Health Maintenance Organizations and the Health Planners*

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Appearing in health policy discussions for the first time in 1970, the concept of health maintenance organizations (HMOs) has been a recurrent theme ever since. The concept was first the object of great enthusiasm, then of some disenchantedment, and more recently of renewed interest as a potential contributor to health care cost containment and as a promising vehicle of delivery system reform. A parallel theme in the health policy debate—but one with a more consistently upward trend in popularity—has been health planning, which has received increasing congressional support since the early 1960s, culminating in the National Health Planning and Resources Development Act of 1973 and its requirement that all states adopt so-called "certificate-of-need" laws giving regulatory teeth to planning decisions. These two themes—the HMO idea and the commitment to health planning—have never been altogether harmonious, but the clash of policies has become audible only recently, as HMOs have encountered difficulties in obtaining needed approvals for their projects from the health care system's planner-regulators. These discordant notes have led to proposals for limiting the health planners' regulatory authority over HMOs. This article examines the treatment that HMOs have received, should receive, and can expect to receive at the hands of the health care system's planner-regulators and concludes that legislation exempting HMOs from certificate-of-need requirements would be desirable.

HMOs are entities which contract with consumers to provide, as needed and for a fixed premium paid in advance, a defined, comprehensive set of medical and hospital services. For reasons to be explored below, they are deemed to have many advantages over traditional fee-for-service medicine—particularly as it is currently

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paid for by third-party insurers, service plans, and government—and to be a promising mechanism for effecting the reorganization of the health care financing and delivery system that many observers believe is needed if costs are to be controlled. In order to accomplish their reform mission, however, HMOs must gain admission to the marketplace and must be free to develop the resources and relationships that their delivery arrangements and efficiency require. It is precisely at this point that HMOs encounter the health planners, who have the authority both to withhold certificates of need authorizing their establishment and significant capital investments and to hold up the flow of federal developmental grants and other money.5

Whereas HMOs are vehicles of change in the health care system, certificate-of-need laws were conceived primarily to retard change, which was thought to be too haphazard, too uncontrolled, and, above all, too costly.6 Although not intended to stop all change, the regulatory mechanisms employed to administer certificate-of-need laws may not be fully capable of distinguishing between those changes that are desirable and those that are not. One possibility is that the political environment may cause regulatory decisions to reflect special interests, particularly the interests of established providers who fear the competition that HMOs introduce into local markets. But even without domination by provider interests, regulators may have other reasons for being reluctant to admit an HMO into a market or to grant it the right to grow in its own way. Aside from the possibility of their being afflicted with simple shortsightedness, regulators may harbor a preference for stability over the uncertainties inherent in the more competitive marketplace that HMOs bring about; or they may feel an overriding obligation to be fair to existing providers by rewarding their cooperation and compensating them for the burdens that regulation imposes; or possibly the planner-regulators will simply believe that they and their provider allies can effectuate such delivery system reorganization as is needed without aid from new market entrants. Even if an HMO is permitted to enter a market or to expand, the political

5. The authority of health planners over HMOs is primarily determined by state law, but present federal law requires the states to adopt in the near future certificate-of-need laws covering HMOs. Id. § 300n(5); 42 Fed. Reg. 4,002, 4,024 (1978) (to be codified in 42 C.F.R. § 122.301(c)). HMOs are also subject to regulation under Section 1122 of the Social Security Act. 42 U.S.C. § 1320a-1(d)(2) (Supp. V 1975); 42 C.F.R. § 100.102(f) (1976). Moreover, HMO applications for federal grants must be approved by local Health Systems Agencies. 42 U.S.C. § 300J-2(e) (Supp. V 1975).

context of certificate-of-need regulation almost guarantees that significant compromises will be forced upon it in order to accommodate those local interests that would be harmed if the full force of innovation were felt. Thus there are many reasons why the local Health Systems Agencies (HSAs) and the State Health Planning and Development Agencies (State Agencies), which are jointly charged with carrying out planning and regulatory functions in connection with certification of need, might stand in the way of the desirable changes that HMOs promise, just as regulatory bodies in other industries have been hesitant to allow technological and other changes to occur freely.7

Despite doubts that very many HSAs or State Agencies are capable of embracing the HMO concept fully and implementing it aggressively, this article attempts to persuade them to attach the highest priority to fostering the development of independent HMOs, not only for their own sake as desirable alternatives, but also as competitive influences in local markets. Indeed, the article seeks to encourage the HSAs and the State Agencies to employ competition—particularly HMOs—as a tool in pursuing their responsibilities, and offers advice as to how HMOs should be regarded and dealt with in pursuing such a strategy. In the article’s final section, however, the conclusion is reached that because the system’s regulators cannot be depended upon to eschew protectionist policies favoring established provider interests, HMOs should be relieved of the necessity of satisfying the planner-regulators before being allowed to operate or to expand.

I. The Promise of HMOs

A. HMOs’ Advantages

The demonstrated advantages of HMOs over traditional insured fee-for-service medicine need not be reviewed in detail here.8 In addition to the advantages that flow from an integrated approach to personal health problems, HMOs have shown an ability to contain cost without sacrifice of essential quality. Because HMOs must function with a fixed budget derived from the subscribers’ monthly

premiums, they have a strong incentive to spend wisely. Even more important than the essential fixed budget feature, however, is the necessity for the HMO to be concerned about its survival in the marketplace in competition with other plans. Such competition forces the HMO to keep its premiums competitive, in effect giving consumers the ultimate say concerning the level of health care spending by the plan. Due to the cost consciousness thus transmitted from consumers to providers, HMOs have been quite successful in containing costs, primarily by using hospitals less intensively than do fee-for-service doctors, placing emphasis on ambulatory care instead. Additional efficiencies may be obtained by HMOs as a result of their use of cost-effective preventive measures, their care in assessing the need for capital equipment and ancillary services, their efficient utilization of paramedical personnel, and other factors. Although individual HMOs will necessarily differ from each other in many pertinent respects, the concept itself is well proved. There is no longer any doubt that many HMOs have indeed succeeded in delivering care of acceptable quality at a lower cost.

Just as HMOs must compete with other plans on the basis of both price and quality, fee-for-service practitioners have begun to recognize HMOs as actual or potential competitors capable of offering consumers a lower-priced alternative to traditional health insurance. In response, as later discussion develops, fee-for-service providers have shown some signs of controlling their own costs, suggesting that HMOs can impose some competitive discipline on an industry whose escalating costs are a national problem.

B. Problems of Market Entry

Despite seeming advantages, HMOs have been difficult to start. Many of the difficulties besetting them are simply problems of entering an existing market and quickly attracting enough enrollment to allow operation on an efficient scale. Consumers are understandably reluctant to commit themselves to a new provider without a reputation in the community and, of course, many potential subscribers are quite satisfied with their existing relationships. Although these problems faced by fledgling HMOs are inevitable in any attempt to enter an established market, many other problems are not inevitable, but are imposed on them by law or by local providers.

Because of the competitive threat it poses, an HMO can anticipate facing a largely monolithic response from the existing system of interconnected doctors and hospitals. Health care providers can frequently generate parallel action based on collective rather than
individual self-interest, and the HMO may therefore find itself barred from drawing on what is available in the community to supplement its own resources and may be forced to supply many of its own needs by building its own facilities and by importing physicians, including specialists. To the extent that the HMO is frustrated in gaining access to a hospital or other resources on reasonable terms or in having its referrals accepted by local specialists, it can establish itself only by becoming an entire self-contained delivery system. The costs and risks of such an undertaking are so great that HMO development cannot be expected except in the presence of such unusual circumstances as a receptive medical community, inspired leadership, a captive population, or an exceedingly deep pocket.\footnote{Although the federal government has provided subsidies for HMO development, the requirements that must be met to obtain such subsidies have limited the federal government's contribution to the encouragement of HMOs. See text accompanying notes 26-28 infra.}

Health system planners and regulators can be part of HMOs' market entry problem or part of its solution. They can add to HMOs' burdens by making the regulatory arena available to HMO opponents to defeat or delay HMO development, to raise the costs of entry to a prohibitive point, or to force compromises on the HMO that reduce its competitive effectiveness. On the other hand, an HSA dedicated to meaningful change could not only frustrate opponents' hopes for impeding HMO development but could also take initiatives on HMOs' behalf, helping them to overcome "stonewalling" tactics by local providers and to obtain the "fair market test" to which they are entitled. This discussion of HMOs is designed to illuminate the regulatory issues that they present as potential market entrants. It should be recognized that there are also many nonregulatory activities that HSAs might undertake on behalf of HMOs.

