UNIVERSITY OF ILLINOIS

1 May 1988

THIS IS TO CERTIFY THAT THE THESIS PREPARED UNDER MY SUPERVISION BY

Jeffery W. Eich

ENTITLED Health Maintenance Organizations:

An Alternative for Implementing Government Health Care Policy

IS APPROVED BY ME AS FULFILLING THIS PART OF THE REQUIREMENTS FOR THE

DEGREE OF Bachelor of Arts

In Liberal Arts and Sciences

Instructor in Charge

APPROVED:

HEAD OF DEPARTMENT OF Political Science

O-1364

Health Maintenance Organizations:
An Alternative for Implementing Government Health Care Policy

By

Jeffery W. Eich

Thesis

for the

Degree of Bachelor of Arts

in

Liberal Arts and Sciences

College of Liberal Arts and Sciences

University of Illinois

Urbana, Illinois

1988

Table of Contents

Introduction:

Lying on a makeshift cot, buried in layers of tattered blankets, a child quietly whimpers, worn down almost completely by the disease which his parents have neither the remedy nor the money to relieve him of. Although this scene may seem more appropriately set in a third world nation such as Bolivia or Laos, it is equally well-suited to the Bronx NY or "Little Town" USA. Despite spending nearly eight billion dollars on health care last year, the U.S. is far from "First World" when it comes to medicine.

The problem with the U.S. health care system stems not from a lack of adequate medical resources, as evidenced by the eight million spent last year, but rather a lack of structure and guidance to the American health care "beast". As a result, the "beast" is in some instances nearly flawless but at others dismally pathetic. The strong points of the U.S. include one of the world's highest levels of medical technology and hospitals that are highly capital intensive. In contrast, then, the weaknesses of the system become even more shocking. With all this high-powered medical technology, the U.S. finds itself with literally millions of its citizens who receive little or no medical care. Moreover, the number of those receiving inadequate medical care is growing rather than decreasing.

The major problems with U.S. health care can be divided into four categories; inequality in medical care, escalating health care costs, inadequacy of long term care facilities, and catastrophic health care expenditures.

The aforementioned symptoms of the U.S. health care system, after being more carefully defined, will form the basis for analyzing the various proposals aimed at remedying the system. These reform measures can be broadly be divided into two categories. The first encompasses governmental attempts at reform of the Medicaid and Medicare systems and proposals for regulation of the health care providers. These measures usually involve either expanding the coverage of the "Medi-insurance" programs or increasing governmental, preferably federal, control or guidance over major health care providers so as to insure a more desirable health care product. The second group of reforms calls for a fusion of government and free-enterprise. These plans call for Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's) to provide health care as a policy tool of government. These organizations could provide government scrutinized health care to the welfare population in return for government reimbursement. In order to gauge the effectiveness of these numerous proposals, however, it is

necessary to first outline the four "problem-criteria" which necessarily define the success of any proposed reforms.

Problem #1: Care for the Poor

Perhaps the most disturbing and most critical flaw in the U.S. health care system involves the great inequality in its distribution throughout the population.. Undeniably, health care is spread unevenly throughout the country with regard to income, geography, and race. Moreover, these discrepancies are directly related to sources of medical care available to certain sub-groups of the general population. While the rich can afford top rate medical attention, the poor must rely on the few sources available. Moreover, those few sources serving the poor are increasingly suffering economic hardships that jeopardize their ability to help the poor.

The inequality in disbursement can be witnessed by several criteria. For example, in a 1977 survey by the National Canter for Health Services Research, it was discovered that approximately seventeen percent of the people living in the western United States had no usual source of health care, while only eleven percent of those living in the north central U.S. fell into the same

category. Moreover, the same study found that seventy-two percent of those persons living in the north central section of the United States recognize a physician's office as their primary source of health care, while less than sixty percent of those living in the western states were similarly categorized (1). While these differences may at least be partially offset by other factors such as population concentration, and regional preferences, other statistics reveal more serious defects in the U.S. health care system.

