THE EFFECT OF HEALTH MAINTENANCE ORGANIZATIONS LEGISLATION ON THE GROWTH OF PREPAID PLANS

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Science in Medical Sociology by Aimee Arnold Deiter

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ABSTRACT

THE EFFECT OF HEALTH MAINTENANCE ORGANIZATIONS
LEGISLATION ON THE GROWTH OF PREPAID PLANS

by

Aimee Arnold Deiter

Master of Science in Medical Sociology

The purpose of this project is to demonstrate the development, implementation and effect of the Federal legislation on Health Maintenance Organizations, those plans which provide health care to a voluntarily enrolled group of patients for a premium fixed in advance without regard to levels of use. It will show:

(1) The increasing interest of the government in health care delivery as the costs of such care became an increasing part of both governmental and private expenditures,

(2) The development of the prepaid method of health care financing,
(3) The emerging Federal strategy of attempting to control health care costs and simultaneously broadening the scope and quality of services through support of prepaid organizations,
(4) The various impediments to growth of prepaid organizations prior to Federal involvement,
(5) The initial legislative effort and its limited effects due to conflicting goals. This original legislation is shown to have attempted to broaden services while requiring the newly formed HMOs to compete with the existing fee-for-service financing system, and,
(6) Subsequent modifications of the law which recognized the need to limit obligations while making the HMOs more competitive.

It was concluded that the Federal efforts to date have not yet effectively altered the health care financing system.

The major conclusion of this study is that in order for the HMO legislation to be effective in its purpose and goals, four critical additions to the law are necessary. They are in the areas of (1) the pricing of insurance, (2) labor relations, (3) taxation, and (4) governmental regulation.
CHAPTER I

INTRODUCTION

The federal government has taken an increasingly active role in planning, financing and regulating the health care of the American public in the last few years. Though the fundamental responsibility for maintaining the health of the public rests with the individual states under our system of dual state and federal governments, the major impetus for change has been on the national level. Through Medicare and Medicaid the federal government has become the major source of financing of privately delivered care. Large parts of the population are served directly in federally sponsored institutions run by the military services, by the Veterans Administration, by the U.S. Public Health Service and by other agencies. Programs for hospital construction, including Hill-Burton, have underwritten many of the private institutions in the country. Revenue sharing funds are frequently used by the states for provision of health services. Medical research, medical training and education of health care professionals are supported by various federal programs and many medical schools owe their continued existence to the education and research funds so provided.
Regulation has increased at all levels as well. States have enacted "certificate of need" laws and the federal government has enacted legislation requiring area wide planning efforts overseen by federally funded and regulated Health Systems Agencies. Professional Standards Review Organizations, or PSROs have been mandated in efforts to control the cost of care delivered under the Medicare and Medicaid program. These require review of the amount and appropriateness of services delivered, on the orders of physicians, to the beneficiaries of these programs. The decisions of the individual practitioners are thus brought under at least indirect governmental scrutiny.

Government at all levels acts under a broad mandate to protect and improve the welfare of its citizens. Among the ways the citizens can be benefitted is attention to the health of the people. It is with this general orientation that these programs are formulated. It is equally the responsibility of the government to see that these programs are financed, and to responsibly disperse the tax monies that are collected.

Among the many areas of federal concern in the field of health care has been those organizations which deliver services of physicians and health care professionals to a defined voluntarily enrolled membership
for a fixed price paid in advance of the provision of such services, as distinguished from traditional fee-for-service practice. These are generically referred to as "prepaid" organizations. If they have qualified under appropriate federal law, they are referred to as Health Maintenance Organizations or HMOs.6,7,8

STATEMENT OF THE PROBLEM

Three main problems of the American health care system can be identified:

1. **Cost** - Health care in America is so expensive (approaching 10% of the gross national product) that the government has come to believe that it must take an active role in the control of health care costs. In spite of the broadening of scope and range of medical and other health care services, it is perceived that health care costs have been escalating disproportionately to the benefit received by the public.

2. **Social Adequacy** - Despite this financial burden, the public does not always receive adequate care, especially among the elderly, the very young, and the poor.

3. **The Organization of the Health Care Delivery System** - The delivery system for health care is a fragmented
"cottage industry" with primarily third party payment mechanisms. This has led to a distortion of financial and treatment incentives which has brought the U.S. government to intervene in the health care market and to attempt a fundamental reform of the health care financing and delivery system.

STATEMENT OF THE PURPOSE

The purpose of this project is to analyze the federal government's attempt to reform the medical system by promoting prepaid Health Maintenance Organizations through legislation and the appropriation of monites, to describe the societal pressures that led up to this legislations, the HMO act and the revisions to it, and to determine if they promoted the growth of prepaid health plans. It will also determine what further action is necessary to encourage HMOs to become the dominant health care delivery system in the United States.

It will thus determine whether Public Law 93-222, the Health Maintenance Act of 1973, was successful in fulfilling the mandate for which it was formulated: "To amend the Public Health Service Act to provide assistance and encouragement for the establishment and expansion of Health Maintenance Organizations . . . ."
It follows from this purpose that the paper will:

1. Analyze the forces that shaped the approach of Congress to Health Maintenance Organization legislation.

2. Quantify the degree of success of the legislation in increasing the "establishment and expansion of Health Maintenance Organizations" as stated in Public Law 93-222.

3. Recommend additional legislation to encourage the development of an HMO program which will meet the health needs of the American people, be cost effective, and become a dominant factor in reforming and reordering the incentives involved in the delivery of health care to a majority of the population.
SCOPE AND ORGANIZATION OF THE STUDY

This project will describe the concurrence of two historical trends, the development of prepayment as a health care financing mechanism and the rise in costs of health care in the country. It will describe this significant rise in health care costs both in absolute terms and in the percentage of the gross national product devoted to health care. It will examine the federal government's increasing role in the financing of health care expenditures through direct payment and through tax deductions for health insurance payment by individuals and by employers purchasing insurance for their employees. Likewise, it will discuss pressure on the government to help control what are perceived as excessive costs to the public for medical care and health insurance, those beyond the amounts that can be deducted and thereby offset against taxes.

This paper will analyze the development of the government's program to accelerate the growth of prepaid organizations. Previous impediments to the growth of such organizations will be examined. The original legislative efforts, the Health Maintenance Organization Act of 1973, will be described in detail, as will be the effects of this act and the efforts of the State of California to use prepaid health plans as providers.
of care for Medicaid (Medi-Cal) patients. The subsequent amendments to the federal law to date are discussed and a presentation of the future amendments to the law which I conclude from this research are essential to the success and proliferation of the Health Maintenance Organization model in this country will follow.

A legislative history, a legal history (court cases and statutes), an historical perspective, and a compilation of statistical data will be used to analyze the major elements leading to and comprising HMO legislation and its effect on the growth of prepaid health insurance plans.

The research will use two main approaches. The first will explore and discuss the data that was gathered by the several agencies of the government concerned with the problem of health care costs both prior to and after the legislation.

The second method will be the legal research method. This method involves a search for authorities, and a description of their historical development and of their significance to the problem under study, the effect of HMO legislation on the growth of prepaid health care plans.

Legal research will be conducted in the following manner. Authorities will be sought from the primary
sources of law that apply to a particular legal situation. Mandatory primary sources, constitutional, statutory, regulatory and judicial pronouncements will be sought first. If none exist, persuasive primary authorities, (court decisions of other jurisdictions) or secondary authorities (treatises, opinions and scholarly publications) will be used.

This methodology emphasizes the need to consider historical, legislative and legal developments as necessary to understanding the evolution to HMOs in today's health care market and to understanding government intervention in health care in the future.
CHAPTER II

HISTORICAL BACKGROUND

To better understand the impetus that underlay federal interest in prepayment as a financing mechanism, it is essential to review two historical trends. The first of these is the escalation in health care costs, both in absolute terms and in the proportion of the gross national product devoted to them. The second trend is the development of organizations which were financed by prepayment and which agreed, for the premium paid in advance, to provide comprehensive medical services. These differed from the traditional fee-for-service payment mechanism fully or partially covered by insurance. Under the traditional fee-for-service arrangement, the patient could comprehensibly protect himself by purchasing appropriate insurance. This shifted the risk to the insurance company with the provider of services fully or partially reimbursed according to the amount of care delivered. The provider bore no risk. Under the prepayment mechanism, the provider received a prearranged payment regardless of the volume of services delivered. The provider and any associated insurance company thereby shared in the responsibility for providing necessary medical services fully paid for by an amount of money determined in advance.
A. RISING HEALTH CARE COSTS

1. THE TRENDS IN TOTAL HEALTH CARE COSTS

Medical care expenditures should be examined in total dollars, in expenses per capita, as a percentage of gross national product and according to the major components. Figure 1 shows the increase in total national health expenditures. Included are costs for hospitals; services of physicians, dentists and other health professionals; drugs and sundries; eyeglasses and appliances; nursing home care; government public health activities; medical research; medical facilities construction and miscellaneous other health services. The increases in dollar amounts rise at a growing rate over the period of almost thirty years. In the earlier years, each five year period is characterized by a growth in expenditures of forty to fifty percent. From 1970 to 1975 total health care expenditures grew by seventy percent and this rise was approximately the same in the last five years.

Some of this rise in prices simply reflects the general inflation, and consequently, some correction must be made for this to gauge the true rise in health care costs. Figures 2 and 3 provide such correction, in different ways. Figure 2 shows total national health expenditures in deflated dollars. What has been done is express the costs of all later periods in terms of 1950
dollars. The result is the increase in expenditures as if there had been no inflation during the period under study. Rather than a nominal rise of $12 billion to $208 billion, there is a real rise in expenditures of $12 billion to $70 billion. The nominal rise represents an increase in spending of 10.3 percent each year while the real rise is 6.3 percent each year. Thus, inflation accounts for approximately 39 percent of the increase in health care costs over the twenty-nine year period and 61 percent represents real increases in the delivery of goods and services. Inflation has been a more significant factor in the last decade and 55 percent of the increase in total cost of health care in the last ten years is nominal rather than real.9

Figure 3, health care expenditures expressed as a percentage of gross national product, corrects for both the inflation in price levels and the increase in the population to whom health care services are being delivered. The increase in the percentage of the gross national product devoted to health care was from 4.5 percent to 9.1 percent, approximately a doubling. Over the 29 year period, the proportion of the nation's resources used for health care thus rose at an annual rate of 2.5 percent.
FIGURE 2
TOTAL NATIONAL HEALTH EXPENDITURES
Deflated Dollars (1950 = 100)

Statistical Abstract of the United States 1976 p. 394
FIGURE 3

HEALTH CARE EXPENDITURES

Expressed as a Percentage of Gross National Product

Source: Statistical Abstract of the United States 1976 p. 72
Time Magazine May 28, 1979 p. 61
FIGURE 4
PER CAPITA EXPENDITURES ON HEALTH SERVICES

Time Magazine May 28, 1979 p. 61
FIGURE 5
EXPENDITURES FOR MAJOR COMPONENTS OF HEALTH CARE
Expressed in Percentages of Total Expenditures

Source: Statistical Abstract of the United States
1976 p. 73
Figure 4 shows the per capita expenditures on health services. The nominal rise in per capita costs was from $76 to $920 over the 29 year period. When this last figure is deflated, and the per capita expenditure expressed in 1950 dollars, the rise is from $76 to $308. This represents an average annual increase of 5 percent.

Thus, the 10.3 percent annual increase in health care expenditures is seen to have several components. 4 percent represents inflation in the level of prices. During this period the population of the United States grew at a rate of approximately 1.2 percent a year. The remainder, 5 percent, represents a true annual increase in the cost of health care services delivered per individual. Of this 5 percent increase, approximately one-half, or 2.5 percent, represents an increase in the gross national product, an increase in the goods and services produced throughout our country. The remaining 2.5 percent represents an annual increase in the proportion of those total goods and services produced which have been allocated to health care.

Figure 5 shows the expenditures for the major components of health care expressed in percentages of total expenditures. The most striking growth has been in the cost of hospitalization. The causes of this, such as advances in technology and increased salary
levels in a labor intensive environment will be examined in the next section. Though the costs of professional fees, drugs and the other components of health care have risen significantly, it has been at a slower rate so that they consume a smaller proportion of the total health care expenditures. Medical, hospital and drug costs are interrelated so that increased services provided by physicians are accompanied by more hospitalization and more medications dispensed to patients.

2. FACTORS INFLUENCING TOTAL HEALTH CARE COSTS

In the previous section, the significant rises in health care costs, in the aggregate, were described. Various changes in health care delivery have contributed to the overall price rise. Among them are advances in technology, increasing personnel costs, the aging of the population, malpractice costs, involving both actual premium costs and the practice of "defensive medicine," increased regulation, inflation, and the increase in the availability of practicing physicians.

Technological advances in the twentieth century have eclipsed all of those since the beginning of recorded history. The first primitive X-ray was introduced in 1896. Since then the ability to image the human body has increased many fold, with ever advancing specificity. Within the past two decades ultrasonography, cineangio-
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graphy, computerized axial tomography, fluoroscopy with image intensification, xeromammography and radioactive isotope scanning have become routine procedures. Though they magnify the ability of the physician greatly, they add very significant costs. Not only do the examinations themselves require costly equipment, supplies and personnel, but they make possible surgical and other treatments that require hospitalization, laboratory studies and significant physician and surgeon involvement.

The hospital has evolved from a simple place of repose to a place in which all of the diagnostic, monitoring and therapeutic equipment can be aggregated. In addition to the many types of imaging that can be performed, hundreds of laboratory tests are available, most requiring expensive equipment and trained technicians. Various levels of monitoring are available, depending on the seriousness of the patient's condition. In the aptly named intensive care units, a patient can be surrounded by a number of sophisticated electronic units which are all connected to a central computer. Internal and external sensors can give information on various important parameters on a continuous basis. Computerized respirators are available to assist breathing, intra-arterial pumps to reinforce the patients failing heart, dialysis machines to replace non-functioning
kidneys and total parenteral nutrition to bypass the inadequate gastrointestinal system. Infants can be monitored in the uterus and, if premature, can be attached to almost total life support systems after birth.

Further, drugs can support failing hearts, destroy virulent bacterial invaders, safely anesthetize the patient, tranquilize him in his daily life, destroy cancer cells in his body, and perform other miracles on a routine basis. Surgical instruments and prostheses allow organs to be transplanted, joints to be replaced, lenses to be substituted for the human lens and countless techniques to improve the quality of life to be performed.

These are costly and added to these are the professional fees of the trained super specialists, physicians and supporting staff. It is not impossible for patients to generate bills of thousands of dollars a day. And, while everyone agrees that the chances of the individuals receiving such treatment are improved, significant questions are raised daily about the appropriateness of applying such techniques to individuals whose age and diseased state are far advances. Such questions are not easily answered. There is no corresponding doubt as to the costs generated.

Hospitals are a labor intensive industry, with a general ratio of 2.64 hospital employees per bed.
Personnel costs have generally accounted for 60 percent of the operating budget.\textsuperscript{11} Over the past three decades, hospital costs have risen eight fold.\textsuperscript{12} Labor organizations and professional associations, expansion of services and shortages of professionals have generated an equal rise in the once depressed wages of the staffs so that labor costs have kept pace with the increasing costs of technology. In some cases there has been so much pressure on wages that in one major urban teaching hospital wages and benefits now in 1979 take 70 percent of the budget compared with 35 percent only 20 years ago.\textsuperscript{13}

The general aging of the population contributes to the demand for service. From 1960 to 1975 the number of persons 65 years old and over increased from 16.7 million to 22.4 million, or 34 percent. During this period, the general population increase were 18 percent. The proportion of the population 65 years old and over increased from 9.3 percent to 10.5 percent.\textsuperscript{14} These individuals are subject increasingly to degenerative diseases for which no cure is available and which require repeated attention to restore some function and to preserve life. While younger people are likewise subject to heart disease, cerebral vascular insufficiency and neoplasms, the incidence increases with age. In a sense, rising costs are an inevitable consequence of the growth
in medical science. The individual who would have died prior to retirement of pneumonia, gall bladder disease, appendicitis or some similar disease a century ago is now easily treated and survives. He now becomes subject to the various degenerative diseases, which are increasingly more difficult and more expensive to treat over his now greatly extended lifespan. Health care costs are generated in the year of the acute but no longer fatal disease. They then continue for many years, often at an ever increasing rate to the time of death.

Practices developed by physicians to avoid or minimize the likelihood of being sued have been termed defensive medicine.

There are two types:

1. Positive defensive medicine - This arises when a test or procedure is performed not because it is perceived as essential or even likely to be useful but it is done so that if the patient has a bad result the doctor cannot be accused of negligence for not having performed the test. This is the major concern of those who argue that defensive medicine contributes to increased health care costs.

2. Negative defensive medicine - This occurs when a physician avoids a potentially beneficial procedure because legal risks might arise from resulting
complications. This type does not contribute to costs and may actually lower them, but there may be a compromise in quality and a denial of a benefit to a patient.\textsuperscript{15}

The Secretary of Health, Education and Welfare's Medical Malpractice Commission concluded that defensive medicine is indeed practiced and that such practice does increase the cost of medical care.\textsuperscript{16} The magnitude of such costs is difficult to arrive at. Overall estimates of 10 percent of hospital bills have been given. However, it is very difficult to be sure of the magnitude of the expenditure, since it is necessary to define the indications for any given test or procedure.

It is not arguable that the direct cost of broadening the basis of liability has contributed to the overall expenditures for medical care since defense costs and malpractice insurance premiums are ultimately passed along to the consumer and become part of the total resources devoted to health care. In the early and middle part of the decade of the 1970s, malpractice insurance costs rose significantly,\textsuperscript{17} and the ability of physicians to obtain insurance at all came into doubt.\textsuperscript{18} What was once a minor expense, amounting to only a few hundred dollars yearly, became an expenditure of up to $35,000 a year for individuals with good records (no previous
litigation), depending on locality and specialty. In a period of rapid escalation in costs, premiums were nothing more than a conservative guess as to the future, with doubt resolved on the high side. Claims made insurance (payable only for incidents which were reported during the policy period) replaced occurrence policies. (Insurance is provided for all events which occurred during the policy period even if they are reported and litigated months or years later). Companies owned cooperatively by physicians did enter the field, allowing for some lowering of premiums, though their stability is not proven, since there is a delay of years between the time the policy is issued and the time that all claims made under the policy are satisfied, the so-called long tail of liability.

This highly publicized crisis generated a new vocabulary, with physicians now "going bare" or practicing without malpractice insurance. It also sparked a physician "strike" or withholding of non-emergency services in California in 1975. Most importantly, it generated a significant rise in fees, justified in the minds of the public by higher premiums for malpractice insurance which had been discussed so widely in the media. Though many other factors were at work in the 1970s, the costs of litigation and malpractice protection is a signifi-
cant contributor to the overall costs of health care. One estimate is that the cost of the hospital share of the malpractice risk alone, in New York State, adds $25 to the per diem patient rate.

Regulation is a significant factor in the cost of delivering medical care. Though any system of scrutiny and accountability is likely to have positive effects on the products and practices of an industry, regulation in its many forms at the federal, state and local level is certainly expensive. A Washington University study estimated that federal regulation alone costs each American citizen $300 a year, or a total of $65 billion yearly, and the government economists estimate that the inflation rate is increased by three-quarters of one percent per year because of environmental and safety regulations alone. A study of more than 300 hospitals and other health-care facilities by the Hospital Association of New York State found that in that state alone there are 164 federal and state regulatory bodies to oversee hospital-based health care delivery, and that 25 percent of hospital costs stem from these regulatory requirements. The annual cost to patients and taxpayers, in those 300 institutions, is more than $1.1 billion, and 115 million man-hours are required, the equivalent of 56,000 hospital employees spending
all of their time with these matters. The forms and reports required by regulation alone cost more than $128 million annually. It was also found that registered nurses, whose duty traditionally has been patient care, spend one-quarter of their time dealing with regulations. In the decade from 1966 to 1975, the period in which health care costs rose from 5.9 percent of the gross national product to 8.6 percent, the volume of federal regulation, as reflected in the number of pages in the Federal Register devoted to health care matters, more than tripled. Since some states have more stringent requirements than others, a reasonable estimate for total regulatory cost is difficult to arrive at. This is further compounded by the fact that much of the behavior carried out in response to regulatory requirements would be carried out anyway in the interest of common sense and good patient care. Nonetheless, it can be estimated that from 5 to 10 percent of the total health care expenditures are consumed in reporting requirements and in compliance with rules that are conflicting, contradictory and of doubtful usefulness.

Inflation is one of the significant factors in the increase in health care costs. This has been extensively discussed in the first part of this chapter, detailing the contribution it has made to expenditures.
Additionally, inflation has been a source of confusion in analysis and discussion since every examination of the cost picture must adjust in some way for the difference between nominal and real costs. Understanding may be obscured if the correcting calculations are not done, or if they are done in different ways at various times.

The increase in the number of physicians in practice has also had an impact on costs. Figure 6 shows the increase in the number of individuals practicing medicine, and also the increase in the number of physicians per thousand of population. This important ratio remained stable until 1965 and then gradually increased from 1.5 per thousand to 2.0 per thousand. Conventional economic thought is that an increase in the supply of goods or services will result in a fall in prices as suppliers compete for the available demand. However, contrary to this classical market theory, no competitive fee cutting has occurred. One estimate is that every time a new doctor begins practice the nation's medical bills go up another $250,000 a year. The reason for this is that doctors generate additional demand for services by instructing their patients to return for additional examinations, by ordering laboratory and X-ray studies, by prescribing drugs and treatments, by hospitalizing patients and by performing surgery. Since
the greatest part of such additional expenditure is borne by third parties, and the rest is considered acceptable to the patient, generally relying completely on the doctor's advice, the expenditures are made without the true resistance that would be expected under ordinary demand-supply relationships.

This component of the increase in medical care costs, the growth of the ratio of doctors per thousand patients in the past fifteen years from 1.5 to 2 derived from several causes. Among them was the maintenance and rise in doctors incomes and opportunities at a time when many other fields, teaching at all levels, law and engineering among them, were becoming overcrowded, with few opportunities available. The medical profession became more attractive to many young people. The increase in technology accounts for some of the increased demand for doctors, for all of the new techniques and treatments require physician participation to a greater or lesser degree. More problems which had previously not been considered medical, but rather problems of living came within the medical orbit. Smoking, drinking, malaise and ennui were now health care concerns. Minor diseases which previously resolved without treatment and without sequellae became occasions for visits to the doctor and a prescription for something.
FIGURE 6

PHYSICIANS

Numbers and Rate Per 100,000 Population

Most important among the factors was simply an increase in federal funding for medical schools and their students. In 1961 8,000 physicians who graduated from American medical schools were licensed, along with a relatively small number of foreign medical graduates. By 1979 that number had grown more than two and a half times, with over 20,000 newly licensed American graduates and several thousand licenses awarded to graduates of foreign medical schools. Classical economic theory had suggested that an increase in the number of persons supplying medical services should encourage competition, with a decrease in costs. This simply did not happen, because of the control on demand that the physician exercises, and the indifference to costs that the third party payment system engenders in the patient.

