, and comprehensive health planning.[353] This provision would reverse *National League of Cities'* incidental exclusion of state and local governments from the Federal HMO Act's option provision,[354] and, by attaching the HMO option to the federal spending power, it attempts to avoid the constitutional question whether a direct mandate of an HMO option on state governments is authorized by the commerce clause.[355]

As a matter of constitutional law, the federal government ap-

347. Fair Labor Standards Act § 3(d), 29 U.S.C. § 203(d) (Supp. V, 1975), *formerly* ch. 676, § 3(d), 52 Stat. 1060 (1938).

348. Rosoff, *supra* note 13, at 231 n.83.

349. *Id.* The Senate Labor and Public Welfare Committee bas confirmed this position. SENATE HMO REPORT II, *supra* note 269, at 21.

350. *See* 40 Fed. Reg. 50213 (1975).

351. CONFERENCE REPORT, *supra* note 235, at 8, § 110(b).

352. *Id.*, at 7-8, § 110(a)(1).

353. *Id.*

354. *See* text accompanying notes 347-48 *supra*.

355. The question whether the commerce power authorizes a direct mandate of an HMO option upon states is discussed at note 245 *supra* and accompanying text.

parently may attach broad conditions to grants to state governments so long as the conditions reasonably are related to the purpose of the spending.[356] Arguably, the expansion of HMOs under an HMO option offered to state and local government employees will promote the purposes of the grants to which the HMO option provision would be attached and therefore a "reasonable relationship" test could be satisfied. A primary purpose of comprehensive health planning is to promote more efficient health care,[357] and the promotion of cost-effective HMOs may be viewed as helping to achieve this purpose. Similarly, the somewhat greater emphasis placed by HMOs on preventive care[358] might help achieve the preventive care purposes of the other grants to which the HMO option would be attached. Nonetheless, these relationships between HMOs and the grant programs seem rather indirect,[359] and the attachment of the HMO option to these grants is a transparent attempt to avoid the commerce clause question. In this situation, it appears possible, if not probable, that the Court might give careful scrutiny to the relationship between the condition and the purpose of the spending, and require in effect some form of "direct relationship" that would be more difficult to satisfy than a mere "reasonable relationship."[360]

The Federal HMO Act expressly preempts the application of three kinds of state laws to qualified HMOs. The first is any requirement that a medical society approve an HMO's organization, that physicians sit on the HMO's governing body, or that participation in the HMO be open to all or some given percentage of physicians in the community.[361] The second type is any requirement that HMOs meet initial capitalization or financial reserve requirements

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356. *See* Oklahoma v. United States Civil Service Comm'n, 330 U.S. 127, 142-44 (1947); Steward Mach. Co. v. Davis, 301 U.S. 548, 593-94 (1937).

357. *See* text accompanying note 377 *infra*.

358. *See* text accompanying notes 82-85 *supra*.

359. In Oklahoma v. United States Civil Service Comm'n, 330 U.S. 127 (1947), the Supreme Court upheld the federal government's requirement that employees of state agencies receiving federal funds comply with the Hatch Act's prohibition of political activity by federal government employees. This condition, it was held, was designed to ensure that federal monies were administered properly at the state level and thus the condition was related to the spending programs. *Id.* at 133-44. This requirement relating to the management of federal money seems more directly related to federal spending than the HMO option provision of the 1976 HMO Amendments, which attempts to construct a more favorable health care environment within which the grant program operates.

360. In this regard, note that the majority in *National League of Cities* expressly reserved decision without giving an opinion on the question whether the federal government could impose minimum wage and overtime requirements on state governments under the federal spending power even though this could not be done under the commerce clause. 96 S. Ct. 2465, 2474 n.17. *See also, id.* at 2487 (Brennan, J., dissenting).

361. 42 U.S.C. §§ 300e-10(a)(1)(A)-(C) (Supp. V, 1975).

established for health care insurers generally.[362] The third kind of state law preempted by the Act is any prohibition against an HMO's advertising "its services, charges, or other nonprofessional aspects of its operation," although this does not authorize "advertising which identifies, refers to, or makes any qualitative judgment concerning any health professional who provides services for a health maintenance organization."[363] By implication the Act also preempts the application to qualified HMOs of the common law rule against the corporate practice of medicine.[364] These provisions are desirable for reasons given above,[365] but they do not go far enough in two respects. First, because of consumer inertia to this new form of practice, HMOs may find it extremely useful to provide potential subscribers with information about the quality of care they render.[366] The Act's preemption provisions do not protect such advertising from the very common state restrictions against advertising by physicians.[367] Secondly, the Act does not free qualified HMOs from state licensure laws that may keep HMOs from engaging in the maximum feasible amount of expanded medical delegation. Because such restrictions continue to be plentiful,[368] federal preemption of these restrictions would seem to be a necessary concomitant to the Act's requirement that qualified HMOs make effective use of ancillary health personnel.[369]

By analogy to arguments supporting preemption of restrictive state laws, the Federal HMO Act also should exempt HMOs from any general federal health care regulations that unfairly restrict HMO development and performance. We have noted the potential problem for HMOs that has been created by the PSRO law.[370] Another potentially significant obstacle to HMO development is presented by the certificate-of-need provisions of the Health Planning and Resources Development Act.[371] This Act in effect mandates

362. *Id.* § 300e-10(a)(1)(D).

363. *Id.* § 300e-10(b).