When analyzing health care data based on income level, the inadequacies quickly become apparent. For example the infant mortality rate for families with an estimated income greater than five thousand dollars per year is 4.9 deaths for every one thousand live births. In contrast, for families with estimated annual earning less than five thousand dollars, the infant mortality rate jumps to 7.8 deaths per one thousand live births (2). Furthermore, surviving the first obstacle is truly just the beginning: the average poverty-line child has had 3.3 visits to a doctor per year compared to a non-poverty child's 4.2 visits on average. In a study done by H. Luft, it was discovered that while on average a white male aged eighteen to thirty-four with an income in excess of ten thousand

dollars has a .46 percent chance of becoming severely disabled, the chances increase to 1.15 percent for white males of the same age group but with annual incomes less than ten thousand dollars (3). These statistics are but a smattering of the wide body of data that correlate the negative relationship between income and level of health care received. While the link between health and income may be unsettling enough when considered alone, when pondering the fact that as of 1984 thirty-six percent of all black families fall below the poverty line, the added stigma of racial inequality creates an even more disheartening effect (4).

Before condemning the U.S. health care system, however, it is first necessary to ascertain if the health care received by the poor is truly significantly quantitatively or qualitatively inferior to that received by the rest of the population or if their poor health is rather a symptom of diet or lifestyle. The most logical starting point for this query would then be to delineate access to health care based on income class. Access can be defined as "those dimensions which describe the potential and actual entry of a given population group into the health care system" (5). This analysis is appropriate in that regardless of actual outcome, if the poor truly have equal access to the health

care system, the system is fulfilling its function.

Limited Access for the Poor

Even by this criteria however, the U.S. health care system fall short. In a 1977 NCHSR study, established that approximately 17.1 percent of persons with an income less than twelve thousand had no usual source of health care. In contrast, the same category applied to only 12.2 percent of those persons earning in excess of twenty thousand dollars a year (6). Granted, there can be several explanations for claiming no "source of care"; such explanations included "does not get sick", "new to area", and "sources no longer available." The evidence, however, indicated that there are restrictions on the availability of health care to the poor. First, of a population of approximately of two hundred and twenty million people, more than twenty two million have no health insurance, private or public, to reimburse their health care costs. This group consists mainly of the "working poor"; persons ineligible for Medicaid yet too poor to afford such necessities as health insurance. This lack of health insurance undoubtedly limits the health care channels that are left open to such people. (It is hard to refute the argument that most doctors are unwilling to take patients who do not have sufficient funds to pay for their

services.) Secondly, the previously mentioned NCHSR study also noted inequitable trends in health care. Of those with incomes less than twelve thousand dollars, fifteen percent indicated that their usual source of health care was either a hospital outpatient department, an emergency room, or a health clinic, while only 58.4 percent of this same group stated that a physician's office was their primary source of health care. In stark contrast, the study revealed that 8.3 percent of those earning more than twenty thousand dollars claimed that their primary source of health care was either a hospital outpatient facility or a public health clinic, with an additional 69.7 percent declaring that a physician's office was their usual source of care (7). Further to the point, a 1977 survey by the Cincinnatti Department of Health ascertained that only twenty percent of the surveyed office-based physicians were willing to take on new Medicaid clients. Conversely, seventy-four percent of the same group were prepared to accept new non-Medicaid clients (8). Additionally, a 1980 study by the New York City Health Department observed that only thirty-two percent of all licensed physicians in New York City actually participated in the Medicaid program to any extent (9). The distinction between the usual sources of medical care for these two groups is critically relevant

in determining the relative quality received by each. There are few people who wouldn't prefer to be treated in a doctor's office rather than an outpatient facility or community health clinic.