3. THIRD PARTY PAYMENTS

THE ROLE OF INSURANCE COMPANIES AND THE GOVERNMENT

The system of "third party payments" has become so comprehensive that patients today pay directly a mere 6 percent of hospital bills and 39 percent of all physicians' fees. The government picks up 55 percent of hospital bills and 24 percent of doctor bills; private insurers pick up 37 percent of each. (The other 2 percent of hospital revenues comes from charity and other miscellaneous sources.)
Figure 7 shows the growth in third party payments over the last three decades. The increase has resulted both in more individuals having coverage, and in more comprehensive payments for individuals who become ill or injured.

The participation of the two sources of payment is detailed in Figure 8. The direct role of the government sources grew rapidly after 1965 with the passage of Medicare and Medicaid. Both the growth of third party payments and the relative share of the two sources is detailed in these two figures.

In addition to direct payment, the federal government provides subsidies for health care through the tax system. Individuals are entitled to deduct health care costs, after meeting certain deductibles.27 Employers are able to deduct all costs which are ordinary, necessary and reasonable in the production of income. Among the acceptable costs are health insurance premiums and direct payments for health services supplied to employees.28

This tax subsidy has reached about $14.5 billion a year. $9.6 billion results from the income tax exclusion for employers' contributions to health plans for their workers. An additional $3.1 billion results from deductibility of health insurance premiums by individuals and large out-of-pocket medical expenses.
FIGURE 7

TOTAL THIRD PARTY PAYMENTS

(Percentage of All Expenditures)

Source: Statistical Abstract of the United States 1976 p.74
FIGURE 8
GOVERNMENT AND PRIVATE HEALTH INSURANCE COMPONENTS
(Percentage of All Expenditures)

Source: Statistical Abstract of the United States
p. 74

Time Magazine May 28, 1979 P.60
borne by individuals. The remaining revenue losses result from deductions for charitable contributions to nonprofit medical facilities and tax exempt bonds for hospital construction.\textsuperscript{29}

4. COSTS BORNE BY INDUSTRY

Fringe benefits for employees have become an increasingly important part of the total compensation package. There is a broad range that can be included and health care insurance is almost always among them. When health care costs were low, the associated liability of the employer was relatively insignificant. This is no longer the case, and companies are spending major amounts of money to provide coverage for their employees, even when the deductibility of such payments is taken into account. One study by Ford Motor Company calculated that, on the average, health insurance costs added $130 to the price of every car the company makes.\textsuperscript{30} Another study, done when an Oldsmobile Cutlass still cost $4,800 (and when medical care costs were comparatively lower) estimated that $220 went to cover the health care insurance premiums of General Motors workers.\textsuperscript{31}

This study of health care costs has explored the magnitude of the rise in such costs, the various components of the expenditures, some of the major causes, and the evolution of financing methods that have shifted
the risk from the individual and the supplier of services to third parties who, for the most part, arrange payment for services according to the amount supplied. We will now turn to the other major historical trend, the growth of prepayment in health care.

B. PREPAID HEALTH CARE

The first prepayment medical practice began in Los Angeles in 1929 when Doctors Donald Ross and H. Clifford Loos organized a group of physicians to provide through a number of clinics for city water department employees. At nearly the same time, Stephan Shadid, a physician in Elk City, Oklahoma, helped farmers form a prepayment cooperative for the provision of health care services.

Consumers organized the first urban, non-profit health cooperative, the Group Health Association, Inc., in 1937, in Washington, D.C. This program was initially offered for federal employees and their families. Later, the plan was opened to all residents of the District of Columbia metropolitan area. The plan, which now serves somewhat in excess of 100,000 employees and their families, still has approximately 70 percent of its members coming from the ranks of the federal government. 32

The Kaiser Foundation Health Plan, which today represents almost half of all HMO enrollees in the country
grew out of the medical care arrangements developed for workers on the Colorado River aqueduct.

Other plans developed after these initial successes. Among the better known are Group Health Cooperative of Puget Sound, Seattle, Washington, 1947; Health Insurance Plan of New York, 1947; and Group Health Plan of Minneapolis, Minnesota, 1957. ³³

By 1972 there were sixteen organizations supplying health care using a closed panel, prepaid, multispecialty type of organization, providing care for approximately 4,000,000 individuals. Of these, half served fewer than 50,000 members and four had a membership greater than 100,000 enrollees. ³⁴

The following chapters will detail the way in which the concurrence of these trends was recognized by the federal government and resulted in legislation supporting the development of additional prepaid organizations.
CHAPTER III
DEVELOPMENT OF THE FEDERAL STRATEGY

In analyzing the programs that were enacted, it is first necessary to study their development, particularly the goals that were set. While all of these did not survive the legislative process, they show, as a group, the philosophical considerations by supporters and opponents. Three major trends can be seen, the desire to control the cost of medical care, the desire to broaden the scope and quality of services available to the public, and the wish to control abuses of the program.

A. STATEMENT OF BASIC GOALS

In general, the proponents of the concept of federal support for prepayment were concentrated in the Senate rather than in the House of Representatives. During the 92nd Congress, the Senate passed a Health Maintenance Organization act but, as the House failed to act, this legislative effort failed. The vote in the Senate was 60-14 for passage.

When similar legislation was introduced in the 93rd Congress, the Senate Bill contained a statement of basic general findings:

(1) medical care is too expensive;
(2) the medical care system is oriented toward the provision of acute care;
(3) Medical resources are maldistributed;
(4) Health maintenance organizations (HMOs) will assist in alleviating the above-mentioned problems;
(5) Technical and resource assistance is needed to establish and operate HMOs;
(6) The quality of medical care varies excessively.  

The Senate bill also stated its purpose as the improvement of the health care delivery system through the support of the creation of HMOs.

The version ultimately passed by the House of Representatives contained no such provisions. When the two versions were reconciled by the Joint Conference Committee, the bill passed confirmed to the House version. 

Though such statements of general findings do not affect the provisions of the law as ultimately administered, they do indicate the assumptions and philosophical positions of the authors. The order itself is not insignificant. First, the question of cost is addressed, followed by statements about the quality and the organization of medical care. Also included are the statements that health maintenance organizations will help to solve these problems and that, under existing circumstances,
they will not succeed in this without federal help.
The attempts to address all of these concerns will be
developed below.
B. FINANCIAL GOALS
1. COSTS

The increase in health care costs has been documented
in the preceding chapter. The rise in expenditures
itself could be considered neutral, if it were felt
that this represented a proper allocation of national
resources. If, however, it was perceived that the costs
were excessive relative to the amount and quality of
the services received, this would be a proper opportunity
for legislative activity.

In fact, it was the opinion of the Senate Committee
on Labor and Public Welfare, to which Senate Bill 14,
the version of Health Maintenance Organization and Resour­
ces Development Act introduced in the 93rd Congress
was referred. They found that the major portion of
these increased expenditures purchased more and better
health care services for millions of Americans. But,
a large portion of that increase was said to have gone
to meet the continuing inflation in health care prices
and to subsidize inefficiency and waste in the delivery
of health care services. More and more dollars were
being spent on health care, with patients receiving less
and less for each dollar spent. Delivery systems developed in the nineteenth century were too inefficient to meet twentieth century problems. The ratio of physicians to patients was declining. (This trend reversed itself later in the decade. See Figure 6 in the preceding chapter.) Part of the problem was that the majority of federal and private funds were spent for reimbursement of health care costs, and that there was no way to control such expenditures. In short, the Congress perceived what has just been detailed in the preceding chapter, that the costs of health care were rising faster than other segments of the economy.\textsuperscript{39}

2. PLURALISM

It was the goal of Congress to develop a realistic alternative, rather than supplanting the existing system. The establishment of prepaid organizations throughout the country was intended to provide consumers with the opportunity to choose the manner in which they pay for and receive health care services. At the time, no such choice existed in most parts of the country. 95 percent of all health care was delivered in a fee-for-service setting, and it was perceived that the availability of prepaid alternatives would alter this. The goal of the legislation was to increase the options from the point of view of the consumer rather than to "remake"
the health care delivery system. By supplying such alternatives, successful functioning prepaid programs had exerted a beneficial influence throughout the community, requiring fee-for-service providers to streamline their practices.

The legislation was not intended to supplant existing forms of medical delivery, such as private practice. Rather, it intended to make available to all Americans a real choice with respect to the form of medical delivery they individually wish to purchase. 40

3. ASSUMPTION OF THE RISK

Decisions regarding the utilization of health care services are most often made by the provider of those services on behalf of the consumer. The physician serves effectively as the purchasing agent for the patient. Such a pattern was perceived as contributing to the inflation in the cost of health care services. The basic characteristic of a prepaid, capitation mechanism of financing health care services, the assumption of the risk for the cost of providing such services, can control expenditures. All forms of the legislation required that a prepaid organization to qualify as a federally sponsored health maintenance organization must assume direct financial responsibility, without benefit of reinsurance, for care up to five thousand
dollars per enrolled individual per year. An exception was made for out of area emergency care delivered by another provider when such benefit is included in the contract with the subscriber.

This provision was intended to strike a balance between financial responsibility for providing health care for enrolled members, with the attendant concern for efficiency and economy, and the continuing viability of the plan. Particularly during the development stage, when the revenues would be low and start-up costs would be great, an unpredictably high rate of illness or injury, even if temporary, could bankrupt the organization. Therefore, the health maintenance organization would be allowed, if it wished, to reinsure for care reasonably valued in excess of the first five thousand dollars per enrollee per year. 41

4. STRUCTURE OF THE PREPAID ORGANIZATION

Originally, the legislation on Health Maintenance Organizations was not neutral regarding the two broad categories of organizations which can deliver services of physicians and health care professionals to a defined voluntarily enrolled membership for a fixed price paid in advance of the provision of such services. In the provision of loans and guarantees, closed panel group practices, where the physicians providing the services are
aggregated in a single or a limited number of facilities, were to receive 82½ percent of the available monies. Individual practice organizations, composed of fee-for-service physicians providing care for prepaid patients as part of their practices, would be eligible for the remaining 17½ percent. It was perceived that the former group, serving large enrolled populations would benefit both from economies of scale and from the specific organizational arrangements. Administrative acumen would be more efficiently used in such large groups, and the individuals would be committed to a much greater degree since there would be no fee-for-service patients to provide some income in the event that the prepaid arrangements were not doing well. Thus, the sponsors felt assured that such group practice prepaid organizations should receive that greatest part of the available funding. 42

However, it was soon pointed out that a number of organizations that did not meet the group practice model, but rather were independent practice associations could conceivably meet such goals as well. Though there were several successful group practice organizations, it was not possible to yet make definite conclusions. It was possible that factors which had not been recognized had allowed these organizations to succeed, rather than
the explanations that were being advanced. Differences in populations, practices and customs which allowed the few "prototype" organizations to succeed might make for failure in other locales or at other times. Consequently, it might be that there was not yet enough experience with different types of prepaid organizations to make an intelligent decision as to which is best. Federal funds might better be used to stimulate innovation in developing the prepaid concept rather than for full-scale promotion of one specific type of health maintenance organization.43

In contrast to the group practice organization, with its administrative and incentive advantages, under certain circumstances individual practice associations might fare better. Patients could continue with their present physicians and their accustomed arrangements, so they would be more likely to enroll. Similarly, physicians would not be faced with a choice of relinquishing their existing methods of practice and their existing patients to join a group. They would likewise be more willing to participate. Since there would be no need to relocate, capital outlay and start-up costs would be minimized. Likewise, there would be little resistance from the medical community, since any or all physicians would be welcome and encouraged to participate. The
The concurrence of these factors, low initial cost, stability of relationships for patients and physicians, minimal personal risk to physicians, and lessened opposition from the medical community, could improve the chances of success in some communities.  

The preference for group practice organization did not become part of the ultimate legislation. The success of the existing group practice prepaid organizations was considered to be too small a sample to justify supporting that model. Rather, it was decided that the availability of funds to those organizations originally denominated as supplemental HMOs, with more amorphous structures, would allow for experimentation with the prepaid concept in areas that would possibly be unsuitable for group practice models. Availability of memberships, investment capital, participating physicians and facilities could be inadequate for a group practice prepaid organization yet sufficient for some other type.

5. PREEMPTION OF STATE LAWS

It was recognized that state legal restrictions could seriously impede the development of health maintenance organizations. Since it was the intent of the legislation to provide Federal commitment to the growth and development of such organizations, restrictive state laws which impair the formation or operation of health
maintenance organizations were preempted. Examples would be laws which restrict group practice, the corporate practice of medicine and which regulate such organizations under insurance laws. Similarly, laws which restrict advertising by health professionals for recruitment of enrollees should not apply, nor should there be required approval by local or state medical societies. Neither should there be mandatory participation by all or a percentage of the physicians in the community as a matter of law. The full scope of such laws and the background to this provision will be discussed at length in the chapter describing restrictions on growth of prepaid health care organizations in prior years.

C. SOCIAL GOALS

A group of proponents of a Federal health maintenance organization program, led by Senators Edward Kennedy and Hubert Humphrey, sought to include in the legislation programs with a broader and more ambitious scope. In addition to the support given to one form of health care delivery, the prepaid plans, they wished to include means to correct what they perceived as basic deficiencies in our national health care delivery system. In order to receive the benefits of qualification a series of new requirements were set out. The benefits were initially meant to be broad, including continuing subsidies as
well as the dual choice provision. This latter required all employers of more than twenty-five workers to offer a qualified health maintenance organization as an option if one existed in the area and if any health care coverage was afforded the employees.

On the other hand, the qualified Health Maintenance Organization was required to provide better care than the existing health system. This section will describe the scope of these requirements and the way in which they were to be implemented.

1. SERVING THE UNDERSERVED, RURAL AND NEEDY

In attempting to address the "maldistribution" of medical services attention was directed at target populations which appeared to be having difficulty in obtaining medical services at the same level of use as the rest of the population.

Among rural populations the problem appeared to be distance, inadequate transportation and communications, the reluctance of health care professionals to locate in these areas, and scattered populations making it difficult to finance the facilities and practices required to provide health care. Additionally, many of the rural areas were suffering from chronic economic depression, with little industry and a small financial base.

Providing such areas with health care through the
the favored method, the closed panel prepaid group practice prototype, did not seem feasible. Consequently another type of structure was envisioned, the health service organization. This type of plan differed from the health maintenance organization in that it allowed for the indirect provision of services through solo practitioners. This ultimately became the individual practice association, which was not limited to rural areas. In addition, the limitations of health care resources in most rural areas made it unlikely that the full range of services contemplated could be provided in all cases. Consequently, it was necessary to give the Secretary of Health, Education and Welfare authority to waive requirements for specific services in the broad range of requirements. However, adequate assurances were required that those services would be provided at the earliest possible time. Initial funding of these health service organizations, or rural individual practice associations, for development and start-up operations, was contemplated to be $215 million.

2. BREADTH OF SERVICES

The Health Maintenance Organization, in order to become qualified, was required to supply a broad range of services to enrolled individuals. In the originally contemplated program, it was recognized that there might
be inadequate resources in an area to provide an individual service and the Secretary of Health, Education and Welfare was given the power to provide a waiver. However, the applicant would be required to present a feasible plan for phasing in the waived service within three years of receipt of initial assistance of any type.

It was contemplated that all of the following be provided:

1. full dental care;
2. extended care facilities for post hospital care;
3. full in-hospital and out-of-hospital diagnostic and therapeutic services within a single organization;
4. home health services including such programs as meals on wheels, visiting nurses and other agencies intended to diminish the need for institutional care;
5. preventative services, including vaccinations, immunizations, diagnostic and early disease detection services, family planning and infertility services, and preventive dental care for children;
6. medical social services to improve the efficiency with which health care services are utilized;
(7) nutrition education for all enrolled individuals through counseling, publications and other appropriate means;

(8) prescription drugs, so that the HMO could establish patterns of patient drug utilization and evaluate the appropriateness of drug usage among the membership (To this end clinical pharmacists or pharmacologists were required to survey, evaluate and review patterns of drug utilization, including drug regimens and therapists, and maintain a drug use profile for each enrollee, to ensure the input of a "drug specialist" into the development of a rational drug therapy for each patient. The pharmacist or pharmacologist involved must be one who had substantial training and experience in designing and monitoring patient drug therapy);

(9) vision care;

(10) physical medicine and rehabilitative services;

(11) mental health services, and

(12) preventative diagnostic and medical and psychological treatment of the abuse of or addiction to alcohol and drugs.

All of these enumerated benefits were to be part
of the basic (obligatory) coverage with the exception of full dental care and extended care facilities. The mental health benefit was to be limited to acute conditions, and it was contemplated that there would be participation of a wide range of health professional in addition to physicians and doctoral-level psychologists. 49

In the development of the basic benefit package there were individuals who felt that this benefit package was inadequate as well as those who felt that it was unrealistically broad. Senator Humphrey was concerned with the fact that some of the proposed services would be provided on an optional basis, in particular in the areas of mental health and of extended care. He urged that these be made mandatory. Likewise, he felt that provision of preventative dental care for children, while an outstanding example of essential services that should be a part of any HMO program, was only a first step to providing full dental coverage through a single organization. An additional need which should be addressed in the same legislation, according to this Senator, was the provision of health care to Indians and to domestic agricultural migratory workers. 50

In opposition to this view was the minority report of the Labor and Public Welfare Committee. Their concern
was that the provision of such a broad package of services would make the premium of an HMO so much higher than that of a commercial insurance carrier that the plans could not function without continuing federal subsidy. It was pointed out that even the organizations used as prototypes in developing the health maintenance organization legislation, such as Kaiser-Permanente, did not provide the range of services this bill would mandate. (In fact, as will be detailed in a later chapter, even the reduced benefit package ultimately mandated deterred Kaiser Permanente from participating in the program.)

In fact, according to the minority view, in addition to providing for permanent subsidization, what was proposed amounted to piecemeal national health insurance. Only a portion of the citizens would be benefited by the subsidization, so that it could be viewed as unfair and discriminatory to the far greater number who participated in the financing, through taxation, yet received no direct benefit.51

3. QUALITY ASSURANCE

Title IV of the Senate Bill provided for the formation of a Commission on Quality Health Care Assurance. It would consist of eleven members and would be an independent agency of the Federal Government. Four of
the members at any given time were required to be consumers unrelated to the health care industry and the remainder would be professionals drawn from health care disciplines in such a way so that they be representative of various aspects of the health care industry.

The commission was to be authorized to promulgate standards relating to qualifications and characteristics of personnel and facilities. Part of the function would be to replace the functions of the state laws and regulations preempted by the legislation. It was not intended that the commission engage in the determination of how the professions should be practices. What would be required would be monitoring health care practices in such a way as to enable the commission to eventually determine the formulate criteria for what constitutes good health care practices and to identify reasons for deviation from good health care practices on the part of both providers and consumers.

The commission would be empowered to ascertain that an applicant for certification have an approved quality health care assurance system. While no attempt was to be made to describe the system in detail, it was required that there would be compliance with general criteria established by the commission. Reporting requirements could be mandated so that the commission
might gather and compile data which would make possible the establishment of norms for health care practices.

The commission would be authorized to issue certification to health care providers meeting its requirements regarding standards, the operation of approved quality health care assurance systems and consumer disclosure. Certification by the commission would be a prerequisite to eligibility for any assistance under the legislation. Additionally any provider, whether or not a prepaid organization, could voluntarily seek commission certification. In return for this, the qualifying provider would receive a quality health care initiative award, equal in amount to the actual costs incurred in complying with the commission requirements, such as recordkeeping, bookkeeping and reporting.

Most significantly, no provider would be eligible for the preemption of State law or the proposed medical malpractice arbitration unless he became a certified provider of health care under the provisions set forth.\textsuperscript{52}

The costs of the establishment of the commission were to be $125 million and the costs of the "Quality Health Care Initiative Awards" for voluntarily submitting providers were to be $225 million annually.\textsuperscript{53}

In the development of this legislative proposal, various evidences of apparent variation in quality were
set forth. The reliability of various practitioners tended to be variable and the rates at which laboratory tests, operations, and other procedures were carried out were markedly different. This did not necessarily indicate that quality of medical care was low, but rather that it could probably be significantly improved through more widespread monitoring of outcomes and processes of medical care.

It was recognized that the prepayment concept, when coupled with the assumption of financial risk by health care providers, provides incentive to reduce services rendered to the lowest possible level in order to conserve resources and to stay within the income generated by premium revenues. Although this was the desired effect of the capitation prepayment mechanism, it requires that there be an effective mechanism to assure the quality of care provided and to guarantee that care is provided in adequate quantity as well.

One of the greatest difficulties to be faced was the rudimentary state of the art with regard to the measurement of the effect of the health care services provided to the population being served. One of the mandates given to the commission was to help develop the technical knowledge and criteria to measure the results of health care services and to accurately assess
cost-benefit ratios. The reliance on private, provider-controlled, voluntary agencies, such as the Joint Commission on the Accreditation of Hospitals, to undertake the assessment and regulation of health care on the basis of outcomes, was considered to be incomplete and ineffective. Likewise, it was considered impractical to require all providers to submit to the necessary Federal regulatory commission since the diversity of individual practitioners would make the setting of meaningful requirements and reporting methods so complex as to be meaningless. The compromise was the obligatory participation of qualified health maintenance organizations and the voluntary participation of other providers who could comply with the guidelines set forth and the mandatory reporting requirements.57

The inclusion of the Quality Health Care Commission in the Health Maintenance Organization and Resources Development Act brought sharp criticism. It was alleged that such a commission had nothing to do with HMOs but was designed to develop quality standards for all doctors, wherever and however they practiced. If such standards were indeed developed and implemented, it was possible that physicians who failed to comply with them would be forced from practice in the very areas of shortest supply. Likewise, it would be quite contrary to the goal of the
act to require prepaid plans to comply with a set of standards that their competition need not meet, and yet expect them to compete on an equal footing. Even if competing health care delivery systems chose to voluntarily comply with commission standards, they would still be at an advantage. The qualified HMO would not receive specific reimbursement for the costs of compliance while the voluntarily participating organization would receive an "Initiative Award" equal to the costs incurred in meeting commission requirements.

At the time of consideration of the legislation there was no prepaid organization, including Kaiser Permanente, there was no foundation in existence nor was there any health service organization of any type in existence that could meet the requirements to qualify as a Health Maintenance Organization. Each would be required to modify its way of doing business, even if the legislation included no special quality control provisions. The additional burden of a Quality Health Care Commission, with broad powers to mandate methods of data collection and delivery of health care, could impose a burden far beyond the ability of many organizations to carry out. 58

4. MEDICAL MALPRACTICE

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4. MEDICAL MALPRACTICE

Originally, the legislation also provided for the
arbitration of medical malpractice disputes, the limitation of contingency fees in such arbitration proceedings, and the establishment of a Federal medical malpractice reinsurance program. These provisions were viewed as important reforms to assure stability and equity for both the provider of care and the patient. It was felt that litigation did not provide an effective method to monitor quality health care standards in the past but that arbitration would be an effective monitor of health care practice. The arbitration program would be under the aegis of the Commission on Quality Health Care and the Commission would use the findings in settlement and arbitration proceedings to evaluate health care and provide data for establishing criteria and standards for quality health care. Such findings were ultimately to be incorporated into the criteria for certification. This, the organization that submitted itself to the Commission, or the organization that was required to comply with Commission guidelines, would receive the benefit of malpractice reforms widely desired by medical care providers. Both arbitration and the limitation of attorney's contingency fees were viewed as effective ways to counter the escalating costs of medical malpractice disputes and their settlement. The availability of Federal reinsurance programs would
stabilize costs as well, and assure the availability of protection for providers in areas in which malpractice coverage was difficult or impossible to obtain. The increasing instability in the professional practice insurance market and the rapidly rising costs of available policies made these programs highly desirable.\footnote{59}

5. HEALTH EDUCATION

Title III of Senate Bill 14 provided authority for funding Area Health Education and Service Centers. This was in addition to the health education requirements for Health Maintenance Organizations and their continuing education functions. The problem addressed here was the paucity or absence of adequate educational capability in rural areas. The centers were to be closely related to service programs and were intended to develop more and new categories of health care personnel to provide momentum for improving the capability for the delivery of health care services in rural areas. It was expected that such centers would help alleviate the sense of professional isolation felt by many health professionals practicing in remote and rural areas and would provide additional incentives for practice in such places. Additionally, such center would stimulate the development of programs keyed to the special needs of the areas.

