THE DEVELOPMENT AND IMPLEMENTATION OF FEDERAL POLICY
CONCERNING HEALTH MAINTENANCE ORGANIZATIONS

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By

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ABSTRACT


There is some controversy which centers around the question of whether a particular government policy or program may be judged successful. This dissertation takes the position, with due respect to the difficulties of such a task, that policy success can be evaluated and that it is important that such evaluations be made.

Traditionally, health care in the United States has been delivered by the solo medical practitioner on a fee-for-service basis. A relatively new concept in the health care delivery system combines group practice with prepayment for services. These types of practices were designated as Health Maintenance Organizations in 1970 by the Nixon Administration.

The major question of this dissertation is whether or not the HMO policy of the federal government has been a success. Along with this question the primary focus of this dissertation is upon the development and evolution of the federal HMO program. The dissertation shows that the HMO program of the federal government has not been a success
and that numerous factors account for this lack of success. Some of these factors are opposition from organized groups, difficulties in adapting HMO's to the traditional system of American health insurance, conflict with other federal health programs, and problems in the administration of the HMO program. Finally, a framework is presented for evaluating HMO's as a health care concept in general, including a discussion of the advantages and disadvantages of HMO's.

Interest in HMO's has been largely in response to the tremendous escalation in health care costs in recent years. The growing national debate over hospital cost containment and national health insurance center a great deal of attention on HMO's as the delivery system of the future. Whether HMO's are indeed as efficient and rational as their supporters claim are important national questions. Thus far, HMO growth has not lived up to the rhetoric of its early supporters. From evidence presented in the dissertation, future prospects for HMO growth are also taken into consideration.
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Traditionally, health care in the United States has been delivered by the solo medical practitioner on a fee-for-service basis. A relatively new concept in the health care delivery system combines group practice with prepayment for services. Before 1970 this type of practice was known as a prepaid group practice (PPGP).

In 1970 the Nixon Administration began a major effort to promote prepaid group practices, designating them as Health Maintenance Organizations (HMO's). The principal HMO advisor of the Nixon Administration was Paul M. Ellwood, M.D. Not only did Ellwood coin the term "Health Maintenance Organization," but he shaped it into an ideological concept that was acceptable to the Nixon Administration. Ellwood viewed HMO's as a device to promote competition and "pluralism" in the health care field (2, p. 132).

Prototypes of modern HMO-type organizations go back to the 1920's and, some contend, even earlier. In 1929 Michael Shadid, M.D., established the Elk City, Oklahoma, Community Hospital Association. This association was a prepaid medical cooperative for farmers in a Dustbowl-stricken area of Oklahoma (7, p. 313). In 1942 the Kaiser Foundation established
a prepaid group medical practice in Southern California. During World War II, Kaiser provided medical care to steel workers in this region. Membership was made available to the general public in 1945 (4, p. 84).

Although there has been some growth in the number of prepaid group medical practices since 1945, according to Ira Greenberg and Michael Rodburg they have remained out of the "mainstream" in terms of health care delivery modes in the United States (5, pp. 933-934). Until the early 1970's, PPGP growth in the United States was not a product of governmental incentives. Increases in the number of PPGP's was basically due to physician and consumer group initiative (5, p. 982).

In the early 1970's the Nixon Administration assumed that, with governmental support, there would be a large increase in HMO growth and the past record of slow PPGP growth was not seen as an inhibiting factor to rapid change (3, p. 391). This dissertation will investigate why HMO's have not become as successful as early proponents predicted. In 1971 the Nixon Administration estimated there would be 1,700 HMO's serving 40 million Americans by 1976 (6, pp. 1443-1444). In 1978 the Department of Health, Education, and Welfare (HEW) reported there were only 79 federally-qualified HMO's in the United States with a membership of 4,785,442 (8, p. 1). A federally-qualified HMO is one that complies with the HMO Act of 1973.
Subsequent chapters will examine the reasons behind the HMO movement's lack of success. The focus of Chapter Two will be on HMO definitional problems and organizational characteristics. The problem of defining what an HMO is has impeded Congressional action and also the public's understanding of HMO's in general. From an organizational standpoint, HMO's have not been immune to the management, personnel, and financial difficulties that plague other organizations.

Another reason the HMO movement has not been a success may be opposition from organized groups. Chapter Three will examine the nature and scope of the opposition of organized groups to the federal government's efforts to promote HMO's. Before HMO's are widely adopted, they must also overcome or adapt to well-established private and governmental health insurance practices. Another possible explanation for the slow growth of HMO's may be the difficulties encountered in transferring established private and governmental insurance practices to HMO operations. Chapter Four will investigate the differences and similarities between HMO's and traditional private health insurance practices. Chapter Five will trace the difficulties that have been encountered in adapting HMO's to the federal government's Medicare and Medicaid programs.

According to Robert Alford, there is little valid information concerning the cost or quality of different
health delivery systems and the results of these studies are in conflict (1, pp. 247-248). Conceptually, HMO's have promised to offer higher quality health care at a lower cost than traditional fee-for-service medicine. Chapter Six will deal with the health economic problems that perplex policy makers. It will show how federal support for HMO's has been stalled by the difficulties encountered in attempting to evaluate the costs and benefits of a relatively new health delivery system.

Congressional hearings have revealed that many of the delays in the federal HMO program have come from the fragmented manner in which the HMO Act was administered. Witnesses have also questioned the ability and expertise of HEW to administer the HMO Act. Therefore, Chapter Seven of the dissertation will be devoted to the assumption that HMO growth in the United States has been impeded by the difficulties in the administration of the federal HMO program.

Interest in HMO's has been largely in response to the tremendous escalation in health care costs in recent years. The growing national debate over hospital cost containment and national health insurance center a great deal of attention on HMO's as the delivery system of the future. Whether HMO's are indeed as efficient and rational as their supporters claim are important national questions. Thus far, HMO growth has not lived up to the rhetoric of its early supporters. This dissertation will, therefore, trace the
policy evolution of a major new concept in the health delivery field and, from a careful examination of the problems encountered in the federal HMO policy, it may be possible to provide additional evidence regarding the incremental nature of policy change in the United States. It is also the intention of this dissertation to contribute some clues as to the kinds of obstacles that must be overcome in order to achieve substantial change in the HMO field. In addition, the dissertation may provide a framework for evaluating the advantages and the disadvantages of HMO's and to offer some insight into the question of whether HMO's will become more successful in the future.
CHAPTER BIBLIOGRAPHY


CHAPTER II

THE FEDERAL HMO INITIATIVE

History of HMO Legislation

The Nixon Administration sponsored legislation in 1971 to promote Health Maintenance Organization development through grant and loan programs that would total $4.2 billion by 1976. This Administration also wanted to encourage HMO development through Medicare and Medicaid funds. In 1972 the Health Subcommittee of the Senate Labor and Public Welfare Committee held hearings on HMO bills sponsored by the Nixon Administration and by Edward M. Kennedy (U.S. Senator from Massachusetts). On September 20, 1972, the Senate passed a Kennedy-sponsored HMO bill, which authorized over five billion dollars for HMO development (27, pp. 771-773). The Subcommittee on Public Health and Environment of the House Interstate and Foreign Commerce Committee held HMO hearings in April and May of 1972 on several HMO bills. On September 21, 1972, the Subcommittee reported an HMO bill to the full Committee, but the House did not pass HMO legislation in 1972 (27, p. 774).

During the campaign of 1972, HMO's lost favor with the Nixon Administration. This change in attitude is attributed to opposition from organized medicine (13, p. 53). In 1973 the Kennedy HMO bill, which was similar to the bill approved
by the Senate in September of 1972, was reduced to $800 million by the Senate. In 1973 William Roy (U.S. Representative from Kansas) and Paul G. Rogers (U.S. Representative from Florida) co-sponsored HMO legislation in the House. Concerning the House HMO legislation, Patricia Bauman asserts, "From the outset the House bill was less global in its objectives than the Senate's, both in intent and dollar authorizations" (2, p. 134).

On December 29, 1973, President Nixon signed a compromise version of the Senate and House HMO legislation that became the HMO Act of 1973 (Public Law 93-222). The Act set up organizational, service, enrollment, and quality assurance standards for federally-qualified HMO's. The Act also provided feasibility, planning, and initial development grants for HMO's. The $375 million authorized by the HMO Act of 1973 was a compromise between the House HMO bill (H.R. 7974), which authorized $240 million over a five-year period, and the Kennedy-sponsored Senate HMO bill (S. 14), which authorized $805 million over two years (20, pp. 499-505).

In 1975 Congress heard testimony from numerous groups involved with HMO's that the 1973 HMO Act placed too many restrictions and service requirements upon HMO's to enable them to compete successfully in the health marketplace (15, p. 608). In 1976 Congress, in Public Law 94-460, passed amendments which reduced the service, organizational, and
enrollment standards of the 1973 legislation, in order to promote more competitive HMO's.

Oversight hearings in 1976 revealed that HMO-type organizations in California had not complied with their legal or service obligations. The California HMO scandals have caused many to question the integrity of the entire HMO concept. In 1978 Congress amended the HMO Act to place stricter controls on the financial disclosure procedures of HMO's. The amendments also provided for an HMO management intern program to provide training for HMO administrators. The HMO Amendments of 1978 (Public Law 95-559) extended the federal HMO program through 1981.

The HMO Definitional Problem

The HMO identity question is of considerable importance to health care policy makers. But it is a question which has resisted the confines of a single definition. In 1974 Paul M. Ellwood argued that the HMO was a concept whose time had arrived. He stated,

The HMO idea is viable because it does not insist that providers and consumers adhere to a single organizational structure, but instead allows structural variety. It is built upon the entrepreneurial and free enterprise spirit traditional in the United States (10, p. 86).

Ellwood devised a market-oriented HMO strategy for the Nixon Administration, in which "the invisible hand" of the free market would minimize government intervention into the health sector. Patricia Bauman contends that Ellwood was
naive in thinking that HMO's would be self-regulating mechanisms. She adds, "In practice this proved utterly impossible. . . . Government could not avoid thorny problems of definition, standard-setting, monitoring, and enforcement" (2, p. 132).

In a 1972 hearing by the House Interstate and Foreign Commerce Committee's Public Health and Environment Subcommittee, Ernest W. Saward, M.D., President of the Group Health Association of America, said that an HMO incorporated five basic principles. These included prepayment, group practice, a hospital-based plan, voluntary enrollment, and comprehensive benefits (36, pp. 182-183). Merlin Du Val, Assistant Secretary for Health and Scientific Affairs in the Department of Health, Education, and Welfare, testified before the Senate Labor and Public Welfare's Health Subcommittee on July 20, 1971. He stated,

Under prepayment methods, members pay a fixed amount, within which HMO’s must operate, thus creating a strong incentive for these organizations to do as their name implies—to maintain health and prevent illness and the progression of disability, and to uncover latent health conditions before they have advanced to the stage of great suffering and large cost to the patient as well as the organization (47, p. 110).

The HMO definitional problem includes within it the difficult task of deciding whether or not a PPGP or group practice-like organization is really an HMO. On one hand, there is the viewpoint that classifies almost any kind of health organization as an HMO. This is the position taken by Ellwood. Saward, on the other hand, outlined five basic
principles which point toward a more restricted HMO organizational format.

The Blue Cross Association of America claims that under existing insurance arrangements a majority of Americans already have prepayment for many medical care costs. It has also been noted that a significant proportion of U.S. doctors already practice in groups (8, p. 22). The HMO definitional problem, therefore, concerns not only the mesh, but also the dissimilarities, between the HMO concept and current health insurance and group practice arrangements. Paul Starr claims,

In the last few years, intermediate structures combining elements of group practice and foundation plans have proliferated in bewildering variety suggestive of the adaptability of the HMO concept to diverse economic interests and political environments (29, p. 72).

The definitional problem associated with HMO's also leads to conflicting reports concerning number of HMO's and size of HMO membership. The Department of Health, Education, and Welfare in 1970 claimed there were 33 HMO-type organizations in the United States with 3.6 million members (15, p. 608). Another source, however, contends that 7 million members were enrolled in 135 PPGP's in 1971 (47, p. 113). The variation between these two reports is considerable and causes further complications when one attempts to determine whether or not the "HMO movement" has been a success.
Closed Versus Open Panel HMO's

Defining an HMO has been a source of considerable confusion. In 1973 the House Committee on Interstate and Foreign Commerce stated that a Health Maintenance Organization was an "umbrella" concept which included varied types of organizations. These ranged from the Kaiser model, which represented a closed-panel group practice where staff doctors work on a salaried full-time basis, to an open-panel HMO, where doctors were bound together only by a loose contractural arrangement (38, pp. 9-11).

The 1973 HMO legislation in Section 1301 (a)(3) stated that HMO services ". . . shall be provided through health professionals who are members of the staff of the health maintenance organization or through a medical group (or groups) or individual practice association (or associations) . . . ." (41, p. 915). The HMO Act recognized three types of HMO's. The staff HMO is an arrangement in which physicians receive salaries directly from the HMO and practice in a clinic setting. In a group practice arrangement, the HMO contracts with a medical group, partnership, or corporation of health professionals to provide care. This HMO model, like the staff HMO, involves centralized group practice. In a group practice HMO, doctors are usually paid a salary based on the number of patients they treat. An Individual Practice Association (IPA) is often referred to as an open-panel HMO. In this arrangement, the HMO is paid a monthly premium by its subscribers. The HMO then contracts with individual doctors.
to provide health services (6, pp. 94-95). Since IPA doctors are not centralized in one location but generally dispersed throughout the HMO service area, the IPA has been referred to as an "HMO without walls."

According to Edmund K. Faltermayer, the Kaiser closed-panel model has many advantages. Access is easy because of a centralized practice. Referral is facilitated by the inclusion of many specialties within a single clinic. In the Kaiser Organization, hospitals adjoin outpatient facilities. In the large HMO clinic, the consumer is in a position to be selective and choose his doctor on a comparative basis. In the closed-panel HMO, doctors are spared financial and administrative responsibilities and concentrate their energies on patient care. Peer review is facilitated by the close proximity of physicians (12, pp. 82-83). In 1972 HMO hearings, Harold Newman, M.D., Director of the Group Health Cooperative of Puget Sound, argued that a hospital-based HMO was the most efficient type of HMO (36, p. 209).

In 1972 the American Medical Association claimed that closed-panel prepaid practice would not work in a rural setting or with the "high risk" population in the ghetto (36, p. 337). The American Dental Association also thought that the proposed HMO legislation placed too much emphasis on one model, the closed-panel HMO (37, p. 1477). In the first session of the Ninety-Second Congress, Kennedy recognized that the Kaiser closed-panel HMO had highly specialized
requirements. These included an industrialized community with a recession-resistant industry and a per capita income between $8,000 and $12,000 (47, p. 113).

Herbert E. Klarman credits Ellwood, an HMO advisor of the Nixon Administration, for putting the closed-panel prepaid group practice into the same package with IPA’s, which he claims are creatures of local medical societies. To Klarman, the real identity of an HMO is often perplexing to the consumer (19, p. 120). Ownership, profit status, and service provisions of an HMO are areas in which the consumer may be confused.

Under a medical foundation, which closely resembles an Individual Practice Association HMO, doctors agree to a predetermined fee schedule and allow their bills to be evaluated by the foundation. George A. Silver contends that this type of supervision is "least onerous" to doctors, due to the fact that control is usually under the direction of the local medical society (28, p. 280). Silver alleges that, "Physicians have to be particularly social-minded to allow themselves to be placed under the relatively light discipline of the foundation or the more comprehensive supervision of a prepaid group practice" (28, p. 281).

The IPA may be regarded as a much less radical form of HMO and less of a departure from the traditional practice of medicine than the closed-panel HMO (17). Some believe that an open-panel HMO, with its established patient-physician
relationships, has a competitive advantage over closed-panel HMO's (3, p. 695). These sources contend that families with young children are more likely to be attracted to an open-panel HMO, if it offers a wide range of services and is competitive from a market standpoint. They see the young, the middle-aged, the middle-income group, and the employed as being the primary target group of newly-started HMO's. Low income, they claim, is positively correlated with the tendency to join closed-panel HMO's (3, pp. 695-696).

A study by Anne Scitovsky, Nelda McCall, and Lee Benham showed that the choice between an open- and closed-panel HMO is affected basically by income and distance from home. Lower-income individuals tended to choose a closed-panel HMO due to cost. Upper-income individuals placed primary emphasis upon proximity and convenience and personal physician care (26, pp. 672-673). They also found that the length of a plan's existence was important. Upper-income members tended to stay with the open-panel plan, despite its higher costs. This behavior was attributed to established physician ties (26, pp. 672-673).

The question of whether the closed- or open-panel HMO should have legislative priority has been the subject of controversy among committees. Organizational requirements of HMO legislation have tended, however, to favor neither the open- nor closed-panel HMO format.
Federal Organizational Requirements

In 1972 Elliot Richardson, Secretary of HEW, testified in favor of H.R. 5615, the Administration-sponsored HMO bill. He said that an HMO was a "comprehensive health care delivery system." He saw HMO's as being varied from an organizational point of view. To Richardson, HMO's included prepaid group practices and IPA's (36, pp. 57-58).

The 1973 Senate HMO bill (S. 14) promoted by Kennedy was biased in favor of the closed-panel HMO structure. Kennedy's Health Subcommittee reported that administrative centralization was one of the primary reasons behind HMO economy. According to the report, a closed-panel HMO enables a variety of health care personnel to be integrated into a close-knit team (43, p. 15). The Health Subcommittee stressed that, before an HMO can be a workable unit, its doctors must have virtually no fee-for-service income (43, p. 16). Individual Practice Association doctors receive income from both HMO patients and also from fee-for-service patients.

Senate HMO bills in 1972 and in 1973 required HMO services to be provided by the HMO staff or through a medical group. According to the Senate bills, a medical group had to consist of at least four physicians or dentists (40, p. 34). The 1973 Senate HMO bill was designed to promote closed-panel HMO's. The Senate Committee on Labor and Public Welfare maintained that this type of HMO, with its central location, was well-suited for areas of high urban density.
Not only did a central location encourage accessibility, it provided for continual evaluation. Centralization of records, according to the Senate Committee, made diagnosis and treatment easier (43, pp. 9-10).

For communities unable to support closed-panel HMO's, the Committee argued that "supplemental" HMO's might be more advantageous. These included medical foundations and IPA's. Senate bill S. 14 gave limited financial support for supplemental HMO's. Only 17.5 per cent of the loans and grants provided for HMO's under this bill were reserved for this type of HMO (43, p. 21). The Senate report argued that supplemental, open-panel, or individual practice HMO's would develop without federal assistance, since their capital requirements were much less than the closed-panel HMO (43, p. 22).

House HMO legislation introduced in 1971 defined a medical group as "... a partnership or other association or group who are licensed to practice medicine, osteopathy, or dentistry in a state and who ... as their principal professional activity and as a group responsibility, engage in the coordinated practice of their profession" (35, p. 7). This bill required that HMO providers pool their income and distribute it according to a predetermined plan (35, p. 7).

In 1973 the House HMO bill defined an IPA as a "... partnership, corporation, association or other legal entity which has entered into an arrangement (or arrangements) with
persons who are licensed to practice medicine . . ." (34, p. 72). Use of allied medical personnel, sharing of records and equipment, and provision of continuing education was encouraged by this bill. It also left physician compensation arrangements up to the IPA (34, pp. 72-73).

The 1973 Conference Committee adhered basically to the organizational requirements of the House bill. Health Maintenance Organization's had to provide basic services through its staff, medical groups, or by an IPA (40, p. 35). The 1973 legislation distinguished a medical group from an IPA by declaring that the health professionals of the medical group must devote their "principal professional activity" to the HMO (41, pp. 918-919).

In November of 1975, Harry Stamey, of the American Group Practice Association, told the Subcommittee on Health of the Senate Committee on Labor and Public Welfare that the 1973 HMO law's requirement that professional members of a medical group devote more than 50 per cent of their practice to HMO's was a serious mistake and a real obstacle to HMO growth. With modifications in the law, he claimed that group practices could furnish a strong base for future HMO growth (44, pp. 368-369).

In these same hearings, Steven Epsteine, Counsel to the American Association of Foundations for Medical Care, argued that the 1973 HMO Act's requirement that IPA foundations operate as two corporations was a duplication of legal and
business practices. He also maintained that IPA's could offer HMO-type care, "... not under one roof, as in a group practice --but as a 'clinic without walls' ..." (44, p. 375).

David F. McIntire, Benefits Manager for General Mills Corporation, said that the 1973 Act's principal activity provision was a handicap to two Minneapolis group clinics in becoming federally-qualified HMO's. In both clinics, 90 per cent of the work was done on a fee-for-service basis. He claimed that, in Minneapolis, experience showed that the merging of fee-for-service group practice with HMO-like practices was a successful idea (44, p. 322). Edward L. Field, who represented Federated Department Stores, objected also to the legislative restrictions on the amount of time a group practice doctor had to devote to his HMO practice. He was of the opinion that a doctor's HMO time should be determined by market demand (44, p. 318).

In the report on its HMO Amendments of 1975, the House Committee on Interstate and Foreign Commerce admitted that the 1973 Act's requirement that professional members of a medical group devote over 50 per cent of its time to HMO service had proven difficult to achieve in practice. The report stated that a medical group could not be converted from a fee-for-service operation to an HMO overnight. The House amendments (H.R. 9019) would permit a five-year waiver of this requirement (39, pp. 19-20). The Committee
recognized that the 1973 HMO legislation prevented an HMO from using various combinations of provider sources. House bill H.R. 9019 proposed to permit HMO contracts to include various combinations of provider arrangements (39, p. 12).

The 1976 HMO Amendments stated that an HMO could provide medical services through any combination of staff, medical groups, or IPA's (42, p. 1945). The 1976 Conference Committee accepted the position that, in obtaining professional services, an HMO could contract with individual professionals in addition to a medical group or an IPA. However, the amount of contracted service could not exceed 30 per cent of HMO physician service in rural areas or 15 per cent in an urban area (32, p. 20).

The 1976 HMO Amendments followed the Conference Committee's recommendations on altering the "principal professional activity" section of Public Law 93-222. The medical group requirements state that the group "... as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization" (42, p. 1948). A substantial portion of a medical group's time devoted to HMO service was interpreted by the Committee to mean 35 per cent of the group's time (14, p. 544). The 1978 HMO Amendments permit HMO's to use medical groups that do not meet the
organizational requirements of the Act for a period of up to forty-eight months (33, p. 21).

The reduced organizational requirements, in terms of provider arrangements, enables HMO's to provide medical services through a large number of possible arrangements. This, according to an HEW official, is a definite advantage to HMO's. It offers flexibility and promotes convenience for HMO members (18). For states with laws which prohibit the corporate practice of medicine, it allows HMO's to use IPA's and medical groups to a larger extent.

Federal HMO Subsidies

In 1973 the House Committee on Public Health and Environment, chaired by Paul G. Rogers, recognized the difficulties that new HMO's had in getting started (38, p. 8). The House bill H.R. 7974 authorized three types of grants for HMO's. One category of grants was for HMO feasibility studies. The House report stated that feasibility studies should be designed to show interest of consumers, providers, and major employers in HMO's. The report said that these studies should focus on the availability of skilled management and state laws concerning HMO's. The House Committee saw the feasibility grants as the first stage in the federal HMO investment (38, p. 24).