Preferences don't deceive. The advantages of office-based treatment over the other mentioned sources are numerous. First, being treated by one physician over a period of time guarantees consistency and uniformity in medical service whereas emergency rooms and health clinics are staffed by a variety of doctors who frequently move from place to place. Secondly, emergency rooms, outpatient facilities, and public clinics tend to dehumanize the relationship between doctor and patient and prevent the patient from feeling comfortable and secure. In the doctor's office, however, the one-on-one relationship between doctor and patient and the privacy afforded patients allows them to become more relaxed and at ease with the office environment. Lastly the quality of the physicians found in places such as public clinics is far below that found in a general practioners office. This because facilities such as outpatient departments and emergency rooms are usually staffed by interns who are much less seasoned and skilled than their office-based counter parts. Clearly then, the inequality in access to health

care is a significant problem that threatens to severely diminish the quality of life enjoyed by the poorer persons of this country. Before moving on to discuss the problems associated with cost containment in the medical industry, it is first necessary to take a brief overview of those hospitals that do serve the poor- the health clinics and public hospitals.

Public Hospitals

There has been a trend through the last decade for a growing number of private hospitals to refuse to admit patients who are either Medicaid recipients, or worse yet, patients who have no reliable sources to pay for their treatment (10). This trend is a result of hospitals trying to cope both with escalating medical costs and the ever increasing burden of indigent patients. For this reason, health clinics and especially public hospitals have been taking an increasingly larger share of the burden in caring for Medicaid recipients and indigents. A significant number of these hospital have an average of over forty percent of their patients who are either unable to pay or are Medicare/Medicaid beneficiaries. The economic hardship placed upon the hospital by those unable to pay is quite easy to see. Studies by government agencies such as the Congressional Budget Office and the Department of Health

and Human Services indicate that hospitals serving a substantial number of Medicaid/Medicare patients (over twenty percent) incur significantly higher costs (12). Neither report could pinpoint the exact reasons for this phenomena, but proposed as plausible explanations: 1) the higher severity of illness for low income patients, and 2) higher operations and overhead costs due to the special needs of the poor and elderly, and as a result of the location of these hospitals (13). Further to the detriment of these hospitals, many experts in the health care field feel that it is very difficult for hospitals to pass these added costs on to paying customers (14). As a result of this problem and because public hospitals and clinics are in general poorly administered, these institutions have come under extreme financial pressure in the past decade, forcing a considerable number to close down. Thus, the dire straits faced by many of America's poor becomes all too evident when one considers the deteriorating position of their already limited health care alternatives.

Problem #2: Health Care Cost Containment

An equally distressing problem that afflicts all Americans alike is the incredible explosion of health care expenditures that has occurred over the last twenty years.

During this period, health care expenditures have increased at a rate that greatly outpaced the overall rate of inflation. For example, over the last twenty-five years, 1960-1985, health care costs have increased by approximately thirteen percent a year- an average well above the general rate of inflation for any single year during that span (15). An even more shocking statistic is the increasingly large share of the U.S.'s Gross National Product that is being gobbled up by health care expenditures. In 1960, health care expenditures consumed 5.3 percent of the nation's GNP, by 1983 they had enveloped a 10.7 percent slice of the economic pie (16). Not only does this trend reflect a seemingly unconscious shift in the nation's utilization of its resources, but also threatens to jeopardize the solvency of the federal and state health care aid programs. Government expenditures, both state and federal, have expanded from 6.3 billion dollars in 1973 to more than thirty billion dollars in 1983 despite a modest decrease in the number of people receiving aid. By most estimates, if government expenditures continue to grow at this rate, and there is little reason to doubt that they will, the federal Medicare program and Medicaid trust will be completely exhausted by the early 1990's unless other significant sources of

funding are found (18). Perhaps most frightening, however, is the knowledge that this explosion has taken place amidst a furious barrage of governmental activity aimed at arresting the problem. Unfortunately, for both government and consumer, the roots of the problem are complicated and numerous. Although the problem is far from being clearly understood, it may be helpful to outline the most popular professed causes that have been set forth.