C. The Limitations of the HMO as a Vehicle of Reform

There are several respects in which HMOs, while a promising and highly desirable alternative, do not provide, even potentially, the final answer to the health care system's problems. First, HMOs' innovative contributions to the delivery of health services, while real and important, do not exhaust all the possibilities that deserve to be tried. Second, HMOs present some negative features that suggest the need to maintain other alternatives and to allow room for further innovation. For one thing, HMOs dilute the doctor-patient relation-
ship by adopting a “team” approach in place of the frequently valuable professional ideal. Further, the incentives at work in an HMO could sometimes lead to greater concern for the HMO’s financial health than for the patient’s physical health. Moreover, departure from the incentives of the fee-for-service method of payment necessarily has some negative effect on physician productivity. Finally, an individual patient’s preferences, though generally expressed in the original choice of plan, may not weigh heavily with the HMO in particular treatment circumstances. Particular preferences often cannot be expressed through a willingness to pay for more and possibly better care, though the subscriber’s freedom to go outside the plan (at his own expense) provides some protection.

Even if the planner-regulators of the health system should seek to encourage competition, making HMO development a high-priority objective would probably not, by itself, restore adequate market discipline in local markets. Entry barriers will continue to be high, making HMO development uncertain and undoubtedly slow. Since HMOs are usually nonprofit or professional enterprises, their tendency may not be to compete aggressively in price or to seek rapid growth beyond the size necessary to break even. Moreover, many circumstances in local markets, such as an HMO’s arrangements for hospital use, its relations with specialists or the medical society, or its involvement in health planning or other regulatory activities, may result in tacit, or even explicit, agreements between an HMO and local fee-for-service providers not to compete in certain ways or very intensively—agreements to live and let live, as it were. 10

Not only may it be unrealistic to expect HMOs to be independent and aggressive competitors, but their opportunities for competitive innovations, especially of a cost cutting variety, will frequently be limited by circumstances beyond the HMO’s control. Thus HMOs will be subject to regulatory constraints, such as the restrictions in the federal Health Maintenance Organization Act of 1973 (HMO Act), 11 that limit their innovative capability. More ominously, local Professional Standards Review Organizations (PSROs), which will inevitably be dominated by fee-for-service practitioners, have been given the power to supervise the quality of care (as such practitioners define it) in HMOs, raising “grounds for concern that range from the danger of inadvertent homogeniza-

10. See text accompanying note 25 infra.
tion of medical practice to the worrisome opportunities presented for anticompetitive or other intentional misuse of PSRO power." 12

Finally, malpractice law, drawing its standards from prevailing practice, also inhibits change and perpetuates the cost-is-no-object approach that has become customary under insured fee-for-service practice. 13

Although HMOs have sometimes been seen as something approaching a panacea, there are many reasons why the HMO concept is not a cure-all, but is only one of many promising and highly attractive alternatives that should be cultivated and made available. 14 The limitations and drawbacks of the HMO model must be recognized, but they should never be cited to justify excluding HMOs from the marketplace altogether. By any reasonable standard, the HMO concept is entitled to a "fair market test." 15

II. HMOs and Competition

HMOs compete with other health care providers at precisely the point where competition is most clearly appropriate and constructive and where the case for curbing competition is weakest. Persons presented with the opportunity to select an HMO over one or more alternative health plans face prices that are relatively well specified in advance, as are benefits, so that comparisons can be made. Due to the comprehensiveness of benefits, HMO enrollment will often cost significantly more than the insurance alternative offered, requiring a valuation of the extra protection—which usually must be paid for out of pocket. Even where the subscriber's employer is paying the full cost under an employee benefit plan, the subscriber is concerned with getting as much value as he can. In exercising his choice, the subscriber is normally healthy and not faced with the necessity for choosing under trying or emotional circumstances. Moreover, potential enrollees most often face the choice as members of an organized group that has screened the plan or that can offer advice and accurate information concerning it.

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14. While HMOs necessarily offer comprehensive benefits, insurance plans might experiment with less comprehensiveness in coverage, saving insureds money by selectively increasing self insurance to discourage consumption, particularly of those services not likely to be worth their cost. For a discussion of this alternative, see Havighurst, Professional Restraints on Innovation in Health Care Financing, 1978 Duke L.J. (forthcoming).
15. See Institute of Medicine, Nat'l Academy of Sciences, HMOs: Toward A Fair Market Test (1974). The principle should also hold for any reasonable variation on the basic model.
Choices are renewed periodically, giving subscribers the chance to withdraw if experience has not been satisfactory. Although choices may not always be easy, they are about as straightforward as they can be, given the complexity of the product. In these circumstances, competition should work well and serve as a generally constructive force in the market as a whole.

A. Perceptions of HMOs

Despite the attractiveness of HMOs as part of a competitive strategy to bring some order out of chaos in health services, the wide support that the HMO idea has attracted, including the enactment of the federal HMO Act, does not signify equivalent support for the idea of competition. Indeed, HMO supporters fall into two distinct camps, with widely varying perceptions of the HMO and its role.16

The first camp, typified by proponents of the HMO Act, values HMOs as a model health care system, providing a large population with comprehensive services of good quality and plowing savings from efficiency in resource use back into improved accessibility, better care, and more extensive services. Under this view, heavy subsidies are deemed appropriate to help create large multi-service HMOs. The HMO Act makes such subsidies available, but only for HMOs meeting very substantial requirements and restrictions designed to foster those aspects of HMOs thought to be desirable and to minimize potential bad aspects. To those who hold this view, the HMO model is a promising way to improve the quality of care and to extend more health care to people, particularly those whose health needs have not been well served. Government support for HMOs is also embraced as a means of restructuring the health care delivery system along more rational lines. It is fair to say that, for this group of observers, the challenges of improving quality and meeting previously neglected health needs have long been paramount, and the problem of containing the total volume of health services and their cost to the nation has been of only secondary concern.

The other camp of HMO supporters responds to all of the positive quality and access benefits of the HMO, but sees as the cardinal virtue its cost consciousness and its consequent potential for restoring effective price competition, as well as quality competition, in the market for health services. These observers view such competition

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16. This and the following paragraph are adapted from Havighurst & Bovbjerg, supra note 12, at 386-87 (footnotes omitted).
as supplying a needed brake on the health care system's capacity to consume, without considered justification, an ever-increasing share of the nation's resources. They anticipate that fee-for-service providers, facing the active price competition which could be supplied by HMOs would, in due course, be induced to cooperate in keeping health insurance premiums competitive by curtailing over-utilization of resources. Supporters of HMOs as a new competitive force do not seek to obtain subsidies for them so much as to obtain freedom of entry and a market test from which might emerge a mixed system of fee-for-service providers and HMOs of many kinds, some emphasizing comprehensiveness and high quality and others offering somewhat lower quality, but adequate, care at less cost. Even imperfect market competition among delivery systems is seen as the best available way to steer a safe course between the Scylla of unnecessary care, over-utilization, and extravagance, which too often characterize fee-for-service medicine, and the Charybdis of inadequate care, which might occur in an excessively cost-conscious HMO. Holders of this view of HMOs and the health policy problem are simultaneously dubious that governmental or professionally imposed controls can approach a proper balance between the cost and the value of health services consumed by Americans.