364. *See* IOM REPORT, *supra* note 1, at 21-23. The Act's preemption provisions do not mention the corporate practice rule, *see* 42 U.S.C. § 300e-10 (Supp. V, 1975), but any application of this rule to forbid operation of a qualified HMO would so directly conflict with the Act that preemption would seem to be a certainty. *See* Holley & Carlson, *supra* note 5, at 677-81.

365. *See* notes 142-46 *supra* and accompanying text.

366. IOM REPORT, *supra* note 1, at 42-43.

367. *Id.*

368. *See* text accompanying notes 55-59 *supra*.

369. *See* IOM REPORT, *supra* note 1, at 28-29.

370. *See* notes 283-86 *supra* and accompanying text.

371. 42 U.S.C. § 300k (Supp. V, 1975). Provisions of this Act that apply to certificate-of-need regulation are scattered throughout, but the main provisions are *id.* §§ 300m-

states to establish certificate-of-need regulations to control entry by institutional health providers into the health care market on the basis of the public need for health services.[372] Institutional providers are defined to include inpatient facilities, ambulatory surgical centers, and HMOs;[373] this definition subjects new ambulatory facilities of HMOs, but not new fee-for-service medical clinics, to certificate-of-need controls, an unequal and apparently unfair provision[374] that can only be explained by the unwillingness of Congress to regulate the opening of all new physician offices.[375] Perhaps a more significant problem for HMO development lies with this Act's complex regulatory structure, which promises to give fee-for-service providers substantial influence over the development of local certificate-of-need criteria and individual decisions.[376]

The purpose of certificate-of-need regulation is to eliminate wasteful and duplicative expansion of health care facilities and

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2(a)(4)(B) and (b)(2). For an analysis of state certificate-of-need laws that existed prior to this Act see Havighurst, *Certificate of Need Regulation, supra* note 211.

372. Although certificate-of-need regulations are to be implemented by "agreements" between HEW and state governors, 42 U.S.C. §§ 300m, 300m-2(a)(4)(B) (Supp. V, 1975), states will lose substantial federal health funds if they do not establish certificate-of-need regulations by Sept. 30, 1980. *Id.* § 300m(d).

373. Section 1531(5) of the Act, 42 U.S.C. § 300n(5) (Supp. V, 1975), defines institutional health services to include HMOs and "health care facilities" as defined in existing Social Security Act regulations. 42 C.F.R. § 100.102(e) (1975). These regulations limit the definition of health care facilities to inpatient facilities, freestanding hemodialysis units, and ambulatory surgical centers. *Id.*

374. *See* SENATE HMO REPORT II, *supra* note 269, at 27. The Senate's version of the 1976 HMO Amendments would have exempted HMO ambulatory facilities from certificate-of-need regulations, S. 1926, § 16(a), but this provision was not adopted by the conference committee on the theory that this change should be considered in the context of a later revision of the certificate-of-need law. CONFERENCE REPORT, *supra* note 235, at 36.

375. Any attempt to distinguish between "ambulatory medical clinics" and "physicians' offices" is essentially arbitrary since both function in the same way. Thus in establishing the scope of certificate-of-need jurisdiction under the Health Planning and Resources Development Act, 42 U.S.C. § 300k (Supp. V, 1975), Congress was faced with a choice of regulating all or none of HMOs' ambulatory service competitors.

376. *See* Havighurst, *Certificate of Need Regulation, supra* note 211, at 1185. Under this Act the public need for any new institutional health service is to be determined through a rather complex and costly process. Final determinations of need are to be made by a state health planning agency, 42 U.S.C. §§ 300m-2(a)(4)(B), (c) (Supp. V, 1975), but only after general planning for health services has been undertaken, and a specific recommendation on the proposed new service has been made by the appropriate regional health systems agency (HSA). *Id.* (For details of the nature of the planning and review functions of HSAs see *id.* § 300*l*-2.) HSAs may be nonprofit private corporations, public regional planning bodies, or a unit of local government if the government's jurisdiction is coextensive with the designated health planning area, but any HSA must have a governing body of which at least a majority are consumers and 1/3 are providers. *Id.* § 300*l*-1(b). Consumers, who generally have neither the resources nor the expertise of providers, seem unlikely to be a strong counter-force to providers. *Cf.* Havighurst, *Certificate of Need Regulation, supra* note 211, at 1185.

services that seems to result from the easy availability of health insurance to cover fee-for-service payments and the generally weak market constraints on health care providers.[377] Although in some cases HMO entry into an oversupplied market might increase the supply of services and areawide health care costs on a permanent basis,[378] it would seem on balance that HMOs' interest in and ability to introduce more efficient health care,[379] and the real danger that HMOs will be unfairly excluded by the certificate-of-need process,[380] justify exempting HMOs from this type of regulation.[381] The Health Planning and Resources Development Act gives limited recognition to these arguments by providing that certificate-of-need criteria "shall include consideration of . . . [t]he special needs and circumstances of [HMOs] for which assistance may be provided" under the Federal HMO Act.[382] This provision seems inadequate, however, because it grants special consideration only for HMOs that qualify under the Federal HMO Act.[383] It also is difficult to imagine how any effective special consideration may be given to HMO entrants that falls short of either special federal review of unfavorable HMO certificate-of-need decisions,[384] or total exemption of HMOs

377. Havighurst, *Certificate of Need Regulation, supra* note 211, at 1155-69; *see* text accompanying notes 38-39 *supra*. The perverse nature of medical economics is such that increased supply does not necessarily reduce prices because suppliers can generate new demand and can exercise substantial market power to raise prices on an inelastic demand schedule. An increase in supply may even result in increased prices if each of a larger number of suppliers attempts to maintain a given income while providing fewer services.

