HMO Act of 1973

Health Insurance Regulation
Working Paper No. I-1

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Section I. Introduction

Background

Rationale
This Act was part of a major Nixon administration cost containment initiative. The Act was intended to be pro-competitive, pre-empting, for example, all state laws or regulations that posed a barrier to HMO formation (even if there was no direct conflict with the federal regulations).\(^1\)

Statutory Authority
This act (which established Title XIII of the Public Health Service Act), along with subsequent amendments in 1976, 1978 and 1981 and implementing regulations at 42 CFR Part 110, established a number of conditions for becoming a federally qualified HMO.

Key Elements
Conditions for becoming federally qualified include a minimum benefits package, open enrollment and community rating. Some of the most costly restrictions were later removed. Likewise, for selected employers (with more than 25 employees subject to federal minimum wage requirements), the original Act mandated that those offering health benefits must offer an HMO option if a federally qualified HMO in the local area requested it. However, this provision was eliminated by 1995 (Havighurst, Blumstein and Brennan and 1998).

Theoretical Impact
Costs. In the aftermath of its passage, there were strong criticisms leveled at this Act on grounds that the conditions required for federal qualification imposed costs on HMOs that made them less competitive in the market (Mitka 1998).

Benefits. In theory, the Act was intended to reduce costs by eliminating other regulatory barriers inhibiting HMO development and by encouraging the proliferation of what was viewed as a more cost-effective delivery system.

\(^1\) Full details of the Act are provided by Uyehara and Thomas (1975).
Section II. Methods

Literature Search and Review

Sources

Peer-Reviewed Literature

We performed electronic subject-based searches of the literature using the following databases:

- MEDLINE® (1975-June 30, 2004) and CINAHL® (1975-June 30, 2004) which together cover all the relevant clinical literature and leading health policy journals
- Health Affairs, the leading health policy journal, whose site permits full text searching of all issues from 1981-present
- ISI Web of Knowledge (1978-June 30, 2004) which includes the Science Citation Expanded®, Social Sciences Citation Index®, and Arts & Humanities Citation Index™ covering all major social sciences journals
- Lexis-Nexis (1975-June 30, 2004) which covers all major law publications
- Public Affairs Information Service (PAIS), including PAIS International and PAIS Periodicals/Publishers (1975-June 30, 2004) which together index information on politics, public policy, social policy, and the social sciences in general. Covers journals, books, government publications, and directories.
- Books in Print (1975-June 30, 2004)

A professional librarian assisted in the development of our search strategy, customizing the searches for each research question. In cases where we already had identified a previous literature synthesis that included items known to be of relevance, we developed a list of search terms based on the subject headings from these articles and from the official indexing terms of MEDLINE and other databases being used. We performed multiple searches with combinations of these terms and evaluated the results of those searches for sensitivity and specificity with respect to each topic. We also performed searches on authors known or found to have published widely on a study topic. In addition to performing electronic database searches, we consulted experts in the field for further references. Finally, we reviewed the references cited by each article that was ultimately included in the synthesis. We did not hand search any journals. This review was limited to the English-language research literature. A complete listing of search terms and results is found in Appendix A.

“Fugitive” Literature

In some cases, relevant “fugitive” literature was cited, in which case we made every effort to track it down. We also performed systematic Web searches at the following sites:

- Health law/regulation Web sites
- Health industry trade organizations
• State agency trade organizations and research centers
• Major health care/health policy consulting firms
• Health policy research organizations
• Academic health policy centers
• Major health policy foundations

These searches varied by site. In cases where a complete publications listing was readily available, it was hand-searched. In other cases, we relied on the search function within the site itself to identify documents of potential relevance. Because of the volume of literature obtained through the peer-reviewed literature, including literature syntheses, we avoided material that simply summarized existing studies. Instead, we focused on retrieval of documents in which a new cost estimate was developed based on collection of primary data (e.g., surveys of state agencies) or secondary analysis of existing data (e.g., compilation of agency enforcement costs available from some other source). We excluded studies that did not report sufficient methodological detail to permit replication of their approach to cost estimation.

**Inclusion Criteria**

We developed the following inclusion criteria:

- **Sample**: wherever results from nationally representative samples were available, these were used in favor of case studies or more limited samples.
- **Multiple Publications**: whenever multiple results were reported from the same database or study, we selected those that were most recent and/or most methodologically sound.
- **Outcomes**: we selected only studies in which a measurable impact on costs was either directly reported or could be estimated from the reported outcomes in a reasonably straightforward fashion.
- **Methods**: we only selected studies in which sufficient methodological detail was reported to assess the quality of the estimate provided.

