COST OF HEALTH SERVICES REGULATION
WORKING PAPER SERIES

HMO ACT OF 1973

HEALTH INSURANCE REGULATION
WORKING PAPER NO. I-1

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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, but 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 that inhibit HMO development and encouraging the proliferation of what was viewed as a more cost-effective delivery system.

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). However, another nationwide study of HMOs from 1990-1995 showed

[1] Full details of the Act are provided by Uyehara and Thomas (1975).

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 are less likely to fail. However, mergers are 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 E-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).

Acronyms

HMO Health Maintenance Organization
IPA

References

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