Health system planners and regulators, because they are close to the local scene, may be induced to see the HMO as more than merely a desirable means of delivering services and meeting unsatisfied needs. They may perceive that the example of and competition from an HMO can begin to impose on the local market the needed discipline that they despair of being able to supply all by themselves. Sensing their own inability consistently to say "no" to providers, the planners may see merit in offering consumers a chance to say "no" for themselves to excessively costly or doubtfully efficacious increments of "quality" in the services available. In effect, the HMO gives the consumer, for the first time, the opportunity to opt out of the big, costly, provider-dominated system into an alternative designed with the consumer in mind. Planners and regulators, not knowing themselves just how much economizing is appropriate or how to improve the system's organization in fundamental ways, may recognize an advantage in pursuing the approach of providing consumers the opportunity to economize for themselves, if they so choose, and to buy into an organized system assuring access and availability. Planner-regulators conceiving these objectives would attach high regulatory priority to making sure that a reasonable range of choice is available to consumers and that choices are exercised under optimal conditions, with good information and advice.
B. HMOs' Competitive Influence on Fee-for-Service Practitioners

One of the leading expositions of the competitive strategy featuring HMOs is the 1974 policy statement of the Institute of Medicine (IOM) entitled HMOs: Toward a Fair Market Test. In discussing the merits of HMOs, the IOM statement makes the following point:

Analyses of evidence of HMO performance have consistently ignored the possibility that HMOs may have induced beneficial changes in the fee-for-service system. Assessments of the benefits from HMOs should look beyond the advantages to HMO enrollees since the benefits from stimulation of total system improvements may be at least as great—and, indeed, may offset some seeming disadvantages of HMOs. These matters have not been studied systematically, although there are indications that the extensive development of HMOs in the West (leading to substantial market penetration in Seattle, Portland, San Francisco, Los Angeles, and Honolulu) has brought about a positive response from the predominant fee-for-service sector.17

Taking their cue from this speculation, two Federal Trade Commission (FTC) staff economists recently examined the degree to which the fee-for-service sector has responded to HMO development.18 They tested certain performance characteristics of fee-for-service providers in different localities to determine whether the presence of HMOs in a market is correlated with better fee-for-service performance. Their most striking finding was that hospitalization of Blue Cross subscribers is substantially lower in areas where HMOs have become well established, suggesting a cost saving resulting from competition. Certain other presumed impacts were also found, particularly on the benefits package offered by Blue Cross plans. These findings suggest that a competitive strategy does indeed pay dividends and that the introduction of a competing delivery system which is largely independent of the existing system and free to respond to consumer wants that the fee-for-service system neglects is a promising means of "reforming" the health care delivery system. The FTC study is hardly conclusive, however, since it can point to a clear apparent impact only in four Western states, where cultural or climatic factors might also explain the different behavior of the fee-for-service sector.19

17. Institute of Medicine, supra note 15, at 13.
19. For a critique, see Enthoven, Competition of Alternative Health Care Delivery
Another weakness of the FTC study is that the precise mechanism whereby the fragmented fee-for-service sector has presumably responded as an entity to HMO competition is sometimes hard to identify. If one cannot trace how the alleged competitive response occurred, it may be necessary to conclude that the correlation between HMO presence and good performance was fortuitous or related to other variables and not the result of competition at all. Nevertheless, HMOs have tended to stimulate the formation by local medical societies of fee-for-service-oriented individual practice associations (IPAs) and foundations for medical care. These plans are sometimes classed as HMOs themselves—IPAs are one variety of HMO under the federal law—but they are more appropriately seen as defensive responses by the fee-for-service sector to HMO competition. To the extent that they do improve the performance of fee-for-service providers, the primary credit for that improvement should be given to the potential or actual competition from the independent HMOs that stimulated their formation. For example, the well known San Joaquin Foundation for Medical Care was an explicit medical society response to the threat that the Kaiser Foundation Health Plan would enter San Joaquin County, California. Here is at least one mechanism by which the fee-for-service sector has, in fact, responded to HMO competition by improving its own performance.

Further evidence that HMO competition is beneficial comes from news reports such as the following:

In order to cut hospital costs, the Minneapolis Physicians Health Plan, an individual practice association model HMO sponsored by the Hennepin County Medical Society, has sent a letter to its 1,100 participating physicians indicating that overuse of hospital facilities is a "major, continuing abuse" that increases the cost of medical care. According to Russell Wilson, executive director, the plan is conducting pre-admission reviews to monitor charges and medication, develop physician profiles and identify problem areas. The new measures are necessary if the plan is to remain competitive with the six other HMOs operating in the Twin Cities area, and if the plan is to become self-sustaining. "If we could cut one day from the average length of stay in hospital, we could make the plan workable," according to Wilson.22

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20. See text accompanying notes 30-34 infra.
It is a striking fact that no other initiative has ever stimulated equivalent interest in reducing hospital utilization among fee-for-service practitioners. Without such a competitive stimulus, the PSRO program seems unlikely to be effective in controlling costs.\(^{23}\)

Some evidence suggests that meaningful competition leading to a significant competitive response may require the presence of more than one independent HMO in each market, as in Minneapolis. A study by ICF, Incorporated, finds more active price competition, higher overall market penetration by HMOs, and other positive features in such markets.\(^{24}\) Professor Alain Enthoven suggests that where HMO-type care is monopolized, especially by a nonprofit firm lacking interest in rapid growth, "it may settle into an equilibrium with premiums about equal to those of Blue Cross and other third parties, and an overall 25 percent advantage in per capita cost."\(^{25}\) Not only is the HMO likely to relax in such a comfortable setting, but many features of local markets for health services, including professional associations, hospital affiliations, PSROs, and the HSAs themselves, facilitate accommodations between the HMO and the fee-for-service sector, leading to the noncompetitive "equilibrium" that Enthoven identifies.

Health system planners and regulators can hardly fail to see the promise that competitive HMO development offers. Even if the HMO concept cannot achieve an immediate millennium, it can significantly affect the prevailing incentives.

C. Federal HMO Policy: Competition Slighted

The HMO Act of 1973 was supposed to provide a major impetus for the HMO idea. Although the HMO concept came into prominence as a policy initiative as early as 1970, it was not until late 1973 that Congress enacted legislation designed to advance it materially. That law turned out to be something of a "white elephant,"\(^{26}\) however, since the requirements to qualify for the Act's benefits were quite extensive, creating high costs and uncertainties that set back or aborted many HMO initiatives already underway. Long delays in writing implementing regulations created additional problems.

\(^{23}\) See generally Havighurst & Bovbjerg, supra note 12.


\(^{25}\) Enthoven, supra note 19, at 28.

Some observers have felt that the federal act was, on balance, a step backward since it interrupted what had been promising private initiatives and favorable developments in the states.

The HMO Act was amended in 1976 to make HMOs more competitive with the existing system. It was recognized that the idealistic regulatory requirements included in the original enactment had hampered HMO development, and the stated intention of the amendments was to improve HMOs’ prospects. Nevertheless, extensive qualification requirements were retained, and federal law still seems to embrace the HMO more as a model system than as a feature of a rejuvenated market for medical services. The most likely reason that the amendments did so little is that the changes were made primarily to benefit the large, well-established HMOs which lobbied intensively for the changes. Congress made only a limited effort to minimize the problems of those prospective HMOs that could come into being only if nonrestrictive policies were adopted and the costs and risks of entry into the market were reduced.

That increased competition flowing from relative ease of market entry by HMOs has not been high on Congress’ list of priorities is also revealed by the provisions of the HMO Act dealing with “dual choice.” The 1976 amendments actually cut back substantially on the original law’s chief contribution to competition, namely the obligation of certain employers to offer the HMO option (dual choice) to their employees. Only relatively large employers are now subject to the dual choice requirement; thus HMOs serving only a small service area have less chance of being offered to employees. Moreover, labor unions are now permitted to decline the employer’s offer of an HMO option, thereby precluding individual employees from exercising the choice for themselves. Competitive opportunities were thus actually reduced by the amendments out of regard for the complaints of employers who did not want the trouble of offering a choice and for unions wishing either to maintain total control over their members’ fringe benefits or to protect their own health plans from competition.