An area health education and service center would
be a hospital, educational facility, or other public
or private non-profit entity, affiliated with a
university health center for the purpose of providing
clinical training in a nonmetropolitan area. It would
stress cooperative interdisciplinary training in the
use of the team approach. Grants would be available
to various university health centers regional medical
programs or nonprofit provider groups to assist in meeting
the costs involved in the development of such centers.
Goals would include relating the training of health
manpower more closely to the health service needs of
the community; providing an opportunity for existing
health service and educational institutions, such as
hospitals and community colleges, to become involved
in the definition of community manpower needs and
priorities, thus making training more relevant to service
needs; and, establishment of a professionally attractive
environment which would promote retention of health
care providers in rural communities that were under-
served.}

Initial funding for Title III and the establishment
of Area Health Education and Service Centers was to
be $65 million. Continuing annual expenditures would
approximate this amount.
6. COSTS AND SUBSIDIES

Senate Bill 14, when originally presented to the Labor and Public Welfare Committee, provided for a budget of $5.2 billion. The corresponding House of Representatives Bill, H.R. 7974, was presented to the Health Subcommittee of the Interstate and Foreign Commerce Committee with a budget of $300 million and was cut to $280 million during the deliberations of that subcommittee.

Several of the provisions outlined above, the Commission on Quality Health Care Assurance, the Area Health Education and Service Centers, and the medical malpractice reinsurance programs among them added significant costs. By far the most expensive program was the capitation subsidy. This was originally envisioned as a permanent program, but they were ultimately limited to the three year period of the bill. They were intended as a partial substitute for a national health insurance program, to provide care for an estimated twenty percent of the population with no health insurance at all. Organizations required to take such patients, heavily weighted toward the chronically ill and chronically deprived among the needy, would not be financially viable, given the breadth of the required basic services, unless some subsidization was provided.
The people targeted were those who were too rich to qualify for Medicaid and too poor to purchase private health insurance, working class and lower middle income people, especially the elderly.63

The massive federal subsidies envisioned in the bill were made necessary by the broad range of services which each HMO would be required to make available to its enrolled members at one premium rate. Programs not ordinarily included in private medical care plans were mandated, including prescription drugs, social services, health education, vision care, physical medicine and rehabilitative services, mental health services, treatment of alcoholism and drug abuse and preventive dental services for children. In addition, for an additional premium, the prepaid organization must provide extended care and dental services for those who chose them. The mandated benefit package had to be made available by every qualified Health Maintenance Organization without regard to the needs or desires of the enrolled population.

Since none of the existing organizations provided the mandated range of services, and none could afford to do so and remain or become economically viable, premium subsidies would have to become permanent. Otherwise, no company or organization providing the benefit
package could be competitive with medical plans which provided the usual range of reimbursement for far more limited services. 64

In the interest of financial reality, and in the interest of promoting prepayment as a viable concept, most of the "social goals' did not survive the legislative process. (The final form of the law will be detailed in the next chapter.) The proponents of the competitive growth strategy largely prevailed, though significant social goals were included enough to adversely affect the development of the envisioned prepaid programs throughout the country. It was felt that, with the compromises included and the exclusion of the unrelated provisions from the law, prepaid health care providers would be able to compete in a manner consistent with fair market principles and demonstrate their economic viability and efficiency with minimum government intervention. A description of what happened will occupy a large part of the remainder of this project.

D. CONTROLS

In addition to the recognition that assumption of financial risk by prepaid health care providers could cause a decrease in the provided services below the optimal level, one of the stimuli for the Commission on Quality Health Care Assurance, several other possible
abuses were recognized. Safeguards against them were proposed in some cases.

The practice of denying or delaying the provision of services needed or demanded by enrolled members as a way of controlling costs within a prepaid health care program is called "skimping". This became a major issue in the investigation of the prepaid health plans developed in California to provide health care services to Medi-Cal beneficiaries.

"Skimming" is the practice of a health insurance program which seeks to insure only the healthiest people and to eliminate or exclude those with a previous history of poor health or those in groups who are likely to require medical services. When permissible, it can be formalized into experience rating, a closely allied practice in which the individuals likeliest to use the services are not completely excluded but pay a rate determined by underwriting experience. The result is often the same, since the experience rated premium may be so high as to completely exclude the most likely users of service.

Though skimming and experience rating are equally possible in prepayment and indemnity arrangements, the legislation under consideration intended to apply a remedy only to the prepaid plans which participated in
the program. The mechanism was the open enrollment provision, which required a qualified Health Maintenance Organization to have at least thirty days each year during which it would accept applicants for enrollment in the order of receipt, without regard to previous health history. In this way it was hoped to avoid institutionalizing skimming. For experience rating as an abuse, an even simpler remedy was developed. All plans which qualified had to be community rated, or uniform throughout the service area, and independent of individual claim experience or of the experience of any one group of enrolled members.65

There was acknowledgment of the fact that such a requirement imposed a significant competitive burden on the HMOs since the same stringent requirement did not apply to indemnity insurers or other types of health care plans. The solution was to provide annual grants to qualifying Health Maintenance Organizations if the open enrollment policy generated a continuing general premium increase. This was closely allied to the capitation subsidy, and provided a mechanism for financing a perceived needed benefit for a segment of the population through a reimbursement mechanism for costs incurred.66

Another possible abuse was the transfer of funds
given to support programs authorized under the legislation to other purposes. This is a frequent provision in enabling legislation of all types which contemplates subsequent funding and has the obvious purpose of assuring that monies are used toward the goals set forth.67

It was the purpose of this chapter to describe the way in which the Health Maintenance Organization and Resources Development Act of 1973 was developed. A later chapter will describe the final version which emerged from the legislative process.
CHAPTER IV

IMPEDEMENTS TO THE GROWTH OF PREPAYMENT

In the evaluation of the government program to stimulate Health Maintenance Organizations as a cost cutting method, a critical question arises. If HMOs are competitive and effective methods of delivering health care, why did they not succeed on their own? Were there forces at work in the economy and in the community which prevented growth?

An initial possibility would be that, like any business, there would be difficulty entering a market in the face of established competition. However, this is known to be an insufficient impediment throughout the rest of society, since capital becomes available for all sorts of ventures. In addition, some large prepaid organizations did succeed, notably Ross-Loos and Kaiser, though the latter with the backing of the industrial complex started by Henry Kaiser, which made available resources, primarily through lines of credit arranged with major banks.

It is the purpose of this chapter to explore two major causes for the difficulty of the prepaid sector to become a more significant source of delivery of medical services, more than its current four percent of the population served by prepaid plans.
influence the situation and to "set it right." Thus, if costs are too high, maximum fees are set, if hospital stays are too long, agencies are created to deal with this, if there are "excess" hospital beds, restrictions on new construction are enacted. Even in the delivery of services the problem is attacked "directly." If the quality of care if not satisfactory, standards are set and agencies or institutions created to first enunciate and then administer the standards. If doctors or other providers are thought not to be keeping abreast of developments, educational requirements are established and compliance is mandated.

The second part of this chapter will describe some of these requirements, regulations and controls and their effect on the prepaid sector. It will then show how there has been a developing awareness that the system of regulation has affected competition between fee for service providers and has limited the ability of prepaid plans to compete effectively. This, there is a growing feeling that the removal of regulatory barriers may improve the competitive position of prepaid health care institutions, particularly those that are qualified Health Maintenance Organizations.
FIGURE 9
EXAMPLE OF A CONTRACTUALLY DEFINED HMO
ORGANIZATIONAL STRUCTURE

DHEW Publication No (HSA) 74-13020 (1974)
A. THE OPPOSITION OF ORGANIZED MEDICINE - ANTICOMPETITIVE BEHAVIOR

1. DENIAL OF MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS AND ON HOSPITAL STAFFS

It has been recognized for centuries that certain economic and commercial behavior is undesirable, leading to an increase in the price of goods, a decrease in the quality and availability of the goods, and a possible loss of employment opportunities in the industry.68 As society became more complex, the governments of the United States and the various states enacted statutes to protect the public, making these commercial behaviors illegal. A conspiracy in restraint of trade or a monopoly or attempt to monopolize were made illegal by the Sherman Antitrust Act in 1890.69 The Clayton Act70 prohibits tie-in sales (requiring the purchase of one product to secure another) as well as mergers which have the effect of substantially lessening competition or tending to create a monopoly in any line of commerce in any section of the country. The reasonableness of an activity which lessens competition has been defined by a series of cases.71 Certain commercial behavior is judged by the effect it has, while other behavior is considered per se anticompetitive and thereby illegal. Such per se illegal behavior includes boycotts,72
allocation of markets,73 price fixing,74 and tying.75

Although the medical professions stated reasons for opposing the development of prepaid plans and other health care plans with effective cost containment features have been set forth in meliorative terms, the preservation of "quality of care," "free choice of physician," the "doctor-patient relationship," and "professional independent," these efforts have had a self-serving side as well. The financing programs that have been acceptable to the medical profession, fee for service with third party reimbursement, have had the effect of stimulating demand, since the patient can have unlimited service without payment and the doctors' income is limited only by the hours they can work. The mechanism of third party payments has removed incentive from both the supplier and the user to limit services. Particular attempts have been made to limit the growth of closed panels, which offer an alternative to "free choice" insurance plans.76

As a result of their long enjoyment of professional autonomy and limited outside interference, physicians and other professionals react strongly to such outside interference, using whatever methods are available to them. In the medical field these would include national, state and local societies, and hospital staff organi-
zations. Initial efforts involved the use of ethical rules to deny professional opportunities to physicians who cooperated with new plans which offered an alternative to traditional fee-for-service practice. In American Medical Association v. United States, a 1943 case, expulsion from membership in the county medical society was found to be an effective tactic against the Group Health Association, an early prepaid plan in the Washington, D.C. area, since members could obtain hospital practice. This was done through the mechanism of requiring all members of a hospital staff to be likewise members of the local medical society in order to qualify the hospital for internship programs. The AMA thus used its power over accreditation of educational programs to control all physicians desiring access to the hospital that qualified for such programs, often the only quality institutions in the area.

Today, medical societies have been limited in their ability to control hospital privileges and many courts have struck down requirements that physicians be members of local societies as a precondition to hospital staff membership. However, there are other professional and even social benefits that may accrue to members so that denial of membership remains a significant threat. Though these powers have diminished as well, it was
customary for medical specialty boards and other specialty associations to delegate a determination of "good character" to the local society. Lack of membership in the society was an irrebuttable presumption of poor character for the purposes of membership in the specialty society or certification by the specialty board. Though this did not preclude the individual from all practice, since the state licensure is the precondition to practice rather than certification by the specialty board, it had profound economic advantages. Patients prefer to patronize people with full credentials, reassured by the granting of this certification. Hospitals likewise prefer, and may require, board certification to perform some or all procedures performed by medical specialists.

This loss of power by the medical society has not completely thwarted the physicians who wish to control the practice of others in the community. Access to the hospital can be indirectly limited as described above. However, there is a more direct means of controlling the access to the hospital, which is through the hospital structure itself.

Legally, hospital boards of directors have the same power and responsibility as the board of any corporation, they are ultimately responsible for everything the staff does. However, since these individuals are
generally members of the community rather than health professionals, they must of necessity delegate the functions related to hospital staff membership. Traditionally, this delegation has been to the medical staff. Thus staff physicians, who are competitors in the market for providing health care services, have the opportunity to pass on the credentials and supervise and review new physicians who are associated with alternative delivery operations. Thus the hospitals in effect bring together the physicians and afford them an opportunity to control the availability of an important requirement of medical practice, the ability to admit patients to a hospital.\textsuperscript{81, 82} Though this power is currently seriously eroded by due process requirements, the obligation of a fair review, there is the implicit or even explicit threat by the medical staff to desert to another institution if the hospital chooses to deal with a prepaid plan.\textsuperscript{83, 84}

2. EXCLUSION FROM CONSULTATION AND REFERRAL NETWORKS

Another method of control of practice which is not fee-for-service has been provided by the increase in specialization in the practice of medicine. An individual practicing with an HMO may have difficulty in obtaining certification in his own specialty because of the participation of competing physicians in the
in the board examination process or because some of them have contacts on the examining board and exert pressure to the applicant's disadvantage. More significantly, a specialist who cooperates with an HMO may jeopardize his referrals from other physicians upon who he or she is dependent for the majority of the practice income. This is particularly debilitating to newly formed prepaid groups whose subscriber rolls are small, since they cannot provide specialist services from within the closed panel. Likewise, for an independent practice association, a group of physicians working on a prepaid basis in their own offices (to be discussed later) the absence of participation by a few critical specialists could render the group ineffectual.

The threat of a loss of referrals for cooperation with a prepaid group is particularly dismaying since it can occur without an active call for a boycott, but simply by subtle cooperation. Since the specialist cannot really gauge all the myriad considerations that go into a decision to refer or not to refer to him by non-HMO doctors, the fear of losing referrals of fee-for-service physicians may be overwhelming, whether or not participation in an HMO actually damages him. An individual referral elsewhere can always be justified on the basis of another specialist's superior
qualifications. 87

3. EXCLUSION FROM THIRD PARTY PAYMENT MECHANISMS

Another threat to the prepaid physician has been exclusion from a fee-for-service dominated plan, such as Blue Shield or a county medical service bureau. Some plans and service bureaus have exclusive dealing clauses which prevent the physicians from becoming associated with HMOs. 88 Since the physician may be dealing with a large percentage of fee-for-service patients such a restriction may be disasterous. It effectively requires the physician to make a choice between a complete prepaid or fee-for-service practice. Again, this is particularly effective during the start-up phase of any prepaid system, when it is financially impossible to provide all necessary services within the group or panel and outside specialist services must be obtained.

In addition to a total refusal to deal with cooperating physicians, hospitals may view HMOs as competitors to themselves or their physicians, who comprise the major source of their income through the choice to use an individual hospital. They may fear that the prepaid plan will ultimately build its own inpatient facilities, thus removing a part of the patient population the hospital currently serves. 89 The hospital may respond in several ways. It may refuse to recognize the HMO as a
bulk purchaser of services and therefore deny special rates. Second, it could shift costs onto the HMO by arranging its fees so that those services used more frequently by the HMO bear a disproportionate part of the hospital's fixed costs. Finally, it could refuse to allow the HMO to participate in discounts the are offered to Blue Cross plans or other fee-for-service insurers. 90

4. INCONVENIENCES TO PATIENTS OF PREPAID PROVIDERS

Another way to harass a prepaid plan is to make it inconvenient for the patient member of the plan. One method that has been used has been the refusal of doctors in the community to accept payment in the form of checks drawn by the prepaid plan for services obtained by subscribers on referral. The individual patient was required to pay and then to secure reimbursement. 91 Since physicians will ordinarily cooperate with patients to secure payment from insurance companies, refusal to do so can represent a considerable inconvenience. In addition, it imposes a significant burden upon the prepaid group which cannot make payment directly to the doctor, or jointly to the doctor and patient, to be certain that the patient actually has paid for the service, rather than simply pocketing the money. The doctor's cooperation with the indemnity company obviates
this problem for that company.

All of these powers are formidable enough that they need not be regularly or frequently exercised to achieve the desired control. Merely raising the question of the propriety of a physician's action, or the wisdom of it in that particular community, would be sufficient to discourage participation in any new or different arrangement that was not approved of by the fee-for-service practitioners. Even if the powers described have been eroded by statutes and court decisions, the fear of jeopardizing carefully nurtured professional relationships, lines of referral and personal ties will affect the behavior of many doctors. The prepaid plans need to rely on various outsiders, foreign graduates, minority members, women, for example, may make the prophecy about prepaid practice having recruiting and other problems self-fulfilling. 92

The systematic denial of hospital staff membership, exclusion from consultation and referral networks, exclusion from third party payment mechanisms and inconveniences to patients were formidable and effective ways of coercing providers who might participate in prepaid plans or other innovative programs. However, these types of behavior were illegal under the Sherman Antitrust Act and the Clayton Act. With increasing
attention to these practices, by the courts, and by the regulatory agencies charged with enforcing the anti-trust laws and policy of the states and federal government, it ceased to be possible to control a physician's participation in practices other than traditional fee-for-service.\textsuperscript{93}

Since the opposition to such practices continued unabated, it became necessary to modify tactics. Therefore, a new tactic, preemption, became the most effective and most widely practiced. Preemption is the attempt by organized medicine to provide what seems to be the same services, and thereby what appears to be all the advantages, of the competitive health care system.

5. PREEMPTION THROUGH INDEMNITY PLANS

The earliest attempts at preemption did not involve only prepaid plans, but were aimed at the provision of any type of third party insurance mechanisms to provide health care. It took the form of medical society sponsored Blue Cross and Blue Shield programs to compete with commercial insurers.

Preemption specifically intended to compete with prepaid plans takes the form of independent practice associations, groups of providers of health care services who provide services to subscribers according to a
compensation arrangement which allows the provider to continue practice undisturbed. Most of these involve individual or small group fee-for-service doctors who agree to provide care for the IPA subscriber at a fixed rate, usually slightly less or equal to their usual fees, with a mechanism for holding back part of the fee to cover unexpected cost overruns of the program as a whole.

The third type of preemptive approach is the foundation for medical care, which is aimed at cost control and delivery innovations of all types, including both prepaid plans and government programs. These are medical society sponsored programs which install a "peer-review" mechanism to try and control costs while continuing with the usual fee-for-service and third party reimbursement practices of the participants. Like earlier Blue Cross and Blue Shield programs, they likewise preempt commercial insurers who might institute effective cost cutting plans.

The initial change in the payment mechanism which confronted the medical profession occurred when the commercial insurance companies first began to offer coverage for health expenses. This was a great innovation which occurred only about fifty years ago. Prior to this medical expenses were actually small compared to
the cost of other goods and services or, alternatively, for parts of the population, beyond the possibility of payment. This apparent contradiction arises from the fact that health care, in those days, consisted almost exclusively of outpatient services. Babies were born at home, there was little treatment beyond bedrest for many diseases presently treated in hospitals, such as heart disease and stroke, and these patients remained at home as well. Surgical indications were much narrower and far fewer operations were carried out. The elderly and terminally ill died quietly at home. Under these circumstances many families could afford medical care, which consisted of payment to the doctor. Since there was often a close personal relationship between the family and the physician, it was often rather unbusinesslike. Traditionally fee payments were slow, and there was much care given for little or nothing, further enabling individuals to ignore medical care as a pressing and primary expense.

On the other hand, a major medical expense was simply an impossibility for large portions of the population. In such cases patients turned to charitable institutions or became charity patients in private institutions. In marginal economic times there were individuals who could afford neither payment for the
simplest services, nor insurance, had it been available. These individuals were dependent on the charity of institutions or of the individual practitioner.

Under these circumstances, the limited medical services available, the willingness of physicians and institutions to provide charitable care and the unprecise business practices of the health care industry, it was possible to maintain a fee-for-service payment mechanism well into this century. However, with the advances in medical science bringing more effective treatment, with social changes which broadened the definition of entitlements, so that medical care began to be thought of as a right rather than a privilege, and with benefit programs for employed persons coming to include health care, a more predictable payment mechanism became necessary. Neither individuals nor employers who undertook to provide health care benefits could risk the possibility that the illness of a few individuals could cause financial disaster. Thus the conditions for third party payment were created.

Organized medicine strongly resisted the concept of prepayment in any form. The opposition to indemnity plans was almost as fervent as to any other. The same fears and arguments were stated, preservation of quality of care, free choice of physician, preservation of the
doctor-patient relationship free of outside restraints, and independence of professional decision and action. Thus, when the profession agreed to offer professionally sponsored indemnity or reimbursement type plans, it could limit the structure of the plans in such a way that its concerns for the ethical, professional and patient-care questions appeared to be its sole motives. The AMA assumed the power to regulate the insurance carriers, in the form of the Blue Cross and Blue Shield plans, and it was therefore free to promulgate principals under which they could operate, apparently from strictly altruistic motives. Further, since no economic or personal interest appeared to be involved, it was possible to influence the laws and state insurance regulations under which the plans operated, and to structure them in such a way that non-fee for service insurance plans would have difficulty qualifying, or could not qualify at all. Typically, these statutes have required any non-profit medical service 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 wish to join.

The effect of indemnity plans sponsored by organized medicine has been great. Until the last few years they wrote the majority of reimbursement type insurance,
almost without competition from commercial insurers. More important, they have been able to influence the legislation regulating reimbursement practices, to their own benefit. They are powerful enough and flexible enough that they can form the basis for other types of preemption. This will be discussed further below under independent practice associations, some of which have been sponsored by Blue Cross and Blue Shield Associations.

6. PREEMPTION THROUGH MEDICAL CARE FOUNDATIONS

The second type of preemptive behavior has been the emergence of medical care foundations or MCFs. These are medical society sponsored plans designed to control utilization and costs more effectively than have the Blue Shield and Blue Cross plans, which are likewise under medical society sponsorship. The term as used here is limited to those arrangements which provide for payment mechanisms and for intensive peer review, but which do not provide for a participation in risk. The addition of the risk sharing, the possibility that the participating health care providers will fail to receive part of the agreed upon fees if cost overruns occur, is the characteristic that distinguishes the independent practice associations from these foundations.

The preemptive behavior here involves attempts at
achieving the goal of cost containment set out in the various government programs. Since control of expenditures is the primary purpose of government support of alternative health delivery systems, an effective review mechanism, applied to the price of services as well as to the volume of services delivered, would answer the government's needs. In addition, a system like this would require no reorganization of the fee for service delivery mechanisms, and would therefore obviate any possible increased expenditures in setting up new and competing systems. These would include capital expenditures and any start-up costs, cost that must be borne for future savings which might or might not materialize. Since front end costs are a reality and since foundations for medical care allow the traditional ethical, professional and doctor-patient relationships to continue, they are popular with the government for the former reason and with the medical profession for the latter. 98

The medical care foundations offer little new, compared with any innovative pricing or reimbursement mechanism that they preempt. The Blue Shield plans have been shown in previous litigation, to have a chilling effect on competing systems, 99 and there is no reason to believe that this latest method, sponsored by the same organizations, and by the same type of practitioners as
their predecessors, will have any greater success in controlling costs of services or the volume of services delivered. They are not aimed at practices which are universally accepted, even though the practices, in their totality contribute to higher costs. The proscriptions of the medical care foundations are aimed at excesses, and the worse of those at that. By such a focus, they imply approval of existing practices of the majority. From the standpoint of an efficient allocation of the nation’s available resources, a societal priority, they are simply too mild and too powerless to be effective. They may be warmly embraced by many well meaning physicians, anxious to root out abuses within their own profession. This serves both to increase the stature of physicians as a group and to forestall the introduction of more effective and far-reaching cost control mechanisms by less controllable institutions, most notably the government. The foundations can be taken as a token of the profession's good faith in attempting to control medical care costs and to correct abuses by the most egregious abusers. But control remains in the hands of those who are to be controlled, so highly effective measures are not likely to be forthcoming.

