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Recent Developments

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RECENT DEVELOPMENTS

Health Maintenance Organization Act of 1973 —Federal Regulation and Support of Prepaid Group Health Care Plans—Preemption of Restrictive State Laws and Practices

I. INTRODUCTION

On December 29, 1973, President Richard Nixon signed into law the Health Maintenance Organization Act of 1973.[1] As an alternative to the traditional fee-for-service, sole-practitioner method of health care,[2] this act provides for affirmative federal regulation and financial support of the health maintenance organization (HMO) concept. It is a response to the prediction that the delivery of health care in the United States will be in dire need of government and private aid to avert a total breakdown.[3] The symptoms of the present health-care crisis include tremendous increases in the cost of health care, a scarcity of physicians and medical facilities, inefficient use and allocation of available medical resources, and a distressing lack of quality in the services offered.[4] Although the prepaid group health care plan is not a novel approach to the impending crisis in delivery of medical services, the development of HMOs has been hindered seriously by restrictive state laws and practices.[5] The instant federal legislation is designed to aid significantly the development of prepaid group health care by providing financial assis-

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1. Pub. L. No. 93-222 (Dec. 29, 1973), 87 Stat. 914, *amending* 42 U.S.C. §§ 201 *et seq.* (1970), *as printed in* 1973 U.S. CODE CONG. & ADMIN. NEWS 5129-56.

2. According to the traditional fee-for-service concept, a patient contacts an individual physician who provides health care for a fee that is determined by the time spent and the type of service performed. If the patient's needs are beyond the physician's capabilities (knowledge, time, facilities), the physician will refer him to another source of care (physician, hospital, clinic).

3. *See* Finch & Egeberg, *Report to the President, cited in* U.S. NEWS & WORLD REPORT, July 21, 1969, at 9.

4. *See* Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations,* 24 STAN. L. REV. 644, 646-47 (1972) [hereinafter cited as Holley & Carlson]; Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis,* 84 HARV. L. REV. 887, 891-901 (1971) [hereinafter cited as Note]. *See generally Symposium — Health Care,* 35 LAW & CONTEMP. PROB. 229 (1970).

5. *See* Rothfeld, *Sensible Surgery for Swelling Medical Costs,* 119 CONG. REC. S6934, S6935 (daily ed. Apr. 10, 1973).

tance to qualified HMOs and preempting restrictive state regulations.[6]

II. WHAT ARE HMOs?[7]

A health maintenance organization is a legal entity that accepts the responsibility and risk of providing comprehensive health care services in return for fixed periodic payments. The volunteering patient-enrollee pays without regard to the number of visits or the type and extent of services actually rendered by the HMO. Rather, the fee is based on the cost of the services required by the whole community enrolled in the HMO. These services are comprehensive, including hospital, clinic, and home visits, but the benefits offered vary with the particular needs of the community. The health care is provided by a team of physicians who are employed by the HMO and who typically use centralized facilities and supplies, thus giving the client easy, one-source access to these services. The physicians are compensated on a prearranged distribution from the pooled income as opposed to the fee-for-service basis.

Although the term "HMO" is relatively new, organizations with these characteristics have been in existence for over forty years.[8] Today, approximately eight million clients[9] are served by these organizations.[10] Although these entities, collectively referred to as HMOs, have a variety of forms and sponsors,[11] the overwhelm-

6. *See* Pub. L. No. 93-222, § 1311 (Dec. 29, 1973), 87 Stat. 931, *as printed in* 1973 U.S. CODE CONG. & ADMIN. NEWS 5150-51.

7. The sources for the following general definitional account of HMOs are: Havighurst, *Health Maintenance Organizations and the Market for Health Services,* 35 LAW & CONTEMP. PROB. 716, 718-24 (1970) [hereinafter cited as Havighurst]; Holley & Carlson, *supra* note 4, at 648-53; Morris, *HMO (Horrendous Malpractice Obituary),* 39 INS. COUN. J. 518 (1972); Note, *supra* note 4, at 901-18; Phelan, Erickson & Fleming, *Group Practice Prepayment: An Approach to Delivering Organized Health Services,* 35 LAW & CONTEMP. PROB. 796, 797-803 (1970) [hereinafter cited as Phelan].

8. *See* Rothfeld, *Sensible Surgery for Swelling Medical Costs,* 119 CONG. REC. S6934, S6935 (daily ed. Apr. 10, 1973).

9. *Id.* at S6934.

10. Among the more famous and successful organizations are Kaiser Foundation Health Plan (California, Hawaii, Oregon, Washington, Colorado and Ohio), Group Health Cooperative of Puget Sound (Washington), Group Health Association, Inc. of Washington, D.C., Health Insurance Plan of Greater New York, and Ross-Loos Medical Group (California). *See* Note, *supra* note 4, at 910-18; Phelan, *supra* note 7, at 805-08; S. REP. No. 129, 93d Cong., 1st Sess. 9 (1973).