Unfortunately, the dual choice provisions have, from the beginning, reflected a congressional notion that it is the opportunity to choose an HMO meeting federal requirements that is important, not

competition. The dual choice provisions require employers to offer one HMO of each of two types: a prepaid group practice HMO and an IPA. A second qualified HMO of the prepaid group practice variety has no right to be offered, and HMOs not meeting all the demanding federal requirements have no improved chances of being offered as a result of the law. The implication of the dual choice provisions is therefore that one HMO of each type is sufficient in Congress' view and that more HMOs would be superfluous. Yet it is elementary that two or three competitors in a market may not be enough to insure meaningful competition. Especially in the health care sector, with its traditional toleration of explicit or tacit agreements to divide markets and to avoid competition in other ways, the introduction of one independent HMO and a medical-society-dominated IPA promises only small improvement compared to what more intense competition might bring.

Fortunately, it remains open to state legislatures and to State Agencies and HSAs to recognize that meaningful competition requires more than federal law currently contemplates. Congress is not, to say the least, the ultimate source of wisdom on how HMOs can best contribute to the health of the health care system.

III. DISTINGUISHING AMONG HMO TYPES

The HMO concept covers a wide variety of organizational arrangements, and it is important for health system planners and regulators to recognize distinctions among the various types. Meaningful competition is most likely to be supplied by HMOs that are independently organized and are neither sponsored by nor directly or indirectly beholden to local health care interests with a stake in the fee-for-service sector. Nevertheless, the federal legislation gives roughly equal recognition to such HMOs and HMOs that are organized by local medical societies. Although IPA-type HMOs are not bound to be captives of the local medical establishment, it seems inevitable that most will be unless some intervention compels a different result. The thesis here is that health system planners and regulators should not be favorably inclined toward HMOs of the society-sponsored type.

A. Regulatory Policy Toward Medical-Society Initiatives

It is difficult to see any reason why medical-society-sponsored HMOs, either IPAs or foundations for medical care organized without regard to the HMO Act, would aggressively seek to contain costs or make material changes in medical practice in the absence of meaningful competition, such as that disclosed in the Minneapolis
area by the news report quoted earlier.\textsuperscript{29} Indeed, there is a significant risk that such HMOs might pre-empt the market opportunities of independent plans or serve as a "fighting ship" to eliminate a fledgling HMO competitor. Even if an IPA or foundation-type plan were to make some marginal improvements in the fee-for-service sector's performance, the net effect could well be detrimental if independent HMO development were thereby foreclosed. A substantial competitive issue would therefore be presented by a certificate-of-need application from a medical-society-sponsored IPA or foundation-type plan. Such HMOs may be more anticompetitive than procompetitive, and HSAs and State Agencies could appropriately seek to exclude them from the market altogether or to foster them only if effective competition from independent HMOs was already present to such a degree that the medical society's move could be said to be a competitive response, not an exclusionary tactic.

The proposition just advanced—that medical-society-sponsored IPAs and foundations for medical care (FMCs) should be viewed with suspicion—defies the conventional wisdom in the health services industry and requires some elaboration. This author has argued in the past that prepayment plans raise serious antitrust problems when sponsored by organized medicine.\textsuperscript{30} Of course, health system planners and regulators need not be concerned with antitrust doctrine, but they are free to give effect in local markets to the serious policy considerations raised in the following discussion of the issue:

[I argued, in an earlier article,\textsuperscript{31} that FMCs] might easily be found to violate the Sherman Act because they represented a combination of independent economic units—namely, fee-for-service doctors—to keep a competitive form of medical practice—namely, HMOs—out of the market. I said that, in my view, such a combination might be in restraint of trade even if its object was merely to curb universally recognized abuses such as high charges and overutilization. This conclusion follows because such activity by a trade association of competitors is prompted by a desire to lessen the attractiveness of new entry into the marketplace and thus to stifle future competition, which might be more beneficial to consumers in the long run than is the self-regulatory activity. . . .

FMCs seem capable of moving in either of two directions de-

\textsuperscript{29} See note 22 \textit{supra} and accompanying text.
\textsuperscript{31} \textit{Id.}
pending upon the market circumstances in which they find themselves. The FMC which exists to the exclusion of the other HMOs will probably limit its enrollment to those groups most likely to sign up with new HMO entrants. These groups will include the poor, the Medicaid population, who might otherwise find their way into HMOs under contracts with cost conscious state governments.

In a competitive market setting with HMOs present, the FMC would probably have a different line of development. Rather than narrowing its coverage, it would probably broaden it. The tendency would be toward taking over the present system of conventional health insurance by providing a program of effective cost controls. Monopolization of insured fee-for-service medicine would be a possible result, particularly since insurers facing excessive costs might actively seek to bring their beneficiaries under the FMC umbrella; but monopoly might be avoided if insurers were not inhibited from initiating cost-control plans of their own.

Thus, although I think the appearance of FMCs helps to prove my argument that HMO competition will induce responsive change in the entire health care system, I see two reasons to be fearful. The first is that the FMC might monopolize prepaid HMO-type care, excluding independent HMOs such as the San Joaquin foundation appeared to do in California. The second is that the FMC might monopolize fee-for-service care. . . . These two monopolistic dangers are great enough that only unusual circumstances would prevent the FMC from violating antitrust principles. For these reasons, my position on the antitrust issue remains approximately what it was when I wrote the [earlier] article. . . . In the absence of either (1) meaningful competition from the active operation of an independent HMO in the market or (2) some reason to think an HMO could not support itself; FMCs should be held (at least after passage of a reasonable amount of time) to violate both Section 1 and Section 2 of the Sherman Act. Where such meaningful HMO competition is present, I think an FMC should still be deemed presumptively illegal but should be subject to redemption if it can establish that it is an essential mechanism in the preservation of insured fee-for-service medicine. If this defense can be made out, I would willingly endorse the restraints implicit in the FMC as ancillary to a legitimate and ultimately pro-competitive, overriding purpose, namely, the preservation of a time-honored kind of medical practice that particularly emphasizes quality and personalized attention to patient needs and provides important incentives for physician productivity. But, since . . . health insurers may ultimately be the better and more competitive vehicles for introducing meaningful cost controls through spontaneous peer review and other mechanisms, an essential item of proof
in establishing the antitrust defense of the FMC is a showing that insurers are unable or unwilling to take on this job.\textsuperscript{32}

The author's present position is that encouraging insurer competition, specifically competition focusing on cost containment, would be preferable to relying on FMCs, medical-society-sponsored IPAs, or PSROs to control costs in the fee-for-service sector.\textsuperscript{33} Such competition could well lead to formation by insurers of independent HMOs, IPAs (under insurer rather than medical society auspices), or "health care alliances," a promising variation on these models.\textsuperscript{34} HSAs and the State Agencies have an unparalleled opportunity to foster such competition in local markets and to prevent medical society domination of the next phase of innovation in health care financing.\textsuperscript{34.1}

B. Other Variations on the HMO Concept

The federal HMO Act does not itself determine the boundaries of the HMO concept, which is much broader than the definition contained therein. Indeed, federally qualified HMOs are quite costly and so difficult to start that less ambitious HMOs, organized under state law, may prove in the long run to be at least an equally realistic prospect for bringing the promise of the HMO model to a particular community. Health system planners and regulators should therefore foster independent HMOs of all kinds and should assist them in getting started. Lobbying before the state legislature to improve the prospects for non-federally qualified HMOs would be a step in keeping with this objective. In particular, experimentation with relatively small and unpretentious HMOs would seem highly desirable. Thus a small number of primary care physicians might be encouraged to organize an HMO, using reinsurance and referral to fee-for-service specialists as its modus operandi. A local HSA could be extremely valuable in helping such a plan establish itself and encouraging employers to make enrollment in such an HMO available as an option to their employees.

Of course, not all HMOs will be clearly desirable additions to the local scene. Certain abuses in prepaid health plans in serving California's Medicaid population have revealed the depth of the problems that can arise. Perhaps the surest way to avoid similar

\textsuperscript{32} Havighurst, Speculations on the Market's Future in Health Care, in Regulating Health Facilities Construction 249, 258-59 (Havighurst ed. 1974).