The Committee Report expressed the hope that feasibility studies would enable HMO's to avoid conflict with existing health programs. State comprehensive planning agencies were
expected to oversee HMO applications and HMO's should work to enlist the support of local medical societies. The report also said that feasibility studies must be completed in twelve months after a grant was made (38, pp. 24-25). The report stressed that HMO management must have a thorough knowledge of its service area to be effective (38, pp. 11-12).

The 1973 House bill also gave the Secretary of HEW the authority to award planning and development grants to HMO's for two years, if adequate progress was being made by HMO's in expanding its membership and services and if the HMO showed continued cooperation with planning agencies and with its local medical society. These grants were designed to prevent HMO start-up failure (38, pp. 26-28). The bill also authorized the Secretary of HEW to make loans and loan guarantees available to HMO's in their first thirty-six months of operation. The House conditioned loan and grant approval on HEW's having access to HMO records (38, pp. 29-30).

The 1973 Senate bill provided HMO capitation grants which were not authorized by the House. Capitation grants were provided for individuals unable to pay their own expenses. Senate subsidies were designed to cover part of the cost of the HMO premium. The Senate bill would authorize the Secretary of HEW to take both public and private funding into account in making capitation grants. A three-year limit was placed on this type of subsidy. The Committee
expected a national health insurance law to be in effect by that time (38, p. 29).

Senate bill S. 14 contained no provision for loan guarantees to profit-making HMO's. The Conference Committee accepted the House provision for providing loan guarantees to profit-making HMO's (31, pp. 39-41). Initial development was defined by the Committee in accordance with the Senate formula, which included enrollment expansion, arrangements for health services, development of internal organizational format, and recruitment and training of personnel. The Conference Committee, however, added the House's four-year limit for an HMO's initial development program and the House provision that initial development grants be contingent upon the Secretary's approval of sufficient feasibility planning (31, pp. 41-42).

The Conference Committee version authorized loans for the first three years of HMO operating expenses, but rejected a Senate provision for operating expense grants. It decided in favor of the House position that the aggregate amount of loans and loan guarantees to an HMO could not exceed $2.5 million. The Conference Committee rejected the Senate's authorization formula, in favor of the House's aggregate yearly authorizations. The conferees provided special assistance to rural areas. The bill specified that 20 percent of the funds appropriated for HMO's should go to HMO's with predominately non-urban residents. The conferees also
rejected the Senate bill's provision for capitation grants and premium subsidies to HMO's (31, pp. 44-48).

The House HMO bill authorized $240 million for HMO development; Senate bill S. 14 provided $806 million for HMO's over a two-year period. The HMO Act of 1973 authorized $325 million for HMO's over a three year period. The Act's monetary settlement was a substantial reduction in the $5.2 billion in HMO assistance approved by the Senate in 1972 (16, p. 1161).

In the Ninety-Second Congress, the Nixon Administration pushed for large-scale HMO funding, but in 1973 the Administration requested only sixty million dollars for fiscal year 1974 (20, p. 499). Patricia Bauman implies that the American Medical Association had some influence in causing the Nixon Administration to scale down its HMO program requests (2, p. 136). The legislators who finalized the 1973 legislation had few exaggerated hopes for HMO's. They claimed that federal assistance was designed to promote increased provider and consumer interest in HMO's and to assist in making market entrance easier for HMO's (31, p. 46).

In 1975 the House Interstate and Foreign Commerce Committee recognized that there were many administrative problems in the federal HMO program, but despite these problems HEW had awarded 172 grants to 157 potential HMO's. The Committee expressed regret that there was little grant activity toward HMO's which were designed to serve medically
underserviced areas (39, p. 8). The 1976 HMO Amendments extended the HMO program funding through 1979. In 1976 Congress authorized an additional $135 million for the HMO program (14, p. 54).

In 1978, additional amendments to the HMO Act authorized loans and loan guarantees for non-profit HMO's to acquire and construct ambulatory care facilities (33, p. 14). These types of grants were rejected by Congress in 1973. The 1978 law also extended the HMO program through 1981 and initial development loans and grants were expanded from $1 to $2 million dollars and initial operating loans were increased to $4.5 million (33, pp. 13-15). Despite these changes, the history of limited federal financial support for HMO's indicates that, from the program's inception, many in Congress held doubts concerning HMO's.

Adjustments to a New System

Since HMO's are a relatively new health care system, questions concerning how they differ from the traditional practice of medicine are important. Experience with HMO operations indicate that they are not trouble-free operations. Fred Anderson, however, maintains that the fee-for-service mode of delivery is inadequate for today's health care needs (1, p. 16). He believes that the solo practitioner system with its "vast array of interlocking referrals, specialties, clinics, hospital services and financial
arrangements . . ." produces only "sporadic" care at best (1, p. 16).

Leonard Hodberg and Gelvin Stevenson hold that the solo practitioner system has been made obsolete by changes in the mode of medical care production. These writers believe that the current practice of health care in the United States requires a high degree of capitalization. This factor has partly contributed to the growth of group practices in the United States (24, p. 106). If HMO-like arrangements represent the direction in which medical practice is heading, it may be fair to assume that organizational and management problems, which plague most large organizations, will also apply to HMO's.

Irvin Rubin and Richard Beckhard contend that the internal processes of the group practice of medicine are quite different from the traditional ways in which medicine has been practiced in the United States. First, the group must learn to function as an interrelated team. This is not easy and conflicts with traditional patterns and physician training (25, pp. 322-323). Rubin and Beckhard claim that the specialist role, for which doctors have been trained, may be inappropriate to a more generalist role which they must assume under group practice. Group practice, according to these writers, may require a redefinition of medical roles (25, pp. 323-324). However, doctors have strong
professional ties with their specialty. These ties make team loyalty difficult (25, p. 323).

Ronald Bohr and Howard Kaplan also hold that group medical practice has the potential for serious conflict. They allege that the modern health care agency is a complex social organization which comprises heterogeneous personnel with diverse vested interests. As such it constitutes an arena for the exercise of social power and authority (5, p. 2229).

The vested interests of upper administrative and lower-ranking health personnel differ. Bohr and Kaplan think that labor-management conflicts are likely to occur, despite the existence of shared goals among a medical group (5, p. 2230). Thomas J. Bodenheimer argues that HMO's will not end fragmentation in the delivery of medical care. He contends that successful HMO's are, in fact, fragmented organizations (4, p. 1325).

In writing the 1973 HMO legislation, the Conference Committee agreed to the Senate bill's (S. 14) requirement that HMO's utilize nurse practitioners and physician's assistants (31, p. 38). Avedis Donabedian questions the greater use of para-professionals and non-professionals in HMO's. He states,

One must also consider the effects of the division of labor on the social-psychological aspects of the patient-physician relationship. Both patient and physician satisfaction may be less tolerant of the subdivision of tasks than the efficiency expert would like to recommend (9, p. 245).
Donabedian claims that the "imperfectly professionalized" health care practitioner could pose a serious danger to the nation's health system (9, p. 245).

There is some evidence that finding a role for para-professionals in an HMO is not an easy task. In 1971 the Kaiser Health Plan of Portland, Oregon, hired a nurse practitioner sanctioned by the American College of Nurse Midwifery. She was a Certified Nurse Midwife (CNM) with a Master's degree in midwifery from Yale University (7, p. 355). John Cassals and Harold Cohen studied how this person would fit into the status hierarchy of the complex Kaiser HMO. Her formal job description placed her in the Obstetrical/Gynecological Department "... with lateral rather than vertical relationships to the nursing structure" (7, p. 360). The study showed that only 16 per cent of her patients were referred to obstetrical or gynecological doctors. There were some adjustment problems with referrals. Referral within the HMO was heavily dependent upon the Appointments Center, which directed patients to providers. Cassals and Cohen reported that after four and one-half months doctors and patients tended to be satisfied with the CNM (7, pp. 357-360).

Theodor J. Litman conducted a survey of 253 non-urban Midwesterners. They were questioned concerning their willingness to accept treatment from a medical assistant. Sixteen per cent said they would accept such treatment.
Thirty-eight per cent preferred treatment from a family doctor. Litman claims that there is a considerable amount of disagreement over the role of medical assistants. Support for para-medics was conditioned upon family physician support. There was also some hostility against such personnel performing maternity-related services. Litman warns that reservations concerning the use of physician assistants are important and should caution us against broader utilization of this kind of personnel (21, pp. 343-346).

The issue of finding sufficient and capable management personnel for HMO's appears to be one of the most important tasks in the effort to expand the nation's HMO network. In 1972 House hearings, a statement by Robert Gumbiner, M.D., Executive Director of the Family Health Program (FHP) of Long Beach, California, reflected this concern. He said that the major reason HMO's had not caught on was the lack of entrepreneurial talent (36, p. 601). He also claimed that consumers lacked the knowledge to be directors of HMO's (36, p. 611).

One of the significant provisions of the 1978 HMO Amendments was the establishment of an HMO management intern training program. In 1978 the General Accounting Office had reported that shortage of managerial talent was one of the primary reasons for the lack of HMO growth. The Senate bill (S. 2534) provided a five-year authorization for HMO management training grants for seventy candidates a year.
The House Interstate and Foreign Commerce Committee also endorsed an HMO intern training program. The Committee felt that the HMO managerial training program should stress on-the-job practical experience of HMO management and that academic training should be secondary (40, p. 62).

As the federal HMO program got under way in the early 1970's, HMO managers appeared apprehensive rather than certain concerning the federal HMO program and the public's acceptance of HMO's in general. One study reported that HMO directors felt uneasy about federal regulations accompanying federal financial support, but saw federal support as necessary in making HMO's viable. Over 60 per cent of the directors interviewed felt that public ignorance about HMO's might cause recruitment problems (22, pp. 1198-1199). Another survey, reported in 1978, revealed that three-fourths of the HMO managers believed that gaining market access, or being able to attract new members, was the number one HMO problem (6, pp. 108-109).

I. S. Falk admits that the complexities of organizing HMO's are enormous. Their attempt to make comprehensive medical service available on a 24-hour basis at a cost which can compete with health insurance premiums is not an easy assignment. Numerous management difficulties involve acquisition of facilities and capital, staffing, and marketing, according to Falk (11, pp. 212-213). Jordan Braverman is of
the opinion that an HMO should break even with 30,000 enrollees, after $2 million have been spent for marketing, staffing, and securing facilities. He thinks this process will take at least three years (6, p. 111). In 1979 the Comptroller General, however, stated that "overemphasis on enrollment may hurt an HMO's chances of becoming financially independent" (23, p. 8). The Comptroller General's report also said that an HMO can achieve cost stability at an early stage in its development (approximately 10,000 members) and that continued growth in membership will not lead to lower subscriber rates. The report maintains that "sufficiency of subscriber rates" is the key to HMO viability (23, pp. 8-10). From these and other reports, it appears that the picture of HMO's operating without organizational and management problems is hardly realistic.

In 1970 the HMO idea was a vague and imprecise concept. Many questions were raised concerning how new HMO's would operate. Definitional problems were of considerable importance in Congress' efforts to pass HMO legislation. The 1973 HMO Act defined an HMO in language broad enough to permit several types of organizational formats. The 1976 HMO Amendments attempted to make HMO organizational arrangements even more flexible to accommodate varying provider arrangements. Even though federal legislation permits organizational flexibility for HMO's, there is still controversy as to which type constitutes a "true" HMO.
One of the reasons why the HMO program has not been more successful may be that the definitional problem has confused the public in general as to what an HMO is. Three officials who have participated in the federal HMO program contend, "The limited increases in HMO membership, although steady, means the public is inadequately informed of HMO's or that many persons are choosing not to join" (30, p. 49). The major purpose of the HMO Act, according to these officials, was to see if the HMO concept could be successfully transplanted to other environments (30, p. 34). In 1973 Congress rejected the Senate's plan for substantial federal aid to HMO's. Instead, Congress chose a limited funding approach for HMO development. This fact may also account, in part, for the limited success of HMO's.


17. Interview with Director, County Medical Society, April, 1979.


35. House Bills, H.R. 11728, 92d Congress, 1-34.


CHAPTER III

OPPOSITION FROM ORGANIZED GROUPS

The AMA's Resistance to Change

The legislative health setting is rich in economic, ideological, and personality conflict (25, p. 77). Health Maintenance Organization policy is not exempt from these conflicts and controversies. The American Medical Association's (AMA) long-standing position is that governmental intervention in the doctor-patient relationship will only cause trouble (11, p. 387).

It can be argued that the medical profession is far from monolithic. In fact, the medical profession is often disunited and fragmented with different viewpoints from competing groups. The AMA, the American Hospital Association, and the American Association of Medical Colleges have different interests and orientations (25, p. 77). Although the many medical professions have varying interests and doubts about HMO's, the AMA has been in the forefront of these groups in opposition to HMO development.

According to Pierre deVise, the AMA had changed by 1923 from a liberal professional association to a conservative protectionist trade union. He noted that from 1939 through the 1960's the AMA contributed to the defeat of numerous
health bills in Congress (? , p. 22). In 1965, the AMA con-
ceded to Medicare only under the condition that the federal
government, under its Medicare programs, would not interfere
with the way medical care was delivered. Congress agreed
that it would leave the fee-for-service system intact (15,
pp. 988-989).

Erwin Knoll is of the opinion that the 1965 compromise
involving Medicare and Medicaid was disastrous. He contends,
"In the process of enactment both were modified and compro-
mised to the point where their primary impact has been an
enormous contribution to the cost of medical care and the
enrichment of the medical profession" (21, p. 29).

Eli Ginzberg argues that the non-regulated private medi-
cal care market has proven unreliable in providing adequate
manpower, facilities, or accessibility for the nation's
people (11, p. 392). He states, "The untrammeled rights of
purveyors of health services to pursue their interests can
result in serious diseconomies resulting in excess capacity,
unnecessary services, and dangerous products" (11, p. 392).
According to Ginzberg, social control over those who deliver
health services is imperative (11, p. 392).

Social control, if it implies governmental direction,
has been resisted by the AMA for many decades. In 1932 a
Presidential Committee on the Costs of Medical Care con-
sisting of fifty doctors, dentists, health workers, and
social scientists issued its final report. Under the
chairmanship of Lyman Wilbur, M.D., Dean of Stanford University Medical School, the Committee recommended replacing individual fee-for-service medical practice with group practice in community medical centers. The Committee also felt that if medical care was to be extended to the entire population, group payment plans were necessary (22, p. 198).

The AMA condemned the Committee's plan, using the slogan, "Americanism vs. Sovietism" (22, p. 198). In the 1930's, the AMA supported private fee-for-service practice and refused to accept the idea that the individual family practitioner was outdated (22, p. 199). Roy Lubove alleges "... the reluctance of organized medicine to endorse group practice or health insurance and its suspicion of government involvement reflect an emotional, even irrational, response to impersonal forces affecting medicine and American society" (22, p. 199). The AMA's opposition to government health programs was not entirely based on economic considerations, according to Lubove. Health reform measures brought out fears relating to the loss of freedom and status associated with the bureaucratization of medicine (22, p. 226).

During the Depression, federal involvement in health care came with the numerous welfare and relief programs of the New Deal. The Farm Security Administration (FSA) may have established prototype prepaid group plans. The FSA employed doctors who were paid according to a uniform fee schedule. Farm Security Administration families pooled
yearly insurance premiums and got "home and office care, emergency surgery and hospitalization, obstetrical and dental services and drugs" (22, p. 199). The FSA involvement in health care was based on findings which showed that farm mortgage defaults were often caused by the ill health of farm families (22, p. 199).

Fred Anderson contends that during the 1940's the AMA succeeded in obtaining laws in twenty states which were inhospitable to PPGP's (4, p. 16). The ability of medical societies to influence state medical policy has been considerable, according to Pierre deVise. He asserts, "If doctors tend to regard nurses as their handmaidens, they look upon health commissioners as their eunuchs" (7, p. 19).

In 1973 the Senate Committee on Labor and Public Welfare was of the opinion that pre-emption of restrictive state laws was necessary for HMO success. The Senate Committee also did not think that an HMO should be required to get the approval of a local medical society in order to operate (34, pp. 26-27). The 1973 HMO Act pre-empted federally-funded HMO's from state laws which 1) required medical society approval for HMO's to operate, 2) mandated that doctors make up a certain percentage of the HMO's governing body, 3) stated that all doctors, or a certain percentage of doctors in an area, provide services for an HMO, and 4) required HMO's to comply with insurance regulations (33, p. 931).
Dean A. Clark, Director of Boston’s Massachusetts General Hospital, testified before New York’s Joint Legislative Committee on Health Insurance Plans concerning the long history of medical society discrimination against the Health Insurance Plan (HIP) of New York’s doctors. He said, "This is a very old story, and it is always the same. When physicians enter upon an economic arrangement which is completely legal, honest, and open, their colleagues often use their influence to exclude these physicians..." (5, p. 76). This testimony was made in reference to the history of fee-for-service doctors denying hospital privileges to physicians participating in PGP plans.

In 1929 Michael Shadid, M.D., founder of the Elk City, Oklahoma, Community Hospital Association, was removed as a member of his local medical society by its members dissolving the society and then reconstituting the society without him. The Governor of Oklahoma had to intervene to prevent Shadid’s license from being revoked (27, p. 313). The doctors who organized the Ross-Loos Medical Group in Los Angeles were expelled from their local medical society and the organizers of the Group Health Cooperative of Seattle, Washington, were subjected to intimidation, expulsion, and denial of hospital staff privileges (27, p. 314).

Ira Greenberg and M. I. Rodburg contend that the AMA as a professional association has a tremendous impact upon a new HMO’s chances for success. The denial of hospital staff
privileges can be a serious blow to a non-hospital based HMO. Local chapters of the AMA may regard HMO's as unethical and refuse membership to a doctor who participates in such a plan. The impact of these sanctions upon a new physician is considerable. The threat of being socially ostracized by one's fellow professionals is also a possible retaliation (15, p. 956).

The personal opinion of John T. Farrar, M.D., of Virginia Commonwealth University, is that the close rapport and trust between the doctor and the patient breaks down under group practice plans. He asserts that doctors who know their patients recommend expensive tests only when needed. He argues that the breakdown in the doctor-patient trust relationship under group plans will not only encourage more expensive tests but also promote additional malpractice suits (6, p. 37).

Ira Greenberg and Michael Rodburg argue that the depersonalization of American medicine is due to increased specialization and the technological orientation of its practitioners and that the personal relationship between doctor and patient is likely to be non-existent in our urban and highly mobile society. They also imply that the "clinical atmosphere" of modern medicine is not confined solely to group practice plans (15, pp. 939-941). However, they add,

Unless prepaid group practice plans make significant efforts to promote the doctor-patient relationship to the extent that people retain belief in the notion of
the 'family doctor,' group practice prepayment's ability to grow significantly will be limited (15, p. 941).

Eli Ginzberg is of the opinion that the increased significance of third party reimbursements in medical care is making the AMA's trust relationship position more difficult to accept. In 1974 consumers paid only 34 per cent of their medical costs directly (11, p. 387). Ginzberg believes that the personal concern for the patient has been eroded by intermediary reimbursements and a "taut" supply of doctors (11, pp. 387-388).

For the past forty years PPGP's have been in various stages of rejection and acceptance by the medical profession. Today they are no longer referred to as "Medical Soviets" (8, pp. 243-244). There is one opinion which holds that in recent years the active hostility of the AMA toward PPGP's has diminished somewhat (15, p. 960). The label of "socialized medicine" often applied to health care reforms by the AMA has partially given way to a different set of polemics and tactics in relationship to the federal government's efforts to promote HMO development during the 1970's. One county medical society director, however, thinks that the HMO program was initially conceived as an effort to force socialized medicine upon the American public (17).

In the early 1970's, PPGP's were renamed HMO's. Their former identification with the political left was replaced by new advocates who saw the HMO as a means of restoring
competition to the health care marketplace (26, p. 71). In
the early 1970's, the Nixon Administration's HMO strategy was
based on the idea that the medical sector is restricted by
non-competitive practices. It viewed the HMO as a device
which could bring competition and, eventually, cost reduction
into the health field (8, pp. 243-244). Paul Starr contends
that "this political redefinition of prepaid health care as
a cost saving measure—the substitution of a rhetoric of com-
petition and rationalization for the rhetoric of cooperation
and mutual protection . . ." (26, p. 71) cost HMO's support
from the left.

Joseph Marcarelli, M.D., President of Health Maintenance
Associates, the provider group for Blue Cross' HMO in Arizona,
believes that in a rapidly changing medical world the AMA can
no longer play the "ostrich." He sees the inevitability of
change and views the HMO as an alternative between the status
quo and the possibility of socialized medicine (23, pp. 536-
537).

The AMA has announced that it is not against the HMO
concept as part of America's pluralistic delivery system.
But the AMA has denounced federal subsidies to promote HMO's
over other forms of medical delivery (16, p. 1451). Accord-
ing to one doctor, without government subsidies HMO's will
do little to enroll the nation's "high risk" members, i.e.,
the poor and elderly (15, p. 934). Another doctor believes
that an HMO is little more than a public relations
euphemism (20, p. 312). The inevitability of change in the nation's system of medical care delivery is not a position taken by all doctors. According to a county medical society director, fee-for-service and the solo practice of medicine are still viable concepts (17). He also thinks that HMO's have little chance of survival once government subsidies are removed (17).

Anti-HMO Testimony

In the spring of 1972, the Nixon Administration's support for HMO's began to waver. Elliot Richardson's departure from Health, Education, and Welfare was also a setback (26, p. 74). The transition from a firm Administrative commitment to tentative support did little to encourage a large scale federal HMO effort. In 1972 Secretary Richardson had testified in House HMO hearings that the HMO was a proven concept. In 1973 Under-Secretary of HEW Frank Carlucci was tentative as to whether or not HMO was a proven concept (31, p. 85).

Paul G. Rogers, Chairman of the House Subcommittee on Public Health and Environment, expressed appreciation for the Nixon Administration's changed position. He said, "We didn't think we should thrust the public into this system overnight" (31, p. 85).

In December of 1971, the AMA championed the present "pluralistic" delivery system of the United States. The AMA representative said that there was no evidence that HMO's
would lead to reduction in medical cost. The AMA said that early screening of patients by HMO's was still in the experimental stage and that there was no evidence that early detection would reduce costs. The AMA also questioned the satisfaction of the health consumer with HMO's (36, pp. 1338-1342).

The thrust of the Congressional testimony by the AMA in 1971 was that HMO's be regarded as "experimental." Questions the AMA felt to be unanswered were: Are doctors more productive in a large group setting? In regard to size of HMO's, where do economies of scale begin and end? Does prepayment promote high quality care? Will HMO's work in areas of low population density? (36, p. 1343). Clinton McGill, an AMA spokesman who testified before the Senate Health Subcommittee in 1971, said that the passage of HMO legislation would be based upon the dubious logic of the Queen of Hearts in *Alice in Wonderland*: "Sentence first, verdict afterward" (36, p. 1344). Edward Kennedy, Subcommittee Chairman, asked the AMA representative to return in two years and state what the AMA liked and disliked about HMO's experimental program (36, p. 1345).