11. *See* Note, *supra* note 4, at 910-18. The largest entity, Kaiser Foundation Health Plan, is composed of an administrative corporation that contracts for health services with both a hospital service corporation that owns hospitals and regional physician groups. This tripartite organization stresses centralized control and efficiency. The Health Insurance Plan of Greater New York (HIP) is purely an administrative entity. Unlike Kaiser, it contracts with

ing majority of established and proposed HMOs are nonprofit organizations.[12] There has been a continuing debate, however, over the appropriateness of a profit-making enterprise in the health care area.[13] Advocates of the profit-making form contend that it provides needed sources of capital for the development and maintenance of HMOs; however, there are fears that the profit motive will shift the physicians' allegiance away from the patient to the organization and its goal of economization.[14]

The continued interest in HMOs can be traced to the distinct advantages of this type of health-care organization. The major advantage is its stress on preventive medicine. Faced with the task of balancing variable costs with a fixed income, these organizations emphasize early detection and prevention of prolonged illnesses that otherwise would require costly services.[15] This approach also avoids the built-in economic pressure on physicians to perform unnecessary services for clients who are paying on a fee-for-service basis. Thus a client's treatment more likely will be based on his health rather than his ability to pay.[16] Although there is a possibility that the quality of care will suffer due to cost pressures, these same pressures induce the organization to use its facilities and referral services efficiently, thereby assuring the client of more continuous, nonduplicative attention.[17] The goal of efficiency, which requires organization, also promotes easier access to health care for consumers. Instead of the extremely inefficient fragmentation existing in traditional health-care delivery,[18] the HMO concept provides access to comprehensive health services from a single entity, with various

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independent medical group partnerships that, in turn, contract for hospital services on an individual basis. This decentralized approach is dependent on independent contractors and affects the plan's efficiency and economy. Thus HIP is beginning to provide its own centralized services. The Ross-Loos Medical Group of Los Angeles is the oldest and largest physician-run plan. Its enrollment is largely employment related. This plan provides most of its own services, but hospitalization is provided by independent hospitals reimbursed by the plan's own insurance.

12. *Id.* at 918.

13. *See Hearings on S. 1182 Before a Subcomm. on Health of the Senate Comm. of Labor and Public Welfare*, 92d Cong., 1st Sess. 157-61, 469-72 (1971).

14. *See* Havighurst, *supra* note 7, at 748-59.

15. According to a survey of health costs by the Health Manpower Commission of the U.S. Public Health Service, cited in Zak, *Comprehensive Prepaid Health Care—Why?*, 117 CONG. REC. 4416 (1971), during 1960-65 the Kaiser Foundation required 1.69 hospital beds per 1000 clients per year and a total of 528 hospital-patient days per 1000 clients per year while the area fee-for-service hospitals required 3.39 and 891 respectively.

16. *Id.*

17. *See* Havighurst, *supra* note 7, at 720-22.

18. In the present system of sole practitioners, the consumer has many possible sources

specialists using a central depository of health records.[19] This consolidation of health-care personnel, facilities, and administration has resulted in decreased costs for the services rendered.[20] Also, the physicians have the advantages of the decreased cost of practicing medicine, internal consultation with colleagues in the HMO, opportunity for a regular work schedule, decreased financial risk in entering medical practice, and more time for continuing their professional education.[21]

In spite of the apparent viability of HMOs as an alternative to the traditional fee-for-service system, there are twenty states without any form of HMOs in existence.[22] The major reason, besides the absence of necessary capital, is the existence of restrictive state laws and practices.

III. Restrictions on the Development of HMOs[23]

In response to pressure by organized medicine, various restrictive measures have been enacted by the states to combat the threats, such as control of health services by laymen and competition for the traditional fee-for-service approach, embodied in prepaid group health care plans.[24] Moreover, contributing to the restrictive climate surrounding the development of HMOs[25] is a feeling of uncertainty due to the inconsistent enforcement and interpretation of these measures by state authorities.[26] The Department of Health,

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of health care, often leading to confusion over the proper specialist needed for the situation. An error in choice leads to referrals that can result in test duplication and misplaced medical records.

19. *See* Havighurst, *supra* note 7, at 721-22.