Where possible, we limited the review to studies using from 1975 through June 30, 2004 reasoning that any earlier estimates could not be credibly extrapolated to the present given the sizable changes in the health care industry during the past two decades. Other exclusions were as follows:

- Unless we had no other information for a particular category of costs or benefits, we excluded qualitative estimates of impact.
- Estimates of impacts derived from unadjusted comparisons were discarded whenever high quality multivariate results were available to control for differences between states or across time.
- Estimates that focused on measuring system-wide impact generally were selected over narrower estimates (e.g., per capita health spending vs. cost per inpatient day) on grounds that savings achieved in one sector may have induced higher spending elsewhere in the system; hence narrower comparisons might inadvertently lead to an inappropriate conclusion.
Section III. Results

Empirical Evidence

Indirect Costs: Stringent Requirements Led to Few HMOs. One expert, Alan Hillman, claims that “the HMO Act of 1973 didn’t have much impact—there were fairly constraining requirements placed on them at that time and not many new ones came on line. The HMOs didn’t start to take off until the early 1980s, when the constraints on them were lifted” (Mitka 1998: 2059).

• Compliance Costs: Health Care Expenditures. In a study using data from all operational non-Medicaid HMOs in the US between 1985 and 1993, the results found that being a federally qualified HMO was associated with 6.6% higher premiums. However, the study also found that federally qualified IPAs were associated with 6.5% lower premiums. (Feldman, Wholey and Christianson 1996). Another nationwide study of HMOs from 1990-1995 showed that, after controlling for a large number of plan characteristics, area characteristics and regulatory factors, there was no significant difference in the premiums for federally qualified HMOs compared to others; such HMOs constituted just over half of their sample (Feldman, Wholey and Christianson 1998).

• Indirect Costs: Plan Proliferation. A study of HMO formation over the period 1977-1991 found that the requirement that employers offer an HMO was not a significant determinant of HMO formation (Wholey, Christianson and Sanchez 1992).

• Indirect Costs: Plan Survival. A study of all 81 HMO mergers that occurred in the US between 1985 and 1992 found that being federally qualified was an important organizational characteristic. Results showed that merged-into HMOs were more likely to be federally qualified. In addition, federally qualified HMOs were less likely to fail. However, mergers were not necessarily welfare enhancing since there is some evidence that premiums rise when the number of competitors in a market area falls (Feldman, Wholey and Christianson 1995).

Net Assessment

We have calculated the regulatory costs in the following fashion (minimum and maximum parameter estimates are shown in parentheses: full details of methods and sources are in Table I-1).

• Government Regulatory Costs. We include no estimate of federal spending to administer this Act.

• Compliance Costs: Health Care Expenditures. In the context of the explosive growth in managed care over the past decade, most of the evidence shows there is no particular advantage to being federally qualified. Thus, even though the Act remains in force, we conclude that currently it imposes no regulatory burden on the health care system. However, as an upper bound, we use the Feldman,
Wholey, and Christianson (1996) results showing a 6.6 percent increase on group/staff premiums and a 6.5 percent reduction for IPAs; we multiply these times gross estimated HMO premiums of each type based on InterStudy survey data showing that 40.3 percent are enrolled in IPA model plans. In the case of premium increases, we assume these represent additional services of some value to patients. But because it is free care to them, patients do not value it at its cost, so we adjust the figure downward using RAND Health Insurance Experiment estimates of the amount of “waste” involved in providing patients with free care as a basis for this adjustment (i.e., 31%). Since this value is an average, it probably understates the amount of waste at the margin. Therefore, for our upper bound calculation, we assume the marginal amount of waste is double the RAND-measured amount.

- **Indirect Costs: Plan Proliferation and Survival.** We saw no obvious way to translate the proliferation and plan survival findings into a monetized measure of costs or benefits, so these effects have been excluded.

- **Social Welfare Losses: Efficiency Losses from Regulatory Costs.** All industry compliance costs, including additional uncompensated care induced by pools are presumed to be roughly equivalent to an excise tax, i.e., raising prices and reducing demand/output correspondingly. We therefore multiply these costs times the marginal excess burden associated with output taxes, using 21% (15%, 28%) as the expected value of MEB (see Table B-1 for details of how MEB is calculated).

