

# HMOs, Competition, and Government

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*This article considers the role of three sets of forces affecting the development of health maintenance organizations (HMOs) during the early 1970s: legal restrictions, market conditions, and the federal government's policy stance. Our review of the evidence suggests that the rapid increase in the number of HMOs during this period was primarily due to favorable market conditions in certain areas of the country combined with a highly encouraging federal policy toward HMOs. Legal restrictions do not appear to have been as serious a barrier to HMO development as was earlier believed.*

*In 1973-74, major new legislation was enacted at both the federal and state levels, ostensibly to encourage HMO development. Our review of this legislation suggests that, while it removes many of the old legal requirements which apparently were not serious barriers to HMO development, the new legislation imposes a host of new conditions and requirements on HMO participation in the health care marketplace. Ironically, some of these new features may impede the operation of the very market forces which encouraged the earlier HMO growth.*

In 1970 the term Health Maintenance Organization (HMO) was coined, and HMOs were loudly and widely proclaimed as a major component of a new federal initiative to "restructure" the medical care delivery system.<sup>1</sup> Much of the HMO concept's appeal was based on evidence that HMOs could offer their members comprehensive care at lower costs than conventional fee-for-service

<sup>1</sup>The sine qua non of an HMO is prepayment for medical care in contrast to the fee-for-service mode's use of postpayment. More specifically, we define an HMO as an organization which accepts contractual responsibility to assure the delivery of a stated range of health services, including at least ambulatory and in-hospital care, to a voluntarily enrolled population in exchange for an advance capitation payment, where the organization assumes at least part of the financial risk or shares in the surplus associated with the delivery of medical services. This definition includes many of the so-called "foundation-type HMOs." The federal HMO strategy was officially unveiled in a March 1970 statement by Robert H. Finch, then Secretary of HEW (Lavin, 1970). President Nixon's February 1971 Health Message to Congress strongly reinforced the HMO strategy as a major federal initiative. Later that year, an HEW White Paper called for a national goal of 1,700 HMOs in operation by 1980 (HEW, 1971:37).

providers.<sup>2</sup> But just as important, HMOs were also seen as offering benefits extending beyond their membership in the form of a strong competitive stimulus for improved performance by the traditional fee-for-service sector. Competition from HMOs would, it was asserted, improve the efficiency of health care delivery and help contain rapidly rising medical costs for everyone. By the same token, most HMO advocates recognized (Havighurst, 1970; Ellwood et al., 1971) that effective competition from fee-for-service providers would be an important incentive for HMOs to maintain high-quality standards.

From the vantage point of the early 1970s the outlook for HMO development was mixed. On the one hand the cost and price record of the "prototype HMOs" relative to the fee-for-service delivery method indicated HMOs could compete effectively in the health care market. Yet on the other hand, the establishment of HMOs appeared to be blocked in many areas by consumer ignorance of the HMO concept, provider hostility, and what were thought to be serious legal barriers to HMO development created by various state and federal laws and practices.

In this article we examine two aspects of HMO development. First, we note the rapid recent growth in the number of HMOs and attempt to determine the relative importance of *market*, *legal*, and *policy* conditions in influencing this rapid HMO growth during the 1970-73 period.<sup>3</sup> We find that the available evidence is consistent with the hypothesis that the number of HMOs has grown primarily in response to favorable market conditions and high-level-policy encouragement from the federal government. Legal conditions, with two exceptions, do not appear to have greatly retarded HMO formation.

Second, in light of these results, we evaluate the major changes in legal conditions which occurred during 1973 and 1974.

<sup>2</sup>These contentions were supported by data on "prototype" HMO-like organizations such as the Kaiser Foundation Health Plan, the Health Insurance Plan of Greater New York (HIP), Group Health Cooperative of Puget Sound, and the Foundation for Medical Care of San Joaquin County. See, for example, Donabedian (1969) and Greenberg and Rodburg (1971); the most recent comprehensive review of HMO performance is by Roemer and Shonick (1973).

<sup>3</sup>Our definitions of "market, legal, and policy conditions" are given in the text which follows.

We conclude that while most of these new laws—ostensibly aimed at encouraging HMOs—do remove some legal barriers, they replace them with new ones. Paradoxically, the new laws intended to encourage HMOs may ultimately be more detrimental than those they replace.

### HMO Growth in the Early Seventies<sup>4</sup>

As a starting point in examining HMO development, Table 1 summarizes our estimates of the increasing number of operational HMOs in recent years. In this table, in most of the data which follow, California is distinguished to highlight special trends in that state.<sup>5</sup> Table 1 shows that the number of operational HMOs has increased dramatically since the end of 1969. For the country as a whole, the number of HMOs increased fivefold in just five years. This precociousness is even more impressive in light of the length of time involved in starting an HMO. InterStudy's survey data indicate that for HMOs becoming operational during 1970–73, this process took about two and a half years.

Total HMO enrollment in the country was around five million in mid-1974, of which nearly 70 percent was in the two largest organizations, the Kaiser Foundation Health Plan and the Health Insurance Plan of Greater New York (HIP). Almost half the HMOs had fewer than 5,000 enrollees. Thus, while enrollment trends will become a major indicator of HMO success or failure over the long run, at this stage we feel it most appropriate to focus on the growth in the *number* of HMOs.

<sup>4</sup>Much of the information for this article (InterStudy, 1973–74; Schlenker, Quale, and McNeil, 1973; Schlenker, Quale, Wetherille, and McNeil, 1974; and Schlenker, 1974) is taken from InterStudy's ongoing program of HMO research.

<sup>5</sup>California's uniqueness stems, among other things, from a long history of HMO presence in the state (notably Kaiser) and from its Medicaid (Medi-Cal) policy which, in contrast to other states, encourages recipients to obtain their medical care from HMOs (or, as they are called under Medi-Cal, Prepaid Health Plans, PHPs). Considerable controversy surrounds this aspect of Medi-Cal, and many contend the program lacks appropriate safeguards for both the Medi-Cal recipients and the state. Supporters maintain (Medical Care Review, 1973) the program has been very successful in restraining the previously uncontrolled costs of the program.