20. Senator Cranston noted that in a 1967 Health Manpower Commission study for the period 1960-1965, the per capita medical care costs paid by private consumers in the U.S. increased 43.5% while the increase for enrollees of Kaiser Foundation was 19.1%. 118 CONG. REC. 7971 (1972). For other studies and views on the relative advantages and disadvantages of HMOs see *Hearings on H.R. 5615, 11728 and All Identical Bills Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce,* 92d Cong., 2d Sess. (1972) and *Hearings on S. 935, 703, 837, 1182, 1301, 2827, 3327 Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare,* 92d Cong., 1st & 2d Sess. (1971-72).

21. *See* S. REP. No. 129, 93d Cong., 1st Sess. 2 (1973).

22. *See* 119 CONG. REC. S23430 (daily ed. Dec. 19, 1973) (remarks of Senator Javits).

23. *See* Hansen, *Group Health Plans—A Twenty-Year Legal Review,* 42 MINN. L. REV. 527, 531-48 (1958) [hereinafter cited as Hansen]; Holley & Carlson, *supra* note 4, at 653-62; Comment, *Group Health Plans: Some Legal and Economic Aspects,* 53 YALE L.J. 162, 166-82 (1943) [hereinafter cited as Comment]; Note, *supra* note 4, at 954-75.

24. *See* Hansen, *supra* note 23, at 527-31.

25. This restrictive climate has led such organizations as Kaiser Foundation to consider the state of the law in a prospective area as an element in expansion decisions. *See* Note, *supra* note 4, at 975.

26. *Id.* at 964.

Education and Welfare has estimated that twenty-two states have specific restrictive statutes while admitting that as many as forty-nine states may prohibit HMO development in some manner.[27]

A. Restrictive Enabling Acts

The purpose of enabling acts in general is to regulate the formation and operation of legal entities. In setting up regulatory statutes for prepaid group health care plans,[28] the states developed controls which necessarily would inhibit the development of plans not favored by organized medicine.[29] The various controls imposed include: (1) medical society approval of the plan's articles of incorporation;[30] (2) medical society sponsorship, or control of directors or sponsors, of the plan;[31] (3) actual medical society control of the plan's operations;[32] (4) required membership of an absolute number of the local physicians;[33] (5) open membership for all physicians who desire to join;[34] (6) required statutory form of organization;[35] and (7) freedom of an enrollee in the plan to choose any physician, even one not associated with the plan.[36] These statutes also exempt the plan from insurance laws and the corporate practice rule,[37] thus further monopolizing the health care market for organized medicine by subjecting nonqualified (nonfavored) plans to more regulations.[38] An extreme restriction is found in a Virginia law which limits competition among HMOs by prohibiting more than one medical and one surgical plan to exist in a stipulated geographical area unless the Insurance Commission determines that the public welfare requires more than one plan.[39]

Although many states have statutes that clearly restrict the

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27. 118 CONG. REC. S14385 (daily ed. Sept. 8, 1972) (cited by Senator Kennedy). *Contra, HMOs as Seen by the AMA — An Analysis,* 117 CONG. REC. 47847 (1971) ("probably no real barriers exist to legal development of HMOs.") (cited by Representative Roy).

28. Approximately 10 states have no enabling legislation for prepaid group health care plans, although such plans do exist in those states. *See* Holley & Carlson, *supra* note 4, at 654 n.43; Note, *supra* note 4, at 963.

29. *See* Comment, *supra* note 23, at 175.

30. *See, e.g.,* ALA. CODE tit. 28, § 305 (1958).

31. *See, e.g.,* N.H. REV. STAT. ANN. § 420:7 (Supp. 1972).

32. *See, e.g.,* GA. CODE ANN. § 56-1809 (1971).

33. *See, e.g.,* IOWA CODE ANN. § 514.17 (Supp. 1973).

34. *See, e.g.,* GA. CODE ANN. § 56-1814 (Supp. 1973).

35. *See, e.g.,* KAN. STAT. ANN. § 40-1901 (1973) (nonprofit).

36. *See* ALAS. STAT. § 21.87.160(c) (1966).

37. For a discussion of the corporate practice rule see text accompanying notes 51-59 *infra.*

38. *See* Hansen, *supra* note 23, at 531.

39. VA. CODE ANN. § 32-195.9 (1973).

development of HMOs, a literal reading of these statutes is often misleading.[40] Modern advocates of HMOs have devised ways to evade these restrictive acts, recognizing that they were passed without regard to HMOs by legislators who were sometimes totally ignorant of the method of operation involved.[41] These methods have included: (1) creating a legal fiction in licensing an HMO (Health Insurance Plan of Greater New York) under a medical indemnity insurance plan statute; (2) obtaining an opinion by a state attorney general stating that the statutory delegation of approval to the medical society is inoperative because of vagueness and indefiniteness; and (3) incorporating an HMO under an alternative nonprofit corporation statute.[42] Restrictive enabling acts have been attacked directly on constitutional grounds. Statutes that authorize private groups such as medical societies and hospitals to control the establishment of prepaid group health care plans have been held to be unconstitutional delegations of legislative power and to violate due process by not providing adequate safeguards.[43] These piecemeal reactions to restrictive enabling acts, however, have not provided the impetus necessary for unanimous modification of all such laws.