Causes of Expenditure Increase

Technology:

The first and most apparent contributor to the expenditure boom has been the rapid development of medical technology. Only a decade ago terms such as CAT scan and laser surgery were words foreign to medicine. The development and application of such tools has meant that hospitals have had to undertake tremendous capital expenditures. For example, the Swan Catheter, a high-tech medical instrument developed at the beginning of this decade was fully implemented into most hospitals by 1984 and added approximately three hundred million dollars a year to the nation's health care bill (19). There is no doubt that these advances in medical technology have saved countless lives: what has been questioned, however is to

what extent and at what cost these advances should be introduced into the health care system. Truly, no one would place a price on a human life but real world conditions constrain the amount of resources available for human consumption. A dollar spent on health care is a dollar that can not be spent on food, shelter, or transportation. It is simply necessary to apply cost-benefit analysis to determine if gains in made in medical gains justify setbacks caused by resource transfers from other fields. This is not a proposal to completely halt medical research; rather it is a question of degree. Every hospital should have X-ray equipment; there is no debate. Whether every hospital needs CAT scan technology and advanced coronary care units is another question. Yet when considering that CAT scan equipment which can cost as much as one hundred thousand dollars, and is only infrequently used, one must dispute the wisdom of hospital administrators who make such equipment standard capital. Instead of cooperating with other area hospitals in planning capital procurement, most hospital administrators seem intent upon developing advanced care units and purchasing the latest medical technology so as to create a more marketable "medical package" than that of their nearest "rival." Such practises have contributed greatly

to the upward spiral of health care expenditures.

Consumer Preference:

A second and equally responsible factor has been the fantastic increase in the use of the health care system. This growth is not solely a result of population growth, but is also a consequence of a greater medical turnover rate. More simply put, people are going to the doctor more often. The reasons for this augmented turnover rate are several. First, Americans have evolved into a highly health conscious society. Not only is it considered important to exercise and diet, but also to see a doctor regularly for a checkup and to utilize the latest in medical technology and technique, people are becoming more confident in the competence of medical personnel. Only a few decades ago it was considered a bit risky to check into the hospital unless it was absolutely necessary. Now, although the hospital is anything but perfectly safe, medical standards have risen to such a level that many are willing to go to the hospital for even minor ailments. Lastly, and possibly most responsible has been the evolution of comprehensive health insurance policies. These policies, which cover almost any imaginable medical expense, requiring only a minimal payment on the consumer's part, have created a great incentive for people to over-

utilize medical resources. Thus, by requiring little or no payment on the consumer's part, the insurance companies drastically reduce his/her marginal cost to purchase medical services. Thus, the consumer is likely to make many more trips to his private physician than if he had to pay for each such visit out of his own pocket. Clearly, no one group can be tagged with the blame for increased use of medical resources, nor is it necessarily a completely negative phenomena; rather it is a complex problem that must be approached on many fronts.

Monopolistic Health Care Markets:

A third and related cause of "health care inflation" is the structure of the health care market. Instead of the consumer purchasing services directly from the provider, he does so indirectly through an insurance company. The problem with this arrangement is that no where in the system are there any checks to restrain unnecessary price increases. If the consumer were to deal directly with the provider, he would have incentives to take such steps to constrain price increase as to choose the lowest cost provider or to reduce health care expenditures as much as rationality and common sense would allow. In contrast, health insurance have little incentive to keep health care costs down. They have neither the manpower nor the will to

investigate individual claims. If medical costs rise, they can simply pass these added costs on to the policy holder. Assuming that these costs rise uniformly across the country, all insurance companies will face roughly the same cost curve and will not suffer any loss in business as consumers will have little choice but to endure the increase in premiums. As far as the hospitals are concerned, so long as there is no tangible penalty, it is considerably easier to be efficient than it is to be efficient. Thus, it should be quite evident that the health care reimbursement system contains serious flaws that if left unchecked will continue to add to health care cost inflation.