TABLE 1

Estimated Number of Operational HMOs  
(at End of Each Year)

	1969	1970	1971	1972	1973	1974
Total						
Number of HMOs	37	41	52	79	133	183
Percentage increase over previous period	—	11	27	52	68	38
Total excluding California						
Number of HMOs	21	25	34	51	75	102
Percentage increase over previous period	—	19	36	50	47	36
California						
Number of HMOs	16	16	18	28	58	81
Percentage increase over previous period	—	—	13	56	107	40

### Conditions Influencing Recent HMO Growth

Although the number of HMOs has grown rapidly, Table 1 masks considerable variation across geographical areas. We have attempted to analyze these variations to assess the relative importance to HMO development of various legal, market, and policy forces. Because of the time lag involved in HMO start-up, we concentrated on conditions in existence around 1970–71.

#### *Legal Conditions*

As of August 1973, 25 states had one or more HMOs in operation. We compared this group of states to the 25 states without HMOs for those laws usually cited as barriers to HMO development. Since very few states changed these laws prior to 1973 (and many states still have not changed), a comparison of the two groups of states should give some indication of the influence of these state laws on HMO development. Table 2 shows that while there are some differences in legal conditions between the HMO and non-HMO state groups, there are no clear differences in the frequency

TABLE 2  
State Laws Affecting HMOs<sup>a</sup>

	<i>Strict insurance regulation</i>	<i>Some insurance regulation</i>	<i>Physician control</i>	<i>Open physician panel</i>	<i>Nonprofit only</i>	<i>Advertising prohibited</i>	<i>Professional corporate restriction</i>	<i>Certificate of need: outpatient</i>	<i>Certificate of need: inpatient</i>
Total number of states with provision	3	33	14	9	40	15	3	11	20
By subgroup:									
25 states with HMOs	0	18	6	2	22	8	2	8	14
25 states without HMOs	3	15	9	7	19	7	1	3	6

<sup>a</sup>These laws are those usually cited as legal barriers to HMO development. "Insurance regulation" requires HMOs to meet various financial reserve requirements, although, in contrast to insurance companies, HMOs provide services and not dollar payments. "Physician control" refers to laws which require that physicians constitute all or a part of an HMO's controlling body. "Open physician panel" provisions are a part of some states' Blue Cross enabling act and require an HMO to allow the participation of any physician in the HMO. "Nonprofit only" indicates a requirement that a key component of the HMO (usually the plan entity) be organized on a nonprofit basis. "Advertising prohibited" indicates that the HMO cannot advertise its benefit package and rates. "Professional corporate restriction" indicates a restrictive application to HMOs of laws controlling the incorporation of physician groups. "Certificate of need" laws are discussed later in the text; basically, they require governmental approval prior to certain changes in services or expansion in facilities. For more details, see Schlenker et al. (1973: Chapter III).

with which the laws thought to severely restrict HMOs appear in the two groups.

This table shows that HMOs succeeded in becoming operational in states with every legal barrier except "strict insurance regulation." (We found only three states which we considered as having such regulation, Alaska, Nebraska, and North Carolina. As we shall see, other conditions could well be responsible for the absence of HMOs in these states at the time of the study.) State laws requiring "physician control" and "open physician panel" are the only legal conditions which seem to associate with complete HMO absence.<sup>6</sup>

InterStudy's mid-1973 survey of operational HMOs also indicates that these legal conditions are less important in limiting

<sup>6</sup>State legal conditions could, of course, slow the growth in the number of HMOs and affect their organizational form; and this would not be revealed by our comparison. For example, InterStudy's mid-1973 survey suggests that HMOs adopt special organizational forms to avoid laws against for-profit operation. Nearly half the HMOs indicated they were "nonprofit" but had for-profit subsidiaries.

HMO formation and development than originally believed. We asked HMO administrators to cite the factors they perceived as significant barriers to their HMO's formation and growth. Three-fourths saw gaining access to employer and other potential member groups as their most serious formation and growth problem. The second most serious formation barrier was opposition from other providers, followed by problems of obtaining financial support. For growth barriers, obtaining financial support was second, and provider opposition third. The fourth most serious barrier for both formation and growth was expanding physician staff. A legal barrier was, in general, felt by HMOs to be only the fifth most serious formation or growth barrier they faced.

### *Market Conditions*

In contrast to legal conditions, market conditions seem strongly related to the presence or absence of HMOs in a state. The HMO and non-HMO state groups reveal striking differences in a number of variables indicating demand, supply, and price conditions in the medical care marketplace. Table 3 presents the averages of a group of these variables for the two groups of states. The data indicate that states with HMOs, as compared to the states without HMOs, tend to have higher incomes, larger and more urbanized populations, more physicians per capita, higher hospital costs per day and per capita, and greater public and private insurance expenditures. While such differences are, of course, far from conclusive, they are consistent with the hypothesis that HMOs will locate where they can best compete with the conventional medical care delivery system, and that they can best compete where consumers spend considerable amounts on medical care (and especially on hospital care) through insurance, out-of-pocket expenses, and taxes for government medical assistance programs.

### *Legal and Market Conditions in Urban Areas*

State data provide only gross measures of conditions affecting HMO development. Local area conditions may be much more important. To explore this issue we have made a preliminary examination (Schlenker, 1974) of both legal and market conditions during the 1971-73 period in Standard Metropolitan Statistical

TABLE 3

HMO and Non-HMO State Group Comparison  
for Selected Market-Related Variables

<i>Variables</i>	<i>Average for HMO States</i>	<i>Average for Non-HMO States</i>
<b>Demographic-Economic<sup>a</sup></b>		
1. Total population, 1970	5.3 million	2.8 million
2. Population density per square mile, 1970	225	64
3. Percent of population in urbanized areas, 1970	59	30
4. Mean family income, 1969	\$11,341	\$9,570
<b>Health Resources and Expenditures<sup>b</sup></b>		
5. Patient-care physicians per 100,000 persons, 1970	126	93
6. Short-term hospital beds per 1,000 persons, 1971	4.1	4.5
7. Hospital costs per day, 1971	\$84	\$67
8. Hospital costs per person, 1971	\$94	\$77
9. Insurance premium per person under 65, 1970	\$105	\$90
10. Medicare payments per enrollee, 1970	\$328	\$277
11. Medicaid payments per inhabitant, fiscal 1971	\$27	\$16

<sup>a</sup>These data are all from the 1970 U.S. population census.