In those same hearings, Michael Bromberg, Director of the Federation of American Hospitals representing the nation's proprietary hospitals, stated that HMO's were still in the experimental stage. He felt the management necessary for the new delivery systems would be forthcoming only with
the absence of bureaucratic regulation. He felt that for HMO's to succeed doctors must be made "full partners" in HMO's, not just "employees." He also stated that HMO success depended upon privately owned for-profit status for HMO's. Congress, according to him, had sanctioned in previous legislation both profit and non-profit health care institutions (36, p. 1506).

Bromberg also stated, "In particular you will find investor-owned hospitals in towns that grew so rapidly in population . . . or communities that were too poor to finance tax exempt facilities" (36, p. 1505). In 1971, he estimated that there were between $3 and $4 billion invested in 70,000 proprietary hospital beds (36, p. 1505). In response to a question from Alan Cranston (U.S. Senator from California), this witness argued there was no conflict of interest when doctors owned hospitals (36, p. 1512). Bromberg stated that the nation's 6,000 group practices with their existing plants and facilities held the key to HMO success. The profit incentive was necessary to convert these group practices into HMO's (36, p. 1507). This person was also against the government's regulating the contract between an HMO and the physician.

In a statement in 1972 before the House Subcommittee on Public Health and Environment, the President of the American Hospital Association (AHA) voiced the opinion that his organization felt that pending HMO legislation included benefits
that were too comprehensive. He stated that many individuals would not be able to afford HMO's and that a change in the nation's method of financing health care must accompany HMO legislation (29, p. 541).

The American Hospital Association's position was that HMO's would not solve the main problems of accessibility maldistribution and duplication of medical services. The AHA favored a Health Care Corporation which, according to an AHA statement, represented maximum organizational flexibility within a corporate structure. The AHA also felt that prepayment to HMO's placed too much risk and burden on the provider (29, pp. 545-547). The AHA, in the 1972 hearings, stated, "We doubt that we presently have the actuarial know-how and the risk taking capabilities to immediately go to total capitation payment" (29, p. 547). The AHA advocated prospective rate setting instead of prepayment.

The lack of support for HMO's by hospitals and insurance companies, according to one source, is due to the fact that both of these institutions tend to view HMO's as potential competitors. Under the threat of HMO competition, a hospital may refuse to provide beds or services to a non-hospital based HMO under a contractual relationship. Another possible response to the threat of HMO competition is for hospitals and insurance companies to form their own HMO's (24, p. 332).
In the 1972 HMO hearings, the American Dental Association (ADA) expressed concern over proposed HMO legislation. This Association was concerned with the fact that HMO legislation placed too much emphasis upon one model, the closed-panel HMO, which according to the ADA served only 4 per cent of the nation's population (30, p. 1477).

Doctors today are faced with a number of governmental intrusions, such as increased paperwork for Medicare and Medicaid patients and review of treatment procedures. One doctor claims that he did not turn his clinic into an HMO because it would involve too much time in complying with governmental regulations (19). Eli Ginzberg contends that doctors "have little to gain and much to lose from a major restructuring of the health care system" (12, p. 202). Both the AMA and the Association of American Medical Colleges oppose legislation restricting the physician's freedom of specialization and location (12, pp. 200-201). One possible fee-for-service physician response to competition from HMO practice is the formation of a medical foundation. In 1954 the San Joaquin Foundation in California was established by doctors in response to a Kaiser HMO entry into their market (13, p. 81).

Eli Ginzberg argues that the AMA does not oppose radical change in the delivery mode when it comes to servicing the poor. He contends that AMA even accepts service being provided for the indigent by closed-panel HMO's. This same
observer states, "Experimentation and innovation with services for the poor were possible because the poor did not affect the central stream of purchasing power" (10, pp. 92-93). Ginzberg believes that the AMA is responsible for most of the problems with the nation's medical care delivery system, but he is of the opinion that blame must also be shared with hospital administrators, health agencies, business groups, and labor unions (10, pp. 36-39).

Fred Anderson is of the opinion that, with a large campaign fund at its disposal, the AMA is in a key position to control the nation's health care system (3, p. 18). Anderson alleges that doctors' "right" to set "reasonable fees" for services protects both doctors and hospitals from public oversight. He maintains that under the present system there is a considerable incentive for doctors to milk both the federal government and the "Blues" (Blue Cross-Blue Shield) (2, p. 17).

The issue of doctors being "reduced" to mere salaried employees is one of the serious questions involved in a large federal HMO program. In 1929 the mean income of doctors in the United States was less than lawyers and accountants. In 1978, according to the White House Council on Wage and Price Stability, physicians had risen to the highest income group with a mean income of $62,799 annually. During the period from 1950-1977, doctors' fees rose 273 per cent as compared with a 150 per cent increase for all other prices (28, p. 8).
Another complaint voiced by practitioners of fee-for-service medicine against HMO's is that the doctor under an HMO arrangement will be deluged with patients with insignificant medical problems (19).

On the other hand, John R. Kernodle, M.D, Vice Chairman of the AMA Board of Trustees, testified to the House Subcommittee on Public Health and Environment that in an HMO practice doctors would cut needed medical services to stay within the HMO's budget. He expressed the view of the AMA that under-utilization of care would result if doctors were reimbursed by salary or hourly wages (29, p. 336). He also stated that HMO emphasis on cost control would be harmful to the patient who would be serviced by a "non-physician technician" and that patients under these conditions would seek help outside the HMO. He also believed that doctors would not be attracted to HMO's and the HMO concept did not appeal to the consumer (29, pp. 335-336).

Russell B. Roth, M.D., Speaker of the AMA House of Delegates, testified in these same hearings that prototypes of HMO's had been a dismal failure in company towns (29, p. 338). Roth also stated that, in general, monetary concerns did not enter into matters of health care and that the fee-for-service reimbursement method did not enter into the question of what was to be done medically and that it did not lead to over-production of medical services (29, p. 352).
The position of the AMA was that the 110 HMO experimental feasibility grants, sponsored by HEW under its authority to investigate alternate modes of medical care, were enough. The AMA argued that results on experimental HMO's should be ascertained before the federal government took further action to promote HMO's (29, p. 351). The AMA spokesmen stated that HMO's sponsored by these feasibility grants were unproven (29, p. 339). They also maintained that the lower utilization rates of capitation practice were deceptive (29, p. 340).

The AMA wanted the federal HMO effort to be limited to an experimental program. The position of this organization was that the health system of the United States was in the midst of a great scientific and experimental revolution and that there was no need to limit the pluralistic development to one pattern (29, p. 342).

John G. Schmitz (U.S. Representative from California) sympathized with the position of the AMA. He said that government subsidy would give HMO's an unfair competitive advantage. He also believed that government subsidies would continue even if HMO's proved to be unsuccessful (29, pp. 343-344). Richardson Preyer (U.S. Representative from North Carolina) agreed also with the AMA's HMO position. He urged that Congress not adopt a "bandwagon" approach to HMO's (29, p. 341).
Roth of the AMA contended that in no way could Kaiser be considered an ideal prototype HMO. He said that this large HMO was not satisfactory to its doctors or patients in many ways (29, p. 339). Kernodle of the AMA expressed concern that the 20 per cent of the population targeted by HEW to be HMO members would represent only the healthy members of society and not those from the urban ghetto or rural areas (29, p. 344). Roth agreed with his AMA colleague. He testified that no HMO-type operation in the nation was operating as an HMO was supposed to operate. His list included Kaiser, Puget Sound, and Health Insurance Plan of New York. The AMA warned Congress that these HMO's used selectivity in their enrollment policies (29, p. 344).

An HMO sympathizer on the Committee responded with irritation to the AMA's remarks. William R. Roy (U.S. Representative from Kansas) objected to HMO's with thirty years of experience being classified by AMA representatives as experimental. He said that HMO's cannot be "all things to all people" and he felt that the nation's HMO's were not "floundering," as AMA spokesmen claimed (29, pp. 350-351).

Efforts to implement the 1973 HMO Act encountered many difficulties. In 1975, HMO proponents wanted many of the requirements of the 1973 Act reduced in order to make HMO's more competitive with other types of medical care. The AMA, perhaps realizing that the legislation of 1973 was more obstacle than stimulus for HMO growth, appeared in the chambers...
of Congress with renewed efforts to thwart the federal HMO program.

Edgar T. Beddington, M.D., Vice Chairman of the AMA's Council on Legislation, claimed in July, 1975, before the Health and the Environment Subcommittee of the House Committee on Interstate and Foreign Commerce that the strict standards of the 1973 legislation were being watered down by amendments, to a degree that the whole HMO concept was being endangered (32, pp. 162-163). He was especially critical of removing required HMO services, community rating, and open enrollment requirements. He said, "It was our view that the HMO, as such, was a creature of the statute, and until defined by Congress its existence could not be ascertained" (32, p. 161). He felt that the proposed amendments would "gut" the entire HMO concept (32, p. 162). He added also that the amendments would reduce the HMO to a PPGP and HMO's would become "paper" organizations. With the reduction in required services, the AMA representative stated that the concept of comprehensive care was being abandoned and that the people were being led to believe that an HMO was more than it really was (32, pp. 164-165).

The position of the AMA in 1975 was that the federal HMO "experiment" should proceed under the 1973 Act without amendments (32, p. 165). Beddington announced, "We feel, that the thrust of the arguments that were presented when Congress first enacted the HMO Act, was a criticism of the
on-going health care delivery system" (32, p. 166). The AMA's Beddington was not only against any change in the 1973 law, he was also against additional funding for the HMO program (32, p. 172).

Paul G. Rogers, Chairman of the House Health and the Environment Subcommittee, did not believe that the proposed amendments would alter the basic HMO concept. His view was that they would make HMO's more competitive. Rogers argued that HMO's had demonstrated the capacity to save public money in the health care sector (32, p. 171). Unlike his colleague, Tim Lee Carter, M.D. (U.S. Representative from Kentucky) noted that the HMO experiment was failing. He was also against changing the 1973 law. By adding amendments, he said, "... we are cutting the very heart out of the bill" (32, p. 173). House member Richardson Freyer reiterated the point that federal HMO legislation was not intended to be a critique of fee-for-service medicine but to promote pluralism in delivery modes (32, p. 166). James F. Hastings (U.S. Representative from New York) was more critical of the AMA's opposition to HMO's. Speaking of the Congressional probe, he said, "The attempt is to find out whether the federal government, as part of a huge subsidization of the entire health care that we find ourselves engaged in, whether or not we should provide some federal direction" (32, p. 170).

On January 19, 1976, Beddington of the AMA testified before the Senate Labor and Public Welfare's Health
Subcommittee. He stated that the federal HMO program, as it was originally conceived, was designed to serve the medically under-serviced, the sick, the poor, and the elderly. The AMA's position was that by modifying HMO open-enrollment standards, Congress was abandoning one of its basic HMO aims (35, p. 586). Edward M. Kennedy said that Beddington's concern about open enrollment represented "crocodile tears" (35, p. 585).

Conclusion

The AMA in 1977 included less than one-half of the nation's doctors and the AMA's membership included mainly elderly fee-for-service doctors (25, p. 77). The organization in 1977 included 207,000 active members (1, p. 2082). Of considerable importance to the federal government's efforts to promote HMO's is the acceptance of this new delivery concept by young doctors. One HEW official believes that the younger generation of doctors are less hostile to HMO's than the older generation (18).

In 1972 hearings, George Blatti, President of the Student AMA, told members of the Senate that medical school curricula tend to leave out courses on delivery modes (36, p. 2392). Fred E. Graham also contends that medical curricula tend to ignore medical care organization and delivery questions. He is of the opinion that the focus of medical education may be too restricted (14, p. 205). Graham asks
the question: Is there a correlation between educational methods and attitudes? (14, p. 207).

George Blatti's testimony to the Senate Subcommittee indicated that the HMO program would lose its appeal to young doctors if it became entwined in a "massive" federal bureaucracy. This future doctor stated, "An HMO is not a C-5A transport, or a nuclear aircraft carrier, or even a space bus. . . . We can neither legislate nor buy quality health care" (36, p. 2393).

The discretion of the American doctor to generate "demand" in the health care field and, thereby, controlling a larger portion of the nation's Gross National Product is viewed by Peter D. Fox as a major justification for government intervention in the health sector (9, p. 23). From the early enthusiasm of the Nixon Administration to the grim realities of the HMO legislative-administrative process of the middle 1970's, it is apparent that the opposition of organized medicine to HMO expansion has not had an insignificant effect in keeping the HMO movement "bottled up."

However, the designation of the federal HMO program from 1971-1978 as "experimental" reflects more than AMA opposition to HMO's. The possibility of "restructuring" the nation's medical care system may not be politically feasible. If the nation adopts a system of national health insurance, many contend that HMO's will play an important role in such a bill (9, p. 18). At the moment, Fox
observes that "the political compromise is to do nothing" (9, p. 1).

Milton Terris asserts that change in the nation's system of medical care has been "imminent" for many years, but it has yet to materialize. He warns, "We are a nation of contradictions. We are remarkably innovative in technical matters and remarkably conservative in social questions. Our behavioral outlook comes from the frontier, farmer, and solo practitioner mentality" (27, p. 317).
CHAPTER BIBLIOGRAPHY


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CHAPTER IV

PROBLEMS IN ADAPTING HMO'S TO PRIVATE HEALTH INSURANCE PRACTICES

HMO's Versus Private Health Insurance

The ability of Health Maintenance Organizations to compete with the traditional American system of financing health care was an important consideration to those involved in HMO-type health care. An important issue raised in HMO Congressional debates was to what extent would HMO's be allowed to deviate from the prevailing practices of the American health insurance industry.

In 1973 the Group Health Association of America (GHAA), representing the nation's prepaid group plans (PPGP's), stated that one of its primary concerns was that the federal HMO effort not impede the growth of non-federally supported PPGP's. The GHAA claimed also that the benefit requirements of the proposed 1973 HMO legislation were unreasonable in terms of HMO variation and flexibility (33, p. 195).

The traditional American health care financing system classified by some as a "non-system" revolves around Blue Cross-Blue Shield (BC-BS) plans and commercial health insurance, known as indemnity plans. In 1929 a group of school teachers in Dallas, Texas, established a group fund for
hospitalization. The "Dallas Idea" caught on and quickly spread to Michigan and New Jersey. During the Depression, many of the members of the American Hospital Association who were operating in the red supported the Dallas concept. In 1934 they adopted the blue cross as their symbol and established standards for hospital insurance (26, p. 34).

Blue Shield was organized by medical societies on a similar basis in 1939 in California to pay for medical and surgical fees. The Blue Shield plans were organized on an individual state basis, as was Blue Cross. The merging of the two Blue plans has occurred in marketing and claims processing. In the 1960's, commercial insurance companies imitating the BC-BS plans surpassed them in number (26, p. 35).

Blue Cross-Blue Shield is a provider-sponsored health insurance that offers "service benefits" to subscribers on a fee-for-service basis. Under this arrangement the providers are reimbursed "directly" by the plan. Commercial health insurance offers free choice of provider and indemnifies its policyholder rather than provide for pre-agreed amounts (5, pp. 21-22).

The prevailing contractual arrangement in Blue Cross plans specify that the provider will be reimbursed at 100 per cent for "reasonable costs." David Brown and Charles Brown are of the opinion that this method has a built-in inflationary tendency. "Reasonable cost" often, according to these writers, includes dubious items such as hospital
depreciation, lobbying, and public relations expenses, plus a surcharge of 2 per cent. He adds also that under "reasonable cost" reimbursement, the Blue plans have become subservient to hospital providers. They also have become unwilling to effectively oversee hospital construction, length of stay policy, or provider efficiency (5, pp. 23-25).

In 1975 BC-BS controlled 40 per cent of the health insurance business in the United States (4, p. 237). Lawrence G. Goldberg and Warren Greenberg hold that Blue Cross' marketing dominance enables it to negotiate discount rates with hospitals. Its non-profit, tax-exempt status also contributes to its dominant market position. Each of its seventy-four local plans, however, enjoy a considerable amount of autonomy from the national association. The fragmentation of Blue Cross is not so great, however, when contrasted with the twelve hundred commercial health insurance carriers. None of these plans controls more than 5 per cent of the health insurance market (12, pp. 14-15).

Edmund K. Faltermayer contends that, unlike health insurance which is sickness insurance, HMO's take the responsibility for keeping their subscribers well. Monthly HMO prepayment fees include hospital services, doctor's visits, surgery, lab services, and preventive care attention (10, p. 82). Roger Blair, Paul Ginsburg, and Ronald Vogel are of the opinion that BC-BS do not attempt to maximize health care benefits in spite of often being exempted from state
premium tax, property tax, and corporate income tax (4, p. 240). These researchers argue that the larger the proportion of people in an area covered by a plan, the smaller the administrative cost to the plan. Using a regression model, they found no evidence of economies of scale in terms of administrative costs for Blue Shield plans. Diseconomies of Blue Shield were attributed to administrative "slack" (4, p. 246). They argue also that "hierarchical" inefficiencies and group decision-making problems were promoted by the vague objectives of the Blue programs (4, p. 240). They contend that evidence is scarce that private non-profit corporations achieve "technical efficiency" (4, p. 238), and the vague community service objectives of the non-profit organization may be, in fact, the grounds for their inefficiency (4, p. 240).

In theory, one of the significant advantages of HMO's over the health insurance fee-for-service system is that it has no built-in prejudice concerning one particular type of care (10, p. 82). Sylvester Berki believes that under the prevailing American insurance system both doctors and patients tend to select treatments covered by insurance policies. Policy selectivity dictates kind of treatment which negates alternate and possibly more economical treatment methods. For those who have hospital rather than ambulatory benefits, it is cheaper to be hospitalized (2, pp. 126-127). Katey Walker alleges also that current health insurance
reimbursement has a tendency to promote the most expensive kinds of care. She adds, "Physicians tend to define optimum care without regard to cost" (43, p. 53). She contends that non-profit hospitals have little motivation to improve efficiency or control costs when it is known they can be passed on to the intermediary. Patients prefer to have simple surgery and tests done in hospitals because they are covered by their insurance. The payment mechanism of HMO's, according to Walker, allows for greater use of outpatient and ambulatory care facilities. She believes the BC-BS plans have caused many health care dollars to be devoted to hospital construction and care and not enough for preventive and outpatient care. It is her opinion that the fee-for-service system "over-services" those who can afford to pay and "under-services" those who cannot (43, pp. 56-57).

Christine Bishop maintains that changes in payment methods to doctors are at the center of efforts to reform the United States health system. She contends that a prospective national health insurance program is likely to include HMO's payment mechanism (3, p. 209). She adds, "Physicians have apparently been able to raise fees without reducing demand for their services or affecting the financial situation of patients since third parties (insurance companies and government agencies) pay the bills" (3, p. 208). She holds also that fee-for-service earning power in the
United States negates federal efforts to redirect both the distribution and specialty area of doctors.

Frank A. Sloan and Bruce Steinwald argue that medical costs often go beyond the most comprehensive types of health insurance coverage and that doctors practicing in high income areas with "prestigious credentials" are even unlikely to regard health insurance reimbursement as full payment for services (28, pp. 237-238). These writers state that few individuals today have no health insurance coverage. With Medicare and Medicaid and the growth of private insurance, even the poor have limited health insurance coverage (28, p. 244). They believe that the charity motive as a reason for doctor's participation in Blue Shield may be a facade to cover-up a profit-maximizing motive. Sloan and Steinwald are of the opinion that the charity orientation in the practice of medicine may actually inhibit governmental regulation and intervention (28, p. 244).

Since HMO's operate on a fixed budget with payment made in advance of treatment, it is argued that HMO's have little incentive to place a patient in a hospital unless it is required (13, p. 925). Furthermore, since treatment by inferior physicians tends to be costly, prepayment groups tend to emphasize competence among physicians and specialists selected for the group. Proponents of HMO's allege that HMO's encourage frequent consultation among practitioners and high standards of professionalism (13, pp. 929-929).
Elliot Marshall warns, however, that there is a cost increment mechanism in the field of health care that is insatiable. He states that it is supplied by

... the desire of sick people to be cured at whatever the cost, combined with healthy people's determination to become even healthier. ... Doctors, hospitals, insurance companies and massive federal agencies are all borne along on its tide (24, p. 23).

He thinks that the schemes for prospectively setting fees are to a large extent hopeless in view of the many forces involved. He says that governmental intervention into health care "... doesn't discourage the hypochondriac's imagination or doctor's greed, reduce reliance on drugs, cut unnecessary hospitalization or create efficient patterns of work" (24, p. 23).

The HMO has been held up by its proponents as a means of controlling costs. Rita Cambell contends that there are people in the federal government who believe that doctors practicing in an HMO will behave more altruistically and be less concerned with money than doctors in fee-for-service practice. However, she tends to think that doctors in HMO's are no less motivated by a desire for high incomes than doctors in fee-for-service practice (7, p. 21).

She questions also many of the assumptions about HMO efficiency and challenges the validity of HMO's as an organizational mechanism to hold down health care costs. She argues, "There is little evidence that any cost savings resulting from group techniques are necessarily passed on to
consumers in the form of lower prices" (7, p. 25). She claims that doctors practicing in groups tend to have higher incomes than the solo practitioner.

Savings of their HMO, according to one official at the Kaiser-Prudential HMO of Dallas, would be used to expand Kaiser HMO's in other areas. He does not see HMO economy being used to lower HMO subscriber rates (20). The Marketing Director of Metrocare HMO of Tarrant County, Texas, is of the opinion that HMO care is not inexpensive and will cost the consumer as much as traditional medical care. He also admits that there is little basic difference between an HMO and private health insurance (21). Evidence suggests that issues surrounding the differences and similarities between HMO's and traditional health insurance would pose a number of "thorny" problems to policy makers as they attempted to differentiate HMO's from traditional private health insurance in the United States.

Congressional Efforts to Differentiate HMO's

From Prevailing Health Insurance Practices

Many of the legal requirements of the federal HMO program run counter to prevailing health insurance practices in the United States. The framers of the 1973 HMO Act placed in the legislation a requirement that a federally-qualified HMO base its monthly per capita fees upon community rating
rather than experience rating, which is the prevailing practice in the private health insurance industry.

The 1973 Act stated,

Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but as otherwise authorized . . . such rates must be equivalent for all individuals and families of similar composition (37, p. 919).

The requirement that HMO's charge individuals the same rate regardless of prior sickness or health history is contrary to experience rating, which bases insurance rates upon the past medical history of its subscribers. Fred Anderson alleges, "When costs become too great for insurance companies, they raise premiums, refuse to insure for more and more kinds of illness and costs, and turn down high risk applicants" (1, p. 19). In 1975, Theodore Cooper, M.D., Assistant Secretary of HEW, confirmed this same point by admitting to the members of the Senate Committee on Labor and Public Welfare's Health Subcommittee that private health insurance enjoyed a great advantage in regard to the flexibility they had in pricing, determining benefits, and underwriting policies (40, p. 193).