B. *Insurance Laws*

Insurance laws and regulations present another legal obstacle to the development of HMOs. By guaranteeing medical services paid for in advance, HMOs superficially resemble insurance organizations.[44] Regulation by insurance laws has placed great burdens on prepaid group health care plans, including large financial reserve requirements, restrictions on the percentage of assets that can be used for organizational expenses, and unreasonably low rate limitations.[45] These burdens are unreasonable because the main purpose of HMOs is not to indemnify losses of clients, but to provide medical services which require large amounts of capital investment.[46] Thus, these laws are not the appropriate quality-control measures needed to supervise HMO operations. Fortunately, the courts have recog-

40. *See* Note, *supra* note 4, at 963-64. *Contra*, Hansen, *supra* note 23, at 533-34 (finding a permissive/mandatory dichotomy in enabling acts).

41. *See* Note, *supra* note 4, at 964.

42. *Id.* at 964-66.

43. *See* Illinois Hosp. Serv., Inc. v. Gerber, 18 Ill. 2d 531, 165 N.E.2d 279 (1960); Group Health Ins. v. Howell, 43 N.J. 104, 202 A.2d 689 (1964); Group Health Ins. v. Howell, 40 N.J. 436, 193 A.2d 103 (1963); 7 DUQ. L. REV. 125, 130-32 (1968).

44. *See* Hansen, *supra* note 23, at 536-37.

45. *See* Note, *supra* note 4, at 970.

46. *Id.* at 973.

nized this distinction and have found that prepaid group health care plans are not subject to insurance law regulation.[47] In *Jordan v. Group Health Association,*[48] the leading case in this area, the District of Columbia Circuit concluded that risk distribution or assumption was incidental to the other features of Group Health such as the rendering of a service, a preventive medicine outlook, and a goal of cost reduction.[49] This judicial reaction, however, may be limited by a revision of the insurance laws by the legislatures attempting to maintain control over HMOs that successfully evade enabling acts.[50]

C. The Common-Law Corporate Practice Rule

The corporate practice rule prohibits licensure of a corporation for the practice of a learned profession.[51] Based on considerations of public policy[52] requiring high standards of competency and freedom of choice for the consumer, and the fear that a physician's loyalty will favor the corporation over the patient,[53] the rule prevents a corporation from practicing medicine under licensure statutes requiring personal qualifications of competency.[54] Various arguments have been advanced to combat the reasoning behind the rule, but most courts see the physician as an agent for the corporation, and therefore, under respondeat superior, the corporate principal is deemed to practice medicine.[55] Nevertheless, while subject to the rule in theory, a nonprofit corporation has never been held to violate the corporate practice rule.[56] This judicial distinction[57] is based on

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47. *See, e.g.,* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939); Note, *supra* note 4, at 970.

48. 107 F.2d 239 (D.C. Cir. 1939).

49. *Id.* at 247.

50. *See* Holley & Carlson, *supra* note 4, at 656-57. For continued insurance-type regulation, *see, e.g.,* ALAS. STAT. §§ 21.87.200-.220 (1966).

51. *See* 1 W. FLETCHER, PRIVATE CORPORATIONS § 97 (perm. ed. rev. vol. 1963).

52. *See, e.g.,* People *ex rel.* State Bd. of Medical Examiners v. Pacific Health Corp., 12 Cal. 2d 156, 158-59, 82 P.2d 429, 430 (1938); Batron v. Codington County, 68 S.D. 309, 326-29, 2 N.W.2d 337, 345-46 (1942).

53. *See, e.g.,* People *ex rel.* State Bd. of Medical Examiners v. Pacific Health Corp., 12 Cal. 2d 156, 158, 82 P.2d 429, 430 (1938).

54. *See, e.g.,* Parker v. Board of Dental Examiners, 216 Cal. 285, 295, 14 P.2d 67, 71 (1932); State v. Bailey Dental Co., 211 Iowa 781, 785, 234 N.W. 260, 262 (1931).

55. *See* Comment, *supra* note 23, at 167-68. One argument, for example, characterizes physicians as independent contractors, not agents for the corporation, thus, the corporation is not practicing medicine. *Id.*

56. *See* Comment, 7 DUQ. L. REV. 125, 128 (1968); Hansen, *supra* note 23, at 536. *Contra,* 7 DUQ. L. REV. *supra* at 128 n.14 (Ohio attorney general disputed the profit-nonprofit distinction).