<sup>b</sup>The physician data are from *Distribution of Physicians in the U.S., 1970* (American Medical Association, 1971); the hospital data are from *Hospital Statistics, 1971* (American Hospital Association, 1972) and the *U.S. Statistical Abstract 1972*; insurance data are from the *1972-73 Source Book of Health Insurance Data* (Health Insurance Institute); Medicare data are from *Medicare: Reimbursement by State and County, 1970* (HEW, SSA, Office of Research and Statistics, 1973); and Medicaid data are from *Medicaid and Other Medical Care Financed from Public Assistance Funds: Fiscal Year 1971* (HEW, SRS, National Center for Social Statistics, 1972).

Areas, SMSAs. A comparison of averages for SMSAs with HMOs versus those without revealed the same general pattern for legal and market variables as just presented for the state comparisons.<sup>7</sup> Further, regression analysis indicated that SMSA population size and hospital expenses per patient day were highly significant and positively related to the probability of both HMO presence and new HMO formations in an SMSA. At the same time the legal

<sup>7</sup>Legal conditions, of course, continued to be measured at the state level; each SMSA therefore took on the values of the legal variables of its state.

variables indicating open-physician-panel and control requirements were significant and negatively related to these probabilities. These results are consistent with our earlier findings; in particular, the strong relationship between hospital costs and HMO presence and formation supports the hypothesis that HMOs thrive where they can best compete with other providers by reducing the use of high-cost hospital care.

The regression analysis also indicated the importance of HMO presence in an SMSA prior to 1972 as a predictor of new HMO formation during 1972–73. In other words, once one or two hardy HMOs broke the ice, others tended to follow. Three quarters of the HMOs formed in 1972–73 located in SMSAs which already had one or more HMOs at the end of 1971. This phenomenon of innovation followed by imitation is quite common in a competitive market economy and was noted long ago by Schumpeter (1934). The new HMOs might have followed older ones because conditions favorable to the early HMOs also appealed to later entrants (perhaps more so because of the earlier HMOs' success in overcoming initial obstacles). Or, new HMOs might have followed because the early HMOs posed a competitive threat to other providers, causing them to retaliate by forming their own HMOs. In either case, the phenomenon of innovation followed by imitation lends support to the hypothesis that the pattern of HMO development represents a response to salient conditions in the marketplace.

Other data also support the "market response" explanation of HMO growth. InterStudy's 1973 survey of HMOs revealed, for example, a significant increase in the frequency of Blue Cross/Blue Shield sponsorship of HMOs over the 1970–73 period. This suggests that during this period the Blues may have been "testing the water" with HMOs and responding to a perceived competitive threat from HMOs to their traditional market position. Also, the sponsorship of HMOs by private corporations increased during the same period and this too could be interpreted as a response to market incentives by a group which was in the past usually outside the health care delivery field but tends to respond to market incentives. Finally, physician groups became increasingly involved in HMO sponsorship, especially during 1972–73, perhaps partly in response to the competitive threat posed by new HMOs sponsored by others.



### *Policy Conditions*

Of the conditions which we examined as potential influences on HMO development, "policy conditions" are the most difficult to specify. By that term we mean the posture, other than as expressed in law, which government adopts toward HMOs within its jurisdiction. We distinguish "policy conditions" from "legal conditions" because "policy" is not always embodied in law, especially in the case of a new phenomenon such as HMOs. As we use the term, "policy conditions" indicates a general "governmental acceptance factor" which in turn is indicated by, for example, funding, promotional efforts, and speeches and writings by governmental authorities.<sup>8</sup>

An examination of the status of state and federal policy toward HMOs during the period of rapid HMO development in the early seventies suggests that federal policy probably had a very encouraging effect on HMO development, and that state policy, except in California, probably had very little influence on HMO development.

*Federal policy.* A federal policy of HMO encouragement manifested itself in two ways during 1970-73. The first was strong public statements endorsing the HMO concept. As noted above, the administration first officially outlined its HMO strategy in March 1970 and reinforced this in 1971 with presidential message and an HEW White Paper. These actions prompted wide discussion of the HMO strategy in the professional literature, (see Lavin, 1970; Ellwood et al., 1971; Saward and Greenlick, 1972). This rhetorical initiative undoubtedly raised the legitimacy of HMOs and suggested that more substantive federal assistance would soon be forthcoming.

The second manifestation of the positive federal policy toward

<sup>8</sup>It is also convenient to distinguish between "legal" and "policy" conditions because we are considering both state and federal government. State government has until recently had very little "policy" toward HMOs in the sense of a considered stance toward encouraging or discouraging HMO development. Yet as we have seen above, a number of states had laws which affected HMOs, even though those laws were typically enacted for other purposes. In contrast to the states' "law without policy," the federal government initially had a considered, coherent policy of encouraging HMOs but only limited federal law affecting HMOs.

HMOs during 1970–73 was modest funding. From fiscal year 1971 to 1973 the federal government expended \$28 million in grants and contracts related to HMO development (HEW, 1974b). Of this amount, \$12 million was used to finance resource development and technical assistance for organizations not directly involved in the provision of prepaid health services. The remaining \$16 million went to direct planning and development grants to 79 organizations, of which 17 were operational by March 1974. Also during fiscal years 1971–73, ten additional operational HMOs received some form of technical assistance from HEW. The direct impact of these funds was modest. Federally funded HMOs account for only a small part of the HMO growth over those years, and the funded HMOs' existence cannot be attributed in most cases solely to federal funding. However, the funding and highly visible oratorical activity together were taken by many to presage greater federal encouragement of and assistance to HMOs in the future, and many organizations were thereby prompted to go ahead with HMO development.