Another controversial provision of the 1973 HMO Act was a requirement that the federally-assisted HMO have an open enrollment period for thirty days a year. The 1973 legislation stated that an HMO was to enroll members who were representative of the various age, social, and income groups in
the community (37, p. 916). This was the open enrollment concept supported by the House. The thirty-day open enrollment was mandated by the 1973 Senate HMO bill. Under this Bill, the Secretary of HEW was authorized to make annual grants to the HMO if it could demonstrate that open enrollment caused high premiums (39, p. 30). The Conference Committee for the 1973 HMO legislation conditioned waiver of the thirty-day requirement on proof by the HMO of a large percentage of "high risk" enrollees. Open enrollment could be waived by the Secretary of HEW if the HMO members were "broadly representative" of various community groups (29, p. 37). The Conference Committee added also a provision that an HMO could not expel a member because of his health status (29, p. 38).

Existing prepaid group health plans opposed the open enrollment requirement in the legislation. A representative of the Group Health Association of America testified to the House Interstate and Foreign Commerce Committee's Health Subcommittee that it would be unfair to require a thirty-day open enrollment period for HMO's and not for health insurance companies. Ernest W. Saward, M.D., the GHAA spokesman, said HMO's "cannot right all of the things that are wrong with our insurance coverage of personal health services and their organization as a starting point" (31, p. 185).

Neither open enrollment nor community rating are the prevailing practices of the health insurance industry. The
strongest support for these concepts has come from the Senate Health Subcommittee chaired by Edward Kennedy. He was against efforts by the Group Health Association to amend the 1973 open enrollment and community rating requirements. In a 1975 hearing, he said, "Is it appropriate for the Federal government to acquiesce by action or inaction, to the anti-social practices of the health insurance industry?" (40, pp. 310-311).

Edward L. Field, Vice President of Employee Relations for Federated Department Stores, Inc., Cincinnati, Ohio, favored eliminating open enrollment for newly-begun HMO's. He advocated a reduction in required HMO benefits to enable HMO's to be more competitive with other health plans. This would make it easier for the employer to determine his cost in terms of contribution to an employees' health plan (40, pp. 312-313).

In 1976, amendments to change benefit, open enrollment, and community rating requirements were supported in the Senate by Jacob Javits (U.S. Senator from New York), Richard S. Schweiker (U.S. Senator from Pennsylvania), and Walter Mondale (U.S. Senator from Minnesota) (19, p. 1162). An opponent of these changes was Gaylord Nelson (U.S. Senator from Wisconsin). Nelson cited the example of the Marshfield, Wisconsin, Community Health Plan as an HMO which had been operating successfully for five years with open enrollment.
He, like Kennedy, was of the opinion that open enrollment was essential to the HMO concept (40, pp. 314-315).

Thomas Pyle, representing the GHAA, protested that, unlike private health insurance which used experience rating, HMO's under federal law had to open their membership to "high risk" individuals which increased the premiums for the other members (40, pp. 353-354). In response to a question from Nelson, Pyle stated that open enrollment costs would vary in different parts of the nation. James Lane, representing the Kaiser HMO, said open enrollment would invite a whole community of individuals with a history of "bad experience" (40, p. 356).

Nelson, in a Subcommittee hearing, told of the experience of his father, a small town Wisconsin medical doctor, concerning open enrollment. Nelson said, "He had open enrollment. Everybody who did not pay, he assumed the cost" (40, p. 356). The Senator's probe was directed to the question of how much open enrollment would cost HMO's. Richard Hoffman, representing the Equitable Life Assurance Company, testified that in almost every region of the nation HMO costs were higher than health insurance plans (40, p. 357). The Committee also heard evidence that the Marshfield HMO was not typical, due to the fact it operated in a rural non-competitive environment (40, p. 358).

Thomas Pyle of the GHAA opposed the ambiguity of open enrollment waivers allowed under the 1973 HMO Act. He said
that the lack of clear-cut criteria concerning the federal HMO program "... puts a scare factor in the whole business of federal qualification..." (p. 360). The Senate Committee on Labor and Public Welfare agreed with the GHAA testimony concerning the "adverse" effects of open enrollment. However, its report stated that HMO's which are well established "can openly enroll a limited number of individuals, particularly in return for the market advantages given them by Section 1310" (p. 9). In regard to community rating, the Committee supported a five-year postponement period due to the difficulty which pre-existing prepaid health plans had in negotiating new community rates for its existing subscribers (p. 10). The Senate report, however, stated that community rating was important to the HMO concept.

The House amendment, H.R. 9019, proposed the elimination of open enrollment from the 1973 law altogether, due to its "anti-competitive" effect on HMO's. The House bill, like the one in the Senate, supported a five-year postponement of community rating. It recognized that community rating was not the "normal practice" within the health care field. The House expected HEW to assist HMO's in the transition from experience to community rating (p. 12-13).

Edward L. Field, of the Federated Department Stores, Inc., testified that it was essential for Congress to amend the open enrollment requirement to enable HMO's to compete
with Blue Cross and the indemnity plans (40, pp. 314-315).

Ben R. Lawton, M.D., President of Marshfield HMO, said open enrollment and community rating were essential HMO concepts. He felt that the proposed five-year waiver of community rating would not work. His opinion was that, once HMO's had been granted five years of experience rating by the federal government, they would never accept community rating. He added also that proposed amendments would lead HMO's to service only the healthy (40, pp. 417-418). Walter McClure of Interstudy, a Minneapolis-based research firm, claimed that members registered during open enrollment would cost an HMO 50 to 100 per cent more per member than group-enrolled members (40, p. 355).

In 1976 a Conference Committee accepted a five-year postponement of community rating for both basic and supplemental HMO health services. The Conference Committee acknowledged that prototype HMO's were not community-rated and that a new HMO needed a period of time to adapt to the concept (30, p. 25).

In regard to open enrollment, the 1976 HMO Amendments provided that a thirty-day open enrollment for an HMO was required if the organization had been in existence for five years, had an enrollment of 50,000 members, and incurred no fiscal deficit during the preceding year. The 1976 law, however, stated that the Secretary of HEW could waive this
requirement if the HMO could demonstrate that open enrollment "would jeopardize its economic viability in its service area" (38, pp. 1946-1947).

In 1978 the General Accounting Office (GAO) reported that HEW was not actively enforcing the HMO Act's open enrollment provision (42, p. 35). The GAO, under its statutory requirements, reviewed the activities of fourteen HMO's receiving assistance under the HMO Act. The GAO claimed that there was little evidence that these HMO's had enrolled a broadly-representative population (42, pp. 26-27).

On March 3, 1978, in a hearing, Kennedy inquired from GAO representative Thomas J. Schulz as to how much open enrollment was taking place in the nation's HMO's. The GAO witness pointed out that several of the HMO's reviewed had asked HEW for waivers concerning open enrollment. He said, "I guess the silence they received was confirmation" (42, p. 36).

HMO Service Requirements

*Business Week* magazine detected a "Catch-22" provision in the 1973 HMO Act. While mandating an HMO option in Section 1310, the 1973 law required HMO's to render too many services and the cost attributable to these services made HMO's non-competitive with other types of health plans (9, p. 75). In 1975 James A. Lane, a representative of the Kaiser Foundation Health Plans, stated that the benefit
requirements of the 1973 HMO Act had the effect of making HMO's less competitive. He told the Senate Labor and Public Welfare's Health Subcommittee that federal benefit requirements would increase Kaiser's cost by 10 per cent in Northern California. He believed that the 1973 Act's supplemental health service requirements were unreasonable (40, pp. 344-345). Walter McClure, Director of Interstudy, claimed that federal benefit requirements would make HMO's attractive only to the "very sick" and "very old" (40, p. 352).

In its attempt at differentiating HMO's from more traditional forms of health care, the House Committee on Interstate and Foreign Commerce declared that federally qualified HMO's must offer a list of specified services on a twenty-four hour, seven-days-a-week basis. The Committee said also that HMO enrollees must be informed how and from whom the specified services will be delivered. In other words, the Committee was of the opinion that an HMO must be able to deliver whatever services that may be necessary to maintain the health of its enrollees (32, pp. 9-11).

The 1973 Senate HMO bill (S. 14) contained language not found in the House bill (H.R. 7971). The Senate version represented a more concerted federal attempt to intervene in and restructure the nation's health delivery system than the House bill. The Conference Committee Report on the 1973 HMO Act relied mainly upon the House version of basic services. Senate bill S. 14 required additional services from HMO's.
These included the provision of drugs, social services, mental health services, dental services and physical therapy. The Conference Committee Compromise of 1973 included these services as supplemental health services. The conferees said also that an HMO must offer supplemental services if manpower was available (29, pp. 27-30). The basic health services required by the 1973 HMO Act included physician services; inpatient and outpatient hospital services; emergency health services, short-term outpatient mental health services; alcohol and drug abuse services; diagnostic, laboratory, and therapeutic radiologic services; home health services; preventive dental and vision services; and family planning services (37, p. 917).

Federal supplemental service requirements have also caused concern among those involved in HMO health care. In 1975 the House Committee on Interstate and Foreign Commerce acknowledged that one of the difficulties of the 1973 legislation was that it required supplemental health services which HMO members did not want (34, p. 11). In 1973 the Committee had advocated that prescription drugs be included as an HMO supplemental service, due to the economies which HMO's could achieve in drug distribution (32, p. 121).

Christopher Rodowskas and Jean Cagnon, however, question the ability of HMO's to perform as a drug dispensary. They contend that HMO's serving as a druggist would cause
members inconvenience in terms of having to travel a farther
distance to obtain drugs at the HMO facility. They argue
that the problem with outpatient prescription reimbursement
plans centers around drug cost. It is their opinion that no
acceptable method has been worked out to accurately calcu-
late drug dispensary costs (6, pp. 609-611).

Regarding supplemental health services, conferees in
1976 accepted House amendments which permitted HMO's to in-
clude supplemental health services as basic services. This
was done to accommodate state laws which require additional
services than the HMO law required. In 1976 the HMO law was
changed to require only those supplemental services for
which HMO members have contracted (30, pp. 19-20). In 1976
dental care was removed as a preventive health service while
immunizations and well-child care were added (38, p. 1947).

Questions of Co-Payments

Before HMO's become more widely accepted, they must deal
with the issue of co-insurance and co-payments. Traditionally,
insurance policies in the United States have not covered the
entire amount of incurred injuries or damages. Through
deductibles and co-insurance, policyholders have been required
to make up the difference between policy coverage and actual
cost.

Victor G. Hallman, III, contends that limitations on
coverage, such as co-insurance requirements, deductibles,
and inside limits, add to consumer cost and reduce medical coverage, but limit insurer liability. This observer claims that the insurance industry justifies co-insurance on both moral and financial grounds. Primarily they serve as a means of causing the consumer to exercise caution in building up large medical bills (15, pp. 3-5). Hallman states that in 1972 few group medical policies provided for prolonged or excessive medical expense coverage (15, p. 10).

From an insurance perspective, without limits on health coverage, doctors and other health personnel have an incentive to overcharge for their services (15, p. 12). One AMA officer has claimed that if co-insurance was 100 per cent of medical bills, hospitalization would be reduced by 40 per cent. This reduction would occur if the individual was required to bear the entire social cost of hospitalization (14, p. 101). Hallman, however, maintains that maximum dollar coverage on health insurance policies does not limit medical costs (15, p. 12).

The insurance argument for limited coverage is based, in part, on the concept of "moral hazard." According to this theory, groups that are insured against risks tend to become victims of those risks to a greater extent than non-insured groups. Insurance companies use the moral hazard argument to explain why insured bankrupt businesses catch fire to a greater extent than financially-sound businesses. The cause of
this type of accident, according to insurers, is due to the lack of "morality" on the part of the insured (14, pp. 100-101).

Herbert Grubel maintains that it would be impossible to enforce a law controlling for the "moral hazard" of human behavior, even if such a law would be in society's best interests. He states,

This is so because no one can prove in any court of law that a given patient who stayed in a hospital five days with the costs paid by his insurance would have stayed fewer days, had he been forced to pay the costs out of his own pocket. . . . (14, p. 103).

He, however, is of the opinion that the coverage of the traditional American health plan has a significant impact upon a doctor's decision to commit a patient to a hospital and the length of stay in a hospital (14, p. 101).

Another argument which may be used against HMO coverage is the diffusion-of-responsibility hypothesis. According to this theory, individuals in groups are freed from emotional responsibility by the condition of their group membership. The anonymity of the group justifies behavior which would be intolerable to an individual outside the group (8, p. 79). If this hypothesis has relevance to the HMO program, it raises the question: Can the federal government mandate responsible risk-accepting behavior on the part of an HMO and expect success when group norms resist the fixing of individual responsibility?
Joseph Newhouse and Vincent Taylor assert that, with government subsidies, "People will upgrade the quality and quantity of medical services they consume beyond the level they would choose if they had to pay all of the costs themselves" (25, pp. 85-86). They maintain that all of the proposed national health insurance plans "have not found a way to transfer an appropriate amount of money to the sick person without subsidizing the price of the health service and distorting the overall pattern of consumer choice and resource allocation" (25, p. 86).

Newhouse and Taylor argue that added health insurance coverage has some bad effects. It increases demand while simultaneously raising prices. They state, "This happens because insurance shelters people from the full impact of price rises and thus greatly diminishes the normal tendency of rising prices to curtail demand" (25, p. 81). They add, "Medical insurance also contributes to inflation by reducing consumer's concern for the cost of care they receive (25, p. 82).

In 1972 Paul G. Rogers, House Subcommittee Chairman, wanted to know how HMO's kept out patients who had only minor problems. James Brundle of Health Insurance Practice of New York, who was Chairman of the Board of GHAA, said that it was not the policy of HMO's to keep people away but to educate them concerning when they needed to seek care.
Frank Newman, M.D., of the GHAA stated that HMO's should set up appropriate waiting periods for different types of treatments (31, pp. 290-291).

In 1975 Ben Lawton, M.D., President of Marshfield, Wisconsin's HMO, told the Senate Subcommittee on Health about the transition of the Marshfield Clinic into an HMO. He claimed that the HMO did not greatly change people's habits of going to the doctor. The initial increase in utilization in his HMO was due to the fact that the Marshfield area had formerly been substandard in terms of utilization. The fear of over-utilization, which causes insurance companies to advocate and doctors to speculate that everybody will flood into their offices, was not a problem, according to Lawton (40, p. 420).

In 1973 Senate bill 3.14 prohibited HMO co-payments, but the Conference Committee accepted the House version, which permitted nominal co-payments. Health Maintenance Organization co-payment rates were to be fixed by the Secretary of HEW, but they could not exceed 20 per cent of the total cost of HMO services or exceed 50 per cent of a single HMO's service (29, p. 32).

In 1968 Anne A. Scitovsky and Nelda McCall studied the effect of a 25 per cent co-insurance payment upon the demand for services from Stanford University's Group Health Plan (GHP). After co-payments had been required for one year, demand for doctor's services dropped 24 per cent. Demand
for hospitalization dropped only a small amount and demand for children's services changed hardly at all. The researchers wanted to know if the impact of co-insurance payments on demand for doctor's services was only temporary and whether co-insurance justifies its added administrative costs (27, pp. 19-20).

In a follow-up study by the same researchers, it was demonstrated that, with co-insurance required by the GHP of Stanford University, the plan was less appealing to the non-professional members on the Stanford staff. From 1966 to 1972, total enrollment of the plan dropped from 3,819 to 3,038. Non-professionals accounted for 23 per cent of the GHP membership in 1966 and 16 per cent, in 1972 (27, pp. 20-21).

Scitovsky and McCall contend that comparison among HMO's concerning the degree of user rates is difficult due to different demographic characteristics of the populations. They claim that the definition of an office visit varies from plan to plan and record-keeping procedures vary (27, p. 24). These researchers assert that constraints on HMO utilization rates include long waiting lines and prices. They maintain that the impact of co-insurance is of long-range importance to HMO membership and enrollment policy.

The Kaiser Foundation plan, with no co-payments and lower monthly premiums, was also offered to Stanford
employees. Out of 1,362 non-professionals covered by the two HMO's, 74 per cent chose Kaiser. These same researchers concluded that "... a plan with a relatively heavy co-payment for physician services does not attract lower income families" (27, pp. 26-27).

The use of co-payments by HMO-like plans is another example of HMO's using traditional health insurance control techniques to structure demand for physician services. The attempts of some HMO's to exclude high-risk groups from their service areas raises doubts concerning the ability of HMO's to offer their type of health care to a "broadly representative" cross section of the community. The Controller of the Kaiser-Prudential Health Plan of Dallas, Texas, argues that "HMO's are not for everyone" (20). With the high cost of doing business in the health field as a starting point, HMO's must bring in enough revenue to meet cost. This may cause the HMO planners to design an HMO service area to serve basically high-income clients. The same Kaiser official contends that HMO's must exist in a high density, urban area to be successful (20).

As HMO's adjust to the realities of the health marketplace, it appears that federal qualification is important in terms of marketing HMO health plans. Open enrollment, community rating, and consumer participation requirements of federal HMO legislation may be viewed as inconveniences
which can be controlled by location of HMO facilities and the marketing of HMO plans to only a certain type of consumer. Isolating HMO's to service only the middle class and middle-aged groups in the nation may be the result of governmental health policies, as well as private insurance practices.

The Fair Market Test

Section 1310 of the HMO legislation is considered to be one of the most important provisions of the federal HMO program. The "dual option" provision of Section 1310 requires employers with twenty-five or more employees to offer an HMO option to its traditional health insurance plan, if a qualified HMO is available. This provision was designed to give HMO's a "fair market" test with traditional health insurance. The Act required that the dual choice requirement be confined to qualified HMO's. The 1973 legislation defines a "qualified" HMO as one "... which has provided assurances satisfactory to the Secretary ..." that it meets the organizational and service requirements of the Act (37, p. 930). Dual option enables an HMO meeting federal standards to be offered to employees in large corporate settings (22). General Motors, Ford, Aluminum Company of America, J.C. Penney, Sears, U.S. Steel, Dow, General Mills, American Can Company, and Sun Oil are some of the large corporations which offer an HMO option to their employees (17, p. 1148). Non-qualified HMO's cannot be
mandatorily offered as a dual choice and its services must be marketed without the authority of the dual option provision. The dual option provision may, in fact, be the real teeth behind the HMO Act. Its market potential is important to various groups and insurance companies interested in sponsoring HMO's.

In 1975 Michael Henry, representing the nation's Blue Cross plans, said that Section 1310 requirements of the 1973 legislation were unreasonable, since most large corporations have a widely dispersed employee population. He favored changing the law to make the dual option mandatory only if twenty-five employees lived in an HMO service area (40, pp. 399-400).

The dual choice provision of the 1973 HMO Act required the employer of twenty-five or more to offer an HMO option if a qualified HMO existed in the service area. House bill H.R. 9019, which was the basis for the HMO amendments of 1976, required twenty-five employees to live in an HMO service area before dual option was required. The Senate bill (S. 1926) defined an HMO service area as a geographical area which was "conveniently accessible" to the members of the HMO. In regard to the 1976 amendments, the Conference Committee accepted the House version but left the concept of service area undefined (30, p. 27).

The Conference Committee accepted from the House bill a provision which authorized the Secretary of HEW to give
formal notice to HMO's not meeting the service or organizational requirements of loss of federal qualification (30, p. 30). The HMO Amendments of 1976 also stated that an employer who did not comply with Section 1310 requirements "shall be subject to a civil penalty of not more than $10,000" (38, p. 195).

James E. Anderson, Counsel of Connecticut General Life Insurance Company, expressed concern about dequalification of HMO's in regard to Section 1310 certification. He stated that the complexity of the Act and its regulations made it difficult for HMO's to operate. He claimed that Section 1310 might be used as a weapon of HMO's in competition against each other. He argued that non-qualification should not be viewed as a stigma upon an HMO (40, pp. 306-307).

In regard to the question of non-compliance with Section 1310, in 1976 Congress accepted the House position which authorized the Secretary of HEW to study the gravity of non-compliance and good faith of the employer before bringing civil action. The 1973 HMO Act considered non-compliance a "willful violation" in itself.

Private Insurance Involvement in HMO's

The involvement of private insurance companies in HMO's basically coincided with the Nixon Administration's HMO initiative. Since health insurance is the basic product of Blue Cross, their concern was with the possible loss of
their role under a National Health Insurance bill. In 1973 Walter J. MacNerney, President of Blue Cross, supported Blue Cross involvement in HMO's. John Iglehart claims that this was a survival tactic (18, p. 1830).

In July, 1975, House HMO hearings, Lawrence C. Morris, of the National Association of Blue Shield Plans, favored eliminating many of the required HMO benefits, in order to reduce HMO premiums. He favored eliminating open enrollment and community rating requirements (35, pp. 112-113). He stated that Public Law 93-222's organizational requirements hurt HMO growth and that several insurance carriers already marketed HMO-like plans. If these plans could qualify under the HMO Act, existing insurance arrangements could be more fully utilized. He testified that HMO medical care, but not its administrative costs, was cheaper than traditional medical care (35, pp. 110-111).

The Blue Shield representative also wanted more flexibility in HMO organizational requirements (35, p. 118). Richardson Preyer (U.S. Representative from North Carolina) stated that the legal entity requirement of the 1973 HMO Act was included to create an "arm's length" relationship between the HMO and its providers, to place some risk on the provider, and to aid in the maintenance of good records (35, p. 117).

As insurance involvement in HMO's has increased, it has become increasingly difficult in some cases to distinguish
HMO operations from traditional health insurance practices. For example, Seymore A. Fenichel, an insurance actuary said, "The calculation of a capitation rate for its members is related to the typical actuarial function of calculations of an insurance premium. The objective is a capitation rate that is 'necessary and sufficient' for the operation of the HMO" (11, p. 58). Fenichel contends that actuary methods can help HMO's in considering the adverse selection of enrollees, the probabilities of the occurrence of expensive treatments, the cost of out-of-plan services, and the use of capitation payments to secure needed reserves (11, p. 60).

He raises some important questions concerning HMO operations, which include: Should savings due to lower HMO hospitalization rates be used to reduce enrollee capitation payments or should they be used as provider incentive payments? Should HMO coverage be experience rated? Should HMO's require risk sharing by HMO doctors? How are deductibles to be used in HMO operations? What degree of variation is possible from HMO to HMO? Does dual choice mean that HMO coverage must be equal or greater than private insurance coverage? (11, pp. 59-60).

These actuarial-underwriter questions tend to be based on a profit-making insurance orientation toward health care. They raise the issue of whether incorporation of insurance companies into the HMO field leads to risk and
profit-oriented HMO's rather than to non-profit HMO's basically concerned with the long-range health of its members.

In mid-1973, fifty-one insurance companies were involved in seventy-one HMO's (11, p. 57). In 1975 Blue Cross announced that it was involved in the sponsorship of one-third of the nation's 170 HMO's and that Blue Cross investment in HMO's was thirty-eight million dollars (40, pp. 399-400). By 1978 BC-BS had HMO operations in twenty-six states (36, p. 182).