It would seem at first glance that the commercial insurance industry would be highly active in this arena.
Certainly, the success of the medical association sponsored insurance companies, Blue Cross and Blue Shield plans, deprives them of a great deal of business. In addition, successful cost containment efforts, even though sponsored by others such as the medical care foundations, would result in cost savings on the insurance that they do write.

In fact, the commercial insurance companies have operated at a distinct disadvantage vis-a-vis the Blue Shield and Blue Cross plans. The local control and the legal preferences afforded to the medical society sponsored programs has led the commercial insurers to abstain from active leadership in most health insurance controversies. The commercial insurers contract only with subscribers, the insured, while the Blue Shield and Blue Cross plans have contracts and close relationships with providers as well. Commercial insurance carriers are most successful in competing when dealing with nationwide accounts, employers who contract to provide health care services for employees who are dispersed throughout the country. In addition, commercial insurance companies can write experience rated policies for which the premium charged is based on the projected or actual charges for the insured group only. This takes into account the age structure, health and utiliza-
tion patterns of the individuals comprising the group to be insured, without regard to practices of others in the community. By contrast, Blue Cross and Blue Shield plans (as well as federally qualified Health Maintenance Organizations) must be community rated. They must fix a premium which does not penalize, and thus cannot benefit, one segment of the community in relation to the rest. This gives commercial insurers the ability to charge a lower premium to healthy individuals and to groups whose membership is composed of persons who are on the average healthier than others in the community or whose utilization of services has been shown to be less than the average of the community. 100

The advantages of servicing nationwide accounts and experience ratings have not been significant enough to offset the competitive advantages of the Blue Cross and Blue Shield plans. They have chosen rather to direct their competitive efforts into other lines of insurance which are not characterized by competition allied with the providers of the services to be indemnified. 101

7. PREEMPTION THROUGH INDIVIDUAL PRACTICE ASSOCIATIONS

The third form of preemption, the provision of the services of the Health Maintenance Organization by independent or individual practice associations (IPAs)
is the most germane to the subject. We find an almost immediate confusion in terms since the goals and the method have not been clearly differentiated in the literature and in applicable laws and regulations. It is important to make the distinctions at the outset.

Panels of fee-for-service providers, called "individual practice associations" were contemplated in the original act. The purpose here was to provide all possible mechanisms whereby cost containment strategies could be developed, experimented with, implemented, and, if successful, extended elsewhere. The proposed and expected savings, as developed in the discussions that preceded the law, were largely based on the experience of group practice prepaid plans. The prototypal prepaid plans, among them Kaiser Medical Care Entities, Ross-Loos and Group Health Association depended on a structure quite distinct from the fee-for-service arrangement onto which could be grafted an individual practice association.

In Kaiser, for example, a group of physicians contracts as a group to provide medical care for the subscribers of the Kaiser Foundation Health Plan and to care for the patients admitted to the associated Kaiser Foundation Hospitals. The physicians participate in the planning of the facilities, the decisions as to
the range of services to be offered, the number of members who can be served and in all basic decisions regarding the structure of the organization. More important, the physicians, again as a group, are responsible for both the provision of medical care, and its quality. Since payment is received on a capitation basis, there is no incentive to perform procedures that are not necessary. However, since there is ready and available consultation in all specialties, there is no disincentive in securing necessary expertise for patients who require it. The prepayment mechanism encourages early provision of services to avoid the financial burdens of cases which have become complicated because of delays in treatment, so called preventative medicine.

The confusion in terms between prepaid group practice and Health Maintenance Organizations is understandable since the latter was nominally modeled on the former and many prepaid plans have indeed qualified as HMOs. However, the terms are not identical since the qualification as a Health Maintenance Organization is largely dependent on the provision of the required package of services. There are other requirements, most notably some risk sharing component to provide incentives to cost containment, but a group of physicians can be a qualified Health Maintenance Organization while each
continues to practice in his or her own office and continues to care for all the patients who wish to continue under the traditional system.

It is the preemption of the prepaid model by the individual practice association that is the subject here. The ability of fee-for-service practitioners, without significant change in the system of health care delivery, to enjoy the benefits of the HMO program developed by the government is a most effective tactic in combating innovative or cost cutting competitors, especially if those competitors are not in place and require significant capital outlays and start-up costs. Under these conditions the expected early losses, coupled with funding for fixed costs might overwhelm the would-be competitor and deter him from any attempt to start up at all.

The decision of the fee-for-service physicians in an area to initiate an individual practice association must be considered to be a reaction to pressure by the government as to the threat of a prepaid group practice which has or could qualify as an HMO. It is therefore considered to be a defensive measure, to either deter or to control a more aggressive, independent competitive HMO. Since the primary purpose of the individual practice association is to prevent the entry of more
aggressive HMOs rather than to generate income (this is adequately provided by the majority of patients who ordinarily remain fee-for-service) premiums can be very competitive. The providers must at least nominally not discriminate against their fee-for-service patients, but various costs can be ignored, or various charges not imposed on the IPA patients which are regularly assessed against fee for service patients or their insurers.

If the sponsor of the individual practice association is the Blue Cross or Blue Shield plan in the area, an additional element of competitive pricing can be introduced. The plans are in an even better position to assign costs between various categories of patients or to aid the participating physicians in doing so. As long as it is necessary for the pricing to be maintained at a level that will deter the entry of competition, a tacit agreement between the physicians and the Blue Cross or Blue Shield plan will limit the charges submitted for the care of the prepaid patient in return for more gracious acceptance of charges submitted by the provider for care of the fee for service patient.104

In areas with a single dominant institution, or a cooperating group of such institutions, similar cooperative efforts can be effective defensive measures. The
hospital, perceiving a threat to its source of patients, cooperates with equally concerned physicians, and effectively preempts the marketing of a competing prepaid plan. Similar adjustments in costs and charges are possible, as long as prices must be maintained at an entry deterring level. 105

The effects of preemption are much more subtle and difficult to relate to the anticompetitive behavior prohibited by the antitrust laws than the behavior described earlier in this chapter. Denial of hospital staff membership; exclusion from consultation and referral networks and from third party payment mechanisms and inconveniences to patients are easily placed within existing laws. They will constitute boycotts, refusals to deal, allocation of business, price fixing and tying, all per se violations of the Sherman Antitrust Act and the Clayton Act. Effective methods have been found to deal with the more egregious practices, as has been described above.

Dealing with preemption is a much more difficult matter. First, since the HMO act specifically allows individual practice associations to qualify as long as they offer the required package, compliance with the act can be advanced as a defense to the antitrust laws. This defense is not entirely without precedent, since
other forms of government programs in the health care field can encourage or even mandate behavior which is clearly illegal if carried out without such sanctions. Health Systems Agencies, created under the same cost control objectives, limit the investment in certain types of equipment. They encourage sharing of services in different facilities. Companion state laws requiring certificates of need require a showing that proposed capital expenditures will not adversely affect competing institutions. If it can be shown that the competitors will lose business, the certificate of need must be denied and the applicant required to purchase services from existing suppliers of these services, to continue providing the service at the present level, or simply not to provide the service at all.

Such behavior is unlawful under the antitrust laws unless some acceptable excuse can be found (one possibility is that the behavior is mandated by another law which is found to be controlling). It would clearly comprise allocation of business, conspiracy in restraint of trade and price fixing. However, the actions of Health Systems Agencies and the agencies administering the laws regulating certificates of need have not stirred the interest of trust busters at any level. Indeed, it has been the very anticompetitive nature of the
health care industry that sparked the passage of the certificate of need laws in the first place. The California legislature, for example, recognized that passage of such a law protects existing health facilities from competition by limiting the construction of new health facilities. This ensures that existing hospitals will always have patients, regardless of their quality of efficiency. But, the legislature was willing to take this step because it believed there was little effective competition between health facilities. Though there was no behavior that could be specifically described and proven to sustain the burden of a criminal or civil action, real price or quality competition was not a significant factor in provision of health services by existing institutions. Therefore, government controls were instituted to slow the growth of capital expenditures by health facilities in the hope that this would slow the increase in total health care costs.109

In the face of such an approach to government actions which encourage or require private individuals to violate antitrust laws, it can be presumed that compliance with existing government goals and current statutes, (in the case of individual practice associations compliance with the cost containment programs and HMO laws) will be a strong defense to any antitrust attack. The spectre
of antitrust violations has been raised, but it is not generally considered a real threat.\footnote{110}

It is precisely this protection from prosecution that makes preemption such an effective tool since there is good evidence that preemption is as effective in slowing the growth of innovative medical care delivery systems as was its now proscribed predecessors, exclusion from staffs, referral networks and third party payment mechanisms.

One of the standard anticompetitive practices is known as the "fighting ship" technique. In such a case, an organization wishing to combat competition enjoys substantial power in the market. Rather than lower its overall price structure to compete or undercut by so called "predatory" pricing, which can be quite expensive, it generates a product to compete with the lower competitor. This product bears the loss, but it will be less than competing across the entire line.\footnote{111}

There is good reason to believe that this tactic is being used by fee-for-service insurers and institutions with the hope of discouraging truly competitive and innovative providers of health care services. However, the difficulty in proving such an intent in the practices would be practically insurmountable. One could simply believe, and could not practically disprove, that Blue
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Cross, Blue Shield, or any other established institution in the health care industry is simply trying to improve its product and to respond to government and public mandates for cost containment. One would argue that if any anticompetitive effect ensued, it would be unfortunate, but not intentional.

Agreements to form individual practice associations could be viewed as in restraint of trade, proscribed by Section I of the Sherman Antitrust Act, or as attempts to monopolize as in Section II of the same act. However, as detailed above, the umbrella of government goals and compliance with the HMO laws would be effective defenses to such accusations. Unless aggressive antitrust enforcement was pursued, based on the potential harm which arises from actions by the medical professions chosen instrument to control its own competition, it is unlikely that the preemptive nature of fee-for-service sponsored prepayment will be recognized. It would have to be recognized that anything that fee-for-service sponsored plans could do could be done better through independent insurance companies and groups of doctors whose interest and livelihood are intimately and solely related to the success of the competing plan and its mechanism for the provision of services. ¹¹²

In the discussion to this point I have concentrated
on the behavior of institutions and individuals with regard to competition from alternative plans for delivery of health care services. Their success in impeding effective competition has been described and analyzed without regard to government action, except insofar as the antitrust departments of state and federal government cooperated in halting illegal anticompetitive practices. We will now proceed with a discussion of the all important role of the government. This will be approached from two standpoints. First will be a discussion of attempts by opponents of alternative systems to discourage them through legislation and regulation, the final part of the first section of this chapter. Following this will be an analysis of the government's own regulatory activities (in the second section of this chapter,) which had the net effect of discouraging the very competition which would effectively control costs and which mandated such burdensome requirements that the regulation itself became a source of significantly increased cost. Some recent recognition, by various government officials and other commentators, of government's own anticompetitive effect will be discussed as well.
8. ATTEMPTS BY OPPONENTS OF PREPAID PRACTICE TO INFLUENCE LEGISLATION AND REGULATION

Restrictive use of various laws begins at the most basic level, the attempt to revoke the licenses of physicians participating in prepaid plans. The accusation was generally that the accused physician was participating in 'unethical' practice, evidence by apparent advertising, through the group's publicity and marketing efforts, and delegation of various procedures to paramedical personnel. ¹¹³ This approach is subject to political opinion which limits effectiveness. More important, the power of physicians on medical licensing boards has been limited by the appointment of non-professional, that is non-physician, members and by the fact that the administrative actions of all licensing boards are subject to appellate review in the courts. ¹¹⁴ Since a fundamental, vested right is involved, the ability to earn a living, the review must include an independent examination of the evidence presented to the court, rather than the less stringent "adequate evidence" standard. ¹¹⁵ It is quite unlikely that simple harassment by the members of licensing boards directed against individual physicians will survive such a challenge.

Blue Shield enabling laws have been used to limit the action of groups in establishing prepayment mechanisms.
These were the response of fee-for-service medical practitioners to commercial insurance companies which offered health care coverage. Typically, such enabling laws require than any non profit medical service plan obtain the approval of the county medical society, include a certain number of local physicians (already established in practice) or to be open to all physicians who wish to participate. Since group plans are typically comprised of a panel of physicians with established relationships for patient care and referral, the listed requirements would be impossible to meet. Initially, it was necessary to deal with the limitations of these laws through attacks in state courts and regulatory agencies, using the argument that the legislative intent was not to limit groups or the argument that the state could not delegate the power to approve practice arrangements to a local medical society. The limitations on prepaid plans have been preempted by the HMO Act of 1973, with regard to federally qualified Health Maintenance Organizations, and the various HMO enabling statutes of the states bring the Blue Shield laws into conformity with the desire to use the prepaid form as an alternative.

Another legal restriction applied to prepaid groups was the accusation that they were engaged in the corporate practice of medicine. This is a traditional proscription
on physicians, attorneys and other professionals. It is based on the fiduciary nature of the relationship between the professional and the member of the public who is served. The presumption is that control of the practitioner by the corporation limits freedom of action and brings the practitioner under the power of individuals who have solely a profit motive which is unlimited by a fiduciary relationship.

Until the passage of federal HMO legislation, such accusations had to be met on the state level. The successful defense was that the corporation in question was structured and operated in such a way that there was no significant involvement in the practice of medicine. Consequently, there could be no effective interference with the freedom of action of the professional. Therefore, the evil contemplated in the law could not occur, and the practice need not be restricted under the statutes limiting corporate practice.

In examining the ability of the fee-for-service sector to influence legislation, it is important to consider the legal status of attempts at influence which have the effect of stifling competition. More specifically, under what circumstances may individuals or groups lobby for legislation or administrative decisions favorable to themselves and unfavorable to competitors.
This question continues to be important, even though such efforts to control prepaid practice by the use of Blue Shield laws and injunctions against the "unethical" practice of medicine or corporate practice of medicine have been negated. Much of the basis for preemption through individual practice associations depends on the Health Maintenance Organization legislation allowing the IPA the same opportunity to participate in dual choice, exemption from certificate of need requirements and exemption from provisions of cost-containment programs. If fee-for-service practitioners, through successful lobbying, can gain the same advantages as prepaid groups, they will be able to successfully prevent the entry of such groups, with their cost containment oriented programs, into the community at all.

The line of antitrust law which deals with attempts to secure competitive advantage through influence on the government is referred to as the Noerr-Pennington doctrine. It was first propounded in 1961 when a group of railroad attempted to secure enforcement of laws regulating the competing trucking lines in the long distance freight business. This campaign was carried out through intensive publicity aimed at state legislators and governors. The campaign was indeed successful and the truck lines attempted to have the activities of the
railroad declared to be an illegal conspiracy under the Sherman Antitrust Act. They were unsuccessful based on the Supreme Court's interpretation that the Sherman Act was aimed at business practices rather than at attempts to influence, through information, the behavior of the legislative or executive branches of government. Further, the court raised the possibility that the right of free speech, guaranteed under the first amendment of the Constitution, might be interfered with if the activities of the railroads were curtailed.

The court did recognize an exception to the application of the doctrine, the so called "sham exception." If the activity complained of was not in fact an attempt to influence government activity but was simply a covert attempt to interfere with the business relationships of a competitor, it would not enjoy immunity from the antitrust laws.

In two subsequent decisions, the Supreme Court has upheld the right of competitors to seek to influence favorable action by the government. In the latter instance, the "sham exception" has been extended to cover instances in which the misrepresentations used to influence the legislative branch are used in administrative or judicial hearings. Though it is permissible to use such misrepresentations of the facts to affect
the political process of the legislature, it is not permissible in a hearing conducted in a court or by an administrative agency. This constitutes an effective limitation since falsehoods in court are easier to prove than would be an attempt to interfere directly with the business relationships of a competitor.

This it would seem that the Noerr-Pennington doctrine offers two very important weapons in opposition to the spread of prepaid plans. The first is to generate adverse publicity, ostensibly aimed at the regulatory agency, which has the effect of calling into question the wisdom of any physician dealing with this organization. Presentation to the government forum will likely endow any statement with more stature than propaganda just directed to the public. Accusations that prepaid practice is subject to abuse by failing to deliver the services contracted for is particularly effective, since money is collected in advance of services. Such abuses have indeed taken place and more or less restrictive legislation has been passed to regulate the prepaid section.\textsuperscript{123} It is in the interest of the fee-for-service section that such regulation be as burdensome and expensive as possible and it is, in their argument, strictly incidental that the fee-for-service sector, unburdened by similar oversight, enjoys a competitive advantage.\textsuperscript{124}
Second, general regulatory laws, ostensibly aimed at abuses or possible abuses across the entire spectrum of health care delivery, can be structured or administered to the detriment of prepaid plans. At the original passage, the special circumstances which apply to prepaid plans can be pushed into the background. Later, the administration of the program, which often required the participation of the regulated providers can be made to fall more heavily on the prepaid sector than the fee-for-service sector.

Examples are to be found in the Professional Services Review Organizations, Health Systems Agencies and certificate of need laws.\textsuperscript{125,126} The PSRO depends on review of practice by panels of physicians elected by physician members. Membership is open to all practicing doctors in the community without charge. Since prepaid practice constitutes a minority in essentially all areas, and since the same panels review the facilities of both fee-for-service and prepaid, the latter can be scrutinized more closely, solely in terms of proper performance, with any possible adverse competitive effect argued to be incidental.

Health Systems Agency legislation and certificate of need laws have disadvantaged prepaid plans both in the structure of the regulation and the implementation.
These are community programs whose aim is to look at all the facilities available in the aggregate to determine what additional expenditures for building are necessary. Certificate of need laws are administered by governmental agencies, but they are required to take into account the findings and opinions of the HSA. The HSA, in turn, is controlled by individuals answerable to the most powerful constituencies in the community of health service providers and consumers. Again, since fee-for-service practitioners provide the majority of medical care, the consumers will largely secure their care from such providers. It is in the interest of both the providers and consumers to prevent prepaid plans from building facilities, since these will be available primarily or totally to subscribers in the prepaid plan. The structure of the Health Systems Agency requires that the prepaid plans be represented, but it also effectively guarantees that the fee-for-service sector will retain control. When successful, opponent's use of certificate of need laws can prevent the prepaid plan from building or purchasing facilities and require it to purchase services from the fee-for-service sector at full rates, negating cost savings that the prepaid plan could generate if it supplied the services in its own facilities.

The HMO amendments of 1978 have limited the effect
of the Health Systems Agencies and the certificate of need laws on qualified Health Maintenance Organizations. However, these amendments are not effective until conforming legislation is passed by the state, and may not apply until and unless federal qualification is sought and granted. 127

B. GOVERNMENT ACTION AND ITS EFFECT ON PREPAID PLANS

The final part of this chapter will deal with government action which has been anticompetitive in effect, but which has arisen incidentally to other government goals, and in response to philosophical and policy considerations rather than to the importuning of the fee-for-service sector, as just described. Included here are the myriad efforts to deal with real or perceived problems in the health care industry through bodies of statutory law and regulation and through enforcement of these laws and regulations in administrative and judicial forums. This approach has not been limited to health care but has been present throughout every aspect of our society, demonstrating a preference for direct control and a corresponding suspicion and doubt about the ability of economic forces to deal with very many situations in the most efficient way.

Some idea of the increase in regulatory activity in recent years may be gleaned from the increase in the
volume of regulations. The office of the Federal Register reports that 61,000 pages of regulations were published in 1978 compared to 20,000 in 1970, an increase of more than 200 percent in only eight years. Of the bills introduced in the 95th Congress, 2,883 were health-related, representing approximately eleven percent of the total. This approximates the ten percent share of our economy spent on health care and is a measure of the volume of regulatory attention given to health care at all levels of government. A Washington University study estimates that the cost of regulation of $300 for each American citizen each year, or an annual total of $65 billion, for federal regulation alone. Another study, this one of health care facilities in New York State found that there are 164 federal and state regulatory agencies to oversee hospital health care and that 25 percent of hospital costs stem from these regulatory requirements. Approximately $128 million is spent simply generating forms and reports. Both figures are increasing at approximately four percent each year, in addition to inflation. (The actual cost of regulation is between these two figures since many activities mandated would be carried out anyway, including safety, record keeping and quality assurance. The true cost would be the sum of reporting costs plus the cost of regulations which
are repetitive, contradictory or do not contribute to patient care and efficient operation.)

The range of regulation is broad and all encompassing. Many of these involve traditional protection against injury of those temporarily or permanently helpless and are administered by local agencies. They are similar to regulation of any public buildings and provide protection of the occupants from fire, structural failure, electrical hazard, exposure to toxic substances, falls and myriad other risks. Hospital regulation is bound to be somewhat more costly, given the nature of the activities carried out. Though there are some costs related to this type of regulation, it is part of a general trend, evidenced by OSHA and other safety agencies.

There are types of regulations that are unique to the health care industry. Professional Standards Review Organizations (PSROs) were formed in 1972 to assure that health-care services paid for by the government were "medically necessary, conformed to the appropriate standard, and are delivered in the most effective, efficient and economical manner possible."¹³¹ The Health Systems Agencies came into existence under 1975 legislation¹³² and, coupled with corresponding state certificates of need laws, introduced extensive and expensive activity. The number of employees and consul-
techniques have been mandated, increasing the cost of making available these advances to the public, and thus the charges that must be borne by the patients who receive the treatment.

No one will seriously argue against programs which are set up to protect the health and safety of the citizens through inspection and reporting, with programs which guarantee health care to the elderly, the poor and the disabled, or with advances in medical sciences which make treatable diseased that had been previously hopeless. Certainly one can criticize wasteful programs, pointing out that the benefit to the public and to the individuals to be protected is completely disproportionate to the costs. Likewise, one can fault the government for failing to take into account these costs when deriding and criticizing the providers for the rapid escalation in health care costs.

However, there is an area which has until recently received little attention and which is now becoming recognized as a possible solution to some of the health care costs. It is the recognition that, while programs were being enacted to encourage innovation and cost cutting, such as the Health Maintenance Organization Act and its subsequent amendments, the government itself, through the tax laws and through regulation was dis-
encouraging the very incentives to the competition which could cut costs. The effect of various regulations on prepaid plans has been discussed, as has the attempt by the fee-for-service sector to use regulations to retard the growth of competition from fee for service. Another very significant contributor to increasing health care costs has been the Internal Revenue Code.