*State policy.* In contrast to the clearly favorable federal policy, it is difficult to identify a state policy toward HMOs, much less to evaluate its influence. With the exception of California noted above, most states do not seem to have had a "policy" toward HMOs until at least 1973. As we have seen, most states have applied certain laws to HMOs which were thought to hamper HMO development. But the piecemeal application of these laws—which had been typically enacted much earlier with far different organizations in mind—hardly indicated anything as organized and coherent as the term "policy" implies. If anything, these laws suggest that until very recently most states have not had a "policy" of encouraging or discouraging HMO development.

### *HMO Development in 1970–73, in Summary*

The main conclusion we derive from the legal, market, and policy data is that HMO formation and growth during 1970–73 was primarily a response to favorable market and federal policy conditions. In short, federal policy provided an encouraging backdrop, and HMO development then proceeded in those areas where HMOs could best compete with other providers.

This is not to say that legal conditions were unimportant, but they do not appear to have been as detrimental to HMO formation as was initially assumed. However, in late 1973 and early 1974 major legal changes occurred at both the federal and state levels, heralding a new phase in HMO development. We turn now to consider these new legal conditions in light of the 1970-73 experience.

### New Laws Affecting HMOs

Nineteen seventy-three and early 1974 brought much new HMO legislation at both the federal and state levels. Given the importance of market conditions which seems indicated by the evidence just presented, the standards for evaluating this new legislation must, in our view, also be market-related. Our concern is not simply whether these new laws will encourage or discourage HMO development, but whether these new laws will encourage or discourage *fair market competition* in the medical care delivery system by allowing HMOs and the fee-for-service mode to compete on equal footing and without compromising medical care quality. The basic principle underlying a fair-market-competition standard is that obstacles which unfairly bar HMO entry into the medical care market should be removed, but that HMOs should not receive any special advantages (such as undue subsidization) relative to the rest of the medical care delivery system. This standard has been well articulated in the recent policy statement on HMOs by the Institute of Medicine of the National Academy of Sciences (1974).

Certainly, "fair market competition" is not a completely objective standard. Reasonable people can differ as to whether specific laws are preferential to one group or not. In our estimation, most new HMO legislation reflects the view that competitive market forces cannot be relied on to ensure adequate medical care quality from HMOs. To varying degrees, the new laws constrain the HMO's cost-containment incentives in an attempt to protect the consumer against quality reductions. The evidence on this point to date is mixed, but suggests the danger is minimal. Studies of prototype HMOs have not found inferior medical care, and have often found the opposite (Roemer and Shonick, 1973). On the other hand, allegations of poor quality do surround some of the new

California PHPs. As the discussion below suggests, in our view most of the new legislation sacrifices too much in potential cost containment to gain quality safeguards, many of which may be either unnecessary or ineffective. The primary effects of many of these so-called safeguards may be, unfortunately, to slow the process of HMO formation and to raise the cost of HMO care (perhaps above competitive levels for a large segment of the market) without significantly increasing the consumer's protection against inferior medical care.

A further drawback of many of the new laws is that the beneficial requirements they do impose on HMOs are not also imposed on their competitors (insurers and providers). We hope, however, this imbalance will only be temporary, and future programs such as national health insurance will require all health care insurers and providers to adhere to minimal-quality and consumer-safeguard standards.

The discussion below considers first, at the state level, HMO enabling acts, certificate-of-need laws, and Medicaid. We will then turn to federal laws, specifically to Medicare and the HMO Act of 1973.

### *State HMO Enabling Acts*

As pointed out earlier, in most states the piecemeal application to HMOs of various laws which were enacted with far different organizations in mind hardly constitutes anything as organized and unambiguous as a "policy." It was partly to correct this problem that state HMO enabling acts were advocated and passed. As reported by Holley and Walker (1974a; 1974b), by mid-1974, 17 states had such laws; seven states enacted their legislation in 1974, seven in 1973, two in 1972, and one in 1971.<sup>9</sup> In addition, similar legislation was pending in several other states.

While it is too early to determine the effect of these new laws on HMO development, our analysis suggests that their contribution to HMO development will be mixed. On the positive side,

<sup>9</sup>The states included in this list, with the year of enactment in parentheses, are: Arizona (1973), Colorado (1973), Florida (1972), Idaho (1974), Illinois (1974), Iowa (1973), Kansas (1974), Kentucky (1974), Michigan (1974), Minnesota (1973), Nevada (1973), New Jersey (1973), Pennsylvania (1972), South Carolina (1974), South Dakota (1974), Tennessee (1971), and Utah (1973).

most enabling acts require the state to monitor the quality of care the HMO delivers, require HMOs to have an established mechanism for processing enrollee grievances, and require some form of enrollee participation in the HMOs' policy-making body. All these seem to be positive provisions for protecting consumer interests. In addition, nearly all of the enabling acts also release HMOs from restrictions on advertising and the corporate practice of medicine, though these restrictions do not seem to have greatly burdened many HMOs.

However, the new enabling laws also impose new and more burdensome requirements on HMOs which probably will not advance consumer interests. For example, several states' enabling laws impose financial-reserve requirements on HMOs similar to those applied to insurance companies. While appropriate for insurers, these requirements are not appropriate for an HMO, which contracts to provide medical services and not dollar benefits. Some enabling laws also require state approval of an HMO's rates; most fail to exempt HMOs from certificate-of-need laws, which were designed for traditional hospitals (and are further discussed below). Several laws also require HMOs to have various open-enrollment provisions, which can be expected to significantly increase an HMO's costs and decrease its ability to compete, since few states impose analogous requirements on insurance companies or traditional providers. Few state enabling laws have "dual choice"<sup>10</sup> provisions, which would increase HMOs' access to the market, and in only one state to date (Michigan) does the dual-choice provision apply to more than state employees.

In our view, many of these regulatory requirements will do little to protect consumers and will unnecessarily limit opportunities for HMO development. For instance, in Arizona the HMO enabling act imposes new requirements of \$50,000 deposits and \$100,000 reserves per HMO and a 1 percent tax on net charges. These requirements hindered at least one organization in its efforts to form an HMO. Yet while imposing these financial requirements, the Arizona enabling act is silent in the areas of quality monitoring, grievance procedures, and enrollee participation in policy making.