The concept of consumer participation in the decision-making process of health care is a relatively recent phenomenon in the United States. The 1973 HMO Act required that one-third of an HMO's policy-making body be members of the HMO and that there be "equitable representation" from "medically underserved populations" (37, p. 916). The HMO organizational requirement that consumers be given an active role in policy making of the organization may run counter to the traditional passive role of the American health care consumer in various types of health plans. Milton I. Roemer asserts, "The American pattern of insurance, sponsored by the providers of health care and by private insurance companies instead of consumers, has been almost unique in the world scene" (26, p. 35).

Frank E. Harrelson and Kirk M. Donovan maintain that health care institutions and insurance companies have not been receptive to the concept of consumer participation.
The traditional role of the consumer was defined as voluntary work and honorary appointments to various boards. These sources imply that the new active role of the consumer must first be developed and learned and that this is no easy task (16, pp. 1077-1078).

The case of the consumers' council of the Columbia Medical Plan, sponsored by Johns Hopkins Medical School and the Connecticut General Life Insurance Company, in the New Town of Columbia, Maryland, may illustrate some of the difficulties in achieving meaningful consumer participation in an HMO. After the first year, five consumer members of the council claimed that their advice was not being requested by the plan administrators concerning hospital-community relations and other plan issues. The consumer members on the council also felt they were being asked to be a rubber stamp. Many of the plan members were professionals, who worked for HEW and the Social Security Administration and had the expertise to conduct budget evaluation and other types of PPGP reviews. Despite the quality of the consumer council members, the Connecticut General Life Insurance Company and the plan's providers, the Columbia Hospital and Clinic Foundation, were not responsive to consumer budget intervention (16, pp. 1079-1082).

On June 30, 1978, Roger H. Graham, Assistant Vice-President of Health Systems of Blue Cross and Blue Shield, supported a House amendment which would give to the Secretary
of HEW the authority to approve HMO enrollment procedures. However, Graham stated ". . . but it is inappropriate to regulate the entire scope of HMO marketing activity. Simply stated we oppose intrusion into reasonable management prerogatives" (36, p. 182).

The Blue Cross spokesman admitted to members of the House Subcommittee on Health and the Environment that federal qualification was important for private companies involved in HMO's. He confirmed the point that many employers would not offer an HMO option unless the HMO was federally qualified. He stated that the HMO Act's requirement that one-third of its policy-making board be members of the HMO placed private sponsors of an HMO in a "dilemma." He cited the case of a large employer who wants to form an HMO but cannot ". . . accept HMO members as one-third of its board, given the realities of private ownership" (36, p. 183). In this testimony Graham may have deliberately attempted to confuse the issue by equating a corporate board with an HMO board. The HMO Act requires that one-third of the members of an HMO's board consist of health care consumers. The HMO law does not require a private corporation's board to be composed of one-third consumers.

The 1978 Amendments failed to exempt HMO's from the requirement that one-third of the HMO board members be consumers. After this occurred, one state Blue Cross Association withdrew its efforts to obtain federal qualification
for an HMO jointly sponsored by the Blue Cross and a county medical society (23).

In the House HMO hearings of 1978, Thomas J. Schulz of the GAO reported an example of one HMO whose financial affairs were entirely administered by an insurance company. Schulz confirmed that "... the HMO never asked for an audit on how much it cost to administer these services" (36, p. 145). Gary Kunkle, a Supervisory Auditor of the GAO, informed the House Subcommittee that the HMO's organizational chart diagrams itself as an independent entity, but the insurance company's chart classified the HMO as part of the insurance company (36, p. 144).

In the 1973 HMO Act, Congress attempted to distinguish HMO practices from those of private health insurance companies. In this effort, Congress designed organizational, service, and enrollment standards for HMO's that have been very controversial. The 1973 legislation stipulated that an HMO which complied with the standards of the Act would be entitled to the marketing benefits of the Act. In 1976 Congress amended the HMO Act's oprn enrollment and service requirements to make HMO's more competitive from a marketing perspective.

With political pressure on HEW to promote HMO's, there may be a tendency for the federal government to overlook the fact that HMO practices may be nearly identical to those of
traditional insurance plans in the United States. Reports to Congress in 1978 revealed that little open enrollment has taken place within HMO's studies by the GAO. The issue of insurance company involvement in HMO's raises many difficult questions. However, the federal government's attempt to promote HMO's may have little chance for success without the participation of private insurance companies in HMO development.
CHAPTER BIBLIOGRAPHY


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HMO's and Medicare

The adaptation of HMO's to the federal Medicare program has proven to be a difficult task. Federal Medicare legislation in 1965 basically established a fee-for-service method of reimbursement (33, p. 626). According to Leda Judd, Medicare has also had a great effect upon medical care inflation in the United States (10, p. 206).

Doctors participating in Medicare receive fees based on a complicated formula. Anne R. Somers and Herman M. Somers contend, "The complexity of the formula is beyond the comprehension of anyone other than an accomplished statistician and has been a growing source of bewildered resentment" (16, p. 464). Joseph P. Newhouse and Vincent Taylor contend that under Medicare and Medicaid, "Physicians are paid for the services they render provided their fees meet rather loose standards" (12, p. 83). They add, however, that the regulation of doctors' fees is not an easy task (12, p. 83).

Frank A. Sloan and Bruce Steinwald are of the opinion that comprehensive health plans may have little chance in attracting doctors to service the elderly. They argue, "In
general, measures adopted to economize on reimbursements tend also to reduce the participation rate because fewer physicians will be willing to accept the plan's reimbursement as payment in full" (15, p. 258). According to Sloan and Steinwald, the Social Security Administration (SSA) maintains that high fee reimbursement schedules are an incentive for physician participation in Medicare (15, p. 259). The decision of a doctor to participate in a Medicare plan involves demand, supply, and takes other plan-related benefits into consideration. Sloan and Steinwald also allege that "... participation in Blue Shield is analogous to acceptance of Medicaid patients and assignment of benefits under the Medicare program" (15, p. 257).

Daniel Tiberi, A. N. Schwartz, and W. C. Albert assert that the federal government, in effect, allows Blue Cross and Blue Shield to "check, audit, and authorize" Medicare payments to doctors and hospitals. This, they argue, represents a conflict of interest, because the providers who are in control of the Blues authorize payment to other doctors. These authors allege that this is a dubious policy, because the reimbursing authority is seen as having unlimited funds (17, p. 281).

Another opinion holds that Medicare and Medicaid have made it possible for many low income groups to obtain health care. But the costs of these programs brings up the question of how far the nation should go in providing more and better
medical services (12, pp. 80-81). Newhouse and Taylor assert that "... we will pay for this achievement by having a larger share of our production resources devoted to medical and a lesser share to other goods and services" (12, p. 79).

Fred Anderson contends that Medicare and Medicaid are wasteful because they encourage unneeded use of hospitals by reimbursing many services that are exclusively available in a hospital (1, p. 15). Eli Ginzberg claims that the American Hospital Association supported Medicare reimbursement with its promise of full reimbursement for care of the elderly (5, p. 386).

Prior to the passage of Medicare, the elderly were considered to be a high-risk group and were not sought by PPGP's. The costs were considered too high. After 1965 there was renewed interest on the part of PPGP's in servicing the elderly (13, p. 630). The 1965 Medicare legislation stated that an organization which provided medical care on a prepayment basis could choose to be paid 80 per cent of the "reasonable cost" of their services (13, p. 624). Eligibility requirements for PPGP participation in Medicare included the requirement that the prepayment plan must be a formal organization with contractual arrangements with three or more full-time doctors (13, p. 625).

Initially the Social Security Administration recognized three types of PPGP's. These were community, employer-employee, and physician-sponsored PPGP's. The problem of
adapting fee-for-service concepts of retrospective cost reimbursement to HMO prospective prepayment formulas proved to be a difficult task. Over a period of two and one-half years, the SSA devised a makeshift system for making interim payments to PPGP's. The amount received by the PPGP was based on the adjusted cost of the PPGP operations during the preceding year. The SSA assumed responsibility after deductibles were subtracted for 80 per cent of PPGP costs (13, pp. 626-628).

Prepaid group plans dealt with the SSA in different ways, according to the nature of their plan. The clinic-based Group Health Association of Washington, D. C., dealt with the government through intermediaries on a fee-for-service basis. Kaiser and the Health Insurance Plan of New York classified themselves as the fiscal intermediary for their group. The Group Health Cooperative of Washington's dealings with the SSA were direct and not through an intermediary (13, p. 631).

During the early 1970's, the House Ways and Means Committee was much less skeptical than the Senate about potential Medicare payments to HMO's on a prospective per capita basis. The House formula would have based Medicare prepayments to an HMO based on 95 per cent of the estimated amount of covered services, that is, the cost of the same services if they were provided outside the HMO (23, p. 90). This
payment formula, according to the Committee on Ways and Means, would save the federal government 5 per cent on Medicare costs (23, p. 91). The House also stressed that, under the 1965 Medicare reimbursement policy, there was no incentive for HMO's to keep costs low, since payments to HMO's were based on fee-for-service cost concepts. Under the retro-spective cost system, the House Committee argued that there was an economic incentive to perform non-essential services (23, p. 89).

The Ways and Means Committee was also concerned about the possibility of excess HMO profits. A provision in the House bill was designed to eliminate an excessive amount of HMO "rate retention." According to the House formula, the net profit of an HMO for its Medicare members could not exceed the profit made from coverage of HMO members under sixty-five. The House required that one-half the members of a Medicare-qualified HMO must be under sixty-five years of age (23, pp. 90-92).

The Senate Finance Committee also recognized the incentives of HMO's to achieve efficiency. But this Committee said, "On the other hand, there is also present in such systems an economic incentive to provide less care than is necessary so as to reduce costs and further maximize financial gain" (29, p. 132).

In 1971 the Senate supported a 95 per cent reimbursement formula, but only if the HMO gave assurances that excess
payments be used to add services or to reduce the premiums for its members. The Senate was concerned that the prospective formula might lead HMO's to provide poor quality health care. The Senate proposal would have established an Office of the Inspector General to monitor HMO quality (29, pp. 132-133).

Indications of the eventual position of Congress were expressed in the Senate's concern for safeguards against HMO abuse. In arranging federal payments to HMO's, the Senate Finance Committee said, "... such negotiations will be conducted, on the part of the government, on an arm's length basis by qualified and expert personnel" (29, p. 134). In 1971 the Senate favored giving the Secretary of HEW the authority to retroactively adjust payments to HMO's. This was a necessary precaution, according to this Committee (29, p. 135).

The Senate Finance Committee supported strict oversight of HMO's in Medicare. This was required to assure that beneficiaries are not deprived of benefits through devices such as scheduling appointments at inconvenient times ... and avoiding discrimination against poor health risks through selective enrollment or poor service aimed at encouraging disenrollment of high users of services (29, p. 138).

The Finance Committee was concerned with HMO-type group practices, whose doctors service both prepayment and fee-for-service patients in the same facilities. The Senate Committee foresaw the possibility of this type of HMO encouraging
its high-risk Medicare members to leave the HMO and receive care from the same doctors, at the same location, on a fee-for-service basis. The position of the Committee was that an HMO should not be able to change back and forth between cost and prospective formulas in the Medicare program (31, pp. 238-239). The Committee also stressed that HMO deductibles and co-payments should not exceed the value of standard Medicare rates (31, p. 243).

The primary objection of the Senate to the prospective HMO Medicare formula of the House was based on the belief that methods of prospective per capita determination were not precise enough to prevent HMO abuse and overpayment. The Finance Committee asserted,

First it is clear that the actuarial adjustment process used to determine the amount payable to the HMO will not be of sufficient precision. . . . Factors such as enrolling the disabled and covering the cost of maintenance drugs would involve estimates with which experience is very limited (31, p. 230).

The Committee suspected HMO's could make unjustified profits by enrolling only healthy Medicare members. Similar profits could be made if HMO's gave poorer service by "less qualified" doctors.

The Senate Finance Committee must be given primary responsibility for the restrictive Medicare reimbursement policy toward HMO's. This Committee supported an HMO reimbursement plan that eventually became the basis for HMO reimbursement under the 1972 Social Security Amendments.
In 1972, Social Security amendments revised the procedures for HMO reimbursement for Medicare clients. The 1972 Act defined an HMO as a more inclusive concept than a group practice prepayment plan. The legislation specified two kinds of HMO's, an "established" HMO and a "developing" HMO. An established HMO was one which met all of the Act's statutory and regulatory requirements. Under the statute, a developing HMO could only be reimbursed on a cost basis with retroactively-adjusted interim payments based on cost and utilization data (32, pp. 10-11).

The 1972 Social Security Amendments state that if an HMO has 25,000 members and has served 8,000 prepaid members in the past 2 years or is a non-urban HMO with 5,000 members which has served 1500 persons for 3 years, prior to its Medicare contract, it may enter into a risk-sharing contract with the federal government (24, pp. 1402-1403). An established HMO may choose to be reimbursed under a cost or risk basis. The risk formula allows an HMO to receive interim payments based upon an HMO's estimated cost. At the end of the year, the HMO must present a report of its actual cost. These HMO costs are then compared with a Medicare population of similar size receiving fee-for-service care (32, p. 11).

In relation to interim payments, the legislation states that HMO reimbursement " . . . shall be determined by the Secretary on the basis of each organization's annual operating
budget and enrollment forecast . . ." (24, p. 1397). The interim per capita payments are to equal the estimated per capita cost of providing the required services. Although the 1972 legislation allowed for advanced interim payments, it also specified that final reimbursement for allowable costs to the HMO will be retrospectively determined (4, p. 131).

The legislation also requires that if actual HMO costs are less, savings up to 20 per cent will be shared equally by the HMO and the Medicare Trust funds. Savings in excess of 20 per cent goes initially to the Medicare Trust funds. If the actual HMO costs exceed interim payments, the legislation states that the loss is to be "absorbed" by the HMO (24, p. 1397).

The legislation did little to promote, and much to block, HMO expansion through Medicare. According to Judith Feder, the incentives for prospective payments were not enough to justify the added qualifications imposed by the legislation. Two years after the passage of the Act, little enthusiasm on the part of HMO's was shown for the risk-sharing reimbursement method (4, p. 132).

According to John Iglehart, the SSA was in a quandary in regard to expanding the role of HMO's in Medicare. From 1967 the SSA had statutory authority to undertake reimbursement experiments. Health Maintenance Organizations were included under this authorization. Iglehart contends that the SSA was cautious about expanding HMO Medicare use. The
reluctance of the SSA to push HMO's was based, in part, on the anticipation of a major HMO initiative by Congress (8, p. 1449).

The Bureau of Health Insurance within the SSA also opposed HMO experimentation. This agency's caution was based on the fear that, once excessive payments to an HMO were made, they would be impossible to recover. The SSA approached pre-payment with "extreme caution," in part, due to the fear of being "ripped off" by PPGP's (4, p. 131).

In 1970 there were only thirty-four prepaid group plans participating in Medicare, representing only one and one-half per cent of the Medicare population (2, p. 5). In 1975 there were 378,569 Medicare recipients in HMO's. This was a small fraction of the 23.3 million Americans enrolled in the entire Medicare program (7, p. 1163).

On June 13, 1975, Caspar Weinberger, Secretary of HEW, proposed that the Social Security Act be amended to promote HMO prospective reimbursement. This move was opposed by the Social Security Administration, which clung to its belief that the HMO's would underservice Medicare members. John Iglehart contends that "SSA has a strong ally in its concern in Jay Constantine, a professional staff member of the Senate Finance Committee, who helped fashion the restrictive Medicare policy toward HMO's which is part of the Social Security Amendments of 1972" (7, p. 1163).
According to Judith Feder, SSA resisted the Nixon Ad- 

ministration's HMO initiative. The SSA's position was that the 
experimentation needed to monitor an HMO Medicare program was 
beyond the personnel capacity of the agency. The necessary 
experiments could not be accomplished, according to SSA, with- 
out a long-term political commitment to HMO's (4, pp. 131-
133). According to one HEW employee, the working relation-
ship between the Health Care Finance Administration and the 
Office of Health Maintenance Organizations is not open or well-
established. This person maintains that the suspicions of the 
Medicare program toward HMO's in general are not based on hard 
facts (9).

Feder sees a political motive behind the SSA's attitude 
toward HMO's. The HMO initiative was resisted by the SSA so 
as not to alienate its clients, the health providers. She 
claims, "In part this stemmed from their general avoidance of 
political and administrative conflict. But it also seems re-
lated to their running a payment program rather than a health 
program" (4, p. 135).

Marc Rogers and Ted Bogue, on the other hand, are of the 
opinion that the federal government could subsidize HMO's who 
take Medicare members. They argue, "This could be accomplished 
by sliding the base capitation payment to the HMO up or down 
relative to the 'healthiness' or need of its members" (14, 
p. 675). However, these writers also see in such a formula a 
possibility of abuse. The HMO might classify its Medicare
members in a less healthy category than the one in which they should be classified. Another possibility is that an HMO might allow its costs to increase and claim to have a less healthy membership (14, p. 675).

One place in which the HMO legislation has had some influence over the Social Security health programs is in the definitional and organizational requirement categories. In the Medicare section of the 1976 HMO Amendments (Public Law 94-460), changes were made in Title XVIII of the Social Security Act to correspond with HMO definitional requirements in Title XIII of the Public Health Service Act. In 1976 the Conference Committee accepted these changes from the Senate Amendments. The Conference Committee announced that its members had consulted with the House Ways and Means Committee and the Senate Finance Committee on this matter. The Senate Amendments were accepted by the Conference Committee because they created more uniformity in the federal HMO policy (18, p. 33).

The Conference Committee recognized that the 1973 HMO Act did not provide an administrative device for the HMO provisions of Title XVIII. The 1976 Senate HMO bill required Medicare-qualified HMO determinations to be made by the Assistant Secretary of HEW through the Office of the Assistant Secretary of Health. In making these determinations, the Assistant Secretary was to take into consideration the
continuing regulation requirements of Section 1312 of the Public Health Service Act (18, p. 33).

As of 1979, HMO's have not made great inroads in providing medical care for the nation's elderly population. The enrollment policies of pre-HMO PPGP's did not focus on the elderly. The question of future HMO use by the elderly may have been best represented in a statement by Jeffrey Cohelan, Director of the Group Health Association of America, in response to a 1971 Senate Finance Committee probe. Cohelan was of the opinion that Medicare enrollment in HMO's would be "slow and steady," reflecting HMO acceptance by the general public. According to Cohelan, Medicare members would be hesitant to change from traditional patterns of health care (30, p. 2391).

The reluctance of the Social Security program to encourage a larger Medicare role for HMO's may be of considerable importance in explaining why the HMO movement cannot be regarded as a major success.

HMO's and Medicaid

The history of HMO service to Medicaid recipients has been one of considerable controversy. In 1970 HEW encouraged the states to experiment with a broader use of PPGP's for their Medicaid population. In that same year, the Maryland State Department of Health and Mental Hygiene began an experimental program to promote hospital-based prepaid group plans in Baltimore's inner city from Title XIX Medicaid funds. Reimbursement to the PPGP's was to be based on a
prospective formula that included union wage demands and "technical demands" of the new system (11, pp. 949-950).

Based upon a complicated formula, the State of Maryland was willing to pay between $225 to $290 annually for each Medicaid recipient in a PPGP. The formula took the sum of the number of actual outpatient visits per eligible Medicaid member in a previous year times the estimated cost of one outpatient visit plus the actual in-patient days per Medicaid enrollee times the cost of one in-patient day and added the cost of additional Medicaid reimbursable services (11, p. 950).

James Hester and Elliot Sussman allege that, in theory, prepayment promised to simplify the administration of Medicaid by eliminating individual Medicaid claims. But, in practice, the PPGP capitation rate is difficult to calculate for Medicaid recipients. They argue that fee-for-service utilization data from actuaries and insurance companies is unreliable (6, pp. 431-432). The task of calculating PPGP rates for Medicaid is also aggravated by the high eligibility turnover rate among Medicaid recipients (6, p. 425). The effect of high eligibility status change in the Medicaid population also makes it difficult to educate enrollees concerning the health plan's characteristics (6, p. 417).

Hester and Sussman also contend that, because the Medicaid member does not personally pay for many medical expenses, he lacks the incentive to enroll in a PPGP (6, p. 416). Peter
Levin maintains that some inner-city hospitals have a history of racism and this factor works against converting hospitals into HMO's (11, pp. 954-955).

On November 22, 1976, the Subcommittee on Oversight and Investigations of the House Interstate and Foreign Commerce Committee held hearings into the alleged HMO abuses in the California Medicaid (MediCal) program. Herschel Elkins, Deputy Attorney General of the State of California, testified that in the early 1970's the Health Department of California gave prepaid health plans (PHP's) the opportunity to service Medicaid recipients on a prepayment basis. Prepaid health plans (PHP's) was the name used in California for prepaid group plans (PPGP's). The Health Department specified that participating PHP's had to provide more health services than Medicaid members received under fee-for-service. The State of California was promised a 10 per cent savings in cost. Elkins then added, "Those companies began to arise and began to form and suddenly we discovered we were inundated with health plans . . ." (20, p. 93).

James Scheurer (U.S. Representative from New York) was concerned with reports that Omni-Rx and other PHP's in California were not providing adequate care to Medicaid enrollees. There was evidence that 27 per cent of the children enrolled in Omni-Rx had received no immunizations. There was also evidence that this PHP had no medical records on 3,500 of its Medicaid children (20, p. 116). The Congressman angrily
asserted, "It seems to me that the Federal Government ought to have some way; a computer ought to pop up a red flag when there are thousands of enrollees who are getting no health services at all and for whom patient files aren't even being kept" (20, p. 117).

Edward Dickstein, M.D., President of Omni-Rx Health Care and Chairman of the Board of Directors of Omni-Rx Health Systems, was questioned concerning the failure of his organization to pay contracted emergency health care bills for its Medicaid members. His PHP owed $2.8 million to Los Angeles County hospitals (20, p. 132). Despite testimony from Marvin Gasster, M.D., of the Los Angeles County Hospital, that Omni-Rx had not paid for the care of numerous emergency patients treated for internal bleeding and other serious injuries, Dickstein argued that public hospitals had performed unnecessary treatments and conducted unethical medical experiments on Medicaid PHP members (20, pp. 134-138).

In regard to the question of underservicing, Dickstein said that his plan did not have the obligation to make sure Medicaid children came for vaccinations. He stated that the service was available and that it was the obligation of the Medicaid patient to use it (20, pp. 144-145).

Henry A. Waxman (U.S. Representative from California) informed Dickstein that his organization received twenty-eight dollars per month for each Medicaid subscriber under fifteen years of age. The Congressman felt that the PHP had
the obligation to conduct a health screening for each child, keep adequate records, and give necessary vaccinations. Dickstein maintained that his PHP was entitled to the monthly capitation payment from the government, even if the patient never shows up (20, pp. 188-189). He also claimed that it was not his PHP which was at fault, but Medicaid eligibility standards (20, pp. 191-193).