Under our tax laws, an individual is permitted to deduct a part of medical expenses from his taxable income. An employer is allowed to deduct the entire premium for health insurance and this is not taxable as income to the employee. According to the Congressional Budget Office this represents a federal tax subsidy for medical plans of $14.5 billion a year. It said that current tax provisions tend to eliminate incentives for consumers to choose economical health plans, and encourage more frequent use and more elaborate forms of medical care. As a result, total medical expenditures tend to increase. The expenditures are even in the form of a tax subsidy, since current law allows deductions for plastic surgery, trips to warm climates and other types of elective care. $9.6 billion represents exclusions for employers' contributions to health plans for their workers under Section 162 of the Code. $3.1 billion results from deductibility of individual expenses under
Section 213 of the Code and the remainder results from charitable contributions to non-profit medical facilities and tax exemptions for bonds used to provide funds for hospital construction.

In addition to recent scrutiny of the cost-benefit relationship of regulatory activities, there have been various suggestions to conform the tax laws to the cost control efforts in the health care field. A leading proponent in this area has recommended a plan which would limit the amount an employer could deduct as a contribution to an employee's health coverage.137 Under the present system, there is no incentive for the employee to choose anything but the most expensive and comprehensive plan since he pays nothing. The employer has minimal incentive since he pays only half of the additional cost.

The consumer choice health plan places a maximum on the deductible amount. Both the employer and the employee become concerned about any excess amount, uncushioned by any deduction at all. This becomes a powerful incentive for searching out the most efficient provider. The plan is aimed at decreasing the loss in revenue to the federal treasury and to control the increase in health care costs in general. It will have the additional benefit of removing the competitive
disadvantage to HMOs. Under the present cost reimbursement program, an HMO receives approximately 60% of the reimbursement per Medicare patient as the fee-for-service sector. This is due to a reimbursement pattern based on care provided, at whatever cost and for whatever reason, rather than an amount provided to take care of the health care needs in that year. This plan recognizes the advantage of a flat amount based on efficient provision of necessary services. Legislation to implement this plan is pending under the sponsorship of Representative Al Ullman, chairman of the House Ways and Means Committee. 138

C. CONCLUSION

The question addressed in this chapter was the failure of prepaid health plans to grow prior to the passage of any legislation by the federal government. Later in this paper I will address the incremental effect of the legislation passed, namely the Health Maintenance Act of 1973.

There has been an extensive discussion here of the major factors underlying the difficulty of prepaid health care organizations to become providers of a major part of the medical care of this country. Anticompetitive behavior by fee-for-service providers, preemption by fee-for-service providers, attempts by these providers
to influence the government's activity and the government's own ideas and programs have all been examined.

It would appear that antitrust laws and political pressures will be useful and effective in preventing the most outrageous forms of anticompetitive behavior, such as exclusion from medical societies and hospital staffs. In the face of rising costs of medical care and the intolerance of both the public and the government for the increasing expenditures, providers as a group are constrained from opposing any system that arguably might effect savings. It is also doubtful that arguments based on the unethical practices of competing systems would carry much weight, since the ethics of all types of providers are more frequently being called into question than they have been in the past.

It is too early to know the long term effect of the fee-for-service sectors preemptive behavior and attempts to influence legislation and regulation, and to know the effect of the government's own behavior.

The ability of the fee-for-service providers to change the techniques and the focus of their opposition has been impressive. Over the last several decades the ability to preempt the arguments and methods of their prepaid competitors has grown in effectiveness and sophistication. Likewise, the ability to persuade
legislators and regulators has expanded, so that legislative efforts to encourage prepaid group plans may have just the opposite effect. Existing fee-for-service providers may influence laws and regulations so that they qualify as Health Maintenance Organizations without the necessity to modify their practices and procedures in any significant way. By effectively blurring the distinction between prepaid groups and independent practice associations these providers can prevent anything but the most superficial and cosmetic changes in the medical care delivery system.

Finally, the ability of the government to recognize and modify its own programs which negatively affect the growth of prepaid groups is greatly in doubt. Many of these programs, such as tax laws and regulatory activity within and without the health care industry, have other goals and enjoy strong support from various constituencies. What could be viewed as unacceptable changes might be required. For instance, the consumer choice approach to health care insurance may ultimately cut costs and stimulate competition. However, its initial effect will be to limit an income tax deduction, hardly something that will provoke a groundswell of support from either employers or individual tax payers. Similarly, a reduction in regulation will be looked upon as the
government backing away from a commitment to safety, or quality of care.

Besides existing programs, there are laws yet to be enacted which may be structured in such a way as to negatively impact prepaid groups. Catastrophic health care coverage or all inclusive national health insurance could, depending on how it is written, have tremendous positive or negative effects on prepaid practice. Proponents and opponents of prepaid practice will certainly attempt to influence the form of any such programs. This will be discussed later.
CHAPTER V
INITIAL LEGISLATIVE EFFORTS

A. THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1972

1. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

Requirements for qualification under the Act include both prescribed services which must be provided to subscribers and acceptable methods of organization and operations.

Services provided are divided into basic and supplemental and must be provided, without limitations as to time and cost, unless specifically allowed. Basic services are physicians, including referrals; inpatient and outpatient hospital services; medically necessary emergency health services; short term (not to exceed twenty visits,) outpatient evaluative and crisis intervention mental health services; treatment and referral for abuse of or addiction to alcohol and drugs; diagnostic laboratory and radiology; therapeutic radiology; home health services; and preventive health services (including family planning, infertility, preventive dental care for children and children's eye examinations for vision problems.)

The payment for basic health services must be fixed without regard to the dates of services; to the frequency, extent or kind of health services provided; according
to community rating: and with only nominal supplemental payments which themselves may not be allowable if they serve as a barrier to the delivery of health care services. 143

Supplemental health services may be provided for payments fixed by contract between the HMO and the members if the HMO has the personnel to provide these services and the members wish to purchase them. The services are likewise on a prepaid basis and must be costed out on community rating systems. 144 These services may include services of facilities for intermediate and long term care; vision care beyond the basic benefit; dental care beyond the basic benefit; mental health services not included in the basic benefit; long term physical medicine and rehabilitative services (including physical therapy); and the provision of prescription drugs prescribed in the course of any of the covered treatments. 145

Provision of services must be by health professionals organized either into medical groups or individual practice associations or who are members of the staff of the health maintenance organization. This requirement is unnecessary if the services provided are unusual and infrequent and it would be inefficient to maintain them within the organization. It is likewise unnecessary when the services are provided in emergency or urgent
situations by other members of the staff, who are not health professionals. 146

Medical services, including the basic health services for all and the supplemental health services for those who have contracted, must be available and accessible as promptly as appropriate; when necessary must be available and accessible twenty-four hours a day and seven days a week. A member of a health maintenance organization shall be reimbursed for expenses for securing basic or supplemental health services other than through the organization if it was medically necessary that the services be provided before he could secure them through the organization. 147

In addition to the required services, certain organizational and operational requirements are set forth. 148 Each health maintenance organization shall:

(1) have a fiscally sound operation and adequate provision against the risk of insolvency;

(2) assume full financial risk on a prospective basis for the provision of basic health services; (outside insurance may be purchased or other arrangements made for certain expenses. These include the cost of basic health services which exceed in the aggregate $5,000 for any member in one year, the cost of the services secured
by a member because medical necessity required that they be provided outside the organization, and costs in excess of 115% of the income for the fiscal year, to the extent of 90% of those excess costs);

(3) enroll persons who are broadly representative of the various age, social and income groups within the area it serves: (except that no more than 75% of the enrollment can be members of a medically underserved population unless the area is also a rural area);

(4) have an open enrollment period of not less than thirty days at least once in twelve months during which individuals are accepted according to the order of application up to the organization's capacity; (except that the organization need not enroll a disproportionate number of individuals who are likely to utilize its services more often than an actuarially determined average if such enrollment during the open enrollment period of an additional number of such individuals will jeopardize its economic viability. In addition, the open enrollment period may be waived for up to three consecutive periods if the organization would then
no longer be serving fewer than 75% of a medically underserved population. Additional waivers may be granted if the open enrollment period led to loss of financial stability or an increase, over 75%, of a medically underserved population);

(5) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(6) be organized in such a manner that assures that at least one-third of the membership of the policymaking body will be members of the organization and that there will be equitable representation on that body of members from medically underserved populations served by the organization;

(7) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the HMO (including the groups and health delivery entities providing services) and the members of the organization;

(8) have arrangements for an ongoing quality assurance program which stresses health outcomes and provides review by physicians and other professionals of the process followed;
(9) provide medical social services, health education services and education in personal contributions by each member to the maintenance of his health;

(10) provide for continuing education for its health professional staff; and

(11) provide for confidentiality of patients' records and the doctor-patient relationship as well as provide methods for record keeping and reporting of the cost of operations; patterns of utilization of services; the availability, accessibility and acceptability of its services; and the developments in health status and other pertinent matters.

All of the requirements outlined above, pertaining both to the required services and to the organization of the health maintenance organization are to be further described by regulations to be propounded by the Secretary of Health and Welfare. For the purpose of the administration of the Act, various terms are defined in part, to be further described in such regulations. Among these are definitions of what constitutes a medically underserved population, a community rating system, a member and a rural area.

Important definitions include that of a medical group and an individual practice association. A
medical group is a partnership, association or other group of licensed health professionals, the majority of whom are licensed physicians or osteopaths, who have as their principal professional activity supplying services to the organization, who pool their income from practice and distribute it according to a prearranged salary or drawing account, who share records, a substantial amount of equipment and professional, technical and administrative staff, who use allied health personnel and other methods of delivery to provide for effective and efficient services to the members of the group, and who arrange for continuing education in clinical medicine and related areas for the members of the group.

Individual practice associations (IPAs) have similar requirements for licensure and majority participation by licensed physicians or osteopaths among the health professionals providing services. However, the use of allied health personnel, the sharing of records, equipment and personnel and the arrangement of educational activities must be done only "to the extent feasible."

Further, there is no requirement that participation in the individual practice association comprise a majority of the professional activities; no minimum is stated. All that is necessary is that there be a compensation arrangement established by the entity.
2. GRANTS, LOANS AND GUARANTEES

The act provides for various types of financial backing from the federal government, again administered by the Secretary of Health and Welfare according to regulations propounded by the Secretary:

(1) Grants and contracts for feasibility surveys are available to the amount of $50,000 but may not exceed 90% of the actual costs except if a medically underserved population is being surveyed, when the amount of the grant may be 100% of the actual costs;\textsuperscript{152}

(2) Grants, contracts and loan guarantees for planning and for initial development costs are available such that the maximum planning grant is $125,000 and the maximum grant or loan for initial development is $1,000,000, both subject to a single additional grant in the following year if necessary to complete a project and both subject to the limitation of 90% of the actual costs except if a medically underserved population is involved, when the amount may be 100% of the actual costs;\textsuperscript{153}

(3) Loans and loan guarantees may be made to public and non-profit health maintenance organizations for initial operation costs, covering the first
thirty-six months of operation, to the extent of $1,000,000 in any one year of operation and $2,500,000 in the aggregate.\textsuperscript{154}

The amounts authorized, in the aggregate, for the described loans and grants were:

(1) For grants and contracts for feasibility surveys, for planning and for initial development: $25,000,000 for the fiscal year ending June 30, 1974; $55,000,000 for the fiscal year ending June 30, 1975; $85,000,000 for the fiscal year ending June 30, 1976;

(2) for initial development costs only: $85,000,000 for the fiscal year ending June 30, 1977;

(3) for loan guarantees to non-federal lenders to secure the payment of the principal and of the interest on loans made to any private entity (other than a nonprofit private entity) for a project which will serve a medically underserved population: $75,000,000 in the aggregate for fiscal years ending June 30, 1974 and June 30, 1975. Such loans to organizations which need not be non-
profit may be used for the purpose of planning or initial development.¹⁵⁵,¹⁵⁶

3. EMPLOYEES HEALTH BENEFITS PLANS - DUAL CHOICE PROVISIONS

Each employer subject to federal minimum wage requirements with an average number of employees not less than twenty-five, shall, in accordance with regulation to be propounded by the Secretary, include in any health benefits plan offered 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 the employees reside.¹⁵⁷ If there is more than one such qualified organization and if one is based on a staff or group model and one or more is based on the individual practice association model, then the employer shall provide a choice of at least one staff or group type and at least one individual practice association type.¹⁵⁸

The cost to the employer for health benefits under the dual choice provision cannot exceed the employer's obligation under a prevailing collective bargaining agreement or other contract between the employer and its employees for the provision of health benefits.¹⁵⁹

4. RESTRICTIVE STATE LAWS AND PRACTICES

The Health Maintenance Act addresses the possi-
bility of use of state laws to inhibit the development or functioning of alternative systems by outlawing various state practices or possible practices. Any law, regulation or other mechanism which:

(1) requires approval by a medical society;

(2) requires that physicians constitute all or a percentage of the governing body;

(3) requires that all or a percentage of physicians in the locale participate or be permitted to participate in the provision of services;

(4) requires that requirements for insurers of health care doing business respecting initial capitalization and establishment of reserves against insolvency, shall not apply so as to prevent operation as a health maintenance organization. 160

In addition, no law could be established which prevented solicitation of members through advertisement of services, charges or other nonprofessional aspects of operation. Advertisements which identify, refer to, or make qualitative judgments about any health professional providing services for the organization would not be so protected. 161

In addition to the foregoing major provisions of the Act, there are provisions providing for continued
regulation of qualified organizations or those that received loans or loan guarantees; for periodic program evaluations; for periodic reporting; and for regular and ongoing quality assurance. 162

B. COMPARISON WITH KAISER HEALTH PLAN

The provisions of the Health Maintenance Organization Act of 1973 bear comparison with the benchmark prepaid organization, Kaiser Permanente Medical Care entities which provided care for approximately one-half of all enrolled members of such health plans at the time of passage. It is noteworthy that many of the terms, such as basic and supplemental services, were taken from the lexicons of existing health plans, and that Kaiser had used such terms for many years.

The Kaiser Foundation Health Plan enrolls members and arranges for their medical and hospital care to be provided by affiliated entities of the Kaiser-Permanente Medical Care Program: Kaiser Foundation Hospitals and several medical groups, one each located in Northern California, Southern California, Oregon, Hawaii, Colorado and Ohio. In each of these regions, medical care is provided in hospitals owned by or used by the program, and in medical offices provided by the program. Services are covered benefits only if they are provided, prescribed or directed by a physician
There is no reimbursement for services secured from non-plan doctors, hospitals or other facilities except in emergencies such as a delay would have resulted in death, serious disability or significant jeopardy to the member's condition or because the choice of provider was beyond the control of the member or the member's immediate family. 163

The success of the Kaiser Medical Care Program depended on the ability to market and provide a health plan that was acceptable to large numbers of employers and individuals and which was financially viable. Since Kaiser did not choose to qualify under the provisions of the Health Maintenance Act of 1973, it is important to compare the benefit package mandated under the Act with that provided by such a representative health plan. In this examination, attention will be directed primarily to those provisions affecting services not previously provided by Kaiser and to the provisions significantly modifying the way in which existing services are delivered and altering administrative and operational practices. The operative question, which was addressed was whether, on balance, the benefits of the qualification as an HMO, eligibility for the dual choice provision, the ability to solicit membership, and protection from certain possible State action, was sufficient to offset
Kaiser had always provided most of the basic health services required for qualification. However, some of the mandated basic services were in areas in which benefits had previously been limited, either in scope or eligibility, or not provided at all.

Mental health had previously been available to a few groups and represented less than three percent of the total resources of the program. Most industrial groups were not oriented to receive this benefit, and did not demand such coverage in contracts negotiated by their unions. Employers did not choose to initiate the coverage either. Similarly, alcoholism and drug dependency were limited, primarily to federal workers and to General Motors. Since such small programs did not command much organizational attention, there was a good deal of concern as to how efficiently such services could be provided on a large scale. It was recognized that certain groups, particularly professional employees, could generate significant and uncontrollable costs, since their training and background made them familiar with mental health concepts. Though the benefit was limited for any individual, the number of users and the intensity of use could not be predicted from past experience. Therefore, it would be impossible to
accurately cost out large scale mental health and alcoholism benefits, jeopardizing the financial stability of the program.

Preventive dental services represented even more unfamiliar territory. No dental coverage had ever been provided and the program was completely without experience in costing out such a benefit. 165

Even more important than the mandated benefits and their unpredictable financial effect, were various organizational requirements. The obligation to enroll persons who are "broadly representative of the various age, social and income groups" was viewed as particularly troubling. Until that time, there was no attempt to solicit members to comply with any particular ethnic, social or other non-medical, non-business criterion. Groups were enrolled primarily according to their impact on existing facilities, so that the demand for services could be predictably spread over the hospitals, medical staffs and support services that would be able to satisfy the demand. There was no mechanism to target membership by any such imposed criteria and, indeed, there was no information extant as to whether or not existing membership was sufficiently representative by any criteria other than by age and sex, for which data was gathered. (It is noteworthy that age and sex data was
gathered for medical delivery planning, so that a proper mix of specialists and services could be made available, including provisions for pediatrics, obstetrics and diseases more common in the elderly.)

The open enrollment period was likewise of great concern. The comprehensiveness of the Kaiser benefits, couples with the limited copayments and minimal financial participation by the member, had long been suspected to attract a disproportionately large portion of the chronically ill. Though the law stated that there would be a protection in the case that a disproportionate utilization would jeopardize the viability of the organization, it was felt it would be very difficult to demonstrate this. Likewise, the open enrollment requirement could interfere with marketing of the health plan to new groups. The proportion of individual pay members, approximately ten percent of membership, would increase, bringing the likelihood of long term adverse selection.

The HMO Act required that one-third of the membership of the policymaking body will be members of the organization and that there will be representation of members from medically underserved populations served by the organization. The board of Directors of the Kaiser Foundation Health Plan and Hospitals is a centrally
located institution, in Oakland, California. Members include public figures and the senior officers of the Health Plan. Compliance with this provision presented possible difficulties, the exact nature of which was not known.

The continuing scrutiny of another branch of government, in addition to those already charged with responsibility for the oversight of medical delivery was another concern. Though the health plan already supplied extensive quality assurance programs, member health education, preventive medical and health services and internal analysis of the effectiveness and desirability of all programs, in addition to the full panoply of medical, surgical and diagnostic services, all of these activities had been developed in response to internal needs. There was no assurance that these programs would be acceptable or that they would comply with the regulator's perceptions of proper goals and methods. Additional burdensome requirements for reporting, for documenting activities already considered adequate, and for implementing costly duplicate activities were expected and feared. 166

Such a comparison of the potential disadvantages and advantages of the legislation was, of necessity, carried out by each existing and potential organization that hoped to qualify. In the case of the small group,
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CHAPTER VI

ANALYSIS OF THE EARLY LEGISLATIVE EFFORTS -

THE HMO ACT - 1973

Under the HMO act, prepaid providers of medical services could become eligible for qualification as a Health Maintenance Organization. Such federal qualification made them eligible for the benefits described in the previous chapter, the dual choice provision, protection from restrictive state laws, and participation in programs of grants, loans and loan guarantees.

To evaluate the success of the federal programs, the proper focus is on the number of organizations providing medical and other health care through prepayment as well as the number of individuals to whom such service is provided.

After considering the effects of the initial federal effort to encourage prepaid group practice health plans (including IPAs), the Health Maintenance Organization Act of 1973, the experience with prepaid plans as a health care delivery system for Medicare (Medi-Cal) recipients in California will be examined. These events are significant since they showed a potential weakness which had to be taken into account in subsequent legislation.
A. EFFECTIVENESS OF THE HMO ACT

Prepaid group practice medical care had been in existence for over 40 years by 1970. At that time there were 37 organizations, serving an estimated 3.6 million enrolled members. Though, as we have outlined above, while the prepayment concept seemed sound, there were not enough group practice plans to make a substantial impact on controlling health care costs. The HMO legislative effort was aimed at identifying factors slowing growth of prepaid plans and on providing programs to modify these conditions.

The foremost problem was generating enough enrollment. Two types of problems seemed to be important. The first was that prepaid plans had difficulty in succeeding in the health care market. Since the largest source of health insurance is the place of work, about 80 percent, having employers offer a prepaid option is critical. However, because of established insurance arrangements, and unwillingness to complicate administration, employers more frequently refused to offer employees the choice of an indemnity and a prepayment plan, that is, a dual choice.

The second major problem was that, in many places, the minimum benefit package considered feasible by the prepaid plan, which included inpatient and outpatient
care, physicians' services, laboratory and X-ray and some type of out of area emergency coverage, was too expensive to be marketed. Prepayment plans could not feasibly fractionate service. Besides the obvious medical and ethical considerations, part of the economy of the prepayment mode was that charges need not be applied to individual services provided. This resulted in considerable administrative and accounting savings, but it also meant that experience rating could not apply.

Indemnity insurance companies could more accurately limit services to a maximum. Their liability can be stated in dollar amounts and the charges for this level of service can be more exactly calculated on an actuarial basis. An employer wishing to buy insurance could easily purchase the desired level, according to the benefit he wished to bestow, and that level could be much lower than the minimal prepaid package available in the area.¹⁶⁹

These problems were addressed in the HMO Act, primarily through the dual choice provision. In addition, the problems of inadequate start-up funding and restrictive state laws were addressed in the Act in the provisions described in the last chapter.

Prior to the passage of the HMO Act, there was an impressive growth rate, stimulated by federal interest, preliminary HEW funding and the California emphasis on
providing Medicaid coverage through prepaid plan contracts. Nationwide, the number of prepaid organizations increased 11 percent in 1970, 27 percent in 1971, 52 percent in 1972, and 68 percent in 1973. Nationwide enrollment rose from approximately 3.6 million to 5 million covered individuals.

The provisions of the HMO Act were addressed at existing problems with varying emphasis by two groups of advocates. One group can be described as the "competitive growth" strategists. They wanted to encourage the growth of prepaid health care providers in a manner consistent with fair market principles. It was believed important that prepaid organizations prove their economic viability and efficiency with minimum government intervention. It was feared that there would arise a continuing and inefficient Federal grant program. It was for this reason that grants were limited in scope and amount, could only be used for planning and development, were subject to prevailing market interest rates, and would expire in their entirety in five years. Operating subsidies were not considered an acceptable part of this strategy.

The "social goals" viewpoint as described in Chapter 3, sought a broader and more ambitious program. In addition to aiding the growth of prepaid health care
delivery systems, proponents of this viewpoint wanted to use the legislation to correct basic deficiencies in our national health system that they perceived. To achieve these objectives, a series of requirements were developed which became a precondition for qualification and eligibility for the vital dual choice provision. The prepaid method, through the qualified HMO was seen by some as an opportunity to provide the best kind of medical care—comprehensive health services—in one place or through one organizational entity, in lieu of what was perceived as a fragmented organization of medical care, with consequent inconvenience, inaccessibility, and inefficiency. It was with this in mind that the complete list of basic and supplemental services, including alcoholism, drug dependency, preventive dentistry, and the various educational and social services were mandated as part of the basic services.

Yet another "social goals" objective was to provide access to quality health care for high insurance risks and for low-income people. This was an effort to prevent "skimming," the refusal to sell health insurance to people with a history of poor health, and to prevent experience rating, whereby the premium assigned to individuals or groups depends on the history of utilization of health services by those individuals or groups.
in the past. It was also an effort to overcome the problems of low-income people in gaining access to health care services.