The overall expected cost of this Act in 2002 is $0 million (0, 8,330) while the expected benefits are $0 million (0, 8,037).

**Research Questions**

This working paper covers two major topic areas framed within five research questions, all of which are related to the impact of the HMO Act of 1973 in the U.S. Our primary goal was to identify, review, and evaluate the published literature to answer the research questions with the intent of developing an interim estimate of the costs and benefits of the act; our secondary goal was to identify areas where no evidence exists or where the evidence has important limitations and then describe the type of data that would be needed to more fully address the question.

The questions are listed below by topic area, along with a brief description of our analytical approach, including outcomes of interest.

**Costs of the HMO Act of 1973**

**Question 1a.** What is the amount of government regulatory costs related to the HMO Act of 1973? This includes state costs to monitor and enforce rules related to the act.

**Question 1b.** What is the amount of industry compliance costs related to the HMO Act of 1973? This includes all administrative costs and enforcement penalties borne by private, state or locally owned health facilities subject to the Act. Monetary penalties may be viewed as a transfer, but the remaining costs represent real resource losses to society.
Benefits of the HMO Act of 1973

**Question 2a.** What is the net impact of the HMO Act of 1973 on health expenditures? Historically, the Act was justified on market-perfecting grounds to overcome the weak incentives for economic discipline resulting from a combination of cost-based reimbursement and pervasive third-party payment for health care. According to this theory, the Act could enhance efficiency by regionalizing expensive tertiary HMOs. But skeptics argue that the Act is a form of industry protection from competition. Reduced competition could have adverse effects on health expenditures (by allowing facilities to charge higher prices). Therefore, our search allowed for the possibility that the Act could decrease, increase or have no impact on health expenditures.

**Question 2b.** What is the impact of the HMO Act of 1973 on health outcomes? To the extent that facilities with higher volumes of selected procedures have better outcomes, regionalization resulting from the Act could have a corollary benefit in the form of improved patient outcomes. Likewise, to the extent that the Act efforts to prevent “cream-skimming” were successful, this might allow the survival of certain facilities such as large urban public hospitals that might otherwise be forced to shut down for lack of sufficient paying patients. In theory, this too could result in health benefits and/or reductions in avoidable hospitalizations if indigent patients were able to receive essential care on a timely basis. However, limitations on competition also have the potential to result in lower quality care, so we sought literature that related the act to outcomes in either direction. Changes in either morbidity or mortality could be monetized using conventional methods.

**Question 2c.** What is the impact of the HMO Act of 1973 on access to care? Even if it resulted in no change in patient outcomes, improvements in access to care would be of value, so we sought to ensure to include literature focused on this dimension of the act performance.

**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>IPA</td>
<td>Individual Practice Association</td>
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Listing of Included Studies


Listing of Excluded Studies

Key for Reasons for Exclusion

1. Studies with no original data
2. Studies with no outcomes of interest
3. Studies performed outside U.S.
4. Studies published in abstract form only
5. Case-report only
6. Unable to obtain the article


Appendix A. Evidence Tables
Appendix B. Search Strategies

Database: Ovid MEDLINE(R) <1966 to March Week 4 2005>
Search Strategy #1ab, #2a
--------------------------------------------------------------------------------
1  Health Maintenance Organizations/ (13279)
2  Legislation, Medical/ (13165)
3  (Costs and Cost analysis).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (33671)
4  1 and 2 and 3 (25)
5  limit 4 to (english language and yr=1975 - 2004) (7)
6  from 5 keep 1-7 (7)

Database: Ovid MEDLINE(R) <1966 to March Week 4 2005>
Search Strategy: #2bc
--------------------------------------------------------------------------------
1  Health Maintenance Organizations/ (13279)
2  Legislation, Medical/ (13165)
3  "Outcome Assessment (Health Care)"/ (20850)
4  1 and 2 and 3 (0)
5  Health Services Accessibility/ (21903)
6  1 and 2 and 5 (0)

Database: CINAHL - Cumulative Index to Nursing & Allied Health Literature <1982 to March Week 4 2005>
Search Strategy: #1ab, #2a
--------------------------------------------------------------------------------
1  Health Maintenance Organizations/ (2540)
2  Legislation, Medical/ (134)
3  "Costs and Cost Analysis"/ (3115)
4  1 and 2 and 3 (1)
5  from 4 keep 1 (1)