Malpractice Suits:

Less significant but nonetheless important in the upward climb of medical costs has been the proliferation of malpractice suits. A product of the 1970's and 1980's, malpractice suits have become such a common occurrence that insurance to guard against such suits have sky-rocketed to unbelievable levels. For surgeons, premiums have gone as high a sixty thousand dollars a year. Thus, in order to maintain their present standard of living, doctors must pass these increased costs on to consumers. Although this is a problem that must be dealt with by lawmakers rather

than hospital administrators, it remains a factor contributing to the explosion of health care expenditures.

All of these factors in addition to many other that have gone unmentioned combine to make cost containment a problem both difficult to understand and difficult to solve State and federal governments have instituted policies such as capital investment restrictions and alternate reimbursement policies but met with limited success. Even major insurers such as Blue Cross and Blue Shield have become more aggressive in negotiating contracts with providers- gaining only marginal success. There simply is no easy solution. Unless the problem of cost containment is come to grips with soon, however, health care expenditures could become a cancer that virtually consumes all of our nation's resources.

Problem #3: Long Term Care for the Elderly

Perhaps the most embarrassing if not serious health care issue stems from the pitiful manner in which the elderly are provided for upon retirement. The historian Toynbee concluded that a society's quality and durability can best be measured by the respect and care it gives to its elderly citizens (20). If Toynbee was right, then the U.S. might appropriately be compared to a Yugo brand

automobile. One of the most terrifying thoughts to most senior citizens is to exhaust one's life savings, to lose support of their children, and to become unable to take care of themselves. In this situation the federal and state governments offer two alternatives; either go to a nursing home (Medicaid, with some restrictions, picks up the bill), or go it alone. Considering that the average life expectancy once enrolled in a nursing home is three years, neither choice is particularly exciting (21). It is shameful that, although the elderly are statistically the most likely to need medical attention, our society does so little to provide for their care. The problems with long term care for the elderly are two fold: 1) problems in finance and organization of public programs, and 2) the inadequacy of nursing homes as the primary source of long term care for the elderly.

Problems in Organization and Finance:

Government organization and planning for long term health care of the elderly is best described as ad hoc. There is no formal agency assigned to the specific task of over seeing this topic. Rather most state and federal payments to nursing homes are funded by state Medicaid programs. This is a strange arrangement as Medicare was originally intended to care for the elderly. However,

since the elderly must literally become poor to receive government aid for nursing home care, they fall under Medicaid's jurisdiction. Moreover, unlike most other health care sectors, health insurance providing long term care are a somewhat scarce and unknown commodity. With little help from the government or from private insurers, the elderly is often forced to turn to their own resources and the resources of their families.

Lamentably, the government does not see their families as equal alternatives to nursing homes. For while Medicaid will fully reimburse nursing homes, it fails, in many cases, to cover many out-of-pocket costs such as medicine and physical aides that are not directly related to physician's visits. Although it may at first seem perverse to pay a family to care for its parents, consider the added economic hardship incurred by a family in providing professional nursing and other medical services to an added family member. Moreover, ask yourself which family is more caring, one willing to devote its time and resources to caring for its parents or one that prefers to send its parents off to a sterile and dehumanizing nursing home. Although a few states do provide dependency stipends to families who provide home care to the elderly, these allowances rarely meet costs associated with caring for the

individual. Few families, therefore, have this choice to make because government does not significantly help them in caring for their elders. Moreover, Medicare fails to meet many of the out-of-pocket medical expenses that the self-sufficient elderly make. The elderly, more than any other segment of the population, are in need of a constant flow of medical services. In contrast, Medicare coverage is anything but complete; covering only major expenditures such as hospitalization and physician's office visits. Thus it is not uncommon for elderly persons with incomes less than five thousand dollars spending large percentages of their income on medical care (22). By one estimate, the overall out-of-pocket expenditures of the elderly amounted to fifteen percent of their total income in 1985 and is expected to grow to nineteen percent by 1990 (23). By limiting aid to the elderly and their families who care for them, the government forsakes many elderly to a lifestyle only marginally better than that of nursing home.