<sup>10</sup>"Dual choice" is a provision requiring employers to offer employees an option to apply their health benefits to either an HMO or a conventional health insurance plan. As discussed later, this is a key provision of the federal HMO Act.

Nevada is another example. In the regulations evolving from the enabling act, fledgling HMOs are required to have a minimum net worth of \$100,000; purchase a surety bond of not less than \$250,000; maintain a blanket fidelity bond of at least \$1,000,000; and establish a monthly reserve equal to 3 percent of collected enrollee payment. These new requirements appear to have driven two formational plans from the market and threaten the continued operation of a third. Thus, paradoxically, in many states an HMO "enabling act" may not increase the consumer's protection from shoddy HMOs or encourage fair competition between HMOs and other modes of health care delivery, but may instead decrease the likelihood of effective competition from HMOs.

### *State Certificate of Need Laws*

Certificate-of-need laws require hospitals and certain health facilities to obtain approval, a certificate of need, from a regulatory authority prior to undertaking new construction or certain modifications in services.<sup>11</sup> These laws originated as a legislative response to the continuing increases in the cost of hospitalization. Advocates of certificate-of-need legislation saw these cost increases as a result of several factors: oversupply of hospital beds, the overutilization incentives of third-party cost reimbursement, and the excessive zeal of nonprofit hospitals in undertaking new capital expenditures for elaborate but economically inefficient facilities. Twenty-three states had certificate-of-need laws as of January 1974, and most of these were applied to HMOs. Judging by the number of certificate-of-need bills now pending, it seems very likely that more states will be adopting certificate-of-need legislation in the future. In addition, as of April 1974, 32 states had reached agreements with the federal government for implementation of Section 1122 of the 1972 Social Security Amendments (P.L. 92-603), which in effect establishes a certificate-of-need requirement under federal law for Medicare and Medicaid reimbursement of capital costs.

Although the rationale for and probable effectiveness of certificate-of-need laws in curbing hospital costs is not the subject

<sup>11</sup>An analysis of these laws, with particular attention to their potential impacts on HMOs, can be found in Havighurst (1973; 1974).

of this article, they have been questioned (Havighurst, 1973) by others. The applicability of such laws to HMOs rests on even weaker logical footing, since the central characteristic of the HMO is its incentive to minimize the cost of needed medical care. An HMO's viability depends on its ability to *compete* with other providers. However, it seems likely that the very forces within the traditional system whose stubborn resistance to efficient utilization and cost considerations brought on the passage of certificate-of-need laws in the first place will eventually control the control mechanism. When those controls are then applied to HMOs as well, the outcome is likely to be a reduction of effective competition from HMOs and other innovative health delivery approaches.<sup>12</sup> Anecdotal evidence suggests that this has already occurred in some states.

While most of the HMOs InterStudy surveyed in mid-1973 had formed before many certificate-of-need laws were in operation, many had felt the inhibitory force of these laws on their growth. In states with certificate-of-need laws in effect or pending, 48 percent of the responding HMOs cited such laws as moderate or severe barriers to their growth. Although the overall impact of certificate-of-need laws remains to be seen, it appears unlikely at this point that they will contribute to fair market competition.

### *Medicaid*

Although Medicaid is a joint federal-state program, most of the responsibility for program operations is lodged at the state level. The 1969 Social Security Act Amendments made approving mention of prepayment plans for providing Medicaid services, but participation by HMOs in Medicaid was complicated by requirements that all Medicaid eligibles in a state were to receive the same scope of services, that those services were to be available throughout the state, and that Medicaid eligibles be allowed to choose where they would receive their medical attention. The 1972 Social Security Act Amendments (P.L. 92-603) allowed the states to waive these requirements. Unfortunately, specific regulations

<sup>12</sup>Professional Standards Review Organizations (PSROs) are another control mechanism subject to this danger, since providers from the traditional system will be able to rule on the "quality" of care provided by their competitors in HMOs and elsewhere.

for implementing the Medicaid-HMO provisions of the Amendments were not proposed until 1974 (Federal Register, 1974b), suggesting a less than maximal effort to encourage HMOs to participate in Medicaid.

In view of these facts it is not surprising that HMO participation in Medicaid is not great outside of California. According to the responses of 112 organizations to InterStudy's July 1974 enrollment survey, about 6 percent of the about 5 million HMO enrollees are Medicaid recipients. Although nearly half the HMOs in that survey had some Medicaid recipients enrolled, over half of these HMOs were in California. However, as discussed below, the attractiveness to HMOs of participation in Medicaid may increase as the result of the preference given by the federal HMO Act of 1973 to HMOs with Medicaid members.

If Medicaid participation does increase, this will not necessarily mean an improvement in fair market competition among delivery systems. The states vary considerably in the requirements they impose on both HMOs and fee-for-service providers. Oregon and Maryland illustrate (HEW, 1973) the different financial incentives states provide for HMO participation in Medicaid.

In Oregon an HMO must absorb all financial losses and can keep none of any savings it achieves, while in Maryland an HMO bears no losses and can receive half the savings. Measured against our view of fair market competition, both methods err, although in opposite directions. Oregon may be too harsh on HMOs; Maryland too lenient. To be consistent with our fair market standard, an HMO should absorb any loss it incurs in meeting its contractual obligations. By the same token, when an HMO can meet its obligations at an agreed-upon capitation rate, the HMO should be allowed to retain any savings. Unfortunately, this ideal is not yet a part of the Medicaid program.

### *Medicare*

As noted above, historically most of the important laws affecting HMOs were at the state level; the emphasis has now shifted to the federal level. The remainder of this article focuses on the two most important recent federal actions affecting HMOs: recent Medicare modifications and the 1973 HMO Act. Our subsequent discussion



draws heavily on the work of McClure (1973; 1974) and the Institute of Medicine (1974).

Medicare is presently the federal government's largest health program. As with Medicaid, HMO involvement in Medicare has not been extensive. While close to half (46 percent) of the 112 HMOs responding to InterStudy's mid-1974 survey enrolled Medicare beneficiaries, these beneficiaries accounted for less than 5 percent of all HMO members. In our view, the Medicare program fails to meet fair-market-competition criteria, but for different reasons than the laws previously discussed. This is best shown by an examination of Medicare's policies for HMO reimbursement. Although only one reimbursement method is in use now (under section 1833 of the Social Security Act), two additional alternative reimbursement methods were authorized by Section 1876 of the 1972 Social Security Amendments; but regulations for these methods were still being developed in early 1975.