Database: CINAHL - Cumulative Index to Nursing & Allied Health Literature <1982 to March Week 4 2005>
Search Strategy: #2bc
--------------------------------------------------------------------------------
1  Health Maintenance Organizations/ (2540)
2  Legislation, Medical/ (134)
3  Outcome Assessment/ (3015)
4  1 and 2 and 3 (0)
5  Health Services Accessibility/ (10001)
6  1 and 2 and 5 (0)

Database: ISI Web of Science <1978 to 2004>

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<th>#11 AND #5</th>
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<tr>
<td>#12</td>
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</table>

![Image](image1.png)
Database: Lexis-Nexis <1975 to 2004>
Search Strategy #1ab, #2a

1  HMO Act of 1973 (47)
2  Search within results: cost (47)
3  Of these, 1 selected for detailed review

Database: Lexis-Nexis <1975 to 2004>
Search Strategy #2b

1  HMO Act of 1973 (47)
2  Search within results: health outcomes (7)
3  Of these, 0 selected for detailed review

Database: Lexis-Nexis <1975 to 2004>
Search Strategy #2c

1  HMO Act of 1973 (47)
2  Search within results: access to care (15)
3  Of these, 0 selected for detailed review

Database: PAIS <1975 to 2004>
Search Strategy #1: ALL

#10 (access to care and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (health maintenance organization and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(0 records)
#9 access to care and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(197 records)
#8 (health maintenance organization and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (health outcomes and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (LA:PAIS = ENGLISH) and
(PY:PAIS = 1975-2004)(0 records)
#7 health outcomes and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(52 records)
#6 (cost analysis and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (health maintenance organization and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (LA:PAIS = ENGLISH) and
(PY:PAIS = 1975-2004)(0 records)
#5 cost analysis and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(135 records)
#4 (legislation and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (health maintenance organization and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)) and (LA:PAIS = ENGLISH) and
(PY:PAIS = 1975-2004)(1 records)
#3 legislation and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(14946 records)
#2 health maintenance organization and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(34 records)
#1 HMO Act of 1973 and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(0 records)

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**Database: Dissertation Abstracts <1975 to July Week 4 2004>**

Search Strategy #1: ALL

2. Of these, 3 selected for detailed review

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**Database: Books in Print <1975 to 2004>**

Search Strategy #1: ALL

1. Keyword in Title: HMO Act of 1973 (0)
3. Of these, 15 selected for detailed review

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**Database: Health Affairs <1981 to July Week 4 2004>**

Search Strategy #1: ALL

1. HMO Act of 1973 (exact phrase anywhere in article) (25)
2. Of these, 25 selected for detailed review
Appendix C. Web Sites Used in I-1 Literature Search

Health Law/Regulation Web Sites
We began searching at Web sites known to specialize in health law and regulation generally or specific topics included in this review:

- American Health Lawyers Association
- Findlaw.com—health law
  [http://www.findlaw.com/01topics/19health/index.html](http://www.findlaw.com/01topics/19health/index.html) (no documents found)
- Health Care Compliance Association
  [http://www.hcca-info.org/](http://www.hcca-info.org/) (no documents found)
- HealthHippo
  [http://hippo.findlaw.com/hippohome.html](http://hippo.findlaw.com/hippohome.html) (no documents found)
- National Health Care Anti-fraud Association (NHCAA)
  [http://www.nhcaa.org/](http://www.nhcaa.org/) (no documents found – member-only site)

Health Industry Trade Organizations
Health Insurance Regulation
For health insurance regulation, we searched the following industry and state agency trade organization Web sites:

- American Association of Health Plans (AAHP)
  [http://www.aahp.org/](http://www.aahp.org/) (no documents found)
- Health Insurance Association of American (HIAA)
  [http://www.hiaa.org/index_flash.cfm](http://www.hiaa.org/index_flash.cfm) (no documents found)
- Blue Cross and Blue Shield Association (BCBSA)
  [http://www.bluecares.com/](http://www.bluecares.com/) (no documents found)
- National Committee for Quality Assurance (NCQA)
  [http://www.ncqa.org/](http://www.ncqa.org/) (no documents found)
- National Association of Insurance Commissioners (NAIC)