To compound this problem financing these already restrictive government programs will grow even more difficult in the coming years. From 1960-1982, the percentage of the U.S. population aged sixty-five or greater grew from 9.2 percent to 16.7 percent. Moreover, the proportion of this elderly population over seventy-four

years of age increased from one-fourth to one-third during the same period (24). This trend is likely to continue through the year 2000 as the "baby boom" generation edges toward retirement. With an ever increasing proportion of the population reaching retirement age and living longer, the tax burden on the working ranks may grow to unbearable levels. Therefore unless the government's long term care program for the elderly is drastically revamped, the system faces a coming financial crisis that could threaten its solvency.

Nursing Homes

The second major flaw in the present long term care system for the elderly derives from the primary providers of this service, the nursing homes. Perhaps the epitome of everything that has gone wrong with the long term care for the elderly, a large number of nursing homes are characterized by living conditions more appropriate for people of a backward third world nation than of a wealthy industrial state. In Too Old, Too Sick, Too Bad, Frank Moss characterizes the common complaints against nursing homes as: negligence leading to injury and death, unsanitary conditions, poor food and poor preparation, misappropriation and theft of patients possessions by employees, inadequate control of drugs, unauthorized and

improper use of restraints, and reprisals against those who complain (25). Moss goes on to cite countless case after case, recounting incidents where patients were either negligently or intentionally severely injured by their supposed "caretakers." The fact that eighty percent of those who enter a nursing home will perish there in less than two and a half years only underscores the poor conditions that exist in many nursing homes (26). Granted many who enter nursing homes are old and in poor health, a group with short life expectancies, but a sizeable number of those persons entering nursing homes are quite healthy but simply lack the mobility to lead a normal life and have no where else to turn. The severity of this problem is compounded by the fact that are not a choice among alternatives, but are the only choice for many elderly. Furthermore, although not all nursing homes fit this stereotype, ninety-two percent of all nursing home beds are filled; so getting into a "good" nursing home may require putting one's name on a waiting list that is two years long- time that many elderly do not have (27). Thus, many elderly are put in the unenviable position of either caring for themselves in their declining years or of suffering the conditions of a nursing home.

Problem #4: Catastrophic Medical Costs

The newest and most threatening dilemma confronting the vast majority of people is a side-effect of medicine's brightest gains. Catastrophic health care costs have risen to the forefront of the health care debate in the late 1970's and early 1980's due in part to the great rate of technological advance in the medical field. As techniques and technologies were developed to treat formerly incurable ailments, the cost associated with these new operations rose commensurate with the level of sophistication involved. This process has continued to the point where the cost of certain medical services can literally bankrupt a family. For example, a Congressional Budget Office report established that nine percent of all U.S. families would sustain catastrophic health care expenditures in a given year (28). Before actually delving into the breadth of the catastrophic cost problem, however, it might first be helpful to define just what is meant by the term "catastrophic health care expenditures."

Catastrophic Expenditures Defined:

The most important distinction to be made is between catastrophic health care expenditures and high-cost health care expenditures. Whereas the term "high-cost" denotes a fixed if not arbitrary value, catastrophic expenditures

are defined by an individual's ability to pay. Therefore, expenditures exceeding fifteen percent of annual income, for example, may be considered catastrophic. The importance of this distinction can be seen when comparing the impact of a five hundred dollar medical bill on a family with a yearly gross income of five thousand dollars to its impact on a family with a fifty thousand dollar a year income. Quite clearly the former family will have a difficult time paying the bill while the other will have no problem whatsoever. Not surprisingly the aforementioned C.B.O. study observed that families with an income less than five thousand dollars had a twenty-eight percent chance of incurring catastrophic medical expenses, while only .2 percent of families with incomes exceeding twenty thousand dollars were likely to be victimized by such costs (29). (The study took into account the offsetting effect of public and private insurance policies. Nonetheless, the poor are not the only group at risk of being subjected to such expenses. Those people who earn moderate incomes but, for one reason or another, can't realistically afford comprehensive health insurance and those, regardless of income level, who fail to perceive the potential threat of catastrophic costs, are also in serious jeopardy of losing their lifes savings. Moreover, many