57. *See, e.g.,* United States v. AMA, 110 F.2d 703, 714 (D.C. Cir. 1940), *aff'd,* 317 U.S.

the rationale that the public is more likely to suffer if a physician's loyalty is divided between his patient and the economic needs of the profit-making corporation.[58] Although its impact has been lessened by the profit-nonprofit distinction,[59] the corporate practice rule has continued to be a major roadblock for the establishment of HMOs operated for profit.

D. *Other Restrictions*

The growth of HMOs has been hampered further by restrictive state licensure laws.[60] While these statutes were enacted to ensure competency, in effect they bar the use of paramedics and curtail the performance by physicians of tasks complementary and necessary to their strictly defined areas of qualification. These limitations frustrate HMO attempts to increase efficiency through labor delegation and substitution.[61]

An HMO's access to the consumer market has been restricted by the traditional American Medical Association position against physician advertising.[62] This position has appeared in state statutes that ban advertising and revoke licenses of violators.[63] For example, in Missouri, such a statute was applied against an osteopathic physician whose clinic advertised its services. The court held that he could not accomplish indirectly what he could not do personally.[64] Although there have been favorable court rulings[65] and some liberalization in state statutes,[66] the ban on advertising has continued to plague the growth of HMOs.[67]

Professional restraints also have been imposed by organized

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519 (1943); People *ex rel.* State Bd. of Medical Examiners v. Pacific Health Corp., 12 Cal. 2d 156, 160, 82 P.2d 429, 431 (1938).

58. *See* Comment, *supra* note 23, at 169-71.

59. *See* Note, *supra* note 4, at 962.

60. *See, e.g.,* OHIO REV. CODE ANN. §§ 4731.01 *et seq.* (Anderson 1954), *as amended in part,* §§ 4731.01 *et seq.* (Anderson Supp. 1972).

61. *See* Holley & Carlson, *supra* note 4, at 659-60.

62. *Id.* at 658.

63. *See, e.g.,* MO. ANN. STAT. § 334.100(9) (1966).

64. Bittiker v. State Bd. of Registration for the Healing Arts, 404 S.W.2d 402, 409 (Mo. 1966).

65. *See* Complete Serv. Bureau v. San Diego County Medical Soc'y, 43 Cal. 2d 201, 272 P.2d 497 (1954); Group Health Cooperative v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951).

66. *See* CAL. GOV'T CODE § 12530(a)(3) (West Supp. 1974).

67. *See* Holley & Carlson, *supra* note 4, at 658. Senator Kennedy sees no difference between HMOs and private insurance plans that advertise for subscribers and then reimburse fee-for-service physicians, thus acting as agents for the physicians. 119 CONG. REC. S8981 (daily ed. May 14, 1973).

medicine against physicians who join group health plans instead of adhering to the traditional fee-for-service approach.[68] The sanctions threatened or proposed include denial of medical society membership, denial of staff privileges in private hospitals, and general ostracism.[69] The result has been reluctance on the part of consumers and physicians to join a plan considered undesirable by organized medicine and restriction of the environment needed for HMOs to compete successfully with the fee-for-service approach.[70] Prepaid group health care plans have been successful in combating this type of monopolistic maneuvering by initiating judicial attacks under federal and state antitrust laws.[71] As a result of these setbacks, the prolonged battle waged by organized medicine has diminished.[72]

IV. Affirmative Laws and Proposals

The various successes enjoyed by the HMOs in their battle against restrictive state laws and practices have been local, sporadic reactions—purely defensive, with no positive commitment on the part of government officials to promote HMOs as a viable means of providing health-care services. Also, the various successful evasions of state regulatory laws have raised fears that HMOs will become unmanageable and that the health-care consumer's interests will be left unprotected.[73] Therefore, the need for affirmative action in recognizing, developing and regulating HMOs has become desirable, and various legislative proposals have attempted to implement this approach.

A. State Action

In the desire to promote the development of viable HMOs, a number of states since 1970[74] have enacted legislation providing for the establishment and regulation of these organizations.[75] The stat-

68. *See, e.g.*, Comment, *supra* note 23, at 175-82.

69. *See* Note, *supra* note 4, at 956-57.

70. *Id.* at 955.

71. *See, e.g.*, AMA v. United States, 317 U.S. 519 (1943); Group Health Cooperative v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951).

72. *See, e.g.*, Phelan, *supra* note 7, at 804.

73. *See* Holley & Carlson, *supra* note 4, at 656-57.

74. The predecessor to this current state action is California's Knox-Mills Health Plan Act enacted in 1965. CAL. GOV'T CODE §§ 12530-39.4 (West Supp. 1974).

75. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 20-1051 to -1068 (Supp. 1973); FLA. STAT. ANN. §§ 641.17-.38 (Supp. 1973); MINN. STAT. ANN. §§ 62D.01-.29 (Supp. 1974); N.J. STAT. ANN. §§ 26:2I-1 to -39 (Supp. 1973); PA. STAT. ANN. tit. 40 §§ 1551-68 (Supp. 1973); TENN. CODE ANN. §§ 56-4101 to -4105 (Supp. 1973); UTAH CODE ANN. §§ 31-42-1 to -32 (Supp. 1973); 119 CONG. REC. S23431 (daily ed. Dec. 19, 1973) (table).

utes generally regulate certification procedures, fiscal requirements, provisions of health-care contracts with consumers, prohibited practices such as deceptive solicitation, and violation penalties. A decided minority restrict the establishment of HMOs for profit.[76] Some states maintain a reserve requirement,[77] although all exempt HMOs from insurance regulations. Minnesota further provides state grants to assist nonprofit HMOs.[78] This positive state approach has one major drawback: a new set of legal hurdles for regional or multistate HMOs could develop due to the varying specific regulations enacted in these states.[79]

B. *Federal Action and Proposals*[80]

The first affirmative actions taken by the federal government in this area involved the funding of HMOs. In 1971, President Nixon established a health maintenance organization service in the Department of Health, Education and Welfare, which by the end of 1972 had distributed approximately twenty-six million dollars in planning and development grants.[81] In the 1972 amendments to the Social Security provisions, Congress extended Medicare payments to HMO consumers on a prospective per capita basis;[82] under traditional payment procedures,[83] Medicare reimbursement to HMOs was based on the cost of the service, which defeated the incentive to keep costs low.[84] The 1972 amendments define an HMO, in part, as a public or private prepaid health organization that can reimburse its employee-physicians on a fee-for-service basis. Also, within three years of the beginning of Medicare payments, at least fifty percent of an HMO's enrollment must consist of members sixty-five years or older.[85] This assistance, however, was aimed at states favor-

76. *See* MINN. STAT. ANN. § 62D.02(4) (Supp. 1974); PA. STAT. ANN. tit. 40 § 1554 (Supp. 1973).

77. *See* ARIZ. REV. STAT. ANN. § 20-1056 (Supp. 1973); CAL. GOV'T CODE §§ 12539-39.1 (West Supp. 1974).

78. MINN. STAT. ANN. §§ 62D.26-.29 (Supp. 1974).

79. *See* 119 CONG. REC. S23430 (daily ed. Dec. 19, 1973) (remarks by Senator Javits).

80. *See* Havighurst, *supra* note 7, at 781-92; Holley & Carlson, *supra* note 4, at 668-86; Note, *supra* note 4, at 982-1001.

81. *See* Rotbfeld, *Sensible Surgery for Swelling Medical Costs,* 119 CONG. REC. S6934, S6935 (daily ed. Apr. 10, 1973).

82. 42 U.S.C. § 1395mm (Supp. II 1970) (HMOs would get up to 95% of the costs that a patient would have incurred if he did not go to an HMO).

83. 42 U.S.C. §§ 1395f, 1395 *l*(a) (1970). This provision was first introduced in H.R. 17550, 91st Cong., 2d Sess. § 239 (1970). *See* H.R. REP. No. 1096, 91st Cong., 2d Sess. 52-55 (1970).

84. *See* Note, *supra* note 4, at 988-89.

85. 42 U.S.C. § 1395mm(b) (Supp. II 1970).

able to HMOs and existing HMOs, thus providing no incentive for developing new ones.[86]

In President Nixon's speech to Congress in February, 1971,[87] he called for the Department of Health, Education and Welfare to draft a model act promoting and regulating HMOs for the states to ratify, which would impose some uniformity in the law.[88] In the alternative, he proposed that the federal government directly contract with HMOs to provide care for Medicare recipients and other federal beneficiaries who choose the HMO option, thus preempting inconsistent state laws through federal contracts.[89] This latter method had already been used in Title IV of the Regional Medical Program Amendments of 1970,[90] in which authorized eligible carriers could reimburse nonprofit HMOs for health benefits extended to federal employees and annuitants.[91] After President Nixon's speech, other affirmative[92] proposals were offered to overcome state restrictions and encourage HMO development. One such proposal combined federal funding with the federal incorporation[93] of HMOs and suggested regulations to insure efficient, quality care as a condition for the issuance of a certificate of incorporation.[94]

The Regional Medical legislation and the proposals which include preemption of restrictive state laws are limited to HMOs which are funded by the federal government, because the preemption is based on Congressional spending and taxing powers in view of the general welfare.[95] This was the same rationale used in implementing the Social Security system.[96]

86. *See* Note, *supra* note 4, at 993.