State Agency Trade Organizations and Research Centers
For state agency trade organizations and health policy research centers specializing in state health policy issues not accounted for above, we searched the following Web sites:

Executive branch
- National Governors Association (NGA)
  [http://www.nga.org/](http://www.nga.org/) (no documents found)
- National Association of State Budget Officers (NASBO)
http://www.nasbo.org/ (no documents found)
- Association of State and Territorial Health Officers (ASTHO) http://www.astho.org/ (no documents found)
- National Association of Health Data Organizations (NAHDO) http://www.nahdo.org/default.asp (no documents found)
- National Association of State Auditors, Comptrollers and Treasurers (NASACT) http://www.nasact.org/ (no documents found)

Legislative branch
- National Conference of State Legislatures (NCSL) http://www.ncsl.org/ (no documents found)
- Council of State Governments (CSG) http://www.csg.org/csg/default (no documents found)
- National Academy of Public Administration (NAPA) http://www.napawash.org/ (no documents found)

State Health Policy Research Centers
- National Academy of State Policy http://www.nashp.org/ (no documents found)
- Pew Center on the States http://www.stateline.org/ (no documents found)
- State Health Policy Web Portal Group http://www.hpolicy.duke.edu/cyberexchange/Whatstat.htm#States

Rather than search 50 individual sites, we queried by e-mail the directors of all centers included in this group for relevant reports/studies their centers had conducted or that had been conducted by agencies in their states.

Health Care/Health Policy Consulting Firms
For major health care/health policy consulting firms, we searched the following sites. Some of these specialize in human resource consulting, but were included in the event they had done industry-wide studies of regulatory costs:

- Buck Consultants Inc. http://www.buckconsultants.com/ (no documents found)
- Deloitte & Touche http://www.deloitte.com/vs/0%2C1616%2Csid%25253D2000%2C00.html (no documents found)
- Ernst & Young LLP http://www.ey.com/global/content.nsf/US/Home (no documents found)
- Hewitt Associates LLC http://www.hewitt.com/ (no documents found)
- Milliman USA Inc. http://www.milliman.com/ (no documents found)
- PricewaterhouseCoopers LLP
http://www.pwcglobal.com/ (no documents found)

• Towers Perrin
  http://www.towers.com/towers/default.asp (no documents found)
• Watson Wyatt Worldwide
  http://www.watsonwyatt.com/ (no documents found)

Health Policy Research Organizations
  For major health policy research organizations, including “think tanks” and some advocacy groups, we searched the following sites:

• Abt Associates
  http://www.abtassoc.com/ (no documents found)
• Alliance for Health Reform
  http://www.allhealth.org/ (no documents found)
• AcademyHealth
  http://www.academyhealth.org/index.html (no documents found)
• The Advisory Board Company
  http://www.advisoryboardcompany.com/ (no documents found – member-only site)
• American Enterprise Institute (AEI)
  http://www.aei.org/ (no documents found)
• Battelle
  http://www.battelle.org/ (no documents found)
• Brookings Institution
  http://www.brook.edu/ (no documents found)
• Cato Institute
• Center for Budget and Policy Priorities (CBPP)
  http://www.cbpp.org/ (no documents found)
• Center for Health Affairs (Project HOPE)
  http://www.projecthope.org/ (no documents found)
• Center for Health Care Strategies (CHCS)
  http://www.chcs.org/ (no documents found)
• Center for Study of Health Systems Change (CSHSC)
  http://www.hschange.com/ (no documents found)
• Employee Benefits Research Institute (EBRI)
  http://www.ebri.org/ (no documents found)
• Heritage Foundation
  http://www.heritage.org/ (no documents found)
• Institute of Medicine (IOM)
  http://www.iom.edu/ (no documents found)
• Lewin Group
  (no documents found)
• Mathematica Policy Research (MPR)
Major Health Policy Foundations. For major health policy foundations, we searched the following sites:

- California Healthcare Foundation
  [http://www.chef.org/](http://www.chef.org/) (no documents found)
- Commonwealth Fund
  [http://www.cmwf.org/](http://www.cmwf.org/) (no documents found)
- Robert Wood Johnson Foundation
- Henry J. Kaiser Family Foundation
  [http://www.kff.org/](http://www.kff.org/) (no documents found)
- United Hospital Fund
  [http://www.uhfnyc.org/](http://www.uhfnyc.org/) (no documents found)