378. This might happen, for example, if the HMO was controlled by existing providers and was introduced as a defensive measure to keep truly competitive HMOs out of the market. *See generally* Havighurst, *HMOs, supra* note 5, at 759-77. Another theoretical possibility is that the HMO's substitution of ambulatory care for inpatient care would leave hospital beds vacant and invite their overutilization by other providers. IOM REPORT, *supra* note 1, at 27.

379. HMOs' interest in and ability to introduce more efficient services make it likely that short run supply increases from HMO entry, which may appear wasteful, will in the long run be efficient as higher cost providers drop out of the market or reduce their scale of operations.

380. Unfair exclusions of HMOs may occur from domination of the certificate-of-need process by fee-for-service providers, *see* note 376 *supra* and accompanying text, from failure to give adequate consideration to HMOs' long run efficiencies, *see* note 379 *supra*, or simply from the costs of going through the regulatory process, *see* note 376 *supra*, which costs will bear more heavily on HMOs than other providers to the extent that the HMO sector continues to grow.

381. *See* IOM REPORT, *supra* note 1, at 25-28; Havighurst, *Certificate of Need Regulation, supra* note 211, at 1207-15.

382. 42 U.S.C. § 300n-1(c)(8) (Supp. V, 1975).

383. The provision seems to apply to all federally qualified HMOs, even those that do not obtain developmental subsidies, since it applies to HMOs for which assistance "may" be provided under the Federal HMO Act. *Id.*

384. The Health Planning and Resources Development Act does not provide for federal

from the regulatory process. For example, HEW's proposed certificate-of-need regulations under the Health Planning and Resources Development Act merely restate the statutory provision.[385] HMOs already have experienced some difficulty in obtaining certificates-of-need under prior state laws,[386] and it appears now that the federal certificate-of-need law will increase the barriers to HMO development.[387]

The third benefit offered by the Federal HMO Act to qualified HMOs is the possibility of obtaining developmental subsidies. The Act authorizes HEW to make grants and loans to qualified public and nonprofit HMOs and to guarantee loans made to qualified profitmaking HMOs serving medically underserved populations in order to help cover a variety of developmental costs.[388] Certain priorities are established for HMOs proposing to serve rural areas[389] or medically underserved populations.[390] The Act authorized to be appropriated for these purposes seemingly substantial sums for the four years ending June 30, 1977.[391] One perceived problem is the Act's failure to authorize loan guarantees for nonprofit HMOs,[392] a failure

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review of certificate-of-need determinations. *See id.* § 300m-2.

385. 41 Fed. Reg. 11704 (1976).

386. IOM REPORT, *supra* note 1, at 26; *see* McNeil & Schlenker, *supra* note 9, at 209.

387. The 1976 HMO Amendments would amend the special consideration provision of the Health Planning and Resources Development Act, 42 U.S.C. § 300n-1(c)(8) (Supp. V, 1975), to provide that the criteria established by state agencies under this provision shall be "consistent" with the standards and procedures established by HEW for comments from state health planning agencies on grants to HMOs under the Federal HMO Act. CONFERENCE REPORT, *supra* note 235, at 11, § 117(a). These latter standards and procedures, however, do little more than require consideration of a broad range of factors in addressing the public need question. *See* 42 C.F.R. § 110.204 (1975). This amendment might have the mildly beneficial effect of educating state certificate-of-need agencies on the special characteristics of HMOs, but it seems designed to do nothing more. *See* SENATE HMO REPORT II, *supra* note 269, at 27.

388. 42 U.S.C. §§ 300e-2 to -4 (Supp. V, 1975). These sections authorize HEW to make grants to public and nonprofit private entities for feasibility studies, planning, and initial development costs, *id.* §§ 300e-2, -3; to make loans to such entities to cover operating losses during the first three years of operation, *id.* § 300e-4; and to guarantee non-federal loans made to a profit-making entity proposing to serve a medically underserved population for the purposes of covering planning, initial development costs, or operating losses during the first three years, *id.* §§ 300e-3, -4.

389. *Id.* §§ 300e-2(i), -3(k), -4(e). HMOs proposing to serve nonmetropolitan areas are to be given a "first crack" at 20% of the funds obligated under each section.

390. *Id.* §§ 300e-2(c), -3(d). These sections provide that HEW shall give priority to applications from HMOs proposing to enroll at least 30% of their members from medically underserved populations. The limitation of loan guarantees to profitmaking HMOs serving such populations, *id.* §§ 300e-3, -4, and the 20% reserve for nonmetropolitan HMOs, *id.* §§ 300e-2(i), -3(k), -4(e), also help establish this priority.

391. *Id.* § 300e-8. A total of $250,000,000 was authorized for grants for the 4 years ending June 30, 1977, and $75,000,000 was authorized to be appropriated to the loan fund.

392. SENATE HMO REPORT II, *supra* note 269, at 10-11.

that would be corrected by the 1976 HMO Amendments.[393] Other problems lie with HEW's failures to implement the funding priorities for rural and medically underserved areas,[394] to establish the loan guarantee program,[395] and to spend even available appropriations.[396] One cause of these failures is believed to be inadequate administration of the program by HEW,[397] and the Senate's version of the 1976 HMO Amendments would require HEW to administer the Federal HMO Act "through a single identifiable administrative unit."[398] Another important cause undoubtedly is the Act's rather stiff qualifying conditions that have discouraged HMOs from seeking the financial and other benefits provided by the Act.[399]

(5) Overall Assessment and Recommendations

The main value of the Federal HMO Act may lie with the fact that it represents a commitment of the federal government to reform health care by promoting HMOs, an essentially nonregulatory approach that seems to have substantial merit. Although the Act is too restrictive and incomplete in many respects, its restrictive nature may be fortuitous. Given the current anti-regulation mood that is abroad, it may be much easier to repeal overly restrictive provisions than to add desired regulations to an overly liberal statute.[400] In this vein the federal government's commitment to reforming health care through HMO development could be strengthened by three sets of amendments to the Federal HMO Act.