87. 117 CONG. REC. 3015 (1971).

88. *Id.* at 3017.

89. *Id.*

90. 5 U.S.C. §§ 8901-13 (1970) (contained in Historical and Revision Notes) (added health care benefits for government employees).

91. 5 U.S.C. § 8902 (1970) (contained in Historical and Revision Notes). One article attempted to interpret the Act as including profit-making HMOs. *See* Holley & Carlson, *supra* note 4, at 663-65.

92. An earlier "negative" proposal to withhold all Medicaid reimbursements and other federal funds from states with restrictive laws was made by the (McNerney) Task Force on Medicaid and Related Problems, *cited in HMOs as Seen by the AMA—An Analysis,* 117 CONG. REC. 47845, 47847 (1971).

93. *See* McCulloch v. Maryland, 17 U.S. (4 Wheat.) 415, 430-32 (1819).

94. H.R. 11728, 92d Cong., 1st Sess. § 1116 (1971), *as cited in* 117 CONG. REC. 40630 (1971).

95. U.S. CONST. art. 1, § 8.

96. *See* Helvering v. Davis, 301 U.S. 619 (1937); Steward Mach. Co. v. Davis, 301 U.S. 548 (1937); Chapman & Talmadge, *Historical and Political Background of Federal Health Care Legislation,* 35 LAW & CONTEMP. PROB. 334, 342-43 (1970); Havighurst, *supra* note 7, at 783. The federal government has also used the commerce clause in regulating interstate transportation of foods and drugs and interstate health insurance. *See* Holley & Carlson, *supra* note 4, at 679-80.

V. THE 1973 ACT

After many attempts to pass legislation with similar provisions,[97] Congress enacted the Health Maintenance Organization Act of 1973.[98] This act authorizes 375 million dollars over a five-year period[99] (section 1309) for the Secretary of Health, Education and Welfare to distribute to public or nonprofit private HMO applicants for the following purposes: (1) grants and contracts for feasibility studies (section 1303); (2) grants, contracts and loan guarantees for planning and initial development costs (section 1304); and (3) loans and loan guarantees for initial operation costs (section 1305). Congress defined a health maintenance organization in section 1301 as a legal entity that provides health services for a fixed, periodic, prepaid fee. The fee is based on a community rating system. The services are provided by "health professionals" of the HMO who share medical facilities, records, a pooled income, and who may be physicians, dentists, nurses, podiatrists, optometrists, and others designated by the Secretary of Health, Education and Welfare. The services must be available twenty-four hours a day, seven days a week, and must include inpatient and outpatient hospital services, mental health treatment, drug and alcohol addiction rehabilitation, home visits, and preventive health services, among others (section 1302). The HMO must have an open enrollment period of thirty days during each year and agree that no one will be expelled or rejected because of his health status. Also, at least one-third of the policymaking board must be enrollees. Besides regulating the fiscal operations of an HMO (section 1301 (c)(1)&(2)), defining the type of population to be enrolled (section 1301(c)(3)), and preparing an annual report (section 1315), the Secretary of Health, Education and Welfare, through continuing regulation , can enforce these regu-

97. *See, e.g.,* H.R. 11728, 92d Cong., 1st Sess. (1971); S. 3327, 92d Cong., 2d Sess. (1972); H.R. REP. No. 451, 93d Cong., 1st Sess. 2-3 (1973) (list of major bills). This act was a result of a compromise between S. 14 and H.R. 7974. *See* S. REP. No. 621, 93d Cong., 1st Sess. (1973). Among tbe S. 14 provisions deleted by the compromise were: (1) the arbitration of all malpractice disputes as an option to HMO enrollees; (2) the limitation of an attorney's contingency fees in arbitration or settlements involving an HMO; and (3) a federal reinsurance program to aid medical malpractice insurance companies. *See* S. REP. No. 129, 93d Cong., 1st Sess. 47-55, 84-85, 88-90 (1973); Morris, *HMO (Horrendous Malpractice Obituary),* 39 INS. COUN. J. 518, 522-24, 526-31 (1972).

98. Pub. L. No. 93-222 (Dec. 29, 1973), 87 Stat. 914, *amending* 42 U.S.C. §§ 201 *et seq.* (1970), *as printed in* 1973 U.S. CODE CONG. & ADMIN. NEWS 5129.