*The "old" cost-reimbursement method.* HMOs now enrolling Medicare beneficiaries are reimbursed on a cost basis. Reimbursement must be related to the allowable costs of providing covered services. The HMO neither absorbs any losses nor obtains any surpluses and thus has no financial incentive to provide care efficiently to Medicare enrollees.

*The "new" cost-reimbursement method.* Under the new cost-reimbursement method provided for by the 1972 Social Security Amendments, an HMO can be paid an advance capitation payment for both parts A and B of Medicare. However, this mechanism is still essentially cost reimbursement, because the capitation payment will be *retrospectively* adjusted to reflect the HMO's Medicare-allowable expenses for providing care to beneficiaries. Again the HMO can neither keep any savings nor sustain any losses.

*The risk-sharing reimbursement method.* The other new reimbursement alternative is a risk-sharing plan which theoretically would bring an HMO's efficiency incentives partially into operation. Unfortunately, however, few HMOs will be able to qualify for participation under this arrangement in the near future. The pro-

posed regulations (Federal Register, 1974c) provide that to be eligible for a risk-sharing contract an urban HMO must have a current enrollment of 25,000 members and have had an enrollment of at least 8,000 for each of the two preceding years. For rural HMOs the current enrollment must be 5,000 and for each of the preceding three years have exceeded 1,500. HMOs meeting these requirements are called "mature" HMOs. Other HMOs, denoted as "developing," are expected to use a cost-reimbursement method. Most of the 112 HMOs responding to InterStudy's mid-1974 enrollment survey were located in urban areas, only 18 reported an enrollment of over 25,000, and even some of these could not meet the requirement of at least 8,000 enrollees for each of the two preceding years.

Even if many HMOs could qualify for the risk-sharing method, they would have little financial incentive to do so. Under this reimbursement mechanism, any losses the HMO sustains must be borne by the HMO. However, any savings are split between the HMO and the Medicare Trust Funds, with the added stipulation that any savings beyond 20 percent of costs go entirely to the Medicare Trust Funds.

Thus, given the eligibility problems of the risk-sharing mechanism, and the small potential for financial reward it offers, we expect few HMOs to undertake that relationship with Medicare. This leaves cost reimbursement as the alternative. From our point of view, the problem with cost reimbursement is not that it is burdensome for an HMO, but that it is irrational, given the HMO's incentives.<sup>13</sup> Cost reimbursement treats an HMO like a fee-for-service provider, bypassing and possibly disabling the HMO's prepayment incentive for efficiency. In our estimation, this denies to the Medicare program the efficiency advantages of HMOs and will tend to subvert HMO efficiency incentives or even encourage cost maximization. It might even be possible for an HMO to use its "reasonable cost" Medicare reimbursement to subsidize its other non-Medicare enrollees and thereby gain an unfair competitive advantage over fee-for-service providers.

<sup>13</sup>Other federal policies have shown a greater awareness of HMOs' uniqueness. See the Cost of Living Council's regulations for HMOs (Federal Register, 1974a) under what was to be Phase IV of the Economic Stabilization Program. These regulations were never implemented.

The unattractiveness of risk sharing under Medicare is evident in data from InterStudy's July 1974 survey. Fifty-two HMOs then enrolled some Medicare beneficiaries, and 36 more intended to do so by July 1975. In all, however, only *two* of these 88 HMOs indicated they expected to participate in a risk-sharing contract. Forty-four expected to use one of the cost-reimbursement arrangements, and the remaining 42 were undecided or did not answer. While it is certainly desirable to extend the benefits of HMO services to Medicare beneficiaries, cost reimbursement will not further fair market competition between HMOs and the fee-for-service sector. This is especially ironic since the federal HMO strategy began with the proposal (Finch, 1970) to use the Medicare program as a catalyst for HMO development.

*The Health Maintenance Organization Act of 1973 (P.L. 93-222)*

The most significant new federal policy affecting HMOs is the HMO Act of 1973 (P.L. 93-222). The act establishes a precedent for governmental attempts to encourage structural change in the health care delivery system. Because this legislation had bipartisan support, it could legitimize and encourage many kinds of health-delivery innovations in addition to HMOs, and could thereby prove to be landmark legislation.

Since the act has been law only since December 29, 1973, it is too early to gauge its impact on fair market conditions for HMOs. Regulations have been developed only for portions of the act. Despite its recency, however, some indications of the act's impact can be gained from the statutory provisions and regulations (Federal Register, 1974d) and from InterStudy surveys of operational and planned HMOs conducted in May and July of 1974 to determine HMOs' reactions to the new law.

In examining the act according to fair-market-competition standards, we divided its provisions into four general topic areas: (1) funding, (2) consumer protection, (3) enabling, and (4) regulation. The HMO Act is worded so that it applies only to those HMOs which choose to become "certified" under the act. However, we believe (as discussed below) most HMOs will feel compelled to certify. Certification requires that the HMO be in compliance with the regulation and consumer-protection aspects of

the act, and certification is required before an HMO can benefit from the act's funding and enabling provisions.

*Funding.* In our view, the funding aspects of the act will probably be of only modest significance. As first introduced by Senator Kennedy in Senate Bill 14, the act provided \$5.2 billion for HMO development. By the time the HMO Act became law it had been pared to an authorization for \$375 million over a five-year period, of which \$50 million is specified for research and evaluation studies of quality assurance. Experience from 1971 to 1973 discussed above suggests that funding at this level will probably not have a major impact. This is, however, desirable under our fair-market-competition standard. Except in cases where more drastic action is necessary to bring health care to underserved groups, fair market competition requires that government policy aim at encouraging conditions which allow HMOs to enter and compete their way into the market, rather than having their way paid for them.