First, the Act or its regulations should be amended to ensure that the three specific reforms suggested by the limited reformmongering theory are implemented by all qualified HMOs. HMOs' basic policies should be required to include the full range of preventive maternity and well-child care and all related drug costs. The former

393. CONFERENCE REPORT, *supra* note 235, at 5-6, §§ 108(a)-(c).

394. SENATE HMO REPORT II, *supra* note 269, at 5.

395. *Id.* at 10.

396. In fiscal year 1975, HEW left unspent about half of its $45,000,000 appropriation. N.Y. Times, Nov. 22, 1975, at 17, col. 2. Indeed, throughout the first two and a half years of the Act's brief life, through fiscal year 1976, HEW has made 160 grants totalling only $31,400,000. Kirsch, interview, *supra* note 252. These facts may help explain why the Ford Administration recommended an appropriation for 1976-77 of only $18,000,000, N.Y. Times, Nov. 22, 1975, at 17, col. 2, approximately 21% of the $85,000,000 authorized for 1976-77 by the Act. 42 U.S.C. § 300e-8(a) (Supp. V, 1975).

397. SENATE HMO REPORT II, *supra* note 269, at 4-5, 10-11; *see* note 396 *supra*.

398. CONFERENCE REPORT, *supra* note 235, at 11, § 116.

399. *See* text accompanying notes 254-329 *supra*.

400. The liberalizing nature of the 1976 HMO Amendments is some evidence of this proposition.

change probably could be implemented by regulation, in view of the Act's open-ended definition of preventive services that must be included in an HMO's basic policy.[401] Also, the Act or its regulations should be amended to promote the maximum feasible expanded medical delegation by HMOs by requiring progress reports and professional and consumer education related to this goal.[402]

Secondly, the Federal HMO Act should be amended in six ways to allow nonmodel as well as model HMOs to qualify for the Act's benefits, at least the market access and preemption benefits.[403] Required insurance coverage should be reduced to basic inpatient and outpatient services (including, however, full coverage of all related maternity care and drugs).[404] The three requirements of consumer participation in HMO governance, community rating, and open enrollments should be eliminated. An administrative waiver of the seventy-five percent limit on membership from nonrural medically underserved populations should be provided for HMOs that can show such a requirement to be unrealistic, and the full assumption of risk requirement should be eliminated.

Thirdly, the Act's preemption and market access benefits should be expanded in several ways. Preemption benefits should be expanded to cover all HMO advertising and expanded medical delegation by HMOs,[405] and qualified HMOs should be exempted from PSRO monitoring and certificate-of-need regulation. Finally, in view of the states' general unwillingness to mandate an HMO option

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401. 42 U.S.C. § 300e-1(1)(H) (Supp. V, 1975). The 1976 HMO Amendments would add well-child care to the Act's definition of basic services. CONFERENCE REPORT, *supra* note 235, at 3, § 104(a)(1); SENATE HMO REPORT II, *supra* note 269, at 39.

402. The Act's broad authority for HEW to do this by regulation is discussed in the text accompanying notes 325-29 *supra*.

403. Although we recommend that nonmodel HMOs be allowed to qualify for developmental subsidies as well, it might be politically advantageous to limit developmental subsidies to experiments with model HMOs. *Cf.* text accompanying notes 184-86 *supra*.

404. The remaining requirement that HMOs cover basic inpatient and outpatient services would preclude qualification of specialty HMOs, such as those covering only surgical, dental, or drug services. Lack of experience with these types of HMOs and a variety of theoretical reasons (for example, the danger of underservice if only surgical care and not general medical care were covered by prepayment) justify this exclusion, although the Act might be amended to authorize HEW to fund experimental projects with specialty HMOs. *See* HOUSE UNNECESSARY SURGERY REPORT, *supra* note 72, at 6-7 (recommending that HEW undertake a comprehensive study and fund demonstration projects involving prepaid surgical care); Schoen, *Dental Care and the Health Maintenance Organization Concept*, 53 MILBANK MEM. FUND Q. 173 (1975) (recommending that dental HMOs be promoted).

405. Even with the addition of these preemption provisions to the Act, states would remain free to regulate HMOs concerning financial soundness, marketing practices, and quality of care (which might include, if desired, a mandate of consumer participation in HMO governance as a quality of care control).

as part of health benefits plans offered to state and local government employees,[406] it seems reasonable for the federal government to attempt to impose the HMO option on state and local government employers, as would the 1976 HMO Amendments, notwithstanding the possible constitutional attack on such a provision under *National League of Cities*.

### *B. Medicare, Medicaid, and HMOs*

The Medicare and Medicaid programs together provide publicly financed health care benefits for approximately twenty percent of America's population[407] at an annual public cost in excess of 28 billion dollars.[408] These programs clearly are a potentially rich source for funding HMO operations, and any effective legislative strategy to promote HMOs should consider the relationship between these programs and HMOs.[409] In 1972 the federal government enacted the Medicare[410] and Medicaid[411] HMO provisions to obtain greater participation by HMOs in these programs on a prepaid basis. The 1976 HMO Amendments would amend these provisions to require in essence that an HMO qualify under the Federal HMO Act as a condition to participation in these programs on a prepaid basis.[412]

This legislative effort has been marred generally by two unfortunate circumstances. The first is the inevitable conflict between the short-run goal of government to limit public expenditures and the long-run goal of improving efficiency in the health care system by promoting HMO development.[413] The second has been the

406. *See* note 242 *supra*.