\textsuperscript{33} See Havighurst, supra note 14.

\textsuperscript{34} On health care alliances, see Reynolds, A New Scheme to Force You to Compete for Patients, Med. Econ., March 21, 1977, at 23.

\textsuperscript{34.1} In Massachusetts, an IPA has recently encountered opposition from the insurance commissioner on the basis of antitrust and other concerns. See Controversy swirls around Bay State HMO, Nat'l Underwriter, April 15, 1978, at 28; IPA Hit with Antitrust Charge,
abuses would be to avoid creating HMOs which serve only low-income enrollees. One way this can be done is by conditioning certification of need on the plan’s commitment to enroll low-income individuals or families as no more than some fixed proportion of its total membership. This approach would require the HMO to compete for enrollment by consumers who are paying their own way and who have a range of choice, stimulating desirable competition. It would also guarantee Medicaid beneficiaries and other low-income citizens that they were receiving a reasonable standard of care.

In the aftermath of the California experience, some disenchanted with HMOs has appeared, and fee-for-service advocates have been quick to point to these abuses as a justification for a go-slow attitude toward HMO development. HSAs and State Agencies should not, however, feel that they are ultimately responsible for guaranteeing the quality of all care provided by HMO entrants and should avoid imposing unreasonable standards on HMO developers. For one thing, quality assurance in HMOs is supplied by a variety of other regulatory means. Moreover, as long as consumers have a reasonable range of choice, good HMOs should survive, and poorer ones are more likely to be weeded out than are substandard providers in the fragmented fee-for-service sector, with its “Medicaid mills” and other deficiencies. It is highly desirable that the market be seen as bearing a substantial responsibility for policing the industry and that State Agencies and HSAs see the importance of allowing the market to function. Of course, local HSAs would want to make sure that information concerning alternatives and the quality of care provided is widely available and that HMO enrollees have reasonable opportunities to choose and to withdraw if they are dissatisfied with their choice.

IV. HMOs Under Certificate-of-Need Laws

During the campaign to encourage the adoption of certificate-of-need laws, skeptics occasionally expressed the concern that health system planner-regulators would discriminate against HMOs.35 Other observers doubted that this was a serious hazard, however, since HMOs were thought to be generally popular with

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35. See, e.g., Havighurst, supra note 6, at 1204-15. This reference develops in somewhat greater detail the arguments set forth here.
health planners and seemed more likely to be befriended than persecuted. This view misapprehended the problem, however, because even well meaning regulators can easily fall into patterns of protectionism similar to those into which regulators of other industries have fallen. The discussion here suggests how this can happen and then presents some evidence that it has happened.

A. Why Regulators Might Resist HMO Initiatives

HMO initiatives will usually pose particular problems for incumbent providers in a local market, and these problems may frequently induce sympathy on the part of the regulatory authorities. As in other regulated industries, competition can jeopardize the financial stability of existing providers, particularly hospitals. Because HMOs use hospitals less intensively than fee-for-service providers, an immediate effect on local hospitals’ occupancy rates could be anticipated. If a hospital is not financially secure, the threat to it could be quite substantial, and a convincing case could frequently be made for excluding the HMO altogether or tailoring its operation to the overall community circumstances in such a way as to reduce its competitive impact.

The most obvious possibility is that the regulators will feel a certain responsibility for maintaining the solvency of an existing institution or at least for not taking affirmative action that will drive it into difficulty. Even if there is no such attachment for the institution as such, the planner-regulators may feel an obligation to the population which it serves. Only if the community is clearly “overbedded” will the planners be comfortable with allowing an HMO to drive an existing hospital into bankruptcy and, even then, strong community interests represented on the HSA may appear in support of the institution and combine with provider interests to defeat, delay, or frustrate the HMO application. With such pressures at work, the planner-regulators will be tempted to accommodate them by imposing conditions on the HMO’s entry. For example, the HMO might be forced to reach an agreement to use the threatened hospital’s beds and to pay an excessive rate, reducing the HMO’s competitive impact and denying it the chance to negotiate a better deal or to obtain more satisfactory hospital services elsewhere.

Another set of expedient arguments for minimizing the HMO entrant’s competitive impact would be brought into play by the charge that the HMO is “cream-skimming.” By diverting insured patients from hospitals to outpatient care, the HMO removes an important source of the revenue needed by the hospitals to provide unremunerative services which the HMO does not undertake to
provide. Internal cross-subsidization is common in hospitals and, although the practice is not generally approved and can frequently be minimized by adopting cost-related pricing, some valued services might have to be discontinued if revenue sources are eroded. For example, a hospital’s emergency room and outpatient department may be dependent on the revenues threatened by the HMO. If so, there would certainly be sentiment in the community for excluding the HMO, requiring it to replace the hospital’s lost revenues, or compelling it to serve at a loss the under-served population whose needs the outpatient department was meeting. Again protectionist destruction of the HMO’s competitive capability will seem justified to many, though some of those advancing the arguments will have other reasons for wishing to see the HMO’s impact curbed.

While the foregoing grounds for preventing or limiting competition are essentially the same justifications that have been offered for similar anti-innovation policies in other regulated industries, another consideration seemingly justifying protectionism is peculiar to the health care sector. This is the so-called “Roemer effect”: the alleged tendency of the medical community to make use of available hospital beds even if the hospitalized patients could be treated equally well and at a lower cost on an outpatient basis.36 An HMO’s appearance in a community could spread fear of the Roemer effect among health sector planner-regulators, who might easily see the HMO’s primary strength—its ability to substitute outpatient for inpatient care—as creating a cost-escalating vacuum in the fee-for-service sector’s beds. Hospitals might well be induced to make up for HMO-induced revenue losses by increasing the volume of services provided, and regulators, fearing this effect, might feel justified in penalizing the HMO for the fundamental defects in the fee-for-service system that permit the Roemer effect to occur. If so, they could perpetrate a colossal “Catch-22,” treating th HMO’s greatest strength as the fault warranting either its exclusion from the market or the extraction of its competitive teeth.

The problems that HMOs can expect to encounter in applying for a certificate of need are apparent in the planner-regulators’ common perception that it is discriminatory to approve an HMO application in circumstances where a fee-for-service provider’s similar application would be denied. This perception results in large part from the planners’ fixation on numbers—of beds or other facilities or equipment—and their inability to value the HMO for its different incentives and for the dynamic impact that it might have. No clearer example could be found of the high value that regulators

36. The responsiveness of demand to bed supply was first noted in M. Roemer & M. Shain, Hospital Utilization Under Insurance (AHA Hosp. Monograph Series No. 6, 1959).
customarily place on appearing evenhanded in their dealings with regulated interests, even to the extent of shrinking from distinctions based on efficiency and on differential ability to serve the public.

Beguiling arguments for curbing HMO competition may, of course, be resisted by health system planners and regulators out of a clear-sighted recognition that HMOs' short-run costs will be outweighed by their long-run advantages. But regulators of other industries have not been dependably clear-sighted in comparable circumstances, and the arguments that can be advanced against competition are not palpably foolish. Indeed, they have a potentially strong appeal to the kind of planning mentality that seeks certainty and tight control over events and abhors the unpredictable and uncontrolled processes of working markets. Moreover, the arguments will be advanced by powerful interests, and they supply an easily available rationalization for results arrived at on political grounds.

In particular, it must be recognized that the threat of regulatory discrimination against HMOs does not take only the form of possible outright exclusion of an HMO by denial of its certificate of need. Probably the more realistic concern is that conditions imposed to protect existing interests against the full competitive impact of an HMO will deprive it of some of its market opportunities and competitive effectiveness. Such protectionist regulatory requirements would reflect the regulators' perception of their function as one of mediating the terms on which the HMO can enter the market rather than of allowing the market to function in its usual way. Regulatory protectionism frequently takes such forms. For example, the Federal Communications Commission has not excluded cable television from the market altogether, but it has dictated burdensome terms of entry having the effect of protecting the interests of over-the-air broadcasters. Despite regulators' general receptivity to HMOs, expediency will frequently seem to justify measures that deprive new HMOs of some of their competitive advantages. Such results can only be avoided if planner-regulators recognize that the long-term benefits of intensified competition will usually outweigh any short-run costs and that a willingness to balance the HMO's interests against the interests of incumbent providers creates uncertainties and higher costs that will discourage future HMO initiatives.