The provisions of the Act that attempted to address these issues were: a 30-day open enrollment period during which any applicant had to be accepted; pricing by community rating, a system that establishes a premium based on a given area's recent health experience and charges everyone the same rate; and enrollment of people whose income characteristics paralleled those of the surrounding area. 172

Both groups of advocates were concerned with the quality of medical care in general and, more specifically, about the possibility of withholding services to the enrolled members. The special provisions that would apply to these organizations and which did not affect fee-for-service providers were thereby included. Among them were: Continuing regulatory power vested in the Secretary of Health, Education and Welfare; mandating group practice physicians (but not members of Individual Practice Associations) to have prepaid patients as their principal source of income, greater than fifty percent; grievance procedures; continuing staff education; enrollees as one-third of the policy board; and continuing reports to the Secretary on cost, health status, and
other indicators.

In the Act passed in December 1973, Congress did not clearly choose one strategy over the other, but rather chose a compromise. The major objectives and mechanisms of the "social goals" strategy were accepted - with one vital exception: The operating subsidies were dropped because of the incompatibility of continuing subsidies with the "competitive growth" approach. This compromise should have been a warning that the legislation would have trouble meeting its goals.

The success of the Act might be measured in terms of attainment of social goals, including the provision of comprehensive services, access for high-risk individuals and low-income people and the effective maintenance of quality standards. However, the effectiveness of the existing prepaid organizations in meeting these goals is difficult to measure, and has been called into question repeatedly, as will be discussed in the next section. More important, if only an insignificant number of individuals would secure their health care through prepaid organizations, there could be no effective progress toward these goals. Both the "social goals: and the "competitive growth" advocates would agree that the single most important measure of success of the Act would be an increase in the number of organizations
FIGURE 10

Chart I
Percentage Growth in the Number of Prepaid Plans

Chart II
Overall Number of Prepaid Organizations

Prepared by the staff of the Congressional Budget Office Committe Print - Dec. 10,1976
The Federal Government and Health Maintenance Organizations, A Choice of Strategy; A Need for Consistency
and an increase in the number of individuals receiving care.

As Chart I illustrates, (Figure 10) growth has actually decreased since the passage of the Act. Chart II gives similar information, though it is less dramatic since it is stated in terms of absolute numbers rather than percentages. There was a growth of 50 organizations in 1974, after the passage of the Act, but there had been a growth of 54 prepaid organizations in 1973. The year 1975 actually saw a fall in the number of organizations providing care through prepayment.173

Likewise, congressional intent to encourage prepayment throughout the nation had also been limited. There was only limited expansion into new geographic areas. Rural organizations comprised only 12 percent of the new prepayment plans established in 1974, up just slightly from the existing 10 percent overall proportion. Movement into underserved areas was similarly slight. Only 8.1 percent of grant funds went to "for-profit" organizations, which could qualify only if they served previously medically underserved populations.174

Equally important in assessing the effectiveness of the federal effort is the extent to which prepayment plans applied for qualification under the Act. As of 1976, only 7 of the existing 181 prepayment plans chose
to accept the requirements for comprehensiveness of services, access for high-risk and low-income and continuing scrutiny for equality of care and other measures. Kaiser Medical Care Entities, which at that time, as now, was serving almost half of the individuals enrolled in any prepayment mechanism, did not choose to apply for qualification.

The third measure of effectiveness, the number of individuals enrolled in the 181 prepayment plans, showed an equally unimpressive gain. The estimated number of persons served rose less than 1 million in the two year period following the passage of the Act.

The failure of the Act to meet either of its objectives, the growth of prepaid group practice plans as a health care delivery mechanism and progress toward the various social goals lies in an inconsistency in the combination of these objectives. The Act tied together the dual choice provision with Federal qualification. Since dual choice provisions could be an effective tool in helping prepayment financed organizations overcome their major problem, generating demand for membership, Congress enacted this to help them grow. However, in order in achieve the "social goals" strategy, the Act tied eligibility for the dual choice provision to Federal qualification. However, Federal qualification
requires that an HMO institute the various mechanisms - provide the "basic services" and offer the "supplemental" services, have open enrollment periods, community rate, and so forth - which lead to the "social goals" advocates objectives. Since the Act provided no subsidies, qualified HMOs have to bear the extra costs involved. The prepaid organization was thus in a contradictory position. It needed the dual choice provision to generate more enrollment, yet bearing the costs required to quality raised the necessary charges beyond what could be sold.

Prepayment plans in general, and HMOs as well, compete with private insurance companies that offer health plans, and with Blue Cross-Blue Shield. All that have been successful, whether prepaid or indemnity, have been characterized by flexibility and price competitiveness.

Flexibility is necessary because of geographic differences in price and benefit levels, as well as variation within individual markets. Any area has families at various levels of purchasing power. Further, even within a single income group, different individuals will have varying preferences as to what part of their resources they wish to devote to health care. Health insurers, prepaid and indemnity, have adapted to this need by a willingness to tailor plans to the price levels
and benefit preferences of the buyers, whether they be individuals or employers purchasing health care for groups of employees.

Price competitiveness is essential for two reasons. The first is that consumers will compare what appear to be similar plans on the basis of cost, and will be sensitive to it. It will not be immediately apparent to them that the costs are related to the comprehensiveness of benefits and, if it is noted, such consumers may not feel the broader coverage is necessary. Sales will therefore suffer. The second reason is likewise related to consumer choice. Those people that perceive the advantage of the comprehensiveness of benefits will be the ones who have already existing extensive health needs, or are more at risk to develop them. These high-risk individuals tend to be the ones who remain while total enrollment in the comprehensive prepayment program suffers. The cost of caring for the average individual rises while total income falls. 178

A qualified HMO's ability to meet the market demand for flexibility and price competitiveness is clearly undermined by the Act's qualification requirements. The mandated "basic services" inhibit the ability to tailor a benefit package to the purchasers's desires and ability to pay. This is particularly true of lower
B. THE CALIFORNIA EXPERIENCE

Though California's experience with the provision of health care services to its Medicaid recipients is not directly related to an analysis of the effectiveness of the Federal effort to increase the prepaid sector of health care it is important to examine it for several reasons:

(1) Questions are raised about the potential for abuse by dishonest providers of care under the prepayment mechanism. The problems of excess non-medical costs, excessive profits and diversion of funds are raised. The propriety of the various structures of the organizations is called into question as is the honesty of the individuals involved. Likewise the possibility of providing poor care by the use of inferior hospitals, incompetent doctors, and regular patterns of withholding necessary care is present.

(2) Questions are raised about the ability to audit quality of care in both fee-for-service and prepayment health care delivery systems. Is it possible to compare the effect on the health of the population of a system with an incentive toward overtreatment, with the effect of a
system with an incentive for undertreatment, fee-for-service and prepayment respectively, assuming that each has the same distribution of human frailties among its personnel?

(3) Has there been equal scrutiny of the fee-for-service sector so that it is possible to conclude that the reported dishonesty, or apparent dishonesty, truly represents a defect in the prepayment mechanism?

(4) The California Prepaid Health Plans represent a significant number of the plans included in the statistics given before, and their growth and subsequent decline are reflected therein.


In 1967 the California State Legislature authorized the California Department of Health to undertake pilot projects to explore the feasibility of different methods of providing health care services. In the following four years, several contracts were awarded to medical groups to determine whether prepayment plans could provide efficient and economical health care services under Medicaid. Preliminary evaluations suggested that such
an approach was feasible and that significant cost savings could be achieved. 184

In turn, The Medi-Cal Reform Act was passed in 1971 to supply services on a prepaid basis to Medicaid recipients. The law stipulated that prepaid health plans, or PHPs, would provide or arrange for health care services for persons who voluntarily enroll and are eligible for California's public assistance programs. For this the state would pay PHPs a fixed monthly premium for each enrolled person for providing health care services. 185

Under the Waxman-Duffy Act, effective July 1, 1973, any carrier or association of providers of medical and health services could qualify as a prepaid health plan if it agreed to furnish such services, either directly or indirectly, on a predetermined periodic rate basis and if a mandated group of benefits was supplied. The minimum health care benefits included physicians services; hospital inpatient and outpatient services; laboratory and X-ray services; prescription drugs; and skilled nursing home care. The goals were a more efficient delivery system, a savings of both medical and administrative costs, and an improvement in the quality of medical services to eligible beneficiaries who chose to enroll in these program. 186
Prepaid Health Plans, in order to operate in California, must also meet the requirements first imposed by the Knox-Mills Health Plan Act of 1970 and later replaced by the Knox-Keene Health Care Service Plan Act of 1975. This established net equity requirements for organizations supplying prepaid care, and varying according to size. Plans were prohibited from spending an excess part of their premium revenue for administration. Access is provided the Attorney General to the books and records of the plans and to those of management firms with which they contract.

The equity requirements under the law were rather moderate. Until 1974, a plan serving more than 5,500 families had a requirement of $30,000. Later amendments established a scale for plans serving over 10,000 families. The equity requirement ranged from $40,000 for 10,000 to 20,000 families to $370,000 for plans serving over 500,000 families.

1. POTENTIAL FOR ABUSE

In actual practice, it was quite easy for anyone to get a contract to serve patients. All that was required was the apparent ability to provide medical services, either directly or through contractual arrangements, to eligible medicaid beneficiaries. The pool of potential enrollees was first the existing patients of a provider,
if the provider was already serving eligible individuals. Beyond that, solicitation could be on a door-to-door basis. Advertising and direct mail were not permitted techniques.

Physicians providing services in areas whose populations consisted largely of medicaid recipients perceived that the new program was a threat to them. Patients with established relationships, who agreed to enroll in a prepaid health plan, would now receive all of their health care needs elsewhere. Therefore, in the face of either an actual or perceived threat to the stability of the provider's income and practice, many were induced to submit applications to become prepaid health plans according to the requirements of the Department of Health Care Services of the State of California. In return the State was to pay the plans 10 percent less than the cost to the State per person in the previous 12 months for total health care, not including expenses incurred for long term mental illness.188

Though some of the early providers recognized that true costs savings would not be possible without a more integrated approach to the problems of the enrolled populations, the programs were limited in scope. Such areas of difficulty included substandard diets and living conditions; drug and alcohol abuse; legal, welfare and
employment support; and long term personal and family social and psychological needs. There were no provisions for dealing with these areas, which many people felt would be channelled into the health care system, even more under prepayment than under fee-for-service, if they were not dealt with otherwise. The provider who accepted the contract did not have any provision made for costs which might be related to such social problems, but was at risk for providing all services which had a health component, even if they were of a type that would be more effectively dealt with through non-medical resources. 189

The enrollment practices of the prepaid health plans were early called into question. There was little direction on the part of the regulatory authorities as to what would be acceptable in the way of practices, nor was there a method developed that could allow efficient, representative and stable enrollments. The prepaid health plan was required to actively solicit members, in practice limited to individual or "door-to-door" canvassing. In addition to adding administrative or sales costs, which need not be borne for the fee-for-service sector which retained all non-enrolled patients by default, it was subject to misrepresentation and other manipulative devices. These tended to be highly
publicized, and the practices of a number of unscrupulous administrators or contractors could make the enrollment process suspect. Additional costs would then be necessary to provide safeguards from such abuses, and to persuade increasingly skeptical reporters, public officials and potential enrollees.\textsuperscript{190}

Outright misrepresentations were alleged to have taken place in the attempts to enroll patients. Initially, enrollments were generated from existing practices of providers. However, this did not provide enough individuals to form an adequately broad risk basis for prepayment. It was then necessary to use patients as enrollers, paying a fee of several dollars for each individual who agreed to become a prepaid patient. These patient-solicitors quickly reached the limits of their acquaintanceships, and of their persuasive abilities, and it became necessary to employ professional sales forces. Since these individuals did not have access to groups, the traditional sources of large numbers of patients in the non-medical prepayment sector, other techniques were necessary. These involved prepared speeches given on a door-to-door basis, appearances at community groups whose members could be persuaded to carry forth the message, and sophisticated materials and brochures. Compensation was either on a per capita
basis, or on a salary plus commission basis. There was very little in the way of training programs, seminars, or instructions in acceptable techniques. 191

Under such circumstances, it was not long before complaints of irregularities surfaced. Investigators for the Permanent Subcommittee on Investigations of the Committee on Government Operations found allegations which included forged enrollments in prepaid health plans, misrepresentations by enrollers claiming to be state and local welfare department employees, and enrollers wearing nurses' or doctors' white coats. 192 Social workers received complaints from beneficiaries that they had been misinformed, coerced, or intimidated into joining a plan, and these beneficiaries later found the benefits were not as available or as good as they had been told. 193 Other reports alleged that patients had been informed that they could continue receiving care from their current doctor if they enrolled in the plan, that they would lose all of their benefits if they refused to enroll, that they would receive merchandise or other incentives, or that certain programs would be available which were not included under any prepayment plan. 194

The enrollment of Medi-cal patients into prepaid health plans through door-to-door enrollment, and the
reported abuses, were the subject of investigations by the Los Angeles Grand Jury, the San Diego County District Attorney's Office, the Los Angeles County District Attorney's Office, and several state agencies. At one time, a temporary ban was placed on door-to-door solicitation in Los Angeles and Orange Counties, in response to such accusations and investigations. However, door-to-door solicitation continued to be favored by the state, and no alternatives were allowed. Safeguards were developed, which included professional standards for the solicitors, training programs, and a taped phone verification system, to insure that the enrolled person did indeed understand what had been said, and understood the plan procedures. Alternatives, such as allowing distribution of materials through state and county level welfare agencies describing all of the available alternatives in health services, were forbidden. The potential prepayment beneficiary did not have an opportunity to compare various plans at the same time, nor to visit and compare facilities and staffs in any organized way. Rather, he might be solicited by several plans at different times, or might not learn of their existence at all. Each plan was required to have an extensive and expensive marketing department, or to generate equal expenses to an outside company.
supplying these services. Each prepaid health plan thus incurred significant expenditures to bring patients into the prepayment system. The fee-for-service sector did not bear corresponding expenses since any patient who did not make a conscious decision not to remain in that sector. 196

Another irregularity of which prepaid health plans in California have been accused is selective enrollment. This is an attempt by the providers, who receive a fixed fee for each individual, regardless of health status, to increase profits by enrolling only the healthiest members of the community. A similar accusation has been made of all prepayment plans, including those that have gained national prestige, such as Ross-Loos and Kaiser, and which enroll members through groups and other marketing techniques which do not include door-to-door solicitation. It is often designated as "skimming." 197

The allegation was that the various prepaid plans attempted to limit the number of sicker members and the expenses occurred in their care, through several methods. One such method would be to prepare a guide for the use of solicitors which would describe visible signs of illness. People who appeared to have such signs would not be given enrollment applications. Other
people might receive forms, but be examined by the plan's physician prior to submitting the application. If significant illnesses were discovered, the forms would not be forwarded to the State and the individuals would therefore not become enrolled in that plan. Sometimes a type of blacklist of such patients was thought to be kept, so that if enrollment was attempted in the future, the plan would not accept the individual. Finally, an attempt was made to choose patients from among the various benefit programs, so as to select those least likely to be ill. 198

In order to understand the use of this last method, it is important to know that the California medicaid program, known as Med-cal pays for health care services to persons in four welfare program aid categories: aid to the blind, the aged, the totally disabled, and to families with dependent children. Those persons who fall into the category of aid to families with dependent children are young people, generally in good health, who make fewer demands on the Medi-Cal program than those persons in the other three aid categories. By concentrating on this last group, through various incentives, including differential commissions to its solicitors, a plan could avoid accepting some of the sicker, and therefore more costly individuals who might
otherwise apply.

Indications that these practices were used by at least some of the prepaid health plans were uncovered by various investigators. However, some of the very practices which would lead to good medical care, could lead to the appearance of actual practice of selective enrollment. For example, it would be important for a conscientious medical care delivery system of any type to know, as quickly as possible, the health needs of its patients, especially if large numbers were being enrolled at once. In that way those requiring immediate care could be identified, appointments could be arranged with health care providers, and facilities could be made ready for treatments, surgery and the delivery of pregnant women. If such information was solicited by a provider who had already contracted to accept the applicant, there would be no complaint. Such a situation exists when new health plan members are enrolled through groups, or when an individual has an open enrollment period on beginning employment, with a plan such as Kaiser. On the other hand, the prepaid health plans with which the Medi-Cal program dealt had not yet agreed to enroll the individual whose health information was being sought.199

It is obviously difficult to know how widespread the practice of selective enrollment was, either under
the prepayment programs to provide care for Medi-Cal beneficiaries or any other community-rated health care program. The practices to discourage enrollment of sicker persons can be indirectly assessed through the percentage of enrolled persons on Aid to Families with Dependent Children. This ranged from 81 percent to 97 percent in a representative group of providers. (Kaiser-Permanente Health Plan had 84 percent of AFDC to total Medi-Cal enrollment.)

Selective enrollment is a technique that is only unacceptable if it is practiced by an organization which desires to be community rate or which is required to do so by law. In the fee-for-service sector, many of the third party payers, particularly the "commercials" (as opposed to Blue Cross-Blue Shield) are experience rated. They may offer different groups, classified by age, employment, or other criteria relevant to pricing health care, different premiums. Direct providers of health care in the fee-for-service sector, the doctors and the hospitals are indifferent for the premium structure. They are concerned with the level of benefits to which the patient is entitled and they have a bias toward treating individuals who are both well insured and sick. In this context selective enrollment must be view as an evil which is relative to other evils,
a very difficult thing to do accurately.

Attempts to disenroll individuals, as the practice of removing persons from the rolls of a prepaid health plan was designed, was an equally difficult practice to quantify. Though it was desireable for a plan to be relieved of the burden of sick patients, the plans could not initiate such disenrollments. The state regulations, in response to individuals who were dissatisfied for any reason, allowed individuals to disenroll relatively easily, though this varied throughout the period in which the prepaid program was relatively widespread. More important, individuals would lose eligibility to participate in the Medi-Cal program when they were no longer cash grant recipients, participating to aid to blind, disabled, aged or families with dependent children programs. Either an improvement in financial circumstances or health condition, on the one hand, or a worsening, requiring admission to a long-term facility, on the other hand, could make a person no longer eligible for the cash grant program or for Medi-Cal. 201

Problems arose when it appeared that health plans were coercing individuals into disenrolling, or when applications for disenrollment were received without signatures. Some of these unsigned disenrollment forms were for individuals who were no longer eligible, were
unavailable to complete the form and for whom the plan was obligated to no longer accept payment from the state. However, it is not clear that all such forms received represented patients who were no longer eligible. There were suspicions that some of these forms simply represented sicker individuals for whom the plan simply no longer wished to provide care. 202

The second major area of possible abuse by the prepaid health plans that contracted with the Medi-Cal program was administrative costs. It appeared in many instances that the expenses for administration of the plans, which were diverted from the provision of health care, assumed too much of the premium dollar.

It is either the stated or implied conclusion of the criticisms regarding costs that there was a disproportionate expenditure arising either from dishonesty of the operators of the prepaid programs or else from an inefficiency inherent in the prepaid system itself. (A third possibility is that the administrative structure used, a non-profit corporation contracting for all services with a multitude of other corporations, most of them for-profit entities as the problem, rather than the prepayment mechanism. This will be explored further below.)

It is difficult to reach any firm conclusions,
since even definitions are unclear. In the provision of medical care, in any setting, costs are allocated between the health care professional, usually a physician, professional supporting staff, such as nurses and licensed therapists, non-professional support staff, clerks and secretaries, supplies, equipment, real estate costs, furnishings, and a host of purchased outside services. It is often stated that a doctor's "overhead" approximates 50 percent of gross receipts. This figure can include many services which would be considered administrative in a more formally structured and larger organization. The accounting needs, supplied by an independent accountant to the individual practitioner become the accounting department, the occasional typed report or letter of the individual practitioner becomes a stenographic department, the intermittent interruption of the telephone becomes a communication department, and so for all the myriad of services needed to support a professional practice, small or large. A statement that 61 percent of a prepaid organization's income went for administrative costs, compared with a maximum estimate by the California Attorney General of 25 percent becomes meaningless, without a line for line comparison of costs for each individual service.
The situation is made even more complicated by the fact that the prepaid health plans bore costs that were not borne by fee-for-service practitioners, both in the beginning and in the long term. When the program was instituted, the providers, who accounted for the greatest number of enrollments were, almost without exception, completely inexperience in the provision of health care services on a prepayment basis. It was not unusual for services to be purchased at one rate which were later made available at a far lower rate. For example, one contract to provide eligibility data for Medi-Cal recipients was entered into for $60,000 a month. Identical services were available two years later for $4,000 a month. This discrepancy was explained on the basis of limited knowledge, limited experience and the paucity of then available services. It could as easily serve as a basis for speculation as to kickbacks, diversion of assets or other illegal schemes. Multiple other similar examples exist. If all could be completely dissected, it probably would be found that some represented dishonesty and others inexperienced and inexpert management.

In addition to costs attendant to inexperience, every business is subject to start-up costs. These arise from the necessity to provide services in minimal
blocks before the demand is present to fully utilize the services. One must buy the desk, even if only one customer a day passes it, must rent the office even if one person a day visits it, and must supply all the myriad personnel and equipment while the demand is building. Such start-up costs will distort the efficiency of any organization and make it impossible to compare it will established competitors. The Prepaid Health Plan program of Medi-Cal did not make any attempt to provide sufficient funding and planning support to its contracting providers.205

In addition to initial problems, the prepaid contractors were subject to costs that were peculiar to the administration of the prepaid system. Among these were marketing and enrollment costs, which were a continuing expense in the fact of turnover in membership related both to patient preference and to varying eligibility of individuals. Additionally the prepaid plans were subject to audits far in excess of fee-for-service providers. In fact, the provider of services on a fee-for-service basis rarely if ever is subject to any scrutiny, the sole exception being the case of outright fraud. Office procedures, practices, accessibility, quality and all other aspects of the practice are tacitly assumed to be influenced, in a salutary
manner by the payment for the services provided. Not so in the case of the prepaid organization. They are subject to the scrutiny of the Federal Department of Health and Human Services, California's Department of Corporations and its Department of Health. Each of these has its own medical and financial audit teams, its own priorities, standards and regulations, and its own calendar. These repeated audits are potentially costly and disruptive, occupying a large proportion of organizational and administrative attention. 206

The third area of possible abuse by the prepaid health plans was in their structure. Charts and diagrams of the relationships between the non-profit organizations with which the Medi-Cal program contracted and the various subcontractors, affiliated organizations and suppliers, of the interlocking directorates and of the personal and professional interrelationships are numbing in their complexity. 207 Their very nature raised questions as to necessity and true purpose. Why would anyone develop such a structure except to confuse those who followed, especially if they might be government auditors in search of previously paid funds?

The first assumption that is generally made when analyzing the structural relationships of prepaid health plans, with such juxtapositions of nonprofit and for
profit entities, is that there is an attempt to siphon off funds that should have been used for medical care. In fact, as in other words which initially have neutral meanings, the very word "profit" came to have pejorative overtones. If any part of the dealings of a prepaid organization were with a related company which was not non-profit, there was a presumption that some malfeasance was in process. Though it was not required by law, the State Health Department would reject proposals from organizations which desired to operate on a profit making basis. In one case it did so, even though the projected profit was expected to be not more than 5 percent, and the organization involved had arranged to use a hospital facility reputed to be one of the best in its county.