407. *See* Resource Book, *supra* note 131, at 429, 491.

408. In fiscal year 1975, federal Medicare expenditures were 14.8 billion dollars, *Hearings on President's Medicare Proposals Before the Subcomm. on Health of the House Comm. on Ways and Means*, 94th Cong., 2d Sess. 175 (1976) (statement of David Mathews, Secretary of HEW, and in calendar year 1975 total public expenditures under Medicaid exceeded 14 billion dollars. U.S. Dep't of Health, Education, and Welfare, Social and Rehabilitation Services, Medical Assistance (Medicaid) Financed Under Title XIX of the Social Security Act 39 (1976).

409. For an earlier analysis of this relationship primarily from the point of view of Medicare and Medicaid beneficiaries see Schneider & Stern, *supra* note 13, at 111-22.

410. 42 U.S.C. § 1395mm (Supp. V, 1975).

411. *Id.* § 1396a(a)(23) (Supp. V, 1975).

412. Conference Report, *supra* note 235, at 13 & 14, §§ 201(a) & 202(a).

413. A major practical problem that HMO strategists encounter is that the Medicare and Medicaid laws, because they are primarily viewed as financing laws, are controlled in Congress by the finance rather than health committees. The former can be expected to place much greater emphasis on legislation that limits government payments in the immediate future, *see* Havighurst & Blumstein, *supra* note 38, at 38, even though such limits may not

influence of the quality utopians' approach to HMOs, which has resulted in the establishment of overly restrictive conditions for HMO participation in the two programs. As a consequence of these problems, few HMOs have indicated an interest in Medicare prepayment contracts.[414] Under the more flexible Medicaid scheme, about a quarter of the states have initiated prepayment contracts with HMOs, but most of this contracting has been in California.[415] It does not appear that the full potential of the Medicare and Medicaid programs for promoting HMO development has been realized.[416]

### (1) The Medicare HMO Provision

This law establishes a detailed scheme for HMO participation on a prepaid basis that in certain respects is like that of the Federal HMO Act. There are at least three significant qualifying conditions, and the 1976 HMO Amendments would add two more. First, to be eligible for a prepayment contract, an HMO must provide Medicare subscribers with all Medicare services provided generally in the area.[417] These include posthospital extended care in a skilled nursing facility for up to one hundred days in a benefit period.[418] An appar-

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promote overall efficiency in the health care system. A similar problem exists at the state level with respect to legislative attempts to amend state Medicaid laws.

414. *See* McNeil & Schlenker, *supra* note 9, at 211-13. As of July 1976, only two HMOs had qualified for prepayment contracts under the Medicare HMO provision, and about 20 had applications pending. Telephone interview with Wayne Fowler, Director, Group Health Plan Operations, Social Security Administration, HEW, July 22, 1976.

415. At the end of 1974, between 300,000 and 400,000 Medicaid eligibles were enrolled in 74 HMOs in 13 states and the District of Columbia. Schneider & Stern, *supra* note 13, at 120 n.149. Fifty-four of these HMOs, witb a total Medicaid enrollment in excess of 250,000, were in California. *Id.* at 128-29. In July 1976, bowever, the total number of Medicaid eligibles enrolled in HMOs had probably declined from its peak because of the failure of about 20 HMOs in California. Telephone interview with H.R. Jolley, Director, Office of Program Innovation, Social and Rehabilitation Service, HEW, July 22, 1976.

416. By the end of 1974, when Medicaid enrollment had reached its peak, Medicare and Medicaid beneficiaries had, quite recently, come to constitute a notable proportion of HMOs' total enrollment (about 15%), altbough they were served by a relatively few HMOs. Havigburst & Bovbjerg, *supra* note 13, at 383 n.9. Since that time this percentage may have declined substantially in view of HMOs' rapidly expanding enrollments, *see* notes 8-9 *supra* and accompanying text, and the apparently declining Medicaid enrollment in California. Moreover, it is not clear that all Medicare and Medicaid HMO care is prepaid. McNeil & Schlenker, *supra* note 9, at 213. Adequate cost reimbursement of HMO services to Medicare and Medicaid beneficiaries can also support HMO development, but this payment method eliminates the HMO's incentive to economize and the chance of the HMO to generate cost savings that can be attractive to both HMO investors and subscribers. *See* text accompanying notes 429-36 *infra*.

417. 42 U.S.C. § 1395mm(b)(2) (Supp. V, 1975).

418. 42 U.S.C. § 1395d(a)(2) (1970).

ent problem with this requirement is that the risk of insuring nursing home services may be extremely high[419] and that provision of such coverage and services also may be beyond the general competence of many HMOs.