B. The Evidence Concerning Regulatory Discrimination Against HMOs

Evidence of actual regulatory obstructions to HMO development is beginning to bear out the predictions based on other regulatory experience. Although some health system planners and regula-
tors have been receptive to HMOs, it appears that many HMOs have encountered significant problems. No attempt has been made here to collect and verify all the anecdotal evidence that is beginning to accumulate, but recent congressional hearings have provided glimpses into the difficulties that some HMOs have faced.

Congressional testimony by the AFL-CIO has revealed twelve examples of HMOs that were blocked at least temporarily by local planning agencies. The predominant theme in the several case studies briefly presented was one of providers' use of the HSA as a forum for opposing HMOs and spreading misinformation about them. HSA consumer members and staff appeared not to provide an effective counterbalance to the providers' bias since they were frequently ignorant or had an agenda of their own. Thus one plan was rejected on the ground that it would not locate close to a needy low-income population, reflecting both the HSA members' desire to use the plan as a vehicle for cross-subsidization of services and their disinterest in encouraging competition for the right to serve self-supporting consumers. In one instance where the possibility of having two HMOs in a single area was presented, the HSA was reported to have rejected the idea automatically, turning down the second HMO applicant on the ground of "duplication" without regard to the possible desirability of competition. These examples revealed not only the difficulty of getting HSA members to see HMOs as an infusion of needed competition but also the futility of HSA review itself, which lacked penetration, reflected biases more

37. In an early study, no appreciable problem was discovered. Carlson and O'Donoghue conducted an informal survey of twenty HMOs in 1972 (including all the leading ones as of that time) and found only scattered reports of problems encountered in dealing with comprehensive health planning (CHP) agencies. O'Donoghue & Carlson, Health Maintenance Organizations and Comprehensive Health Planning Agencies: Actual and Possible Relationships, in Regulating Health Facilities Construction, supra note 32, at 271. However, eleven of the twenty had had no contacts concerning capital expansion, and three of the nine that had such contacts reported problems in areas other than capital expansion. Of course, reports of "problems" are not reports of regulatory mistakes or abuse, and no plan found the CHP agencies to be an absolute barrier.

38. Hearings on S.2534 Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources, 95th Cong., 2d Sess. (1978) (statement of AFL-CIO) (unpublished as of April 10, 1978). Brief case studies were included covering the experience of HMOs in Prince Georges County, Maryland; New Brunswick, New Jersey; Lincoln, Nebraska; Baton Rouge, Louisiana; El Paso, Texas; Greenade, Wisconsin; Amherst, Massachusetts; and Buffalo, New York. On the New Brunswick experience, revealing in depth the physicians' opposition and its effectiveness, see Kirchner, Where Fee-For-Service is Under the Gun, Med. Econ., Aug. 8, 1977, at 230.

39. One HMO director was quoted as saying that consumer members had a "strong social agenda of their own. They could not accept any intrinsic value in an organization that valued fiscal solvency or saw its role as different from serving the poor as its top priority." Hearings, supra note 38.
than facts, and appeared to serve no useful purpose.

The AFL-CIO testimony listed, without details, four HMOs which encountered difficulty in the planning process and never became operational. The other HMOs whose experience was recounted succeeded in getting the requisite approvals in due course. Similarly, the Kaiser Foundation Health Plan, Inc., the largest and most experienced HMO, has never been ultimately turned down in any of its projects. Nevertheless, Kaiser and other plans argue that delays and interruptions in scheduled expansions are costly and increase the uncertainties they face. The fact that most HMOs and their projects have been approved in the end may seem to make the HMOs’ complaint less serious, but it also suggests that the trouble, delay, and costs incurred by both the HMOs and the planning agencies themselves have been for nought. Kaiser officials do not admit that their plans have been significantly altered in view of the necessity for obtaining a certificate of need or other approval, and the AFL-CIO case studies reveal no constructive changes resulting from the planners’ input.

A few other examples can be cited. Even the respected certificate-of-need program in Massachusetts, which appears to have escaped provider influence, has for a long time allowed its antipathy toward hospital growth to curb the ambition of the Harvard Community Health Plan to have its own hospital. Unable to treat the HMO as a distinguishable case, it has put the Plan in the position of having to use expensive university hospitals because community hospitals, under pressure from their medical staffs, would not grant admitting privileges to the HMO’s doctors. In this instance, the HMO’s difficulties arose with the State Agency and could not be overcome by appeal to a higher authority. This example best illustrates the problem with regulating hospital construction by HMOs. Older history of HMO hospital construction reveals close votes or reversals of earlier turn-downs, confirming the fear that HMOs do indeed face at least harassment, delays, and higher costs.

A questionnaire recently distributed to HSA directors by the author also elicited evidence of HMO-HSA conflict, indicating that

40. These HMO Plans were located in Windsor, Connecticut; Pascagoula, Mississippi; San Antonio, Texas; and Miles City, Montana. Id.
41. Kaiser’s testimony in favor of limiting HSA jurisdiction over HMOs did not dwell on its own experience. See id. (statement by James A. Lane, Vice-President and Counsel, Kaiser Foundation Health Plan, Inc.).
42. Based on the author’s conversations with officials of the Plan and the Massachusetts Department of Public Health.
43. See Havighurst, supra note 6, at 1209 n.217.
significant problems do exist.44 Of the twenty-six responding HSAs that had encountered applications of some kind from HMOs, seven reported recommending denial of approval, and five of these indicated that their State Agency or other higher authority had concurred. Brief statements of reasons were requested, yielding the following:

1. “lack of viable market and questionable qualifications and motives of ‘principals’”
2. “lack of community and provider support”
3. “incomplete data”
4. “service area contains high ratio of physicians to population; strong opposition from organized medicine”
5. “limited medical community support; lack of appropriate management; unsound financial structure”
6. “We did have a 19-18 Board vote to approve the . . . Project. It is a demonstration grant.”
7. “lack of support from parent organization and medical community and technical weakness of application”

In four cases, lack of provider support is cited as a factor, confirming concern that incumbent providers exert significant influence. Other reasons given could be pretexts or could be seen as legitimate regulatory objections—if one accepts that planners should second guess management decisions rather than leaving them to be tested in the marketplace.

Questionnaire respondents were also asked whether the HSA (or its predecessor) had ever caused an application to be modified or imposed conditions on its approval. Thirteen of the twenty-six that had seen HMO applications answered “yes,” giving reasons (a few of which seem to refer to the same HMOs as the comments above) such as the following:

1. “to expand the service area to larger geographical area”
2. “revised budgeting of expenses”
3. “formulation of a better marketing plan”
4. “viability: marketing, service area; agreements with secondary care institutions; or its management planning”
5. “HMO has moved to more central location to get provider and community support.”
6. “adjustments to financial picture; better analysis of potential members”
7. “staff time and agency resources were expended in the initial development of the applications”

44. All 138 HSAs then in existence were sent questionnaires; sixty-three were returned. The survey was not scientifically designed nor pretested.
8. "forced insurance company to divest itself of corporate control; made applicant amend by-laws to require competitive bids for marketing the plan"

9. "service area; population; financial"

10. "The HMO had to agree to permit 'community' physicians staff privileges at hospitals applied for (on the same basis as the HMO's physicians, i.e., full-time salary)."

11. "required to make arrangements with more than one hospital"

12. "required feasibility study, HMO had no linkage agreements; required clearance with Insurance Commissioner"

It is difficult to distinguish the cases in which the HMO was actually aided by the HSA from those in which additional burdens were imposed, whether as protectionist measures, as accommodations with interested groups, or as expressions of preconceptions about private HMOs' public responsibilities. In some cases, the HMO may have resented the HSA's assumption of managerial decisions, whereas in other cases the assistance may have been welcomed.