According to James Hester and Elliot Sussman, the assumption that prepayment is a self-regulating mechanism for the Medicaid program has not been proven by experience. Overutilization has been replaced by underutilization and exclusion (6, pp. 417-418). From 1967 to 1974, one HMO, Health Insurance Plan (HIP) of New York, had in excess of 30,000 Medicaid members in approximately 30 medical groups in New York. The physician utilization of HIP's Medicaid members was only one-half to two-thirds that of regular HIP subscribers (6, p. 427). Hester and Sussman believe that successful use of prepayment for Medicaid depends on enrollee education and this is no easy task. These writers also claim that Medicaid agencies lack the capacity to monitor prepaid health plans (6, pp. 417-418).

In the California Medicaid program of the early 1970's, the HMO concept was tested on a large-scale basis. Out of this experiment has come numerous documented cases of HMO mismanagement, fraud, self-dealing, and windfall
profiteering. By 1976 the GAO and the Senate Permanent Investigation Subcommittee revealed that high pressure enrollment practices and substandard services were prevalent among the California PHP’s.

A report issued by the California Auditor General’s Office showed that, out of $56.6 million paid by the California Department of Health to 15 PHP’s, only $27.1 million or 48 per cent was spent for health services. The remainder was used for administrative services and profit (22, pp. 23-24).

A predominant practice among these same California PHP’s was to form for-profit corporations, to sell supplies and furnish services to the non-profit PHP’s. Amitai Etzioni and Pamela Doty contend that there are few laws to prevent non-profit HMO’s from becoming "legal fictions" or facades for profit-making organizations (3, p. 443).

Etzioni and Doty argue that "The essence of a 'not-for-profit' organizational structure is that the pecuniary interests of the trustees be decoupled from the rises and falls in the output and income of the corporation" (13, p. 435). For example, some HMO’s give doctors a bonus of any HMO surplus. These writers believe that this is a dangerous incentive due to the fact that, "The fewer services rendered, the higher the surplus, all things being equal" (3, p. 438). Robert Geist, M.D., sees a similarity between the HMO surplus bonus and referral fees in the fee-for-service sector. Fee-for-service
doctors get a bonus by prescribing more services; HMO physicians get a bonus by prescribing less (3, p. 439).

In 1975 David Vienna, Staff Investigator of the Senate Permanent Subcommittee on Investigations, revealed the pattern of PHP abuse. Medicaid patients were sent to unaccredited hospitals and nursing homes and high-pressure enrollment tactics were used by the prepaid health plans. He charged that California state health personnel were aware of these abuses, but did little to prevent them (27, p. 14). Vienna told the Subcommittee that, after the state paid monies to the non-profit HMO's, the entire amount would often be transferred to a for-profit management company, whose members were also on the non-profit HMO's board (27, p. 15). He also revealed a pattern of illegal kickbacks and commissions associated with the growth of consulting firms, which arose to assist the HMO's (27, pp. 47-50).

In its 1978 report, the Senate Permanent Subcommittee on Investigations alleged that the HMO Act had insufficient provisions to regulate HMO abuses. The Subcommittee said, "What the law and program regulations do not effectively cope with is the ability of HMO's to divert and misallocate Federal funds for private gains" (28, p. 55). The report recommended amendments in the HMO Act to make HMO officers liable for the fraudulent diversion of federal funds (28, p. 55).
In its California HMO inquest, the Senate Permanent Subcommittee on Investigations also found no "systematic" monitoring of PHP quality by HEW and lack of sufficient HEW staff to deal with PHP abuse. Health, Education, and Welfare was also "lax," according to this report, in its supervision of the California Medicaid program (28, pp. 49-56). Furthermore, the Subcommittee claimed that the HMO Act, as of 1976, did not adequately control many HMO marketing, enrollment, and corporate abuses (28, p. 41).

In its 1978 HMO hearings, the House Interstate and Foreign Commerce Committee also stressed the necessity of placing restrictions on HMO management practices. The Committee's bill allowed the Secretary of HEW to prohibit certain types of HMO Medicaid enrollment practices. The Committee credited the California PHP hearings by the Senate Committee on Government Operations as the basis for this amendment (21, p. 55). The bill also required the same reporting procedures in the HMO law as found in Sections 1124 and 1902 of the Social Security Act. Section 1124 requires HMO's to report the identity of its owners to HEW; Section 1902 requires full disclosure of HMO contracts which exceed $25,000 (21, p. 64). These sections of the Social Security Act were added by Public Law 95-142. They were part of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of the Social Security Amendments of 1977 (19, p. 18).
The 1978 Senate Amendments required each HMO to file an annual report showing that the HMO is fiscally sound and describing the transactions between the HMO and the "party-in-interest." "Party-in-interest" was defined as "any director, officer, employee, partner, person who is directly or indirectly the beneficial owner of more than five per cent of the equity . . . of the HMO" (19, p. 17).

The financial disclosure provisions in the 1978 HMO Amendments basically adhered to the Senate version, but House requirements of ownership information were also included (19, p. 18). The financial disclosure provisions in Sections 1124 and 1902 of the Social Security Act were included in the 1978 HMO Amendments (25, p. 2135). The 1978 Amendments also require the HMO to report transactions involving the sale or leasing of property, the furnishing of goods or services by the HMO staff, medical group, or Individual Practice Association, and the lending of money between the HMO and the "party-in-interest" (25, pp. 2135-2136).

The Senate report on the 1978 HMO Amendments warned against going overboard in condemning all HMO transactions as categorically abusive (26, p. 12). But the detail and inclusiveness of the financial disclosure provisions in the 1978 Amendments take notice that all has not gone well in efforts to promote greater use of HMO's in the Medicaid program. The amendments spell out federal apprehension of the idea of trouble-free, self-regulating HMO's.
The determination of whether the HMO program of the federal government has been a success must take into consideration the evidence of HMO abuse in the California Medicaid program. In 1978 the Senate Health Subcommittee of Edward Kennedy, which had once been an ardent supporter of a large-scale HMO program, recognized that the California scandals had jeopardized the entire HMO concept. The 1978 report of Kennedy's Subcommittee shows a changed attitude from its earlier endorsement of the HMO concept. Its report, reflecting the findings of the Permanent Subcommittee on Investigations, states, "The Committee believes that the nature of the fraud and abuse problem in the variable and still experimental HMO arena requires a careful screening of potential conflicts . . ." (26, p. 12). The admission that the HMO program was "still experimental" may, in fact, be an admission that the HMO program has not been a success.

The problems associated with Medicaid HMO's have done much to tarnish the reputation of HMO's in general. The California PHP scandals have also demonstrated the difficulties that both state and federal regulatory agencies have had in attempting to supervise HMO operations. Questions of quality of care, financial integrity, and profiteering associated with the California Medicaid program have broad implications for the entire federal HMO program.
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CHAPTER VI

DIFFICULTIES IN APPLYING ECONOMIC ANALYSIS TO HEALTH POLICY

The Health Care Market

The difficulties in applying economic concepts to the health care field are numerous. In the first place, the conditions of a competitive market may not be found in the health care field. According to Penny Feldman and Richard Zeckhauser, this is due to the fact that the consumer is a "captive" of both doctors and hospitals (12, p. 96). Richard Auster and Josephine Gordon concur with this analysis. They claim "a unique aspect of medical care is the extent to which the service provider determines the nature and extent of the services provided" (2, p. 295). Eli Ginzberg also contends that the competitive model does not suffice for evaluating the efficiency or effectiveness of health services (13, p. 382).

Open entry into the health care marketplace is controlled by numerous restrictions. It is partly denied due to the fact that "licensure restricts specific health care tasks to individuals with specific training credentials" (4, p. 210). Clark C. Havighurst holds that numerous
professional and legal restraints prevent the health care market from achieving its potential level of efficiency (17, p. 717). An example of one such legal barrier is law which prohibits advertising of the prices of medical services. Charles W. Baird objects to this type of restriction and he thinks that the public interest would be better served if doctors were allowed to advertise. He also believes that the provision of health services must not be regarded as different from other types of goods and services (3, p. 65).

Despite arguments in favor of competition, there is, on the part of many, a fear and distrust of the profit motive in the health field. Avedis Donabedian is one such person and he argues that "... emphasis on price competition and on corporate profit represents values foreign to the ideals, if not the practice, of medicine" (9, p. 244). Donabedian denounces the corporate practice of medicine for its size and its exaggerated claims of efficiency and he warns that without restrictions HMO's will stress profits over quality of care (9, p. 244).

Along this line of thought, Jane Record maintains that Congress is divided on proposals to make the health field more competitive. In regard to HMO policy, she believes that the House has adopted a market-oriented strategy. The market enthusiasts in Congress want a more
competitive marketplace. They see HMO's as a device for controlling health care costs. She sees the Senate, on the other hand, being dominated by health care reformers who are more concerned with quality of care and accessibility than with competition. The 1973 HMO Act, according to her, was the product of both philosophies (30, pp. 101-102).

The competitive reaction to HMO market entry may be difficult to access, but in 1977 the Federal Trade Commission (FTC) reported that in several areas (West Coast, Hawaii) HMO's have had a significant impact upon the health market. The FTC study states that the competitive reaction to HMO's "... have included the creation of new HMO's, creation of individual practice associations and medical care foundations, increased benefit packages, and more effective cost control" (15, p. 117).

The FTC Report states that fee-for-service physician response to HMO's is to form Individual Practice Associations (IPA's) and medical foundations. The report also contends that where Blue Cross-Blue Shield is in competition with Kaiser they have shown a greater concern with costs. Health Maintenance Organization competition has also lowered BC-BS hospitalization rates (15, pp. 112-115).

Differing Concepts of Need

Does health care have certain qualities which make the economic concept of consumer demand null and void? A. J.
Culyer thinks it does not. He also argues that the concept of health care "need" is often misused by reformers. According to Culyer, the placing of the concept of "need" over demand does not specify who or what groups have a "need." He asserts "... 'need' can never be a market behavioristic concept in the sense that demand is... Is something needed regardless of social costs?" (7, p. 206). Culyer asserts that the use of the concept of "need" in the health field pre-empts public choice.

A serious question raised by Culyer is whether the health care provider or consumer is the best judge of when health care should be consumed. Leon Kass maintains that this is a dangerous question. He states,

This trend is connected by the rise of consumerism and suspicion about all kinds of expertise, and has been fostered by loose talk about health as a commodity, as something money can guarantee, as something determined by the felt needs of the patient and delivered and served on demand by doctors" (24, p. 21).

Kass feels that medical care which aims at gratifying consumer desires and wishes is false medicine. He states that it is not the job of medicine to promote happiness, social adjustment, civic virtue, or to ameliorate social problems (24, pp. 14-16).

Grant Devine and Murray Hawkins, on the other hand, insist that improved information enhances a competitive market's potential. They also assert that a well-informed public and/or "market environment" enhances social
responsibility (8, p. 196). In relation to this question, Robert E. Kime, however, claims that national surveys reveal that the health knowledge of the American consumer is poor (25, p. 3). James Jeffers, Mario Bognanno, and John Bartlett likewise contend that consumers are unaware of their limitations concerning medical knowledge (23, p. 48). They allege that it is unlikely that the consumer will have perfect knowledge concerning his personal health state, modern health care standards, or modern medicine's curative potential (23, p. 52). They contend that the medical profession's definition of need is independent of economic considerations, prices, or financial resources (23, p. 52).

Jeffers, Bognanno, and Bartlett are of the opinion that, when personal health is at stake, the consumer tends to ignore costs. By economic standards, this action is irrational. But it points out one of the difficulties in attributing the characteristics of rational economic man to the health care consumer. Cost-benefit analysis is difficult to apply in light of irrational behavior. These same writers claim

... when people are in pain, are injured, or have other symptoms which disturb them, and when ignorant of the possible causes and consequences of these symptoms, they are prone to seek out medical services without careful consideration of the economic consequences of doing so (23, p. 53).

With the health care consumer in a dubious position of not being able to define need, who is to be given the
authority to decide this issue? Medical professionals, according to Jeffers, Bognanne, and Bartlett, do not view the health care field as an open competitive system, but as a "quasi-public" utility. Decisions of what and how to produce services and who will consume them are determined by producers. These writers also claim that, since the health care field is regarded as a "trust" by health care professionals, prices are lower than they would be if determined by a competitive market (23, pp. 54-55).

On the other hand, Mark Schaeffer contends that the well-informed consumer's wants may differ from the expert's definition of need and he also believes that expert opinion may not be the best judge of need. He claims that some research indicates an inverse relationship between the quantity of health services consumed and vital health statistics. In other words, there is some evidence which shows that as more health services are provided, the population becomes less healthy. Schaeffer alleges that the expert concept of need may fail to take into account broader considerations of alternative uses of society's resources which public officials must take into view (32, pp. 293-294).

Along this same line of thought, Herbert E. Klarman states,

Most of the complex, apparently irrational arrangements in health services stem from certain unique and peculiar characteristics of medical care, particularly
the inability of the consumer to determine how good it is and how much to get. . . . If consumers had adequate knowledge about health care, the service could be priced in the market (27, p. 123).

Klarman insists that HMO's have failed to furnish the consumer with useful measures of quality of care. He argues, "When such measures are lacking and consumers remain unable to judge the quality of medical care they get, it is no longer tenable to posit an identity of interest between the consumers and the HMO's they join" (27, pp. 122-123).

Perhaps William Kissick and Samuel Martin put this controversy in a clearer perspective. They contend that health tends to be an undefinable commodity and they think that the difficulty arises from attempting to place a dollar value on human life and from the widely-held viewpoint that "... unknowns vastly outnumber the knowns" (26, p. 156). Despite these difficulties, Kissick and Martin argue that health policy makers must face up to the necessity of cost-benefit analysis for the nation's health programs. They are advocates of the position that health program objectives be stated in measurable terms, so that costs can be evaluated (26, pp. 156-157).

HMO Efficiency

Paul M. Ellwood, M.D., charges that Congress is not willing to abandon cost reimbursement for prepayment reimbursement in its health programs. Ellwood also claims that Congress and the bureaucracy are preoccupied with a system
of fiscal accountability "... that knows the price of everything, but the value of nothing" (10, p. 98).

In 1971 hearings by the Senate Finance Committee, Jeffrey Cohelan, Director of the Group Health Association of America, testified that Congress did not understand the way in which HMO's work. He said,

When you look at the health care system we are talking about, we are not delivering dollars, we contract to provide services and this is a very important difference ... one of the great difficulties in the health care delivery field with cost reimbursement formulas of one sort or another is that they have been inflationary because we are dealing with dollars; we are not dealing with the offering of services (41, p. 2396).

The claim by HMO efficiency proponents is that HMO's will cost less money and, at the same time, give more and higher quality care than fee-for-service medicine. In 1972 House hearings, the American Public Health Association's (APHA) spokesman testified that the group or team practice of medicine in HMO's was more likely to achieve economy and quality in providing health care than individual practice. The APHA saw HMO's emphasis on preventive medicine as one of the factors in HMO efficiency (35, p. 581). Ralph Andreano and Burton Weisbrod claim, however, that the savings from the preventive practice of medicine are not proven (1, p. 62).

Some HMO proponents point out that HMO's save money due to the economies of scale of large group practice. From an economic point of view, large HMO's may save money
due to central purchasing and management and computerized billing and record-keeping. There is also less opportunity that expensive equipment will not be used (5, p. 17). It is also argued that size, with everything else being equal, lowers cost. Herbert E. Klarman insists that there is little evidence HMO's have achieved efficiencies due to economies of scale. He claims that the assumption that individual practice is inherently inefficient is unfounded (27, p. 122).

Based on research reported in the March, 1975, Social Security Bulletin, there is some evidence that HMO's provide more economical health care than fee-for-service medicine. In this study, Mildred Corbin and Aaron Krute tested the assumption that HMO organizations provide medical care for Medicare members at a lower cost than the fee-for-service system. These researchers selected seven PPGP's from several geographical areas. The experimental prepayment plans were matched as closely as possible with the fee-for-service control groups for sex and age characteristics. Since many PPGP plans are employer-employee and union-sponsored, a particular plan may reflect the socio-economic characteristics of a particular group, making it non-representative (6, p. 5).

Corbin and Krute found that only two of the seven PPGP plans had reimbursement costs higher than the fee-for-service
system. Hospital inpatient care was lower for all of the PPGP's. Affecting the cost of the plans was the degree of control the PPGP had over hospitals (6, pp. 6-7).

The major cost savings in HMO's appear to be in fewer number of hospital days. The Columbia, Maryland, Health Plan averages 370 hospital days per 1,000 enrollees, compared with 800 per 1,000 enrollees for Blue Cross and commercial carrier members in the same area (19, p. 1163). The average HMO hospitalization rate appears to be approximately one-half of the rate for individuals with traditional health plans.

The factors which account for HMO efficiency are somewhat of a mystery to Duncan Neuhauser and Fernand Turcotte. They ask the question: What factors account for the Kaiser HMO's 40 per cent less hospitalization per 1,000 population? They contend that it is unknown whether HMO savings come from an emphasis upon preventive medicine, use of outpatient facilities, salaried doctors, prepayment, or simply the fact that this HMO has fewer hospital beds than fee-for-service hospitals (23, p. 59).

One report holds that the lower hospitalization utilization rates of HMO's cannot be attributed to one factor alone. This report states, "Particularly misleading are 'rational' explanations which argue that financial rewards per se induce desired physician behaviors" (33, p. 46). The authors of this report contend that "group dynamics" is the
main reason for lower HMO hospitalization rates. This process is the "... result of organizational pressures and controls from peers, from medical group directors, and from the interplay of a group organization combined with a capitation based system ..." (33, p. 47).

Rita Cambell claims that HMO's overcrowd physician schedules and require long waiting periods. She adds, "One product of tight scheduling resulting in lowering cost may be a structuring of patient demand" (5, p. 17). This may account, in part, for a high "out-of-plan" physician use by HMO members. In 1958, 16 per cent of the members of the Kaiser Foundation received care outside the plan. A 1968 study by the Labor Health Institute found that members of the Health Insurance Plan of New York used outside doctors for 37 per cent of their surgery (5, p. 18).

James Hester and Elliot Sussman allege that, in evaluating HMO efficiency, one must take into consideration the trade-offs in savings between higher outpatient costs for HMO with higher inpatient costs for fee-for-service (18, p. 421). A major problem of HMO's, according to these researchers, involves conflicting goals. These include the attempts of HMO's to control costs and, at the same time, provide high standards of access and quality of care (18, p. 423).

Due to their widely acclaimed efficiency, HMO's have been proposed as the delivery mechanism in many of the
National Health Insurance bills introduced in Congress since 1970. In 1974 Frank Newman, M.D., President of the Group Health Association of America (GHAA) testified before the Senate Finance Committee. He said, "National health insurance, unless carefully structured in terms of provider reimbursement, may well eliminate the HMO's incentive for improved benefits and reduced costs" (40, p. 201). He added that cost reimbursement formulas penalized HMO's for their efficiency. He favored prospective reimbursement that gave HMO's equal benefits with non-HMO providers. Newman said that if reimbursements exceeded HMO costs the extra money would be used to expand benefits and lower co-insurance and deductibles (40, p. 202).

In Congressional hearings, Wallace Bennett (U.S. Senator from Utah) wondered whether a person who joined an HMO would have a smaller co-insurance payment, if a National Health Insurance bill mandated a $100 co-insurance charge. Frank Newman of the GHAA then said, "If the HMO can provide the services, as far as the Federal Government is concerned, at the same price, and provide a $50 deductible rather than a $100 deductible, we think that that type of situation should be encouraged" (40, p. 203). Bennett replied, "I am puzzled as I face the prospect of writing that kind of provision the law" (40, p. 203).

Amitai Etzioni and Pamela Doty are of the opinion that abuses are difficult to control in HMO's. They hold that
"... it is very difficult to determine when a service is and is not necessary ..." (11, p. 440). Newhouse and Taylor agree with this assessment. They state, "Health insurance programs have been based on price subsidies rather than fixed payments because of the obvious practical difficulty of defining specific degrees of illness and levels of payment appropriate to each" (29, p. 87). With these difficulties in mind, policy makers, with some justification, may be perplexed with the argument that HMO's provide more economical and higher quality health care than the traditional health delivery system in the United States.

HMO Quality Assurance

With HMO "rip-offs" as a point of reference, Congress appears reluctant to commit large sums of federal money to HMO's, without assurances of quality care on the part of HMO's. The difficulties in measuring health quality make this task even more complex.

In May, 1973, Carl T. Curtis (U.S. Senator from Nebraska) told the members of the Senate that the federal government had already developed a large number of health programs, each going in a different direction and all in need of corrective measures. He felt Congress should deal with the problems of these programs before venturing off in a new direction (39, p. 15518). Curtis objected to new quality control measures in the Senate HMO bill that would
conflict with existing programs sponsored by the federal government.

In 1972 John G. Smillie, M.D., Secretary of the Permanent Medical Group of Northern California, said that the contractual agreement by prepaid physicians was a step toward quality health care. He stated that process and outcome assessments of health care were still in a primitive state of development. He believed that peer review and daily contact of physicians within an HMO was the best guarantee of quality care. He stated that audits of process and outcomes would only add to HMO expense. Smillie thought that it would be discriminatory for Congress to require only HMO's to monitor health care outcome. He told members of the House Health Subcommittee of the rigorous program of peer group review among his group's doctors (35, pp. 206-209).

The House HMO bill of 1973 stated that federally-qualified HMO's must have quality assurance programs which stress peer review, use of utilization data and the recording of disability days. The House expected that it would take two to three years for an HMO to develop a quality assurance program. In developing this type of evaluation, the House Committee recommended that Professional Standard Review Organization evaluation data be made available to HMO members (36, pp. 33-34).
The Senate Committee on Labor and Public Welfare did not believe that existing health quality control mechanisms were sufficient to insure HMO quality. The Senate Committee argued that there was a need for a public quality health care body that would not be dominated by health care providers. One of the essential ingredients in the Senate version of the 1973 HMO bill was a provision for the creation of a Commission of Quality Health Care Assurance (CQHCA). The Committee recommended giving to the CQHCA the authority to establish HMO health care standards. The CQHCA would also conduct continuing research to develop new techniques for measuring health outcomes. Using scientific data, the Commission would have the authority to deny federal certification to HMO's. The Senate bill also tied pre-emption of restrictive state HMO laws to certification by this Commission, consisting of eleven members (38, pp. 41-42).

The Committee pointed out that there was a need to establish criteria for measuring health care, based on process and outcome measures. The Committee argued that the delegation of quality assessment power to providers would represent a conflict of interest. The Senate Committee said, "... techniques of quality assessment have not been applied on a systematic basis by an existing provider controlled body" (38, p. 35). The Committee did not see the likelihood of competitors regulating each other in the
health field. It also questioned the constitutionality of giving regulatory authority to a private body, such as the Joint Commission on the Accreditation of Hospitals (38, p. 35).