Secondly, fifty percent or more of the HMO's enrollment must consist of individuals under age sixty-five[420] at least after the first three years of a prepayment contract.[421] HEW's regulations add the additional requirement that fifty percent or more of the HMO's enrollment must consist of individuals who are not covered by either Medicare or Medicaid.[422] These limitations clearly are designed to eliminate "poor peoples'" HMOs and the risk of underservice to a captive population, but the statute's failure to provide for administrative waiver of such limitations in special circumstances may mean that some Medicare beneficiaries are denied unfairly the opportunity to obtain HMO services.[423]

Thirdly, the HMO must conduct annual open enrollments during which it accepts Medicare beneficiaries as subscribers "without restriction, except as may be authorized in regulations," although open enrollments may be terminated if they would result in an HMO population that exceeds capacity, violates the fifty percent limitation on enrollees sixty-five or older, or makes the population "substantially nonrepresentative" of the area's general population as determined by regulations.[424] HEW's regulations on open enrollments merely restate the statutory terms and do not provide any further definition or limitation of this obligation.[425] Some form of open enrollment obligation for HMOs that obtain Medicare beneficiaries as subscribers seems appropriate. As a matter of fairness,

419. For example, the Federal HMO Act merely requires qualified HMOs to offer nursing home services as supplemental services, 42 U.S.C. § 300e-1(2)(A) (Supp. V, 1975), which may be offered to subscribers on a fee-for-service basis, *id.* § 300e(b)(2).

420. *Id.* § 1395mm(b)(7).

421. *Id.* § 1395mm(h) provides that HEW may waive the requirement of 50% membership under 65 for the first 3 years of an HMO's prepayment contract if the HMO is "making continuous efforts and progress toward achieving compliance . . . within such three-year period."

422. 20 C.F.R. § 405.2004(c)(2) (1976).

423. *See* text accompanying notes 216-17 *supra*. Curiously, HEW's regulations do provide for a waiver of the requirement that 50% of the HMO's membership be under 65, if the requirement would make the HMO's population "substantially nonrepresentative" of the general population in the HMO's area. 20 C.F.R. § 405.2004(c)(1)(i) (1976). Although the statute does express concern about an HMO's having to take a higher proportion of Medicare beneficiaries than live in the general population, 42 U.S.C. § 1395mm(b)(9) (Supp. V, 1975), it does not appear to authorize a regulation that would allow HMOs to have more than 50% Medicare enrollments when more than 50% of the general population is over 65.

424. 42 U.S.C. § 1395mm(b)(9) (Supp. V, 1975).

425. 20 C.F.R. § 405.2004(d) (1976).

Medicare beneficiaries residing in the HMO's area should be treated as a group and the HMO should not be allowed to select only low-risk individuals.[426] The current statutory provisions, however, do not provide an HMO with maximum flexibility to negotiate with the Social Security Administration concerning the total number of Medicare beneficiaries it will accept on a prepaid basis. Although an HMO can negotiate for a prepayment contract with the knowledge that it need take Medicare beneficiaries only up to the various limits noted above, the potential enrollment of Medicare beneficiaries during open enrollment periods may be deemed too large or, if the HMO's existing membership is not stable, too uncertain. In this respect the open enrollment requirement of the Medicare HMO provision seems overly restrictive and likely to retard HMO participation in Medicare on a prepaid basis. Finally, the 1976 HMO Amendments would require that Medicare HMOs qualify under the Federal HMO Act, except that the basic health service coverage for Medicare beneficiaries would remain as stated above.[427] This would mean that Medicare HMOs must provide quite comprehensive insurance coverage and community rating for their other enrollees, include subscribers on their governing boards, and assume almost all financial risk of coverage for other enrollees. These conditions are subject to the objections raised above about the Federal HMO Act.[428]

The most significant problem with the Medicare HMO provision is that it severely limits the incentive and ability of qualified HMOs to generate cost savings by efficient performance under a prepayment contract and to use these savings for development purposes.[429] Only HMOs of a certain size and experience may participate on a risk-sharing basis that allows the possibility of retained cost savings, and these HMOs are allowed to retain only some savings. An urban HMO may participate on a risk-sharing basis only if it has a current membership of 25,000 members and has served at least 8,000 persons in the preceding two years; a nonurban HMO may so participate if it has 5,000 members and has served at least 1,500 persons in the last three years.[430] If these HMOs also can

426. This claim may appear inconsistent with our objection to the open enrollment provision of the Federal HMO Act. *See* text accompanying notes 304-06 *supra*. Medicare beneficiaries, however, unlike the general population, are a distinct group since they all pay the same premiums to the Medicare program and are entitled to similar benefits. This substantially strengthens the claim for fairness in this situation.

427. CONFERENCE REPORT, *supra* note 235, at 13-14, § 201(a).

428. *See* text accompanying notes 254-79, 295-306 & 317-24 *supra*.

429. *See* McNeil & Schlenker, *supra* note 9, at 211-13.

430. 42 U.S.C. § 1395mm(i)(2)(A) (Supp. V, 1975). The requirement that urban HMOs

satisfy HEW that they have the capacity to bear the risk of potential losses,[431] they may contract on a risk-sharing basis. Under risk-sharing contracts, cost savings are to be measured annually on a retroactive basis by comparing the HMO's actual costs of serving Medicare beneficiaries with an estimate of what Medicare would have paid out if the beneficiaries had been served by other providers.[432] This provision by itself seems generous enough, although it will involve far greater administrative costs and more uncertainty for the HMO than if a flat per capita payment were made in advance. More importantly, an HMO with a risk-sharing prepayment contract may retain only one half of any cost savings, up to a maximum retained amount of ten percent of the estimated cost of service by other providers,[433] and the HMO is required to absorb all losses except for fifty percent of any losses that can be offset against future savings.[434] All other qualified HMOs may obtain prepayment contracts, but the prepaid amounts are subject to retroactive adjustment on a reasonable cost basis.[435] These HMOs may benefit from improved cash flow generated by advance payment of Medicare funds,[436] but they will not have any incentive to economize on these services nor will they be able to retain cost savings that can be used to attract investors and, by offering extra services and lower copayments, to attract subscribers.