Unfortunately, however, the funding provisions also introduce certain market distortions. For instance, the act distinguishes between nonprofit and for-profit HMOs. The former are eligible for grants, contracts, and loans, but not loan guarantees, while the latter are eligible only for loan guarantees and then only when serving medically underserved areas. The loan program will make available federal money to nonprofit HMOs at the Treasury rate plus an add-on for administrative costs. For-profit HMOs will be borrowing private money under federal guarantee but at significantly higher market rates. This is discriminatory against for-profit HMOs and creates an incentive for new HMOs to adopt the organizational contortions we noted earlier that are presently used by many nonprofit HMOs to claim that status.

*Consumer protection.* We feel that in the long run the most effective safeguard for HMO consumers is the existence of fair market conditions which give consumers the opportunity to make a free and informed choice among HMOs and between HMOs and other providers. This freedom of choice coupled with programs aimed at measuring the quality of care received in *both* fee-for-service and HMO settings should ultimately be the most effective protection for the HMO consumer. However, long-run safeguards are not

enough; short-run abuses should also be averted. Ideally, government intervention to protect consumers should insure against market-safeguard failures but, at the same time, should enable the market to deliver those safeguards ultimately. Achieving this ideal is a difficult balancing act. If too many safeguards are applied (as appears to be the case with many state HMO enabling acts), HMOs will be unnecessarily hindered in entering the market. If too few safeguards are used, allowing well-intentioned (or even ill-intentioned) but slipshod organizations to operate, the quality of care may suffer. We feel the consumer safeguards of the HMO Act effectively balance these two opposing forces.

Under the act, a certified HMO is required to make its services accessible and available to enrollees. When medically necessary, services must be available and accessible 24 hours a day, seven days a week. Certified HMOs are also required to have a fiscally sound operation, and adequate provision against insolvency satisfactory to the Secretary of HEW. In addition, certified HMOs must have grievance mechanisms for enrollees, and are not allowed to expell an enrollee for reasons of health status.

The act also specifies that certified HMOs must have a quality-assurance system and report pertinent data to the Secretary. While there has been little empirical evidence that the quality of HMO care is worse than the traditional system, and some evidence that it is better, there is the theoretical argument that HMOs may underserve their members. To guard against both the appearance and possibility of underservice, it is important to have quality safeguards and to concentrate on *outcome* rather than *process* measures of quality. However, since quality assurance and reporting entail additional expense and are not at this time required of other providers (PSROs may change this), and since the measurement of quality is still more art than science, we feel it is desirable to keep these requirements minimal until all providers are required to meet them.

Perhaps one of the most powerful and simple safeguards in the act prohibits an HMO from enrolling more than 75 percent of its enrollees from a medically underserved population (where the underserved are defined to include Medicare and Medicaid enrollees). This provision will prevent HMOs from enrolling large

numbers of the underserved unless the HMO has also been successful in attracting other enrollees. This consumer safeguard should strengthen market competition as well as protect the underserved.

*Enabling.* Besides funding, the act offers HMOs other benefits from certification. The most important (a) preempt various restrictive state laws, (b) require employers who offer their employees health plans to allow employees to apply their benefits to HMO membership (referred to as "dual choice"), and (c) allow advertising of the nonprofessional aspects of an HMO's services. We refer to these provisions as the "enabling" aspects of the act.

The dual-choice provision is of most importance to the HMOs, as evidenced in the responses shown in Table 4 of 97 operational HMOs to InterStudy's May 1974 survey on their reactions to the HMO Act.<sup>14</sup> Nearly two thirds of the responding HMOs indicated dual choice was a significant advantage to be gained from certification under the act.<sup>15</sup> Far fewer HMOs viewed the funding or preemption benefits as significant advantages.

Even with the potential gains from certification, only half the HMOs responding to the survey indicated they intended to apply for certification. Most of the rest were undecided. A major reason for this uncertainty becomes clear when one examines the regulatory aspects of the act and their potential for reducing HMOs' ability to compete effectively.

*Regulation.* The major regulatory aspects of the act are:

- (1) A very rich basic benefit package. The HMO Act not only requires the generally recognized minimum essential benefits of preventive and therapeutic physician services, emergency and inpatient hospital services, diagnostic X-ray and laboratory services, and out-of-area emergency coverage, but also re-

<sup>14</sup>Organizations planning HMOs provided similar responses to a survey conducted in July 1974. For the sake of brevity, we report here only the results for the operational HMOs.

<sup>15</sup>This is consistent with InterStudy's 1973 survey results reported earlier, which indicated that HMOs perceived gaining access to employee groups as their greatest problem in forming and growing.

TABLE 4  
Enabling Provisions of the HMO Act  
(Percentage of Respondents Indicating Relative  
Attractiveness of Selected Provisions)

Provision	Significant Advantage	Moderate Advantage	No or Slight Advantage	No Response or Undecided
Funding: grants, contracts, loans, loan guarantees	36	18	41	5
Preemption of restrictive state laws and practices	12	21	61	6
Dual-choice re- quirement for employers	62	19	13	6

quires that HMOs offer many other services such as short-term mental-health services and alcoholism and drug-abuse services. Seventy-one percent of the HMOs responding to our survey said they could not meet these requirements without increasing their present benefit package and, hence, their premium.<sup>16</sup>

- (2) Permanent regulation. Section 1312 of the act gives the Secretary permanent regulatory power over any HMO which becomes certified. No time limit or escape clause is provided whereby the HMO could remove itself from such regulation. For example, if a certified HMO (even one receiving no federal funds) found the minimum basic benefit package too highpriced and unmarketable in its service area, there is no way that it could seek relief. No such regulatory conditions have to date been imposed on health insurers or other providers.
- (3) Open enrollment. The act requires that a certified HMO have an open-enrollment period of not less than 30 days a year during which it accepts individuals up to its capacity in the order in which they apply, without regard to health status. This provision could greatly increase HMO costs relative to other insurers with which they must compete, since open enrollment is

<sup>16</sup>The act does allow the use of co-payments for the provision of specific services, although only in very specific and limited ways.

not required of other insurers. One study (McClure, 1974) found that an HMO's costs for persons joining during open enrollment were 80 percent greater than for other enrollees.<sup>17</sup>

- (4) Community-rate rating. Except for some administrative cost differences, HMOs are to charge the same premiums to all their members. Obviously, this means low users of services "subsidize" the high users. Such subsidization may be desirable from a societal viewpoint, but such requirements are usually not placed on insurers or other competitors of HMOs.
- (5) Other miscellaneous requirements. The act also requires each certified HMO to have one third of its policy-making board be enrollees, requires that (after three years) group-practice-based HMOs obtain at least half their revenues from HMO activities, limits HMO purchases of reinsurance, and imposes other reporting, quality-assurance, and continuing-education requirements. Again, while many of these requirements are societally desirable they are usually not imposed on insurers and providers which compete with HMOs.