In fact, the decision to choose a non-profit structure is a complex one, depending on legal requirements, tax structures, public relations considerations and requirements for financing.

A non-profit company enjoys several advantages. It is able to accumulate funds, for reserves and future expansion, without being subject to corporate income taxes, it can, if structured properly so as to have a charitable purpose such as providing medical service to the poor, receive contributions which are deductible from
the gross income of the contributor. It can solicit contributions for such charitable purposes, and it can enjoy the esteem and goodwill of the public that arises from hearing the altruistic term "non-profit" applied to the organization. However, non-profit companies are unable to secure funding through the usual means available to for-profit companies, debt financing or equity financing, the selling of bonds or stock respectively. They cannot be valued in the usual way, since the traditional techniques used by rating agencies, Moody's or Standard and Poor, do not apply. Since it is not legally permissible to sell stock, there can be no money raised in this way. Conventional lending sources, at the outset, demand individual co-signers, since the organization has not yet accumulated any reserves. Likewise, there is no existing goodwill with the public that would allow any type of charitable solicitation. The only source of initial capitalization is generally the participants or an established sponsor, such as Henry Kaiser, who helped establish the program that bears his name through a combination of loan guarantees and business opportunities.

A traditional business venture is structured with a potential for profit, though, of course, not every one will be successful in showing earnings. In this case
the individual who invests has a potential for earning a greater or lesser return on the money committed. Such participants are generally said to have advanced "risk capital" recognizing the fact that many new ventures fail. These individuals who serve as promoters are last in order of receipt of residual assets, after all debts to employees, suppliers and lenders have been completely satisfied. In most cases, if a venture fails, their investment is completely lost.

Though the potential for a profit exists, unless there are extensive sources of such risk capital, most new ventures are underfunded, and have a great deal of difficulty in accumulating the necessary reserves. In certain cases, such as insurance companies, special statutory methods for accumulating reserves have been established, recognizing both the difficulty of establishing them, and the social desireability that it be accomplished.214

In the face of the prevailing regulatory climate and the advantages and disadvantages present in each business structure, profit and non-profit, it would not be illogical to try and combine the two, if it were possible. Thus, an individual looking at the possibility of establishing a prepaid health plan would see the advantage of the non-profit structure in gaining
organization which is not non-profit in order to provide medical services for its members.\textsuperscript{215}

The success of the Kaiser program, with its ability to provide high quality medical care demonstrates that the organizational structure is not alone sufficient evidence of the intent and motives of the provider. A complex business structure was chosen by Kaiser, to take advantage of the benefits of both the non-profit and profit form of organization, as each can be preferable in different aspects of the same overall venture. The structures of the various prepaid health plans with which the California Health Department contracted were more or less similar marriages of profit making and non-profit organizations.\textsuperscript{216}

When asked why they had chosen complex and elaborate corporate structures, the various prepaid plans advanced several reasons. Among them were the belief that for profit organizations were not eligible for contracts with the State Health Department, the belief that the State preferred non-profit organizations even though it was not required to deal exclusively with them, the necessity to have affiliated for-profit organizations as a mechanism for providing initial capitalization, and the need for affiliated for-profit organizations to serve as guarantors of loans from commercial lending
institutions. Even though prudent business planning could be the basis for planning and using particular relationships between non-profit and for-profit components of a particular organization, it was strongly implied that these relationships constituted an abuse which should be controlled either through modification of Section 501(c) of the Internal Revenue Code, or through some other means.

2. QUALITY OF CARE

The second major issue addressed is the ability to measure quality of care in either the fee-for-service sector or in the prepaid health care delivery systems. The question to be addressed is whether the health of the people served is benefitted more by a system with an incentive toward overtreatment or by a system with an incentive toward undertreatment, assuming the same likelihood that the providers will be honest (or dishonest) under each system.

In a hearing to determine abuses or possible abuses related to the quality of care delivered by prepaid health plans, several speakers represented organizations responsible for surveying the quality of care delivered in hospitals. Among them were physicians associated with the California Medical Association which had had a program of surveying hospitals in the state to
determine the quality of care given to the patients. They are particularly concerned with such matters as the qualifications of health care personnel treating patients, surgical qualification, medical procedure review, adequacy of equipment and medical records of individual patients to determine the quality of care given in specific cases.

The testimony indicated that there were, among a large number of hospitals surveyed, a small number of hospitals which were substandard. The statement was made that some of these hospitals were used by prepaid health plans. The speaker then goes on to cite examples of overutilization of hospital facilities, exactly the opposite practice which would be expected from a prepaid plan which was intending to skimp on services which it is obligated to provide to enrolled members. 219

Another witness at the same hearings described a particularly reprehensible practice of "brokering" patients to hospitals. A hospital administrator would pay bribes to physicians who would admit or transfer patients to their facilities so that medical bills could be incurred. Patients subject to admission would include individuals who were sick and required admission somewhere, healthy patients whose doctors would convince them they were sick, and people with minor injuries
suffered in accidents, whose doctors were working with similarly dishonest negligence attorneys involved in the insurance claim. The patients themselves never know they are being "sold," nor are they ever willing or knowing parties to any fraud.220

Again, this is scarcely a practice which would appear to be profitable or desireable for a prepaid health plan which is eager to avoid unnecessary hospitalization rather than to encourage it. A basic confusion appeared to exist as to what abuses were peculiar to the prepaid health plans, what abuses were common to all Medi-Cal providers, and which abusive practices were definitely not in the best interest of a prepaid health plan under any circumstances.

Quality control in medicine is a particularly difficult concept to define, and even more difficult to measure in practice. One of the attractions of prepaid health plans is that members tend to be hospitalized less, have fewer surgeries and suffer less from the complications of surgery and other iatrogenic diseases. In tandem with these advantages to the patient, the payor, whether it be a public agency or private subscriber is not liable for the costs of these unnecessary service, or of services which are duplications, to no benefit of the patient.221
The very real problem arises, unfortunately, that this behavior, which can be salutary when carried out honestly and with sound medical judgment, can result in poor medical care if necessary care is withheld. It takes considerable medical judgment to make the decision in any given instance, and sometimes the wisdom of hindsight is required.

Allegations that needed care was either denied or substandard were made. These included accusations that instructions to "Do as little as you possibly can for the PHP patient, without reason," were actually displayed in one clinic. Other were inadequate treatment for peptic ulcer disease, misdiagnosis, inability to hospitalized and poor record keeping.

The utilization statistics which supporters of the prepaid concept point to with pride can be used to prove that care is poor. An auditor for the California Health Department concluded:

"It is my belief that all too frequently economics, not sound medical judgement, determines the amount and the level of care received by patients. Under the fee-for-service system, there are no economic deterrents to good care. The doctor provides whatever services are needed. Consequently, he writes his own check. Under the prepaid system, there are deterrents to good medical care."223

Such statements of course do not go unchallenged. Specific examples can be given of care of individual patients which can prove this viewpoint, or its exact
opposite. An example given was a patient who had eight hospitalizations to rule out myocardial infarction during a period of one year. On each occasion no disease was found. After becoming a prepaid health plan enrollee a letter was written to the hospital instructing them to simply give pain medication and refer her to the office of her physician for further evaluation. This was presented as proof that a person on fee-for-service can get good care while enrollment of the individual in a prepaid health plan means the care declines measurably. In response, it was pointed out that this sequence of events could as easily constitute an abuse of the fee-for-service system through overutilization as a withholding of necessary care under prepayment. There was simply not enough information presented to make a medical judgment as to which care had been appropriate and which care had been inappropriate. 224

An additional complicating factor is the inability of Medi-Cal patients, either on a prepayment or fee-for-service basis, to secure necessary non-medical services. Individuals who suffer from drug dependence, who do not have access to adequate housing, who have legal problems they cannot deal with, who cannot afford proper food or clothing or who simply cannot cope with their problems do not necessarily have medical problems. However, they
frequently somaticize their complaints or else turn to the medical provider as the only source of possible help, though this is rarely a satisfactory solution. However, the patient may be willing and anxious to continue medical visits for whatever little support they may provide.225

While such utilization by fee-for-service patients may be lucrative and desireable to the provider, it is devastating for a prepaid health plan. Such services are not recognized for reimbursement and are not limited (individual Medi-Cal patients who are not members of prepaid health plans are limited to two visits a month unless prior authorization can be obtained. A prepaid plan could be required to render such quasi-medical service on a daily basis.)

There are currently no accurate measures of the quality of medical care delivered. No one has ever attempted to measure the quality of care provided by fee-for-service providers in an outpatient setting. On the other hand, audit programs have been developed to measure the quality of care on both outpatient and inpatient bases for prepaid health plans. These are, not surprisingly, rather imprecise. The examples cited above regarding misdiagnosis, poor documentation, improper use and analysis of test results and others by auditors
of prepaid health plans are troubling but, in the absence of comparisons with some standard related to fee-for-service practice, inconclusive. In the absence of adequate standards and criteria, there is frequent bias on the part of the auditor. Audits by two different teams may be contradictory.226

The California Department of Health adopted regulations requiring that the quality of care by prepaid health plans be no lower than that available to beneficiaries under the fee-for-service program. However, in the absence of a complete quality evaluation system to monitor and evaluate the quality under the fee-for-service program, these regulations do not state a legal standard by which to measure the prepaid programs. Thus come the subjective and unreproducible results of audits and the significant administrative costs, both to the State and to the prepaid providers, of repeated audits based on vague and transitory criteria.227

So, in the absence of meaningful measurements, and in the absence of controls on quality in the fee-for-service sector one can draw no conclusions as to the relative benefits to the patients in cases in which hospitalization is not involved. Audits of hospitalizations show wide variations in practice by both types of providers and an inability to differentiate between proper
treatment on the one hand and excessive or inadequate treatment on the other. 228

Thus, one can conclude only that both prepayment and fee-for-service neither guarantee good and appropriate care, nor mitigate against it. Once again, it is not the structure of the organization, but the character and ability of the individuals of which it is comprised, that determines good care.

3. SCRUTINY OF THE PREPAID AND FEE-FOR-SERVICE SECTORS

All health care providers are subject to two types of scrutiny, that of regulators at all levels of government and scrutiny by the public, usually in the form of articles and investigations by reporters for newspapers and the electronic media.

In the last section, one type of regulatory activity, related to quality of care was discussed. Prepaid health plans have been made subject to audits and reports by the California Department of Health, the California Department of Corporations, and the federal Department of Health and Human Services (formerly the Department of Health, Education and Welfare). These are conducted independently, using criteria and standards which are not coordinated and which may be contradictory. In addition, mandated levels of service are provided for
prepaid health plans, which may not correspond to that provided by corresponding fee-for-service providers. This observation applies to plans providing prepaid care under Medi-Cal and applies likewise to prepayment plans which serve private patients.

If additional services are being demanded from prepaid organizations in order to qualify as Health Maintenance Organizations, it might be fair to place the same burdens on other third party payment insurers. Though these insurance companies do not benefit from the dual choice provision directly they are, in fact, the other choice that is available in all instances. Additional services such as health education, social work, special audits and open enrollments are built into the rate which an HMO must charge. In order to provide for true competition, in which comparable packages of services are compared, similar benefits should be available to subscribers to indemnity plans.229

Another question of fair treatment involves publicity. Constant criticism in the press of a few dishonest or inept prepaid health plans - unaccompanied by similar reports of abuses by fee-for-service providers - calls into question the worth of the prepayment concept in its totality. It becomes more difficult to recruit physicians and other health professionals to any prepaid
organization, and employers considering purchase of health insurance for their employees, as well as individual potential subscribers, cannot help but be affected. Though it may be inherent that an organization providing care for many thousands of patients receives more scrutiny than an individual practitioner caring for a few hundred, it magnifies both the real and apparent defects of the prepaid organization, and secondarily affects those prepaid plans which should not be criticized at all.²³⁰ Though the press will often recognize that abuses may be possible under both the fee-for-service and prepayment systems.²³¹ Such balanced judgments form a relatively small part of the total reporting. They simply do not generate the interest that reports of individual scandals are able to provoke.

⁴ PARTICIPATION IN PREPAID HEALTH PLANS

One obvious measure of the effectiveness of the prepaid health care program in California is the number of persons who received medical care. There are some 2 million Medi-Cal beneficiaries in California. At the height of the program, there were 250,000 individuals enrolled in 54 plans. By 1977 only a total of 27 plans were still receiving payments, and they were caring for approximately 191,000 persons.²³²

The Medi-Cal prepaid program was effectively
federalized in 1977 by the amendments to the Health Maintenance Organization Act of 1976. Under the provisions of the modified Act, any prepaid health plan, in order to be eligible to receive medicaid funds, must meet the same standards as those applying to the medicare program. (Medicare standards had always been set by the federal government exclusively, since there was no state involvement in the program. Medi-Cal and other medicaid programs were largely federally funded, but primarily administered by the individual states, operating under broad federal guidelines.) Furthermore, such plans were required to become qualified Health Maintenance Organizations, through application to the Department of Health, Education and Welfare, before they could participate in any state medicaid program. California's Department of Health refused to issue provisional rulings on the eligibility or likelihood of becoming eligible of any individual plan, preferring to await an actual determination of qualification from the federal government.

Qualifications under the Health Maintenance Organization Act has been a relatively slow process. At the end of 1976, there were 25 federally qualified HMOs serving just over 160,000 members. By 1978 the number had grown to 65 organizations. Figures for 1979 showed
215 operational HMOs serving 8,226,053 members. California's 31 operational plans accounted for 45.8 percent of the national total, almost 3.8 million persons. Approximately 3 million of these people were members of Kaiser Permanente. The vast majority of Medi-Cal recipients continue to receive their care under the traditional fee-for-service arrangement.

5. CONCLUSION

The experience under the Medi-Cal prepaid health plan program suggests that the structural and organizational attributes of a health care delivery system are not sufficient to assure cost effective and quality medical care. Neither, are they enough to prevent such care from being given. Prepayment was applied to an existing system which differed from the situations to which it had been previously successfully applied. The major prepayment plans, Kaiser, Ross-Loos, Group Health Cooperative of Puget Sound, and the Group Health Association of Washington, D.C. had directed their efforts at groups of employed individuals, usually through contracts with employers or with trust funds administered by unions. By contrast, the prepaid health plans were required to solicit individuals primarily by door-to-door contacts. The facilities used for inpatient and outpatient care and the providers of
services, under these conditions, were necessarily the same or similar to those existing in the fee-for-service sector of the areas involved.

From the evidence cited above, it does not appear that these plans were either better or worse than the fee-for-service programs available to Medi-Cal beneficiaries. Reaching any conclusion is hazardous, since there are no standards for comparing the most important component, the quality of care afforded the patient. Whether the California prepaid health plan program failed because of dishonesty or incompetence can be debated. What seems relatively certain was that, given the population to be served, the providers available, the facilities to be used, and the mechanism of payment, it was not a clear improvement on the existing system. It was therefore effectively abandoned as a solution to the problem of rising cost.

The most important conclusion to be drawn is that the California experience does not extrapolate to the larger question of the ability of the prepayment plan to compete effectively in providing care to the larger population. Medi-Cal programs, as well as other Medicaid programs, are limited by budgets, social problems, politics and other complicating factors. These do not disappear if prepayment is used. Prepayment in a
Medicaid setting is no more characteristic of prepayment in the broader medical community than is fee-for-service practice under Medicaid comparable to fee-for-service as a whole.
CHAPTER VII
MODIFICATIONS IN THE LAWS AFFECTING HEALTH
MAINTENANCE ORGANIZATIONS

A. HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1976

After the passage of the Health Maintenance Organization Act of 1973\textsuperscript{239} it was expected that a rapid and vigorous implementation of the Act would lead to the development of one hundred or more new HMOs throughout the country. The actual experience in the ensuing three years was one of very slow progress and limited success. Consequently, a review of the provisions of the Act and of the effort of the Department of Health, Education and Welfare to implement it was undertaken by Congress and the administration. A number of findings were made.

The original authorization for appropriations was $250 million. In examining the budget history, it was found that appropriations had fallen significantly short of the authorized amounts. In fiscal years 1974 and 1975, total authorizations for grants was $80 million and for loans, $75 million. Actual appropriations were $40 million for grants and $35 million for loans. Of this, only $22.5 million was obligated under both programs. Several possible reasons were advanced for this, including a lack of interest on the part of
applicants faced with the stringent requirements of
the act, the failure to provide technical assistance to
applicants, and the slow pace at which regulations
implementing the Act were developed. This last introduced
an element of uncertainty, since potential applicants
were unaware of the potential benefits and obligations
that qualification as Health Maintenance Organizations
would entail. 240

The most important regulations were concerned
with the vital "dual choice" provisions which required
an employer who employs more than 25 persons and offers
them a health benefits plan, to offer also the option
of joining an HMO if a qualified HMO exists in the
community in which the employees reside and if the
HMO requests the inclusion. First, it was pointed out
that the employees might reside in an area different
from the place of employment, and that a single employee
might reside in an HMO's service area. Second, and
most important, none of the authors of the original
Act contemplated that it might come into conflict with
the National Labor Relations Act or that it might impliedly
repeal that Act in part. Specifically, if a qualified
HMO existed in the area and requested that it be offered
as an option, the employer might make this offer during
the course of collective bargaining and the union
representing the workers might refuse it. Since the union, under the NLRA, has the exclusive right to bargain for employee benefits, it was unclear whether under these circumstances the employer had satisfied his obligation under the HMO Act of 1973 by making the offer to the union. Else, there would be a requirement to make the offer individually to each employee after the offer had been refused in the collective bargaining setting.\textsuperscript{241} Ultimately, this problem was resolved by allowing an offer to the union to suffice, but a considerable delay took place.

Another identified problem was program administration. Though 125 positions had been created, these were dispersed among 21 different offices within the Department of Health, Education and Welfare. This caused obvious confusion for applicants and made it impossible to ascertain the amount of time and effort that was actually being devoted to the development of Health Maintenance Organizations rather than to other programs concurrently the responsibility of the various departments. Other identified deficiencies in the original legislation thought to be major problems included:

(1) The high cost of providing the required basic and supplemental health services;

(2) the anti-competitive effect of the open enroll-
ment requirement placed on HMOs but not on their competitors, and

(3) the requirement that HMO premiums be community rated while their indemnity insurance competitors could use experience rating. ²⁴²

Particularly troubling were the requirements that alcohol and addition services and preventive dental care for children be included in the required services. The former was generally not an included benefit in insurance plans with which the Health Maintenance Organization would be required to compete and might be quite expensive to provide. Dental care for children, even if limited to preventive services, would be likewise a service not offered by competing insurance programs. It would require the HMO to purchase costly equipment, essentially equivalent to that which is normally used to provide complete dental care, even though it is going to be used only for the more limited purpose of providing preventive care to children. ²⁴³

In order to address these and other concerns the Act was amended. The major provisions included:

(1) **Modification of the Provisions Dealing with Supplemental Health Services.** Under the original legislation, there was no provision to include supplemental health services in the basic package
of services. The organization was required
to make available a number of specified services
which were optional with the members with
regard to whether they would purchase them
and how they would be charged. This proved to
be a cumbersome arrangement since each member
could choose a different set of supplemental
health services with the result that the HMO
must cost out, administer and provide a great
variety of benefit packages. In the 1976
law, it was not permissible for the HMO to
include a health service, required to be offered
as a supplemental benefit, in the basic health
services to be provided for the basic payment.244

(2) Provision of Professional Services. The provi-
sions of the legislation originally passed
in 1973 required that services be provided
by the staff of an HMO, by a group of medical
practitioners, or by members of an individual
practice association. It was not possible
to use a combination of these methods to provide
services according to the most efficient arrange-
ment. The new 1976 law eliminated this provision,
and further allowed for a thirty-six month
period during which a newly formed HMO could use
a group of physicians who would not otherwise qualify as a "medical group" (defined in the law as requiring the coordinated practice of the profession and the substantial responsibility for delivering health care services to the members of a health maintenance organization See (6) below). 245

(3) **Open Enrollment.** The requirement to provide an open enrollment period was suspended for any organization until it had either been in existence as a provider of comprehensive health services on a prepaid basis for five years or else had an enrollment of 50,000 members. After that, the HMO must accept individuals for membership in the order in which they apply for a period of thirty days or until a number of individuals is enrolled equal to three percent of its total net increase in members for the preceding fiscal year from groups which were not in a contractual relationship with the organization at the time of qualification, whichever is less. No individual confined to an institution because of chronic illness, permanent injury or other infirmity which would cause economic impairment to the HMO
need be enrolled.\textsuperscript{246}

\textbf{(4) Definition of Services.} Preventative health services now included (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction. The requirement that preventive dental care for children be included in the basic health services was eliminated.\textsuperscript{247}

\textbf{(5) Community Rating.} The combination of open enrollment and community rating was seen as putting HMOs at a particular disadvantage with respect to competing insurance companies.\textsuperscript{248} In addition to modifying the open enrollment requirement, the new legislation eased the community rating section. In the case of an entity which, before it was qualified as an HMO, provided comprehensive health services on a prepaid basis, the dues structure need not provide for community rating for four years. For grant and loan applicants, adequate assurance had to be presented to the Secretary
of Health, Education and Welfare that the applicant had the intent and ability to meet the community rating requirement within an acceptable time.\textsuperscript{249}

(6) Medical Group Requirements. Medical groups providing services for Health Maintenance Organizations were required to practice their profession in a coordinated manner and have as the principal professional activity provision of services for members of the HMO. This required that a majority of services be directed toward the prepaid patients, even though there might be a transition period during which fee-for-service patients were necessary for financial stability in numbers greater than the prepaid patients. The new legislation removed this requirement, demanding only that the members of the group have as their principal professional activity the coordinated practice of their profession and, as a group, have substantial responsibility for the delivery of health services to members of an HMO.

Other provisions of the Act increased the authorization for grants and loans and moved some of the unused authorization into later years;\textsuperscript{250} allowed loans for
private entities which had previously been eligible only for grants which carried more stringent requirements; \(^{251}\) required the Secretary of Health, Educational and Welfare to administer the program through a single identifiable unit within the department \(^{252}\) and to notify state governments of the restrictive laws which had been preempted to prevent their attempts at enforcement; \(^{253}\) and the Social Security Act was amended to allow only federally qualified Health Maintenance Organizations to provide service to federal beneficiaries under the Medicare and Medicaid amendments. \(^{254}\) (An attempt to prevent abuses like those alleged to have occurred under the California program.)