The Senate Committee maintained that the CQHCA was the "key element" in its HMO bill. The Committee acknowledged that, as of 1973, health care measurement techniques in the United States were still in a primitive state of development. The Committee was of the opinion that a centralized approach to health care evaluation was preferable to a decentralized approach (38, pp. 42-44). The Senate Committee saw danger in combining HMO promotional and regulatory functions in a single agency. The Committee pointed out that the Social Security Administration and the Medical Service Administration, which served as third party payors for the Medicare and Medicaid program, were often pressured by Congress to hold down costs and tended to have an ambivalent response to quality-cost issues (38, pp. 37-38).

The question of whether the CQHCA was to be placed in HEW or be made an independent regulatory agency was an important issue, according to Senate Report 93-129. The Committee claimed that, if the Commission were lodged in HEW, it would be easier to hide conflicts between promotion and regulation. Since the established agencies had well-defined constituencies to protect, the Senate
Committee recommended an independent status for the CQHCA (38, pp. 39-40).

Unlike the 1973 Senate HMO bill, the House version did not include a provision to establish an independent commission. The House Committee on Interstate and Foreign Commerce recognized that prepayment cost control incentives might lead to underservicing of its enrolled population. It advised HEW to create supervisory controls that would prevent over- or under-utilization within HMO's (36, p. 12).

In 1973 the Conference Committee rejected the CQHCA (34, p. 49). There was also some objection within the Senate to the CQHCA. On May 14, 1973, Pete V. Dominick (U.S. Senator from Colorado) told the Senate that the CQHCA would have jurisdiction over all HMO's receiving aid under the Public Health Service Act. He said under this arrangement no presently operating HMO in the nation could meet federal qualifications. He asserted, "Everybody wants to leap into the health legislation field without knowing what it provides" (39, p. 15521). Dominick argued that it would be unwise for Congress to allow a commission of eleven members to decide what determines good health for the entire population (39, p. 15521).

Dominick stated that Professional Standard Review Organizations (PSRO's) under the Social Security Amendments should accomplish, on the local level, what the CQHCA was supposed
to do at the national level. This Senator said that, in
effect, S. 14 tells the nation's doctors, "That they have
a standard type of practice that they must follow, and if
they do anything different they are wrong" (39, p. 15521).
Dominick was against national standards and norms. Kennedy,
in these same debates, said that when the government spends
billions for health care it should have some control over
the care for which it is paying. He asked, "Why are there
four times as many tonsillectomies under Medicaid in Cali-
fornia than there are generally among the California popu-
lation?" (39, p. 15522).

The 1972 PSRO legislation required doctors in each
geographic area to form PSRO's to evaluate treatment plans
and discharge goals for Medicare and Medicaid patients (14,
p. 17). Marc Rogers and Ted Bogue allege "PSRO's tend to
increase the flow of evaluative data among physicians
about quality of practice. Comparative data on individual
physicians could have the effect of improving the clinical
performance of less competent doctors" (31, p. 670). Eli
Ginzberg argues that quality health care is extremely
difficult to define, since doctors disagree among them-
selves concerning patient diagnosis and treatment (14,
p. 16). Others argue, however, that group practice tends
to promote consultation among doctors. Doctors are in
closer physical proximity and the individual practitioner's
lack of opportunity for consultation is removed (16, p. 929).

In 1972 House hearings, William D. Roy (U.S. Senator from Kansas) believed that HMO quality review by PSRO's would place HMO's under local medical societies which were hostile to HMO's (35, p. 109). Roy was concerned about whether HEW's monitoring HMO quality would represent a conflict of interest in light of its original purpose of promoting HMO growth. He thought that advocacy and regulatory roles should be kept apart (35, p. 111).

In 1972 Frank Newman, M.D., of the Group Health Cooperative of Seattle, Washington, expressed the opinion that the federal government should not attempt to impose "arbitrary" quality assurance standards upon HMO's. He stated that measurement of health outcomes was an imprecise field. He felt that peer review, utilization data, qualification standards for personnel, and member satisfaction were adequate safeguards for HMO's.

The HMO Act of 1973 requires HMO organizational provisions to include an "on-going" quality assurance program. In 1978 the GAO reported that quality assurance programs varied a great deal among HMO's. The GAO claimed that some HMO's were federally certified before they had established a quality assurance program. They charged that HEW's criteria for monitoring quality assurance were still in the "developmental stage" (37, p. 21).
Metrocare HMO of Tarrant County, Texas, is a recently-certified HMO. It received its HMO certificate in February of 1979. A basic part of this HMO's quality assurance program consists of the use of a computer service to store utilization and treatment data from its physicians. The data are stored in a computer in Wausau, Wisconsin (22).

One employee of HEW's Office of Health Maintenance Organizations (OHMO) in Rockville, Maryland, admits that HMO quality assurance standards are still in the developmental stage. According to her, the federal program relies on private research sources to investigate quality assurance issues and provide HMO officials with information (21).

According to another person involved with quality assurance in the OHMO, the national office has proposed an HMO quality assurance strategy which involves internal and external monitoring of HMO's. The internal approach involves "in-house" or self-regulation based on federal guidelines. An external HMO quality monitoring system has not been finalized, but it might potentially involve a team of "outsiders" who would evaluate an HMO's quality assurance program. This OHMO employee admits that in the past the quality assurance aspect of the HMO program has been an "on-the-shelf" item. She also admits that doctors are sensitive to questions involving availability, accessibility, and quality of care (20).
Despite the rhetoric that HMO's provide higher quality and more economical care than fee-for-service medicine, there is conflicting evidence to justify these positions. In relation to HMO policy, and health policy in general, there is also a great deal of controversy concerning whether economic analysis and market concepts apply to the provision of health care. The difficulties in measuring quality of health care and in applying economic analysis to health care, therefore, appear to be partly responsible for the federal government's tentative efforts to promote HMO's.
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CHAPTER VII

DIFFICULTIES IN THE ADMINISTRATION
OF THE HMO PROGRAM

The Congressional-Administrative Setting

The enactment of legislation does not guarantee that a new health program will be successful. Legislation must be translated into regulations and HEW must implement the law. Coordination and cooperation between Congress and the bureaucracy may be necessary if this process is to be successful. Health Maintenance Organization legislation placed new demands upon HEW. This chapter will trace the difficulties encountered in the administration of the HMO Act.

It is the position of some that the HMO Act of 1973 was passed before HEW had the capability to administer the legislation (28, p. 78). Concerning this charge, the General Accounting Office in 1975 pointed out that HMO legislation went beyond the mere awarding of grant money and demanded that HEW participate in the development of new health care delivery systems. This was a new and unfamiliar role for HEW (9, p. 1164).

Others allege that there may be a conspiracy between bureaucrats and private interest groups in subverting health legislation. Some think "... it is possible that public actions taken as the outcome of political exchange among
bureaucrats and private interest groups resulted in subordinating . . . the offering of services" (5, p. 336). Patricia Bauman, nevertheless, claims that "... there has long been a close and cordial contact between political leaders and their committee staff with their counterparts in HEW and the interest groups . . ." (3, p. 137). She also believes "the cross-fertilization with regard to prepaid group practice had begun long before the HMO was put forth as Nixon policy, and it continues to this day" (3, p. 137). Bauman asserts that subcommittee staffs have significant influence in formulating health policy (3, pp. 137-138).

One factor which has played a large role in developing HMO legislation and may have complicated the HMO policy picture is Congress' multiple committee jurisdiction in health policy. In the Senate, the Finance Committee and the Human Resources Committee have jurisdiction over health programs. In the House, the Ways and Means and the Interstate and Foreign Commerce Committees both write health legislation. According to Edward Kennedy, "HEW has institutionalized in the executive branch the division that has been so counterproductive in the legislative branch" (24, p. 241).

Kennedy contends that narrow committee jurisdiction hinders a comprehensive approach to the concept of health. He also maintains that there has been little cooperation between HEW and Congress in the initial phase of health policy development. He believes that there is a disagreement
on health care goals between Congress and the bureaucracy and sees a poor working relationship among respective staffs (24, pp. 242-243). In a speech delivered at the meeting of the American Public Health Association on October 31, 1977, Kennedy said that "... regulation in the health area is a crazy quilt patchwork of conflicting objectives" (24, p. 243).

Kennedy attributes the HMO program's lack of success to the slow and fragmented manner in which HEW has administered the 1973 Act (6, p. 546). In some ways, Kennedy's attitude toward the HMO program is a mystery. A member of Kennedy's Health Subcommittee staff refused to comment on the Subcommittee's future position on HMO's, until the program comes up for review in 1981 (23). There is some evidence, however, that Kennedy still views HMO's within the larger framework of comprehensive national health insurance (34).

The Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee under Chairman Paul G. Rogers played a significant role in shaping the federal HMO program. The Subcommittee's new chairperson, Henry Waxman (U.S. Representative from California) is familiar with HMO abuses in the California Medicaid program. This Congressman is against initiatives in Congress to deregulate HMO's (22). Waxman and Kennedy are co-sponsors of pending national health insurance legislation. One member of Waxman's staff thinks that a conservative majority of
Democrats and Republicans on the Interstate and Foreign Commerce Committee's Health Subcommittee may thwart Waxman's liberal health policies. She also said that when Waxman became chairman of the Health Subcommittee, the AMA knew it had lost the chairmanship, but with the appointment of additional conservative members to the Subcommittee the AMA may have gained control over the Subcommittee (22).

Another difficulty in implementing a new health policy is the decentralized federal governmental structure. Milton Roemer argues that the large number of public and private health agencies makes coordination difficult. He also contends that these problems are compounded when so many different health programs are involved (31, pp. 184-186).

The federal HMO program has been frustrated by "... the most elaborate regulation imposed by Congress on any part of the health system" (32, p. 68). George Strumpf, Frank Seubold, and Mildred Arill also think Congress passed HMO legislation that was too specific in that it required over forty-five different regulations. They believe that with these legislative restrictions administrative problems were "inevitable" (33, p. 51).

The writing of Section 1310 or "dual option" regulations for the HMO legislation was controversial and involved a number of participants. The question that was before the HMO Office of Certification was whether the entire union as a group or the individual union member was to consider the HMO
option. After initially holding that the individual union member would have the choice, HEW received complaints from organized labor that this interpretation would violate the collective bargaining rights of the union under the National Labor Relations Act. Working with union and Department of Labor representatives, HEW officials agreed to allow the union, rather than the individual employee, to be the sole bargaining agent in considering the HMO option. Dual option regulations published in 1975 incorporated this compromise (1, pp. 431-435).

Drew Altman and H. M. Sapolsky maintain that those who write health regulations must adjust regulatory language to accommodate the "letter of the law" and interest groups affected by the policy (1, p. 421). They contend that the HMO Act raised many questions which were unfamiliar to HEW personnel (1, pp. 428-429). They also hold that regulations development is not immune to the political process. It is similar in this respect to the legislative process (1, pp. 434-435).

Administrative Arrangements of the HMO Program

Of considerable importance to the success of a health program are its organizational arrangements within the federal bureaucracy. Under the Public Health Service Act, HEW has authority to experiment with alternative health delivery systems. In 1971 three HEW offices were involved in
experimental HMO programs. They were the Health Service and Mental Health Administration, the Social Security Administration, and the Social and Rehabilitation Service. In 1971 an HMO project office was also established within the Office of the Assistant Secretary for Health (11, p. 1446).

As the HMO initiative of the Nixon Administration gained momentum, there was an internal struggle within HEW over organizational arrangements for the HMO program. In 1971 Elliot Richardson, Secretary of HEW, designated the Health Service and Mental Health Administration as the principal HMO agency, but others in HEW felt that the HMO program would be better managed if it were assigned to a "special project" category within the Office of the Secretary of HEW (11, pp. 1446-1447).

John Iglehart claims that the Health Service and Mental Health Administration (HSMHA) was not supportive of profit-making HMO's and that the HSMHA took a cautious approach to HMO development (11, pp. 1447-1449). Mildred Arill, however, opposes the view that HSMHA did not take an aggressive approach toward HMO development (15). She is a specialist in HEW's Office of Health Maintenance Organizations in Rockville, Maryland. She argues that those responsible for the HMO program within HSMHA were aggressive in attempting to promote new HMO's. She argues that the HSMHA spent all of the money it could get to start new HMO's. Arill has been with the HMO program from its inception and has worked
closely with Kennedy's Health Subcommittee in developing the federal HMO policy (15).

After the HMO legislation of 1973 was passed, there was fear among some within HEW that without Secretarial priority the HMO program would become just another one of the department's categorical grant programs (8, p. 1825). A regional HEW official in Dallas feels that the Regional Health Administrator of Region VI perceives the HMO program as just one of many health programs within the federal bureaucracy and, to this person, the HMO program is just one of many categorical grant programs within HEW (19).

Concerning this question, John Iglehart maintains that, without Secretarial priority, it is difficult to get a new program "off the ground." In 1971 Secretary of HEW Elliot Richardson gave the HMO program firm support. In 1974 the Nixon Administration reversed its earlier position toward HMO's. Caspar Weinberger, Richardson's replacement, did not regard HMO's as a high priority program (8, p. 1826). Early in the Carter Administration, Joseph Califano, HEW Secretary, announced a new HMO initiative (10, p. 312). Henry H. Warren, Assistant Director for Regional and Intergovernmental Affairs of the OHMO, believes that Secretarial "hyperbole" has been harmful for the HMO program. He also admits that, by the standards set by Richardson for HMO success, the program can be judged a failure (13).
On the issue of top level Administrative support for the HMO program, Patricia Bauman thinks that when the Nixon Administration backed away from endorsing the HMO initiative, the program was severely damaged. She states: "Those responsible for this fledging program found themselves in the unenviable position of not having Departmental support for such basic elements as adequate professional salaries and number of full-time staff" (3, p. 139). She adds, "... the legislature simply cannot compel the Administration to nurture and support a program--and a policy direction--if it does not wish to do so" (3, p. 139). It should also be noted, however, that Congress enacted only a limited experimental HMO program in 1973.

The early HMO program's goal of creating a network of HMO's within a short period of time may have violated the Health Service and Mental Health Administration's incremental style. Patricia Bauman takes this position and she states, "To follow organizational processes is not to move with giant steps . . ." (3, p. 136). With this admonition in mind, the federal bureaucracy may be a less than perfect instrument for instituting rapid change. For example, one OHMO official ponders, "How much can you push the bureaucracy?" (13). Built-in bureaucratic prejudice cannot, according to this person, be changed overnight. He also concedes that medical doctors who are employed by HEW might have a fee-for-service bias (13).
Drew Altman and H. M. Sapolsky charge that the Health Service Administration, formerly the HSMHA, is a bureaucracy with poverty program responsibilities, but they allege that the Health Service Administration saw the HMO program as a non-poverty program (1, p. 427). In the Dallas regional office, this view is still held by one employee who contends that the HMO program is a middle-class program. He thinks that this orientation is necessary in light of the Medicaid scandals in California (19).

The confusion over which federal bureaucracy administers the program may also be partly responsible for the slow growth of HMO's. In 1974 Teodore Cooper, M.D., Assistant HEW Secretary for Health, advocated decentralization of the HMO program. He was supported in this effort by regional health administrators. This strategy was opposed by Paul Batalden, M.D., Director of the Bureau of Community Health Services (BCHS). Frank Seubold, Director of the HMO Office, supported Batalden's position (8, p. 1826). The HMO office had only limited jurisdiction over the HMO program. Seubold's authority was basically confined to writing regulations and awarding planning and development grants. In other words, the HMO program lacked a central organizational structure (8, p. 1827). Some of the HMO staff members also worked on other health programs of the BCHS (8, pp. 1826-1827).

In 1976 Richard Schweiker (U.S. Senator from Pennsylvania) alleged that HMO program responsibility had been split
among twenty-one different HEW Offices (44, p. 16057). The House Committee was of the opinion that the administrative fragmentation of the HMO program was partly responsible for the program's lack of success. The Committee suggested that an HMO Office with bureau status be created and that its administrator should be given full-line authority. The Committee stated that 100 per cent of the unit's time should be devoted to the implementation of the HMO Act (39, pp. 10-11).

The 1976 HMO Amendments required that the HMO program be administered by a single administrative unit within HEW (43, p. 1954). In a 1978 Senate HMO hearing, the GAO reported that in response to the 1976 HMO Amendments, HEW in December of 1977 had centralized the HMO program within the Office of the Assistant Secretary for Health (46, p. 32). A somewhat greater degree of centralization was achieved in the HMO program in 1978 when Howard Viet became the Director of the Office of Health Maintenance Organizations in Rockville, Maryland (10, p. 312).

The 1973 HMO Act required that continuing regulation or evaluation of HMO's be performed by the Office of the Assistant Secretary for Health. John Igleshart claims that HEW ignored this requirement (8, pp. 1826-1827). In 1975 the HMO program was located within two units of the Health Service Administration and the HMO grant program was located in the Office of HMO's within the Bureau of Community Health Services. The HMO evaluation function was centered in the Office of
Qualification and Compliance in the Office of the Administrator of Health Service Administration. The House Committee noted in 1975 that its intent in the 1973 legislation was to separate HMO promotional activity from regulation of HMO activities. The Committee observed that continuing regulation had not been performed by the Office of the Assistant Secretary for Health. The Committee expected HEW compliance in the future (39, pp. 10-11).

The 1978 reorganization of the HMO program affected the HMO program offices in Washington, D.C., but the reorganization did not extend to the regional offices of HEW (46, p. 32). At the regional level, there is still some controversy over the question of separating HMO promotional activities from HMO regulatory actions. One regional HEW official disagrees with the House Committee's view that promotion and regulation of HMO's by HEW should be kept separate. He believes that promotional and regulatory functions can be combined (18). Another HEW regional official, however, stressed that regulation and promotional activities of HMO's should be divided (17). This controversy is related to the broader question of whether there is a conflict of interest involved when a bureaucracy is assigned the task of both promoting an industry and, at the same time, given the responsibility to regulate the industry.
GAO Criticisms of the HMO Program

The General Accounting Office (GAO) and the Comptroller General are agents of Congress that were given the statutory responsibility under the 1973 HMO Act to monitor and audit the federal government's HMO program. In a report published on September 3, 1976, the Comptroller General of the United States informed Congress that one of the primary reasons behind the lack of progress in the HMO program was the slowness of HEW in writing HMO regulations. The report stated that regulations concerning HMO continuing regulation, loan criteria, and dual choice had not been finalized (29, pp. 6-8).

Due to delays in writing regulations for the HMO program, HEW in 1977 changed its regulations procedures. Through the use of "interim regulations," HEW continued to permit implementation of the Act minus completed regulations, but in 1978 the GAO restated its doubts about the ability of HEW to administer the HMO program in the area of regulations and guidelines (46, p. 31).

The GAO has been critical of the administrative arrangements for the HMO program. In July of 1975, G. J. Ahart, Director of the GAO's Manpower and Welfare Division, told the House that there was no single entity within HEW that was responsible for the HMO program. He said, "The program has been decentralized into ten regional offices and functionalized within various headquarter offices, but HEW has not developed a system to coordinate activities or account for the utilization of staff resources" (40, p. 17). The GAO
reported also that the lack of expertise in regional offices had discouraged a number of grant applicants (40, p. 18). Concerning this charge, one member of the Office of Health Maintenance Organizations attributes HEW's lack of expertise to the Civil Service salary schedule, which is not sufficient in the upper grades to be competitive with private business. People with necessary marketing, actuarial, and management skills choose not to work for HEW since they can make more money in private business (13).

The 1975 report of the GAO to the Senate stressed that the HMO program lacked coordination and direction (45, p. 61). The GAO also disputed HEW's claim that the HMO program had full staffing. In response to this criticism, the Bureau of Community Health Services (BCHS), in which the HMO Office was located, maintained that if a task was finished on time, the appropriate amount of staff time had been properly allocated. However, the report was critical that the BCHS could only estimate the actual number of staff days that had been used in the HMO program (45, p. 62). John Iglehart also observed the staffing problems in the HMO program and discovered that, at one point in 1974, the GAO had more staff members monitoring the HMO program than HEW had implementing the program (8, p. 1827).

In 1976 the Comptroller General informed Congress that most of the regional offices of the Public Health Service still operated according to functional arrangements of time.
This allowed staff time to be divided among several programs. The Comptroller General's report said, "This functional structure has minimized the visibility of categorical grant programs and resulted in staffing across programmatic lines" (29, p. 11). In June of 1976, the Comptroller General found that little had been done by HEW to improve the regional organization of the HMO program and that reporting procedures varied from region to region (29, p. 11).

The GAO report said that a majority of HMO positions were not assigned to specialists, but to generalists and that HEW lacked the quantity and quality of people necessary to implement the HMO program. T. J. Schulz of the GAO said that the shortage of qualified people was critical at the regional level and that HMO personnel salaries were too low for the skills demanded (45, p. 73). In response to this criticism, Kennedy argued that HEW had not requested additional personnel for the HMO program (45, p. 74).

In 1975 Theodore Cooper, M.D., Assistant Secretary for Health, opposed specific HMO personnel authorizations by Congress because it would reduce his administrative flexibility (45, p. 129). In 1978 the Acting HMO Project Manager in Dallas had less than 100 per cent of his time assigned to the HMO program (17). In May of 1979, the Assistant Regional HMO Coordinator adhered to the position that, if a job is accomplished on time, it should be the prerogative of HEW, not of Congress, to determine how the job is done (13).
The 1975 GAO report also criticized the HMO program's fragmented organizational structure. The 1973 HMO Act required continuing evaluation of HMO's to be performed by the Office of the Assistant Secretary for Health. T. J. Schulz said that continuing evaluation of HMO's was handled instead by the Office of Evaluation of the Health Service Administration's Office of Planning and Evaluation. The GAO reported that the Health Resources Administration also had two offices involved in HMO evaluations (40, p. 32).

Whether or not prohibitive state HMO laws have interfered with the federal HMO program is an important question. In the 1975 Senate HMO hearings, Administration witnesses stated that HEW had not allowed such laws to interfere with the HMO grant program. Kennedy argued that the GAO report contradicted HEW testimony concerning interference from the states (45, p. 178). The Comptroller General's report of 1976 stated that restrictive state laws had been one of the factors accounting for the HMO program's slow growth (29, p. 8). In 1976 a House HMO report stated that pre-emption of restrictive state laws, as provided in the 1973 HMO Act, had not been put into effect. The 1975 House HMO bill required HEW to inform state governors of state laws pre-empted by HMO regulations (39, p. 15). The 1976 HMO Amendments included this provision. A Senate requirement that the Secretary keep a digest of state laws and regulations affecting HMO's was accepted in the 1976 HMO Amendments. This updated digest was
to be provided to each state governor on an annual basis (36, p. 31). In relation to this issue, an HEW official in Dallas thinks it is best for HMO's to cooperate as closely as possible with the states in developing HMO's (18).

During early stages of the HMO program, a House report was critical that, as of 1975, HEW had given financial assistance to only 157 potential HMO's, totaling $22.5 million (39, p. 3). In Senate hearings, the Assistant Secretary announced that in 1975 he had "reprogrammed" $11.4 million from HMO assistance programs, due to lack of qualified applicants. Kennedy replied that it was difficult to plead for more HMO funds from the Appropriations Committee, when a program had not spent all of the funds allocated to it in the preceding year (45, pp. 127-128). Members of the House admitted that the House Appropriations Committee was reluctant to go along with HMO authorizations, due to the fact that HEW had failed to obligate funds (39, p. 4).