The Medicare HMO provision's limitations on risk sharing and retained cost savings hardly seem designed to promote HMO development by attracting large numbers of HMOs to prepayment participation in Medicare. Only some HMOs may qualify for risk sharing, the administrative costs will be substantial, and the risks of gain will not balance the risks of loss. These limitations have been

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must have a membership of 25,000 or more in order to participate on a risk sharing basis, though inconsistent with the allowance of much smaller rural HMOs to so participate, apparently was intended to protect Medicare program and beneficiaries from smaller HMOs becoming insolvent under a risk sharing contract. *See* S. REP. No. 1230, 92d Cong., 2d Sess. 231-32 (1972) (explaining this requirement as necessary to determine valid HMO prepayment rates). In 1972 it was commonly believed that HMOs needed enrollments of 20,000 or more to be economically feasible, but it now appears that much smaller HMOs with enrollments of 5,000 are generally feasible. *See* note 61 *supra*. Another explanation for imposition of the size requirement on risk sharing HMOs might have been the belief that these HMOs will generate larger cost savings for the government by reason of economies of scale. We have noted above that this belief is not yet well documented. *See* text accompanying notes 60-66 *supra*.

431. 42 U.S.C. § 1395mm(i)(2)(B) (Supp. V, 1975).

432. *Id.* §§ 1395mm(a)(3)(A)(i), (iv).

433. *Id.* § 1395mm(a)(3)(A)(i).

434. *Id.* § 1395mm(a)(3)(A)(ii).

435. *Id.* §§ 1395mm(a)(3)(B), (i)(2)(B).

436. *See* Schneider & Stern, *supra* note 13, at 118-19.

designed primarily to obtain immediate savings in public expenditures,[437] but the limitations and the qualifying conditions noted above apparently have failed even to implement this goal.[438] This approach seems self-defeating and in any event too short-sighted to constitute an appropriate policy toward HMOs.

(2) The Medicaid HMO Provision

This provision simply authorizes states to enter into prepayment contracts with HMOs for Medicaid beneficiaries.[439] HEW's regulations under this provision[440] follow the pattern of the Medicare HMO provision, but in a less restrictive form that leaves state agencies with considerable discretion to implement HMO contracts. This latitude is consistent with both the simple nature of the Medicaid HMO provision and the Medicaid law's general structure, which gives broad discretion to states to formulate and administer their Medicaid plans.[441]

Under these regulations a qualified HMO must provide a "comprehensive" range of services, but these need include only hospital inpatient, outpatient, physician, laboratory, and X-ray services.[442] The HMO may not have more than fifty percent of its members covered by Medicare or Medicaid, but this requirement may be waived by HEW for "good cause."[443] Open enrollments for Medicaid beneficiaries must be provided, but the HMO and state Medicaid agency may set limits on such enrollment by contract.[444] A qualified HMO need assume only a "substantial portion of the risk" of its coverage of Medicaid beneficiaries.[445] Finally, the prepayment contract must "specify how any 'savings' (excess of premiums over allowable costs) will be apportioned between the [HMO] and the state agency,"[446] an apparent requirement that Medicaid HMO contracts must provide for at least some government sharing in cost savings.

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437. *See* S. REP. No. 1230, 92d Cong., 2d Sess. 229-32 (1972).

438. *See* text accompanying note 414 *supra*.

439. 42 U.S.C. § 1396a(a)(23) (Supp. V, 1975). Prior to enactment of this section, uncertainty about the authority of state Medicaid agencies to contract with HMOs existed because of the Medicaid law's provisions that Medicaid services be provided on a uniform basis throughout the state. *Id.* §§ 1396(a)(1), (10) (1970).

440. 45 C.F.R. § 249.82 (1975).

441. *See generally* Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7 (1974).

442. 45 C.F.R. § 249.82(b)(10)(ii) (1975).

443. *Id.* § 249.82(c)(5)(ii).

444. *Id.* § 249.82(c)(5)(i).

445. *Id.* § 249.82(c)(2)(vi).

446. *Id.* § 249.82(c)(2)(v).

These regulations permit state Medicaid agencies to define qualified HMOs in a manner that is substantially in accord with our recommended changes in the Federal HMO Act's qualifying conditions.[447] They also appear to permit prepaid risk-sharing contracts with HMOs that meet most of our objections to the Medicare HMO provision.[448] Nonetheless, the regulations do not require state Medicaid agencies to contract in this fashion, nor do they require that Medicaid HMOs provide full drug and maternity care or make maximum feasible use of expanded medical delegation. Thus what states actually do under these guidelines is a wide open question and great variety in HMO contracting may be expected.[449]

Finally, the 1976 HMO Amendments would require Medicaid HMOs, like Medicare HMOs, to satisfy the qualifying conditions of the Federal HMO Act except the one concerning coverage of basic services.[450] This would mean that Medicaid HMOs must provide quite comprehensive coverage and community rating for their other enrollees, include subscribers on their governing boards, and assume almost all financial risk of coverage for other enrollees. The 1976 HMO Amendments also would require Medicaid HMOs to add family planning and home health care services to their basic policy for Medicaid beneficiaries.[451] The addition of family planning services to the basic policy is consistent with our recommendations for the requirement of a full range of maternity care. On the other hand, the requirement that home health care services be offered is not consistent with our theory and might impose unwarranted costs.[452]

#### (3) Overall Assessment and Recommendations

Federal legislative efforts to engage the HMO movement in serving Medicare and Medicaid beneficiaries seem but halting first steps towards effective promotion of HMOs as a more efficient form of health care. The Medicare HMO provision suffers from its excessive emphasis on the short-term goal of reducing public expenditures by use of HMOs, a goal which appears to be self-defeating. The Medicaid HMO provision is more liberal in what it allows states to do, but one can expect that many state Medicaid agencies also will emphasize saving public expenditures by limiting HMOs'