Obviously, meeting all the above requirements will not be costless for HMOs, and, in most cases, similar costs will not have to be borne by those who compete with HMOs. InterStudy's May 1974 survey shows that the HMOs recognize these potential problems, especially with the open-enrollment and community-rating requirements, as shown in Table 5.

In light of the cost increases likely to be caused by the richness of the basic benefit package, we were surprised that most HMOs did not see this as an important disadvantage, particularly since nearly three-fourths of the HMOs also said this would require changing their minimum-benefit package. Perhaps this optimism is based on a hope that potential enrollees will recognize and desire to pay for the increased services which the act will require.

<sup>17</sup>It is possible for an HMO to obtain a waiver of the open-enrollment requirement if it can show that open enrollment has or would result in the enrollment of a "disproportionate" number of high-risk persons which will "jeopardize its economic viability." This could mitigate the negative effect of the open-enrollment requirement, but it also gives more arbitrary power to government regulators and increases the complexity and uncertainty for HMOs in making cost projections and establishing premium rates.



TABLE 5

Regulatory Provisions of the HMO Act  
(Percentage of Respondents Indicating Relative  
Unattractiveness of Each Provision)

<i>Provision</i>	<i>Significant Disadvantage</i>	<i>Moderate Disadvantage</i>	<i>No or Slight Disadvantage</i>	<i>No Response or Undecided</i>
Permanent regulatory power given to HEW Secretary	23	26	33	18
Minimum basic benefits	12	28	58	2
Open-enrollment and community-rating requirement	40	21	33	6
Requirement that one-third of policy-making body be enrollees	18	16	61	5
Ongoing quality-assurance-program requirement	3	13	78	5
Requirement that medical group's principal activity be prepaid group practice	37	10	42	10

In sum, it seems likely that the ambivalence toward certification which many HMOs indicated in the survey is due to their reluctance to accept the burdens of the regulatory provisions of the act. This, however, raises a crucial dilemma. The dual-choice provision of the act may, in effect, compel HMOs to seek certification. The provision will require employers to offer their employees the option of joining an available certified HMO. Offering a non-certified HMO would not meet this requirement, and would probably create additional administrative costs for the employer. Thus, non-certified HMOs could have great difficulty gaining access to employer groups in areas with certified or potentially certified HMOs. HMOs may thus feel compelled to seek certification, even though certification is likely to increase their costs, possibly to the point that it will be extremely difficult to compete with traditional insurers and providers. Thus the HMO Act could well stifle fair market competition by forcing the majority of HMOs to become high-priced, "Cadillac" HMOs.

There are other aspects of the act which, while desirable on the surface, might have detrimental effects on competition. For example, the priority in funding given to HMOs which enroll the underserved may lead HMOs to seek increased Medicare and Medicaid enrollment. While this is laudable in many respects, we have indicated the pernicious incentives which Medicare's cost-reimbursement system for HMOs creates. Another potential danger is that the certification costs built into the act and the resulting increased competitive pressure could cause HMOs to underserve as a means of holding premium rates down to competitive levels. Ironically, this is precisely what those who advocated the costly regulatory requirements for certification.

While we have not discussed all the ramifications or details of the HMO Act, it is clear that the act escapes simple characterization. It has several very positive characteristics from a fair-market-competition viewpoint. It is a precedent for governmental encouragement of structural change in the delivery system to improve the market's operation. The funding provision of the act, while somewhat biased, should stimulate competition without overly subsidizing HMOs. The act also contains valuable protections for the consumer and an assist for certified HMOs by removing some of the more serious marketing and state legal barriers. However, in our view, the act has drawbacks which offset many of its positive features. While many of the regulatory provisions of the act would be desirable if applied to all health care providers and insurers, their unilateral imposition on HMOs could seriously weaken HMOs' ability to compete in a large segment of their potential market.<sup>18</sup>

## Conclusions

No single delivery mode can incorporate incentives for achieving all the quality, cost, and distribution goals our society has set for health care delivery in the United States. Given this impossibility, we feel the best approach is a system which uses different delivery modes—based on different incentive structures—actively competing with one another.

<sup>18</sup>Rhode Island's recently enacted catastrophic health insurance plan law (HEW, 1974a) appears to adopt a more even-handed approach by requiring *all* insurers and providers to meet certain minimal conditions.

At this point, the future of HMOs and meaningful competition in the health sector is uncertain. Our evidence from the 1970-73 period suggests that HMOs can successfully compete with the fee-for-service delivery mode even when conditions are less than strictly fair. Now, however, the conditions for HMO development have changed. Ironically, many of the new federal and state laws which purportedly are designed to encourage HMOs may inhibit rather than promote competition and pluralism in health care delivery because those laws apply certain constraints only to HMOs.

Yet even this situation is subject to an even greater change in the conditions for competition in health care delivery. The most massive intervention in the health care marketplace yet attempted appears imminent in the form of national health insurance. This intervention presents tremendous potential for either improving or crippling effective competition in health care delivery. The uniform application to all health care insurers and providers of many of the provisions now applied solely to HMOs under the HMO Act would do much to promote effective and beneficial competition.

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Research for this article was supported in part under a Health Services Research Center grant from the Bureau of Health Services Research, Department of Health, Education, and Welfare (Grant No. HS 00471-06). Paul M. Ellwood, Jr., M.D., made valuable comments on a previous draft, and the latter portion of this article draws heavily on the work of Walter J. McClure, Ph.D.

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