The GAO also charged that HEW had failed to establish uniform and consistent practices in making loans and granting loan guarantees to HMO's. The GAO accused HEW of relying on a case-by-case approach in making HMO loans. The GAO said that HEW also lacked competent personnel to administer the HMO loan program (45, p. 66). A 1975 House HMO report reflected the GAO's apprehensions about the inadequacy of the HMO loan program (39, p. 13).
In a memo dated May 17, 1977, William Munier, M.D., Director of HEW's Office of Quality Standards, maintained that the HMO Office had no program to insure that qualified HMO's were following the Act's organizational and service requirements. He said that in its efforts to promote new HMO's, HEW had failed to give adequate attention to compliance (47, pp. 44-45). The California Prepaid Health Plan hearings of 1976 also raised doubts about the ability of HEW to insure HMO compliance. At one point in these hearings, William McLeod, Director of the Compliance Division of the HMO Office, said that he was ready to call a "moratorium" on new HMO qualifications (48, pp. 508-510).

In 1979 the GAO was critical of HEW's tardiness in issuing regional guidelines. The GAO felt that regional offices were in a better position than the central office to detect HMO irregularities (33, p. 15). This view is held by one of the regional HEW officers in Dallas. He thinks that, in the near future, the HMO program will be more involved with continuing regulation and compliance issues of qualified HMO's (19). In May of 1979, the GAO pointed out that personnel with skills demanded for the HMO program could draw much higher salaries outside the government (39, p. 52).

There is indication that some members of Congress are more satisfied with the HMO program today than they have been in the past. A top assistant to the House Health and the Environment Subcommittee thinks that HEW has improved its
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...ministration of the HMO grant program and he was of the opinion that the program would continue to be funded as long as HEW personnel were "doing their job" (12).

HMO's and the Health Planning System

It is possible that one federal health policy can slow the administration of other health legislation. Of some relevance to the success of the HMO program is the federal health planning process. In 1972 Elliot Richardson stated that it was not the Nixon Administration's policy that Comprehensive Health Planning (CHP) agencies should have a veto over HMO enfranchisement. The Administration, however, did support CHP review of HMO capital investments (37, p. 88).

The 1973 House HMO bill, however, designated state and regional CHP's, as defined in Section 311u of the Public Health Service Act, to be used by the Secretary of HEW to review HMO grant applications. The purpose of the CHP review, according to the bill, was to discourage redundancy of services and to see that HMO's were consistent with area-wide comprehensive health plans (38, p. 23). The bill also required the Secretary of HEW to establish procedures for planning agencies to use in their review of HMO's (38, p. 35). The Senate HMO bill did not contain a provision for CHP review of HMO's, but in 1973 the Conference Committee required that an HMO which applied for federal assistance give assurances that it would cooperate with its CHP agency (35, p. 41). This provision was incorporated into the HMO legislation of 1973.
The National Health Planning and Resources Development Act (Public Law 93-641) of 1974 created over 200 Health Systems Agencies (HSA's) in regions varying in size from 500,000 to 3 million. They were given the authority to approve grants for hospital construction, mental health services, child health services, health personnel training, etc. (31, p. 202). Under Section 1531 of the legislation, HMO's were designated as an institutional health service and, as such, were required to obtain a certificate-of-need from an HSA (36, p. 36). Public Law 93-641 authorized HSA's to "... review and make recommendations to the appropriate state health planning and development agency the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency" (42, pp. 2238-2239).

The Federal Regional Offices reported in 1975 that state planning agency review of HMO's were not specific. The Department of HEW complained that the local planning agencies did not have the ability to review HMO's. Lack of uniformity in the HSA review process was also discovered (45, p. 64).

In 1973 HMO legislation required the Secretary of HEW to establish procedures and regulations to be followed by health planning agencies in their review of HMO applications. Section 1532 of the 1974 health planning legislation required planning agencies to follow published standards and regulations, which considered the "... special needs and circumstances of HMO's" (36, p. 36). In 1976 a Senate amendment
required that standards set for HMO review in the health planning legislation be consistent with those established for the HMO Act. In agreeing with the Senate amendment, the 1976 Conference Committee noted that Public Law 93-641 required HSA's to give special consideration to HMO's. The Conference Committee also announced that as of 1976 no guidelines or regulations had been published by HEW on this subject (36, pp. 36-37).

Along this line of thought, the Conference Committee maintained that an HSA should take into consideration the number and type of HMO's in an area, the number of persons enrolled in qualified HMO's and the number of employers who offer an HMO health plan option. The HSA should also investigate whether non-HMO proposals would be as cost-efficient and accessible as HMO's. The Conference Committee also felt that, once an HMO feasibility proposal was accepted by an HSA, further certificate-of-need hearings should not be held (36, p. 37).

The dissatisfaction of HMO proponents with the health planning process was voiced in 1978 when the Kaiser HMO labeled Public Law 93-641 an "anti-HMO Act." Kaiser alleged that the Act was discriminatory in that it required HMO's to obtain a certificate-of-need for ambulatory and administrative facilities and equipment, while exempting the fee-for-service sector from these requirements (41, pp. 1022-1023). In February of 1978, James A. Lane, Counsel of Kaiser
Foundation's Health Plan, Inc., testified that the intent of Congress in its health planning legislation was to restrict capital development in the health field, but in the HMO Act of 1973 Congress attempted to promote HMO growth. He stated that the government was following contradictory policies (41, p. 1017). He argued that there was no over-abundance of HMO's in the nation. He said that the planning process was "... preoccupied with fee-for-service hospitals and providers and totally ignores HMO's" (41, p. 1013). Lane also claimed that there was a bias against HMO's on Health System Agency's boards. He stated that HSA's had ignored the intent of Congress by not taking into consideration the special needs and requirements of HMO's (41, p. 1023).

There is some evidence to support Lane's criticism of HSA's. In an interview with one Region VI health planning official, the question was asked, "How would an HMO be treated if it wanted to construct a hospital in the Dallas-Ft. Worth area?" The official said, "Just like anyone else" (21). In 1978 Louis J. Segadelli, Executive Director of Group Health Association of Washington, D.C., claimed that the certificate-of-need process had delayed the hospital construction of his HMO for over five years (41, pp. 1040-1041). He said that HMO use of community hospitals was opposed by fee-for-service medical staffs (41, p. 1047). Health Maintenance Organization advocates contend that the HSA certificate-of-need process is inappropriate for HMO's,
because HMO's have internal incentives that work against unneeded facilities (41, pp. 1024-1025).

In May of 1973, HEW issued regulations affecting state and local health planning agencies. These regulations required the 205 Health Systems Agencies to send appropriateness-of-service reviews to their state health planning and development agencies. Reviews had to meet with both HSA and state health planning agency standards. Under the health planning legislation, review procedures may vary from state to state, but general criteria for review of new services include "... availability, accessibility, acceptability, continuity, cost and quality" (7, p. 673).

After some delay, on April 2, 1979, regulations were published that specify the special "needs and circumstances" of HMO's that HSA's must take into consideration in reviewing HMO requests for new services. The guidelines state that an HSA may not deny a certificate-of-need to an HMO, unless these agencies determine the facility is not needed by the HMO members or the service is "available from non-HMO providers or other HMO's in a reasonable and cost effective manner which is consistent with the basic method of operation of the HMO" (27, p. 19326). In March of 1979, one health planning official from Dallas stated that HSAs had operated with no guidelines or plans for the number of HMO's in an area. He thought HMO's suffered from being the "outsider" among providers and that HMO's were being discriminated against by
"insider types" on HSA's through a "quiet turning of the screw" (20).

The future direction of the federal government's policy toward HMO's is a mystery to many, but some indication was revealed on May 15, 1979. On this date, the House Subcommittee on Health and the Environment approved a controversial amendment in new legislation to extend the federal health planning program. The controversial amendment was introduced by Phil Gramm (U.S. Representative from Texas). His amendment would exempt both federally-qualified HMO's and unqualified prepaid health plans that offer inpatient and ambulatory care from certificate-of-need requirements for the "acquisition of major medical equipment, the offering of institutional health services, or the obligation of capital expenditures . .." (2, p. 2).

An administrative aide to Gramm contends that the Congressman believes that HSA's should be abolished, due to the fact that they are anti-competitive. Gramm favors eliminating HEW restrictions that impede competition in the health field. He also holds that the government should not impose rigid organizational requirements upon HMO's and that prepaid health plans should be free to offer as many or as few services as the public wants (14). Gramm's plan, however, was not unopposed. A May 1, 1979, memo to Gramm from Hale Champion, Undersecretary of HEW, stated, "It is our judgment, however, that the Gramm Amendment fails to provide an
adequate definition of the entities to be exempted and . . . establishes a fundamentally flawed and unworkable process" (25, p. 3). In an April 10, 1979, open letter to the members of the House Subcommittee on Health and the Environment, Gramm contended, "Under the health planning system, a coalition of local and state consumers and providers essentially collude to frustrate the normal operations of the health care market . . . " (26). This view of the health planning process is not shared by one HEW official in Dallas, who admits that HSA's have delayed HMO applications, but he argues that most members of HSA's are simply not familiar with HMO's or with the impact that an HMO will have on their service area (18).

Concerning deregulation in federal health policy, Linda Demkovich contends that "deregulators" in the Ninety-Sixth Congress have a strong base in the House Health and the Environment Subcommittee. She argues that these members do not want the health planning process to become institutionalized and protect existing institutions from competition (4, p. 687). In May of 1979 Gramm thought that his deregulatory amendment would have a "reasonably good chance" of passing (16). However, there was some concern in HEW that the entire health planning process might be disrupted by the Gramm Amendment (4, p. 687). Health Maintenance Organization proponents support Gramm's efforts to remove HMO's from the grasps of HSA's. A possible irony of the deregulatory trend in Congress is that future development of HMO's may be as
much the result of efforts to sever HMO growth from governmental regulation, as from the federal government's attempts to nurture and develop HMO's through the federal HMO program.

The administrative history of the HMO program of the federal government has been plagued by many difficulties during the 1970's. The HMO Act of 1973 was highly complex and technical in nature and HEW has encountered a number of problems in developing regulations and guidelines for the HMO legislation; the HMO program has suffered at times from the lack of Secretarial support within HEW. Also, there have been reports that HEW has not been aggressive enough in its efforts to promote HMO's. There is some evidence that HMO development has been impeded by the excessive administrative fragmentation of the HMO program and from a shortage of qualified personnel within HEW to administer the legislation.

Concerning the charges of administrative laxity, the weight of evidence in this chapter tends to support the position that HMO development has been slowed, in part, by difficulties encountered in the implementation of the HMO legislation.
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CHAPTER VIII

CONCLUSION

The major finding of this dissertation is that the HMO movement has not been a success. The factors which have impeded the HMO movement are numerous and it is doubtful that one factor can be singled out as the most significant reason for lack of HMO success. The traditional policy of the federal government in the health field has been one of restraint. The market has been viewed as the best allocator of medical goods and services (10, pp. 72-73). Even the Medicare legislation of 1965 stated that the purpose of the legislation was not to interfere with the way in which health care was delivered in the United States (14, p. 291).

The primary emphasis of this dissertation has been on the evolution and development of the federal government's HMO policy. The HMO policy of the federal government, as originally conceived, would have created a nationwide network of 1,700 HMO's serving approximately 40 million of the nation's population by 1976. The radical aspect of HMO policy of the early 1970's was the expectation that HMO's, with the federal government's assistance, would rapidly win acceptance by the people of the nation.
During the early 1970's, two HMO approaches were proposed in Congress. The Senate endorsed an approach which coupled ample funding for HMO's with stringent requirements. A second strategy endorsed by the House employed low financial backing for HMO's with less strict regulation. In 1973 Congress passed HMO legislation which combined low financial support for HMO's with a large number of regulatory requirements (12, p. 74). In its HMO legislation of 1973 Congress authorized only $325 million for direct assistance to HMO development (8, p. 505).

In 1975 Theodore Cooper, M.D., Assistant Secretary for Health, also expressed only a tentative HEW endorsement for HMO's. He said,

We believe that the federal role should be one limited to five years in order to support demonstrations of HMO's through financial and other support and that the HMO movement should grow in competition with alternate financing and delivery systems through consumer choice without large federal subsidies (15, p. 185).

Congress' enactment of limited financial aid for HMO's and Cooper's advocacy of a restricted federal role in HMO development do not deny that there are advocates of the HMO concept within the federal government, but they do indicate that Congress and HEW adopted an incremental strategy for HMO development.

It is apparent that these findings are not unique. Judith Feder has observed this strategy at work in the
development of Medicare policy (3, pp. 143-144). Charles Lindblom thinks that incrementalism in policy making is necessitated by the large number of unknowns in the policy making process. He notes, "Policy making is at best a very rough process" (9, p. 86). Aaron Wildavsky also supports an incrementalist strategy in policy making. He argues, "Errors are easier to correct because the burden of calculation has been drastically reduced" (16, p. 47).

In analyzing difficulties in the HMO movement, John Iglehart offers an interesting insight into the failures of the HMO program of the 1970's. He states, "What makes the trouble difficult to deal with is the fact that no single thing has gone wrong. It is rather an accumulation of small problems" (6, p. 1825). Numerous "small" things have worked together to slow down the federal government's HMO policy.

One of the reasons HMO's have not won greater endorsement from public policy makers has been the opposition of organized groups to HMO development. Traditional medicine, as represented by numerous groups, has used its immense prestige and influence to block large-scale federal aid to HMO development. The American Medical Association has labeled HMO's as experimental and taken the position that HMO-type health care is unsatisfactory to most people in the United States. From the history of limited financial backing of HMO's and strict HMO legislative requirements,
it appears that Congress shares some of the same doubts concerning HMO's as do the organized groups which oppose them.

The resistance of organized medicine appears to be partly based on the suspicion that the HMO policy of the federal government represented an extension of "socialized medicine" and on the unfamiliarity of some doctors to the new delivery mode that HMO's represented. Fear of loss of status and income may also be other reasons why doctors oppose HMO's.

Another problem that partially accounts for the slow growth of HMO's has been the difficulties encountered in adapting HMO's to the traditional system of American health insurance. In 1971 James C. Corman (U.S. Representative from California) asserted,

It seems to me that the problem of HMO's is identical to the problem that insurance companies have. If you leave the purchase of service to individual choice, the insurance companies solve this by excluding pre-existing physical defects from coverage in the policy (13, p. 2176).

Corman saw little difference between HMO exclusionary practices and those of private health insurance.

Since 1973 Congress has attempted to differentiate HMO enrollment and premium practices from those of private health insurance practices. The intent of Congress is expressed in provisions of the HMO legislation, which require HMO's to have open enrollment and use community ratings to
determine member premiums. Neither of these are the prevailing practices of private health insurance carriers in the United States. Most HMO's have shown little enthusiasm for open enrollment or community rating and this lack of interest may have caused some of the members of Congress to weaken in their support for expanded HMO funding.

Efforts to promote HMO's through federal health insurance programs have also made little headway. The Senate Finance Committee has not been inclined to promote HMO growth through Medicare legislation and the Social Security Act reimburses HMO's, in some respects as if they were fee-for-service providers. The reservations against HMO's by the Senate Finance Committee appear to be based on the fear that HMO's will underservice Medicare recipients. Scandals in California involving HMO-like plans have also done much to undermine a broader use of HMO's in the Medicaid program. These scandals appear also to have raised serious doubts among some in the bureaucracy concerning the ability of HMO's to provide quality health care. With numerous health programs pursuing different goals, it is not unlikely that one program will interfere or conflict with another. Health Maintenance Organizations have not been promoted by Medicare and the Medicaid HMO scandals in California have done much to tarnish the reputation of HMO's in general.

Efforts to promote HMO's have also been slowed by difficulties encountered in the administration of the HMO Act.
Administrative fragmentation within HEW has hurt the federal program. Charges that HEW lacks competent personnel to administer the legislation have also been raised. The Department of HEW has encountered numerous problems in developing regulations for the HMO program. It is, therefore, possible that some of the failures of the HMO program may have their origins in the bureaucracy of the federal government.

In conclusion, this dissertation has attempted to establish a framework for not only evaluating HMO policy, but HMO's in general. HMO proponents argue that there are many advantages to their delivery system over fee-for-service medicine. Doctors in HMO's, for example, generally practice in groups and all of the medical specialties are within close proximity to each other. Health Maintenance Organization hospitals often adjoin outpatient facilities and this makes HMO medical care more accessible and convenient to the patient.

Another advantage of HMO's is the lower rates of hospitalization for HMO members when they are compared with similar groups covered by private health insurance. Health Maintenance Organizations are more likely to use outpatient facilities when hospitalization is not necessary, while fee-for-service doctors are prone to treat patients in hospitals. This may be due to the fact that private health insurance, in many cases, will only cover hospitalization costs.
Unnecessary hospitalization may also be prevented in HMO's due to the fact that HMO doctors do not have to put patients in hospitals just to keep their hospital privileges. Since prolonged and unnecessary care is expensive to the HMO, it has an incentive to emphasize preventive medicine and encourage the health education of its members.

Proponents of HMO's contend that they provide high quality medical care. This is due, in part, to the fact that frequent consultation among doctors is promoted by group practice and continuing education among HMO physicians is often mandatory. It would be logical to assume that incompetent doctors would be costly to HMO's and that the HMO peer review system should screen these doctors out of the organization.

Advocates of HMO's also point out that HMO care is less expensive than fee-for-service medicine. For a monthly fee that is comparable to the premiums of private health insurance, the HMO subscriber gets medical coverage that is much more comprehensive than private health insurance. Monthly payments for HMO's include doctor visits, as well as hospitalization. Since HMO's are paid in advance of care, they operate on a strict budget and the discipline which is inherent in this system should eliminate waste and unnecessary costs.

However, HMO's must satisfy their subscribers in order to remain financially solvent. If the HMO member thinks he
is not getting excellent care in his HMO, he may voluntarily leave the organization. From an overall perspective, the job that an HMO assumes is enormous. The HMO takes the position that it can provide high quality and comprehensive care to its subscribers and, at the same time, comply with federal regulations. It may be argued that any organization which undertakes a task of this magnitude deserves governmental support.

The disadvantages of HMO health care may, on the other hand, caution policy makers against further increases in aid to HMO's. The larger HMO's have been criticized for the impersonal medical care they deliver and some charge that the close rapport between the doctor and patient breaks down under HMO's. Health Maintenance Organizations have also been proposed as devices which can transform our traditional system of individual medical practitioners into highly efficient health organizations. Economies of scale which are often associated with large units of production are also a purported characteristic of HMO's. Medical care, however, tends to be a highly personal commodity and it is not yet clear whether larger units are more efficient than smaller units in delivering health care.

Accusations have been made that often HMO's require long waiting periods before a doctor can be seen. These long waiting periods weaken the argument that HMO's make medical care more accessible than fee-for-service medicine.
Evidence presented in this dissertation suggests that some HMO members go outside their HMO to obtain medical treatment and surgery. The argument that HMO's provide comprehensive care is damaged when patients seek treatment outside the HMO.

Health Maintenance Organizations have been held up as delivery systems which can serve a wide variety of environments. There is, however, some research reported in this dissertation which indicates that HMO's will only thrive in middle-class urban environments. Some HMO officers openly admit that they are selective in the kinds of customers they seek. Low income groups, minorities, the elderly, and the chronically sick are groups that are not widely sought by these HMO's; this type of selectivity in membership may indicate that HMO's are trying to exclude "high risk" members from their organization. It appears that HMO's are not really interested in extending medical care to the underprivileged or to medically underserviced areas. Thus far, the penetration of HMO's into the United States health market has been mainly in the urban areas and the term "HMO" is virtually unknown in many small towns and rural areas of the nation. The restricted membership policies of HMO's, therefore, indicate that HMO's are basically designed for the white middle class and, as such, do not deserve subsidies from the federal government.

There is an acute fear that HMO's may actually underservice their patients. The fixed budget under which the
HMO must operate may actually serve as an incentive for the
HMO not to perform certain medical treatments. This charge
has been raised in Congress by the committees which oversee
the Medicare program. The fear of underservicing associated
with HMO's may be particularly troublesome to elected offi-
cials. The issue of overservicing patients with which fee-
for-service medicine is charged may, in fact, be easier for
elected officials to cope with than underservicing from HMO's.

At present there is no clear-cut evidence to show that
younger doctors are more likely to prefer HMO practice to
traditional practice. However, the risks of practicing medi-
cine today are great and increasing fears of malpractice
suits may be the factor which drives younger doctors into
HMO-type practices, where medical treatment decisions can be
defended as the product of group rather than individual de-
cision.

Thus far, the HMO program of the federal government has
not been very successful in causing Americans to switch from
fee-for-service care to HMO's. The federal incremental strat-
egy, however, has broadened the definition of HMO's into a
concept which can now accommodate a variety of group-like
practices. The real impact of the federal government's HMO
strategy may ultimately be in the example of the relatively
few federally-assisted HMO's that are now in operation. Once
an HMO is established, fee-for-service practitioners may
feel compelled to form their own HMO in order to keep up with "new" developments in medical care delivery. If national health insurance becomes politically inevitable, fee-for-service doctors may prefer to form HMO's because they would represent a less radical departure from the delivery system than outright "socialized medicine."

Regarding the future of federal HMO policy, some think that future HMO growth might be more successful if Congress were to deregulate HMO's and allow them to expand without governmental interference. It appears that neither regulatory nor deregulatory approaches to HMO development will be trouble free. Alain Enthoven offers some insight into this problem when he states, "There is no simple solution that will cut through the many market imperfections in the health care sector and restructure it along competitive economic lines. Whatever change does come in the health delivery system is bound to come slowly" (2, p. 347).

Numerous experts in the field of health care have speculated on the reasons for the lack of HMO success. One limitation upon future expansion of HMO's in the United States is voiced by Eli Ginzberg. He argues,

The passage of new legislation is a necessary but not sufficient condition to alter the health care delivery system of the United States. Congress can legislate new structures and agencies into existence, it can entitle new groups of citizens to a range of services, it can appropriate funds to help achieve these objectives. But specific health services can be delivered only by local providers to local citizens,
and this represents the most critical constraint on all reforms (4, p. 168).

To become more widely accepted in the future, HMO's must also overcome many emotional barriers that presently limit health care reform in the United States. For example, the lay referral system is very important to the success of a new delivery system and HMO's in the early 1970's were not part of this informal system of lay advice (5, p. 945). As the decade ends, it seems that in many cases HMO's are still not part of this system of informal advice.

To overcome the many obstacles toward HMO's, it will ultimately be necessary for HMO's to convince the public that their type of health care is more economical and of higher quality than fee-for-service medicine. Presently, there are many obstacles that stand in the path of HMO growth in the United States. This dissertation has shown that opposition to HMO growth is formidable and extends from organized groups into Congress and the bureaucracy. It is doubtful that HMO growth will be rapid in the immediate future and long-term prospects for HMO growth are also uncertain. If medical costs continue to escalate, however, the nation in desperation may be driven toward greater acceptance of HMO's as an alternative to socialized medicine.
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