447. *See* text accompanying notes 403 & 404 *supra*.
448. *See* text accompanying notes 429-38 *supra*.
449. *See* McNeil & Schlenker, *supra* note 9, at 210.
450. CONFERENCE REPORT, *supra* note 235, at 14-17, § 202(a).
451. *Id.*
452. *Cf.* text accompanying notes 417-19 *supra*.

ability to retain cost savings. These laws do not seem well designed to attract HMOs to participate in the Medicare and Medicaid programs on a prepaid basis. Furthermore, the additional restriction to be imposed by the 1976 HMO Amendments will make this process an even more difficult one.

We recommend that the Medicare and Medicaid HMO provisions be amended in three basic ways. First, HMOs should be able to qualify for prepaid risk-sharing contracts under qualifying conditions similar to those we have recommended for the Federal HMO Act. Under these conditions HMOs would be required to offer only basic inpatient and outpatient services, although these should include all related drug services that are paid for by Medicare[453] or Medicaid[454] and a full range of maternity and well-child care for Medicaid enrollees. These HMOs also should be required to make maximum feasible use of expanded medical delegation.

Secondly, the size limitation for risk-sharing participation by urban HMOs under Medicare should be reduced substantially in order to recognize the financial viability of smaller HMOs and the particular benefits they may provide. Thirdly, these amendments also should ensure that HMOs are paid a flat premium in advance, with HMOs bearing the full risk of any losses and able to retain all cost savings. The determination of appropriate premium amounts is admittedly a difficult issue if it is deemed desirable to provide in HMO contracts for some immediate savings in public expenditures. If establishing HMO premiums at amounts equivalent to what it costs to pay other providers for services to similar beneficiary groups is not desirable, the best approach to this issue is the one recommended by the fair market theorists.[455] HMOs should be paid premiums for Medicare and Medicaid services that are equivalent to the market-established premiums they charge other enrollees, with adjustments to the extent that different services are provided to different groups. This formula would not work, however, for HMOs that obtain waivers of the fifty percent limit on Medicare and Medicaid beneficiaries and primarily serve these persons. In

453. Very few outpatient drugs are covered by Medicare. Such coverage is limited essentially to drugs commonly furnished in physicians' offices, 42 U.S.C. § 1395x(s)(2)(A) (1970), and those that cannot be self-administered and are furnished at a hospital. *Id.* § 1395x(s)(2)(B).

454. The Medicaid law authorizes states to cover outpatient as well as inpatient drugs, *see* 42 U.S.C. § 1396d(a)(12) (1970), and today most state plans provide at least some coverage of outpatient prescription drugs. *See* U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, SOCIAL AND REHABILITATION SERVICES, MEDICAL ASSISTANCE (MEDICAID) FINANCED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT 43 (1976).

455. *See* text accompanying notes 213-17 *supra*.

this situation, a proposal that seems fair to HMOs, Medicare and Medicaid beneficiaries, and the public fisc would be to allow Medicare and Medicaid agencies to negotiate "reasonable" premiums with these HMOs that are between ninety-five and one hundred percent of the amount that otherwise would be paid to fee-for-service providers for such services.[456]

This recommended expansion of the Medicare and Medicaid HMO programs should provide substantial benefits to all concerned parties. Nonmodel as well as model HMOs would improve their access to a relatively large consumer market. Medicare and Medicaid beneficiaries, as HMO subscribers, would benefit from any quality of care improvements offered by HMOs, from additional services that may be offered by HMOs to obtain their enrollment, and, in the case of Medicare beneficiaries not also covered by Medicaid,[457] from reduced deductibles and coinsurance payments that also may be offered by HMOs to obtain their enrollment.[458] Government and taxpayer-consumers might benefit from some immediate savings in public expenditures, which may accrue from reduced administrative costs[459] as well as lower payments to HMOs. In the long run these parties also would obtain the benefits of lower costs and improved quality in the health care system generally that may be expected from substantial HMO expansion.

## V. CONCLUSION

In this article we have tried to develop and apply a new theory of HMO legislation, one which borrows from and to some extent synthesizes earlier approaches. Our theory focuses on encouraging HMO development through the play of market forces and, at the same time, on using the HMO as a policy instrument for effecting certain specific health care reforms on a general basis that may not otherwise be obtained. The essential advantage of this theory, we believe, is that it provides better recognition than other theories have of the combined economic and political possibilities of HMOs.

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456. The House of Representatives initially proposed a Medicare HMO provision that would have authorized all HMO premiums to be set at an amount equal to 95% of the amount that otherwise would be paid to other providers, S. REP. No. 1230, 93d Cong., 2d Sess. 230 (1972), which guarantees a 5% savings in government expenditures. We recommend a more flexible provision in order to encourage newer and smaller HMOs to participate in Medicare and Medicaid on a prepaid basis. This seems desirable for reasons given in the text accompanying notes 206-08 *supra*.

457. The Medicaid statute requires states to pay Medicare deductibles and coinsurance for certain categories of Medicaid recipients who are also eligible for Medicare. 42 U.S.C. §§ 1396b(b)(1), 1396a(a)(10)(c)(III), 1396a(a)(15) (Supp. V, 1975).

458. For discussion of the generally steep copayment requirements under Medicare see Schneider & Stern, *supra* note 13, at 113-14.

459. *Id.* at 134.