A full evaluation of HMOs' experience with health planning-cum-regulation would be difficult. Some useful information could surely be obtained by surveying HMOs, but a complete view would require information on HMOs that never got started due to obstacles posed by the regulatory environment. Also one would somehow have to identify and assess the costs and benefits of changes in HMOs' behavior induced by the need to satisfy the planner-regulators. Although only an intuitive assessment is possible, it would seem that some of the blame for HMOs' disappointingly slow development should be assigned to certificate-of-need regulation, which, if nothing else, has substantially increased the number of bases that the HMO must touch and the number of opposing interests that it must attempt to satisfy. Despite this general impression, however, it remains open under existing law and practice for a particular HSA or State Agency to adopt a policy of smoothing the way for HMOs, helping them over the many barriers to market entry rather than constituting one more such barrier.

V. REGULATORY POLICIES TOWARD INDEPENDENT HMOs

An HSA or State Agency which recognizes the potential value of competition in local markets for health services will be favorably disposed toward certificate-of-need applications of HMOs organized by interests not allied with existing providers. Such favorable disposition should lead to unconditional approval of all applications to enter the business of delivering health care as an HMO so long as
the plan is responsibly organized and has a reasonable prospect of serving its subscribers well in competition with existing providers. Even if the community is thought to be more than adequately supplied with primary care physicians and facilities, the HMO should be admitted since it offers a substantial long-run hope of reducing prices and over-utilization by fee-for-service physicians inappropriately stimulating demand for their services.\footnote{A recent study attempted to provide a quantitative rule of thumb for HSAs and State Agencies to use in ruling on HMO applications for certificates of need. ICF, Inc., supra note 24, at ch. 3. Recognizing the temptation for HSAs to be more concerned with short-term costs of “duplication” than with the long-term benefits of competition, this study sought to suggest a standard whereby HSAs could determine when the latter outweigh the former. Although meant to show the value of competition, the study’s quantification effort is essentially misleading since, in attempting to make an irrefutable case, it adopts such conservative measures of benefits and costs as to undervalue the HMO’s probable value. In addition to passing over the possibility that HMO competition would stimulate cost containment in the fee-for-service sector, the study overstates short-run costs of duplication by assuming that all the costs of obsolete capital investments will be borne by the public, not privately. Moreover, assumptions about the minimum efficient size of HMOs are based on arbitrarily restrictive conceptions, primarily the conception in the federal HMO Act. On balance, the study, while effective in showing some of the concerns that health planners might have and in beginning to put them in perspective, seems not to present the strongest case for allowing HMO competition to develop without regulatory restraint. Its conclusions, though presented as favorable to HMOs and competition, may not advance these causes very far, particularly if those HSAs and State Agencies that are already favorably inclined to HMOs should accept the implied invitation to require the HMO to justify itself in quantitative terms before it can be admitted to the market.}

An HMO’s application to build its own hospital necessarily raises more difficult issues for the planner-regulators, who will be concerned about the potential operation of the Roemer effect, driving up costs in the fee-for-service sector as patients are transferred to the HMO’s “unneeded” hospital. Even if utilization controls might prevent hospitals from recouping lost revenue by attracting new patients or providing additional ancillary services, the planners might worry that the costs of unused capacity must be borne, under some reimbursement formulas, by the public and not by the institutions rendered obsolete. Despite these concerns, themselves questionable as grounds for penalizing HMOs, several considerations dictate a liberal attitude toward such applications. First, the HMO’s presence itself will supply a check on the fee-for-service sector’s ability to generate new costs, since higher costs will drive more patients to the HMO; a strong incentive for doctors to conduct effective utilization review is thus supplied by the strengthening of the HMO’s capacity to compete. Second, the pressure on hospitals generated by recognition of the HMO’s ability to build its own facility would greatly improve the HMO’s bargaining power with exist-
ing hospitals. If existing facilities are at all suitable, the HMO should be able to obtain their use on advantageous terms reflecting its efficiency; if the alternative of building is foreclosed, existing hospitals can more easily force HMOs to accept burdensome arrangements.\textsuperscript{44} The planner-regulators may find it necessary to assist the HMO in driving a hard bargain with the hospitals. They should be careful not to force the HMO to accept a substantial compromise that would undercut its efficiency and ability to compete.

Despite the force of the foregoing arguments for a liberal attitude toward HMOs’ certificate-of-need applications, Congress apparently lacks confidence in the health care system’s planner-regulators to reach the correct outcome on the merits of local proposals, even though they are under a particular mandate in the 1974 planning legislation to consider “the special needs and circumstances” of federally qualified HMOs.\textsuperscript{45} The 1976 amendments to the HMO Act of 1973 included an amendment to the planning law that sought to insulate such HMOs from local prejudice by transferring primary responsibility for development of criteria for use in reviewing HMO applications from the State Agency and the HSAs to the Secretary of Health, Education and Welfare.\textsuperscript{46} The conference committee report on this amendment stated that planning decisions should be made “on the basis of the need for HMOs and the need for their services for their enrolled members and reasonably anticipated new members and not on the need for the services in general if proposed by non-HMO providers.”\textsuperscript{47} It also underscored that cost and convenience to the HMO were the primary criteria to be used in weighing HMOs’ applications for new facilities and services.\textsuperscript{48}

Recently proposed regulations under both the HMO Act and the planning legislation as amended would give effect to the foregoing congressional concerns by requiring the State Agencies and HSAs to consider only the needs of the HMO (in being or proposed)

\textsuperscript{44} It is understood that Kaiser has made several unsuccessful bids to purchase existing institutions. The HSA is now seriously considering granting approval for Kaiser to build its own hospital.


\textsuperscript{46} Section 1532(c) of the planning law, 42 U.S.C. § 300n-1(c) (Supp. V 1975), was amended to require the planners’ criteria relating to HMOs to “be consistent with the standards and procedures established by the Secretary under section 1306(c),” 42 U.S.C. § 300e-5(c) (Supp. V 1975), of the HMO Act. This action also had the effect of transferring general responsibility for HMO criteria from the health planning program in HEW to the HMO program. See H.R. Rep. No. 1513, 94th Cong., 2d Sess. 36-37, reprinted in [1976] U.S. Code Cong. & Ad. News 4372, 4372-73.


and its members (present or "reasonably anticipated"). Where the issue was the availability of community resources arguably obviating the HMO's provision of its own, the only allowable considerations would be whether a five-year contract was available, whether the HMO could conveniently use its own personnel, and whether arrangements would be "administratively feasible" for the HMO and would "cost no more." The stated intention is that HMOs' applications not be judged "on the need for the services in general if proposed by non-HMO providers." Further, the HMO's proposals are not to be rejected solely because they are not contemplated in the duly promulgated health plans or because another HMO already exists in the community.

Although it is difficult to imagine how these proposed regulations could be much clearer in depriving the planner-regulators of available grounds for practicing protectionism with respect to HMO initiatives, if adopted they would benefit only those HMOs meeting all the requirements of the federal HMO Act. In view of the possibility that variations on the federally sponsored HMO model might also prove useful influences in local markets, state laws or regulations might make favorable presumptions similar to those in federal law applicable to an expanded class of HMOs. Extending a preference to HMOs not qualified under the federal law would not violate federal policy and could easily be adopted in a state where competition was regarded favorably as a mechanism of social control in health services.