99. Originally there was a much larger commitment to HMO development. *See* S. 3327, 92d Cong., 2d Sess. (1972) ($5.1 billion); S. 14, 93d Cong., 1st Sess. (1973) ($805 million) (figures cited in 118 CONG. REC. S14384 (daily ed. Sept. 8, 1972) (remarks by Senator Kennedy) and 119 CONG. REC. S23430 (daily ed. Dec. 19, 1973) (remarks by Senator Javits) respectively).

lations against HMOs assisted under the act (section 1312). The act in section 1310 also provides another incentive for HMO development by requiring all employers of twenty-five persons or more who pay the federal minimum wage to give employees in the company's health benefit plan the option to join an HMO.[100]

Of particular importance is section 1311, which provides for the preemption of all restrictive state laws that affect HMOs receiving assistance under the act.[101] Section 1311 specifically preempts all state laws that (1) require medical society-approved HMOs; (2) require an HMO governing board consisting of all or a percentage of physicians; (3) require that all or a percentage of local physicians participate or have the option to participate in an HMO; (4) require the imposition of insurance regulations respecting initial capitalization and financial reserves; or (5) prohibit proper advertising for soliciting HMO enrollees. Thus, an affirmative legal atmosphere has been created by the federal government for the development of the HMO concept as an alternative to the traditional fee-for-service approach.

VI. CONCLUSION

Faced with a national health crisis, Congress responded by providing financial support for HMO development and attacking restrictive state laws through preemption. This method appears to be a constitutional application of the congressional spending power for the general welfare, preempting specific, repugnant state laws through the supremacy clause.[102] By specifically describing which restrictive laws are preempted, however, Congress may have been too restrictive. For example, the provision fails to mention restrictive licensure statutes, although these restraints greatly affect an HMO's efficiency through the use of its labor force.[103] No catchall clause is included to cover restrictive laws not specifically mentioned. Preemption of these laws could be accomplished possibly

100. It appears that the authority for this provision is the commerce clause and the regulation of interstate commerce employees through the Fair Labor Standards Act of 1938, 29 U.S.C. §§ 201 *et seq.* (1970), *as amended* 29 U.S.C. §§ 203, 213 (Supp. II 1970). *See* text in note 96 *supra.*

101. H.R. 7974 did not contain a preemption provision. *See* H.R. REP. No. 451, 93d Cong., 1st Sess. 9 (1973).

102. U.S. CONST. art. VI. The Supreme Court determines the extent of preemption of state laws by the congressional intent evidenced in the particular act. *See* LEGISLATIVE REFERENCE SERVICE, LIBRARY OF CONGRESS, THE CONSTITUTION OF THE UNITED STATES OF AMERICA, ANALYSIS AND INTERPRETATION, S. Doc. No. 39, 88th Cong., 1st Sess. 808-09 (1964). For problems with nonspecific preemption see Holley & CARLSON, *supra* note 4, at 665.

103. *See* text accompanying notes 60-61 *supra.*

based on the general purpose of the act as evidenced by the definition of "health professionals," which includes personnel approved by the Secretary of Health, Education and Welfare (section 1301 (b)(3)(B)). This nonspecific approach invites court interpretation, however, and therefore weakens the preemptive force of the Act. Among other restraints not mentioned is the corporate practice rule that still plagues profit-making HMOs tremendously.[104] It is apparent from the Act's definition of an HMO as a "public or nonprofit private entity" and the absence of this type of restraint in the preemption provision that the Act does not include assistance for profit-making HMOs. This is surprising since Congress has recognized that a major roadblock to the development of HMOs as viable health-care providers always has been the need for investment capital. Profit-making HMOs would be uniquely capable of attracting the necessary capital from private investors, and yet Congress has failed in this Act to assist them financially and protect them from restrictive state laws and practices. As shown by the regulations contained in this Act, profit-making HMOs could be controlled to the satisfaction of those who fear the profit motive in health care.[105]

This federal approach does not fully achieve its goal of overcoming state restrictions and encouraging HMO development. Preemption protection is limited to those HMOs able to qualify under this provision; therefore, nonqualifiers will be subject to restrictive laws. Thus it appears that a better approach, albeit a slower one, is the drafting of a model act for state ratification. Such an act would avoid sharply conflicting state statutes, even if amended slightly upon ratification, that would permit the development of regional or multistate HMOs. A model act, well-drafted and sufficiently comprehensive, truly could assist the HMO concept in both its profit and nonprofit forms.

Nevertheless, under the existing statute Congress has attempted by legislation to encourage the development of HMOs as a viable alternative for the health-care consumer. As is often the case in the political world of Congress, the fanfare accompanying a legislative response has obscured the deficiencies of the answer. This act with its limited appropriations, restricted preemption language, and failure to support profit-making HMOs constitutes an experimental approach to the HMO concept, and therefore, only illusionary support for its development.

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104. *See* text accompanying notes 56-59 *supra*.

105. *See* Havighurst, *supra* note 7, at 748-59.