In the year following the enactment and implementation of the Health Maintenance Organization Amendments of 1976, there was a small increase in membership, approximately five percent, with a total enrollment of approximately six million persons. However, the health maintenance organization concept, or prepayment of a premium to an entity which contracted to provide comprehensive medical services continued to enjoy broad support. Their potential cost savings, through a re-arrangement of incentives and their ability to introduce an element of competition into the health care delivery system, was viewed as highly desirable. Demonstrated
decreases in the rate of hospitalization and innovative programs for providing health care services, as well as quality control, were particular attractions. Therefore, it was decided to reauthorize the program of federal support, and with it provide further revision of the program to allow it more ability to attain its original goals. 255

B. HEALTH MAINTENANCE ORGANIZATIONS AMENDMENTS OF 1978

In 1978, in addition to extending the program, legislation was passed to increase the amount of money authorized and to raise the amount that could be given to individual applicants. Planning and feasibility grants would be awarded until 1983, development grants until 1984 and initial operating loans until 1985. Maximum initial development grants were raised from $1 million to $2 million and loan authority could be as high as $4 million. 256

Previous law had forbidden the use of federal assistance for the construction of facilities. Recognizing that one of the most important cost savings features of health maintenance organizations is the emphasis on the use of ambulatory rather than inpatient facilities, provision was made for the use of loans and loan guarantees for such construction. 257 Similarly, it was apparent that significant expansion of services by an existing
organization to new members, or growth into areas not previously served by the organization, posed many of the same problems as initial development. Consequently, provision was made to make available grants, loans or loan guarantees for the expansion of services or the significant expansion of membership or the area served. 258

Other provisions of the bill were:

(1) A program of training and technical assistance 259 to remedy what appeared to be a major impediment to Health Maintenance Organization growth, the lack of qualified management personnel. 260 Internship programs and technical assistance from the Department of Health, Education and Welfare or from private sources were to be provided.

(2) Payroll deductions were to be required for employees who elected to enroll in an HMO under the dual choice provision. The employer was to be responsible for making such deductions and for paying the money over to the HMO. 261

(3) Financial disclosure provisions were strengthened. 262

(4) Experience rating rather than community rating was allowed for full time students at educational
institutions, recognizing the special insurance usually available to such individuals.

(5) "Natural disaster, war, riot, civil insurrection, and other similar events not within the control of health maintenance organization" became allowable exclusions after a good faith effort to provide the contracted services.

(6) Minor limitations were made on regulatory review under Section 1122 of the Social Security Act.

(7) Authorizations for loans and grants for the program were $31 million for 1979, $65 million for 1980, and $68 million for 1981.

C. HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

Neither of the Health Maintenance Organization Amendment Acts addressed one of the most significant impediments to the growth of health maintenance organization, the Health Systems Agencies and the state Certificate of Need laws. These were efforts to control capital expenditures for health services which required that a provider show there was an unfilled need for a particular service before capital expenditures would be allowed.

These laws were particularly disadvantageous to
prepaid organizations. They were community oriented, so that the prepaid entity could not separately plan for the facilities required for either present or future enrollees. It was effectively required to use facilities in the community. Organizational economies would thus be dissipated. The concentration of providers would become impossible, innovative use of paramedical personnel could be stopped by regulations of outside hospitals, and services could become exhorbitantly expensive since the holders of the facilities to supply them would hold a monopoly provided by the law.

The Health Planning and Resources Development Amendments of 1979 provided that state Certificate of Need programs could no longer require that a qualified Health Maintenance Organization obtain a certificate of need for inpatient facilities if it had an enrollment of 50,000 individuals and if at least 75 percent of the patients reasonably expected to receive services would be individuals enrolled in a qualified Health Maintenance Organization. States could still, if they chose, apply certificate of need requirements to major outpatient equipment, though there were a few states which had legislation to do this. (Most certificate laws covered only inpatient facilities and equipment.) The States were given two years in which to pass conform-
ing legislation so that they could be eligible to continue to receive federal planning funds.

The trend since the passage of the original Health Maintenance Organization Act has been to remove some of the most burdensome requirements so that prepaid organizations qualifying as HMOs could effectively compete with fee-for-service organizations, to streamline the administration of programs so that applicants could qualify within a reasonable period of time, to provide adequate funding for initial development and operations, to reduce the potential for fraud, and to issue regulations to clarify both the obligations and the benefits of qualification as a Health Maintenance Organization. Various provisions might be most important to a given applicant, depending on its size and stage of development. For the large, established prepaid organization, such as Kaiser, the elimination of the Certificate of Need requirement would be a considerable advantage while loans, grants and financial assistance would be inapplicable. All benefit from the clarifications of the vital "dual-choice" provision, the removal of unfamiliar and expensive programs like preventive dental care for children, and the exclusion of dishonest operators from the field. Newly formed and small organizations are most concerned with initial aid, both financial
and technical, to assist them during the difficult period of development and early operations.
CHAPTER VIII

FINDINGS AND CONCLUSIONS

AN ASSESSMENT OF THE SUCCESS OF THE FEDERAL LEGISLATION TO DATE ON HEALTH MAINTENANCE ORGANIZATION GROWTH

I have thus far examined the genesis and rational of the interest shown by the federal government for the prepayment or Health Maintenance Organization concept, the legislative efforts to smooth the way for development of that organizational form into a major source of health care for the public, the early effects of the enactments, and some subsequent modifications. Some applicable factors in the competitive environment have also been examined. As a final effort, I will present suggested additions to the law which I conclude will make the legislation successful in achieving its goals.

AN ASSESSMENT OF LEGISLATIVE SUCCESS

As of 1979, 215 operational HMOs served 8,226,053 enrolled members, according to a census obtained by Group Health News. Of the 215 plans, the 134 group/staff models accounted for 84 percent of the total national HMO enrollment. California accounted for 31 operational plans with 45.8 percent of the national total. Of the entire enrollment of the 215 plans, the various components of the Kaiser Health Care entities cared for approximately 45 percent of the individuals.
Kaiser, as well as some of the other plans currently qualified as Health Maintenance Organizations provided medical and other health care under the prepayment form prior to any federal interest in the structure of health care financing. In assessing the effects of the federal programs, one must subtract the greatest part of their membership. (Some growth may be attributable to the dual-choice provisions. It is not possible to accurately separate growth that actually would have taken place from that which was responsive to the stimuli of HMO programs.) This, the total membership of Health Maintainence Organizations is still less than four percent of total population, and much of the success of this form of financing is unrelated to the legislation passed to stimulate this form of health care organization.

In examining the question of present and future success of Health Maintenance Organizations, several points must be emphasized. First, the very term "success" is subject to a number of definitions. In one sense, the number of individuals who are members of Health Maintenance Organizations which have received federal qualification has grown from zero to more than eight million. This has brought a measure of uniformity to the prepaid programs with regard to their benefit structure and methods of operation. Even the individuals
enrolled in previously existing prepaid organizations can be said to have received some benefit under this interpretation.

On the other hand, only about half of that group of eight million enrolled members are receiving prepaid care that they would not have otherwise received. The remainder would have been members of existing prepaid programs, and would have received benefit packages that differed only minimally from the federally mandated programs. The numerical measure is less impressive than the regulatory one.

When success is measured by the number of individual organizations currently providing care, the results are more impressive. The existing 215 programs represent a much greater base for potential future growth than existed prior to the development of the original Health Maintenance Organization and Resource Development Act of 1973. Organizational growth has greatly outpaced individual membership growth, and the former may be a more significant measure of overall potential.

FACTORS ASIDE FROM THE HMO LEGISLATION WHICH WILL INFLUENCE HEALTH MAINTENANCE ORGANIZATION GROWTH

1. The existing competitive climate is a factor influencing growth and development. Many of the impediments to the growth of Health
Maintenance Organizations, such as denial of hospital staff membership and medical society membership, exclusion from consultation and referral networks, and the use of laws and regulations to discourage the growth of alternative health care delivery systems have been eliminated through means other than the Health Maintenance Organization programs. Thus, some of the growth of prepayment is likely to have taken place anyway, to the extent that this form of health care financing is truly competitive with fee-for-service practice. This is again difficult to quantify, but the success of repaid organizations, even in the fact of such impediments suggests even greater success after their removal, even without specific HMO legislation.

2. Existing and future trends in the health care sector as a whole will have complex and often unpredictable influence on the growth of prepayment. The ratio of physicians to population has shown a significant increase in the last decade after remaining stable for many years. Though some of this increase is likely to be "taken-up" by increasing
technology, the possibility of a surplus of doctors exists for the first time. One effect of an oversupply of professionals is the difficulty an individual faces in establishing an independent practice. This is particularly true if a large initial investment is required for space and personnel so that fixed costs can exceed revenues for an extended period. Such a surplus of doctors would benefit organizations which simply place physicians on staff, without a necessary individual investment, such as group practice or staff HMOs. Furthermore, as competition increases, the true efficiencies of the alternative forms of practice, prepayment and fee-for-service, become more important.

3. Another factor likely to increase the competitive strain on the two forms of practice is the practical limitation on the source of income. The increasing percentage of the gross national product devoted to health care has been documented in Chapter II. Economic reality dictates that this rate of growth cannot continue, since there is increasing resistance to further allocation of resources to any single use
as the proportion that it consumes continues to grow. The fact is that the people who pay for health care, the employed, (through their taxes and insurance premiums,) only use a relatively small part of it. The greatest amount is consumed by those who make no current contribution, the retired and the disabled. There are many other demands in our society that are receiving increasing attention and thereby competing for available monies. In addition, the recent publicized problems with the Social Security Trust Funds have convinced many people that our entire health care financing mechanism represents a variant of a "pyramid" scheme. The individual who does not currently require health care is asked, through both public and private financing schemes, to pay for the care of those who need it, in return for a promise that "someone" will do likewise when he or she is in need. In the face of this, it is unlikely that the growth of health care as a proportion of our GNP will continue at its recent rate. This will inject a further competitive impetus for existing dollars between prepaid and fee-for-service providers.
REGULATION, INCENTIVES AND ABUSE AS FACTORS IN CONTINUED GOVERNMENT SUPPORT AND ACTION

The incentive structure of prepaid organizations was compared to that of fee-for-service providers. As has been extensively documented in the section analyzing the experience with Medicaid providers in California, both systems have a potential for abuse. The current fee-for-service mechanism removes the usual incentive for increases in costs to decrease the quantity consumed by removing the responsibility for payment from the individuals who control the quantity, the consumer and provider. The costs to them are so indirect and the benefits so direct that both are in unspoken agreement that the costs be passed on to a third part who assumes responsibility. The potentials for abuse and indifference to costs are obvious.

In the prepaid organization, abuse takes another form. The revenues are fixed, so profits can be increased by rationing the amount of service delivered, thus lowering costs.

The preference of the government for one or the other system, prepaid or fee-for-service, would seem to turn on how effectively the abuses peculiar to each system can be controlled. It would appear that, despite all the difficulties inherent in measuring quality of
care and optimum levels of treatment, it is easier to set a standard level of care and to require a prepaid provider to rise to that level, than it would be to limit the amount of service provided by the fee-for-service provider, in the face of demands agreed upon by both the patient and the physician. While it is not impossible to impose some form of rationing on fee-for-service, (a physician may be allocated so many resources and be required to decide which patients need them most, for example,) it would be a radical departure from the type of regulatory oversign that is widespread in our country. All public utilities, such as electric and telephone companies, are regulated, and there has been developed an extensive body of knowledge on imposing minimal levels of service. The government employees responsible for administering health care proposals will thus have a bias toward regulating prepaid organizations and a greater chance of controlling potential abuses in such programs. 270

Thus, it would seem that, though both the prepaid and fee-for-service financing mechanisms have potentials for abuse, the former has an incentive structure which better lends itself to regulatory control, and is therefore preferable.

The critical question is whether the present
approach, which balances the additional costs imposed by such regulation - compared with the unregulated fee-for-service sector - against the benefits of the federal loan program, the dual choice provision and the special treatment accorded HMOs under Certificate of Need laws, will ultimately favor prepaid organizations or the fee-for-service providers. As the answer develops, will the modifications required to help one or the other be forthcoming? To this point the political pressures of fee-for-service providers have been modest. Will they continue to be such if Health Maintenance Organizations truly flourish? Likewise, will preemption of the prepaid concept by individual practice associations effectively destroy it?

MAJOR CONCLUSION

The present health care system in the United States suffers from fragmentation, inefficiency and uneven distribution. It should be the goal of the government to support a system of health care that is cost effective, high quality, equitable and humanistic. Health Maintenance Organizations are an excellent vehicle for such a policy and they could be made to evolve into the dominant form of health care delivery. However, since the present state of affairs developed without planning and guidance, a number of difficulties face HMOs in their
struggle to reach their goals. It is both within the interest and the power of the government to support HMOs and to make the necessary modifications in existing law and policy that will allow them to compete fairly and effectively with the fee-for-service sector.

The major conclusion of this study is that in order for the HMO legislation to be effective in its purpose and goals, four critical additions to the law are necessary. They are in the areas of (1) the pricing of insurance, (2) labor relations, (3) taxation, and (4) governmental regulation.

1. COMPREHENSIVENESS OF INSURANCE AND COMMUNITY RATING

Health Maintenance Organizations, by their nature, are responsible for a defined population of beneficiaries. The fee-for-service sector cares for individuals in irregular and shifting patterns. Comparisons are virtually impossible with regard to volumes and quality of services provided. The cost of care for a population receiving fee-for-service care can be manipulated by excluding individuals more likely to require service. This is most effectively done by experience rating of the individuals and groups that are insured.
HMOs are required to **community rate** their populations of members. This is a powerful incentive for individuals and groups of patients with poor health histories to choose the prepaid plan. Those with good experience can and do obtain their care at a lower price through an organization that can insure their health based on experience limited to this group of purchasers.

Closely related to experience rating is the requirement for comprehensiveness. Again, those that are in poor health are willing to purchase broad health coverage, since they feel that they are likely to avail themselves of it. The healthier individuals are willing to purchase less, at a correspondingly lower cost, in order to minimize expenses.

The combined effect here is to make the apparent cost of the care provided by Health Maintenance Organizations **approach** that of the fee-for-service sector. Though this might appear to be accurate it actually understates the cost of fee-for-service. This happens because the prepaid costs can be actually measured for the defined population while it is presently
impossible to know exactly how many individuals assumed to be receiving care from the fee-for-service sector are actually uncared for. The government's approach to this problem should be to extend the same community rating requirement to all insurers and providers of health care. In this way the true cost of caring for comparable populations will become evidence for both the prepaid and fee-for-service sector. Likewise, the government should allow reimbursement to HMOs based on 95 percent of the average per capita cost of such care in the fee-for-service sector, rather than the current reimbursement of actual costs. This will serve as both an incentive and a reward for efficiency.

2. LABOR RELATIONS

HMOs are organized systems caring for large numbers of individuals relative to the fee-for-service sector. As such, they are far more likely to become unionized. They are therefore subject to the expenses of grievance procedures, negotiations and work stoppages. The ability to be flexible in offering packages to hire hard-to-obtain professionals is limited
and competitors can be more successful in hiring such individuals. This can limit the availability of services in the Health Maintenance Organization.

More important, HMOs can face frequent total interruption of services since there are many critical services required. The inability to provide anesthesia, for example, can effectively cripple the provision of services. Likewise with nursing, housekeeping, food services and many others. Members, both potential or actual perceive that the medical care they need might be curtailed at the very time it is most necessary. This is hardly an incentive to growth and dominance.

There must be a recognition on the part of government of this problem. The fee-for-service sector, fragmented and composed of small providers, does not face this problem. Though the right of individuals to organize must be preserved, there should be a mechanism to require that the fee-for-service sector extend the same opportunities to its labor force that have been gained by the workers in the larger Health Maintenance Organizations.
3. TAXATION

Providers in the fee-for-service sector enjoy significant tax advantages that are unavailable to their counterparts in Health Maintenance Organizations. These range from the ability to enjoy perquisites provided by the professional corporation ostensibly for business to the opportunity to fashion better tax deductible retirement and benefit plans. The large group is easier to police, and a single audit or edict has a great deal more effect since many providers are involved, rather than the single individual in a fee-for-service practice. The effect of this is to give a significant monetary benefit, in the form of lower taxes, to the individual who continues in an individual practice. It is incumbent upon the government to equalize this so that providers are not deterred from participating in group practice Health Maintenance Organizations.

4. REGULATION

Another area in which the government has unfairly burdened the Health Maintenance Organization is regulation. Since it is obviously easier to deal with a large number of practitioners in
a single organized health care system than
with the many individuals practicing in their
own offices, the government has chosen to
do just that. Consequently, HMOs have a far
greater cost, per provider or per member,
in dealing with regulation, than does the
fee-for-service sector. This is not only the
time spent in dealing with the regulators,
but the multiple formalities and records that
must be maintained.
The government must be fair. It cannot burden
the one while ignoring the other. Measures
of quality, appropriateness and accessibility
for everyone must be equally applied.
Likewise, another type of regulation is critical.
It is quite possible, and it has been done
in the past, to destroy a competitor by under-
cutting prices until the competitor is gone,
and then to resume previous practices. It
is incumbent upon the government to see that
the prepaid programs supported by insurance
companies which primarily provide fee-for-
service care are fairly priced. Otherwise,
it is quite possible for these insurance companies
to preempt the market while making up losses from
their fee-for-service operations. They can thereby destroy the system which the government seeks to institute.

These are the major components of a government program to support and encourage Health Maintenance Organizations as the cornerstone of a system to provide cost effective, high quality, equitable and humanistic health care. It is incumbent upon our leaders to institute them.
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241. Ibid. p. 14
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244. Public Law 94-460 Oct 8, 1976 Sec. 101 (a) - 101(c)
245. Ibid. Sec. 102(a)
246. Ibid. Sec 103
247. Public Law 94-460. Sec 104
249. Public Law 94-460, Oct 8, 1976 Sec. 105
250. Ibid. Sec. 113 and Sec. 109
251. Ibid. Sec. 108
252. Ibid. Sec. 116
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256. Public Law 95-559, Nov 1, 1978 Sec. 3
257. Ibid. Sec. 5
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261. Public Law 95-559. Sec. 8
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263. Ibid. Sec. 10(a)
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GLOSSARY OF TERMS

Adequate Evidence: A standard of appellate review in which the trial court determination is upheld if there is evidence which is adequate to support it. The appellate court does not undertake an independent review of the evidence.

Adverse selection: Disproportionate insurance of risk who are poorer or more prone to suffer loss or make claims than the average risk. This may result from the tendency for poorer risks, sick people, to seek or continue insurance to a greater extent than do healthy people, or from the tendency for the insureds to take advantage of favorable options in insurance contracts.

Appropriations: In legislation, the inclusion of given amounts of money for various programs in a budget.

Assigned risk: A risk which underwriters do not care to insure but which, because of state law or otherwise, must be insured and is usually handled through a group of insurers.

At risk: The state of being subject to some uncertain event occurring; the term connotes loss or difficulty. In the insurance sense it refers to the chance of loss, through having to provide or pay for more than has been received through premiums or per capita payments.
2 Glossary

Authorization: The determination in legislation of the amount of money which will subsequently have to be appropriated into a budget to carry out the programs mandated.

Basic health services: The minimum supply of health services which should be generally and uniformly available in order to assure adequate health status and protection from disease. These may be defined by the insuring organization or may be set forth by statute or regulation.

Benefits: In prepayment programs, the services provided by a program to a member, whenever, and to the extent needed by a member, under the provisions of the plan.

Beneficiary: Any person eligible as either a subscriber or a dependent, for service in accordance with a contract.

Benefit package: A group of specific services provided or assured by a prepaid plan to its subscribers.

Blue Shield Laws: State legislation which allowed insurance companies sponsored by county and state medical societies to function as health care insurers.

Capitation: The amount of money required per person for a prepaid plan to provide covered services for a period of time.

Carrier: An insurer, an underwriter of risk.
3 Glossary

**Community-rated premium:** The practice of setting rates or premiums according to the experience throughout the community rather than according to individual claim experience or the experience of various groups.

**Contract group:** A specific group of persons who are to be provided a particular program of benefits.

**Conversion privilege:** The provision that allows a member enrolled through a group to convert, regardless of age or physical condition, to a direct pay program at the time of retirement or other separation from the group.

**Dependent:** A person other than the subscriber eligible to receive care because of a subscriber's contract.

**Direct payment subscribers:** Persons enrolled in a prepayment plan whereby individual premium payments go directly to the plan, rather than through a group.

**Dual Choice:** The practice of giving individuals a choice of more than one health insurance program to pay for or provide their health services.

**Equity:** The value of the owners shares of assets after all obligations are met. Also, a judicial system which provides remedies beyond those available in ordinary courts of law.
Glossary

Experience rating: The rating system by which a plan determines the rate by the claim experience or an individual or group. This is the common underwriting system in casualty insurance.

Fee-for-service: A system of payments in specific amounts according to the service rendered, as opposed to salary or other contractual arrangements.

Fiduciary: A relationship whereby one individual assumes a position of responsibility for the welfare of another and, in this position of trust, is held to the highest standard of care and honesty.

Fixed costs: Costs which do not change regardless of the volume of goods or services which are provided.

Group health plan: A plan which provides health services to persons covered by a prepayment program through a group of physicians who have aggregated into a single entity.

Health Maintenance Organization: A prepaid plan which has developed an organized system for providing health care and supplying a set of health services to a voluntarily enrolled group of persons for a predetermined, fixed, periodic payment regardless of the level of use of services. Sometimes this designation is reserved for prepaid groups which have received federal
Hospital Affiliation: The hospital or hospitals with which a plan contracts to provide the hospital benefits of the plan.

Indemnity: Reimbursement or payment for obligations incurred by an insured.

Independent Review: A standard of appellate review in which the court undertakes a review of the evidence independent of the trial court and makes its own determination as to the weight of evidence.

Individual practice association (IPA) a partnership, corporation or other legal entity which has entered into an arrangement for the provision of services with persons who are licensed to practice medicine, dentistry, or perform other health services and which arrangement provides that such persons shall supply professional services in accordance with a compensation arrangement.

Obligations: A debt or agreement to pay. In administration of government programs, the assignment of appropriated funds to a particular contract or application.

Open enrollment: A period when new subscribers may elect to enroll in a health insurance plan or prepaid group practice on a first come basis, without regard
6 Glossary

to health or previous utilization of services.

Out-of-area benefits: Those benefits that a plan supplied to its subscribers when they are outside of the area in which the plan ordinarily provides services. They are generally limited to health care services required in an emergency.

Pre-existing condition: A physical condition which existed prior to the issuance of an insured person's policy, which may result in a limitation in the contract or coverage for benefits.

Premium: A prospectively determined rate that an insured pays for the protection purchased.

Prepaid Health Plan: A generic term for an organized system for providing health care and supplying a set of health services to a voluntarily enrolled group of persons for a predetermined, fixed, periodic payment regardless of the level of use of services. This is sometimes referred to as a Health Maintenance Organization though that term is properly reserved for those prepaid plans which have met the requirements for federal qualification.

Service area: The geographic areas within which a plan provides direct benefits to prepaid subscribers.
7 Glossary

**Skimming:** In health programs paid on a prepayment basis and in health or other insurance, the practice of seeking to enroll the healthiest people and best risks as a way of controlling costs.

**Skimping:** The practice of denying or delaying the provision of services needed or demanded by members as a way of controlling costs in a prepayment health program.

**Stop loss:** Insuring with a third party against a risk which an insurance company or prepaid plan cannot manage financially. (Also known as *reinsurance* or *laying-off* of risk.)

**Utilization:** The extent to which a given group uses specified services in a given period of time; usually expressed as the number of services per year per 100 or 1,000 persons eligible for the services.

**Working capital:** Refers to available assets which can be quickly applied to current expenses and obligations.