Another way in which states might go beyond the requirements of federal law in encouraging HMO development would be by streamlining procedures which HMOs must observe before certificate-of-need agencies. Because HMOs are presumptively desirable additions to local markets and because their investments are

53. See authorities cited note 52 supra.
54. 43 Fed. Reg. 11,472.
55. Id. at 11474 (to be codified at 42 C.F.R. § 110.204(b)(1)).
56. Section 1122 of the Social Security Act directs the Secretary of HEW to ignore a negative decision by the state planning agency and allow Medicare or other federal reimbursement of HMO capital costs if he believes that denial of such reimbursement "would discourage the operation of . . . any [HMO, including non-qualified ones,] which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services . . . efficiently, effectively, and economically." 42 U.S.C.A. § 1320a-1(d)(2) (1975). The 1974 planning legislation includes a congressional finding that development of HMOs, without restriction to qualified ones, deserves "priority consideration." Id. § 300k-2 (Supp. 1977).
presumptively efficient, review of HMOs’ applications could be less thorough and less concerned about impacts on existing providers. HEW has suggested that a state may “apply to the Secretary for an exception to the use of the required procedures for review” in certain instances.\(^{57}\) The proposed regulations mentioned above provide that HMOs should not be subjected to certificate-of-need denials where subsequent development is consistent with the objectives, plans, and timetables approved in the review of earlier applications.\(^{58}\) A congressional committee has expressed concern about an HMO’s investing funds in initial development “only to have a certificate of need denied, or the need for an HMO questioned by antagonistic groups late in the HMO’s developmental sequence.”\(^{59}\)

VI. EXEMPTING HMOs FROM CERTIFICATE-OF-NEED REQUIREMENTS

Although some HMOs can expect no opposition from certificate-of-need agencies, and others will have the benefit of the federally supplied protections discussed above, there remain strong reasons for removing HMOs altogether from these agencies’ jurisdictions. The affirmative reasons for dropping entry controls based on “need” closely parallel the substantive arguments advanced above for regulators’ adopting a high degree of receptivity toward HMOs’ certificate-of-need applications. The other set of reasons for exempting HMOs from certificate-of-need requirements has to do with the likelihood that the health care system’s planner-regulators will not face issues surrounding HMOs solely on their merits but will allow special interests and inappropriate preconceptions to intrude. More generally, it may be observed that certificate-of-need laws were intended primarily to correct for the distorted investment incentives of fee-for-service providers whose bills are paid in large measure by third parties and that there is no comparable reason for extending such laws to cover HMOs, whose investments are closely guided by the needs of their subscribers and by the plan’s need to compete on the basis of both price and quality of service. As has been seen, most of the arguments for restricting HMO growth amount to penalizing HMOs for the economic faults of the traditional system.

HMOs’ experience with certification of need has lately led to legislative proposals purporting to “exempt” HMOs from the requirement of a certificate as a prerequisite to commencing opera-


\(^{58}\) 43 Fed. Reg. 11,472, 11,474 (1978) (to be codified in 42 C.F.R. § 110.204(b)(2)).

tions, building ambulatory care facilities, and purchasing equipment. As submitted, however, the bills would merely lift the federal mandate that such investments be covered by state certificate-of-need laws. Because most of the enacted certificate-of-need laws already cover HMOs' outpatient facilities and equipment purchases, a lifting of the federal requirement would neither give rise to an exemption nor automatically result in these laws' amendment. Moreover, new state laws could still cover HMOs in full if that were the preference of the state legislature, as influenced by established providers. If the intent is indeed to "exempt" HMOs from certificate-of-need requirements, the bills must be redrafted.

The pending proposals would leave HMOs fully subject to certificate-of-need requirements for the hospital facilities they might wish to develop. Although some sentiment exists for allowing HMOs freedom in this area as well, congressional faith in planning is apparently too great to be completely overcome, even where it conflicts with emerging enthusiasm for the HMO concept. Congressional leaders, having invested heavily in health planning, are probably simply reluctant to appear to disparage the planners' ability to discharge their primary responsibility as arbiters of hospital construction. But such considerations aside, no valid and relevant distinction exists between an HMO's investments in hospital facilities and its other investments. Moreover, as argued above, the chief consequence of denying an HMO the right to build its own hospital facility is to deprive it of bargaining power. No HMO would wish to build where satisfactory arrangements could be negotiated in the


61. ASPEN SYSTEMS CORP., HMO LAW MANUAL (1978).

62. The most natural way for Congress to create a true exemption from state law would be to add the exemption from state certificate-of-need requirements to Section 1311 of the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e-10 (Supp. V 1975), which overrides certain other state laws affecting federally qualified HMOs. Unfortunately, this approach would expose HMOs which chose not to seek federal qualification to continued certificate-of-need requirements. A useful stroke in support of the HMO concept generally would be to extend the "override" provision, including the exemption from certification of need, to all HMOs, not just federally qualified ones. This would leave the federal qualification requirements in place for federal subsidies and the dual-choice provisions but lift troublesome state law requirements for HMOs of all kinds. State regulation of the quality of care provided by HMOs would not be precluded.
community; and giving it the unrestricted option to build in the absence of such arrangements would vastly strengthen its ability to obtain concessions from a monopolistic hospital, to break up a hospital conspiracy formed to prevent the HMO from negotiating favorable terms in an overbedded market, 42 or to persuade a marginal institution to sell its facility to the HMO. In general, anything that increases the necessity for an HMO to depend on community resources may substantially decrease its efficiency 44 and increase its vulnerability to pressures and burdens that weaken its independence and competitive vigor. It is far from clear that the health planners are any better judges of the HMO’s convenience and needs than the HMO’s management. Indeed, experience suggests that they have other interests primarily in mind.

Although political prospects for some relaxation of the health planners’ authority over HMOs are reportedly good, the relief to be provided seems unlikely to go as far as it should. It is regrettable that congressional leaders, now waking up to the possibilities of competition in the health care system and increasingly aware of the planning effort’s shortcomings, are still unwilling to break with the dream of a planned health care system and to confine health planning to its natural function of rectifying distorted incentives in the third-party-financed fee-for-service system. 45 Perhaps they would be more willing to shift their emphasis if they recognized the possibility that strengthened HMO competition with the fee-for-service system could do much to increase fee-for-service providers’ cooperation with the planners. Thus health planning is more likely to be successful if it is seen by the providers themselves as performing a coordinating and cost containment function vital to keeping insured fee-for-service medicine—otherwise highly fragmented and uncon-

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63. Evidence suggesting a conspiracy of medical staff doctors to restrict the terms of hospital access by HMOs has been discovered in Ohio. Resolution of Eastern Ohio Council of Medical Staffs (discovery evidence), Ohio ex rel. Brown v. Mahoning Medical Soc’y, C76-168y (N.D. Ohio).

64. Anything forcing the HMO to accept the hospital’s terms—such as daily charges not reflecting the HMO’s higher occupancy rates, requirements for possibly duplicative use of the hospital’s lab or x-ray unit, or burdensome staff obligations for the HMO doctors on top of their peer review responsibilities in the HMO—erodes the HMO’s efficiency and competitive effectiveness.

65. The latest versions of S. 2410 and S. 2534, supra note 60, following revision by the Senate Human Resources Committee, would permit the states to cover new HMOs and HMOs’ outpatient facilities only when comparable ambulatory care providers and facilities are covered as well. See Wash. Rep. Man. & Health, May 8, 1976, at 5. This approach reveals a continuing acceptance of planning-cum-regulation as more than a corrective for market failure in the insured fee-for-service sector. States would be free to adopt the more limited conception, however, and to exclude HMOs from coverage.
trolled—viable as a competitor in the market for health services. Free market entry for HMOs is essential if this concept of health planning as a cooperative rather than a coercive enterprise is to be realized.

A total exemption for HMOs from certificate-of-need requirements would not deprive an HSA of its opportunities for promoting HMO development in its community—if it were sufficiently free from provider influence to be inclined that way. Thus an HSA could stimulate HMO feasibility studies and assist in the preparation of applications for federal planning and other grants. It could also assist in the process of consumer and employer education, so vital to the HMO’s marketing effort. Moreover, the attitudes and behavior of existing providers toward the HMO could be monitored by the HSA, which could help the HMO in negotiating its relationships with local providers and in obtaining other needed resources. Local provider conspiracies against the HMO could be combatted, even to the extent of initiating antitrust litigation. Indeed, exempting legislation could, by depriving HSAs of power and the opportunity to play an obstructionist role, cause them to pursue their goals by improving local market conditions rather than by fiat. Those health planners who cling to their jurisdiction over HMOs must be suspected either of representing provider interests or of simply liking power for its own sake.