insurance policies discontinue coverage after a pre-determined maximum reimbursement has been exhausted. The diverse nature of those people at exposed to the potentiality of suffering catastrophic medical expenses makes the coordination of a national program to meet this problem all the more difficult.

Truly, the various definitions of catastrophic, depending upon what income group is being assessed, makes development of an all-encompassing plan nearly impossible. Private insurers could not be involved in a broad-based plan since the cost of insuring is inversely proportional to the insuree's income. More concretely, a poor family may find costs exceeding five hundred dollars catastrophic, necessitating higher premiums than for a family that could sustain substantially higher drains on its financial resources. Thus, since those who are least able to pay require the greatest coverage, insurers, barring government subsidization, would have no choice but to discriminate in issuing policies. Aside from obvious political pressures, the federal government would encounter serious administrative problems with a reimbursement system based on the fluctuating level of people's incomes. Moreover, considering the magnitude of some catastrophic medical costs, the government would fall into financing

difficulties unless it significantly increased the tax burden borne by the middle and upper income groups- a highly unpopular proposition. Thus, because "catastrophic medical costs" means different things to different people, creation of a non-exclusive plan is a goal not easily met.

Government Policy Options

After analyzing the four major problem areas of the health care field, it is now necessary to survey those policy options, both implemented and proposed, open to the federal government to combat these problems. In keeping with the structure of the introductory section, government policy options will be discussed as they apply to the four problem criteria. Therefore, under the heading of cost containment, government policies of Certificate-of-Need requirements, Prospective Reimbursement, and enforced competitive bidding will be highlighted. Second, a section will be devoted to the various legislative proposals at expanding Medicare and Medicaid coverage to include comprehensive long term care for the elderly. One of the most dynamic topics of the 1980's, medical care for the poor, will be discussed in the context of the Hill-Burton Act and the mandatory insurance program proposed by Senator Edward Kennedy of Massachusetts. Last, catastrophic health

care costs, an equally controversial topic, is presently being addressed by the proposed Stark-Waxman Bill.

Government Attempts at Cost Containment

One of the hottest health care issues of the 1970's was containing rapidly expanding health care costs. Although health care costs had been running at a higher rate than the general level of price increases, the severe inflation that characterized the economic climate of the 1970's made these medical expenditure increases even more unbearable. Unlike many other health care issues, government was well-suited to tackle cost containment because minimal revenue expenditures were needed to confront the problem. The two major policy tools that were used by the government Certificate-of-Need (CON) regulation and Prospective Reimbursement, have met with moderate success but contain some potentially serious disadvantages. A third alternative available to the government, one implemented only on a marginal scale, is to compel competitive bidding in health care provider service contracts. These three policies illustrate the three avenues open to government control; expenditure control, price regulation, and anti-monopolistic measures.

Certificate-of-Need Requirements

The Certificate-of-Need requirement originates from the National Health Planning and Resource Development Act of 1974. The National Health Planning Act (NHP) made federal health planning subsidies (Medicare and Medicaid funding) and certain other grants contingent upon a state's adoption of mandatory certificate-of-need review for capital expenditures exceeding $150,000 and for any increases in types of services offered or changes in bed capacity (30). The enactment of the NHP was in response to the inability of the hospitals to voluntarily restrain expenditures. Although a few states had drafted CON laws before 1974, the NHP gave impetus for all states, with exception of Alabama, to enact CON legislation by 1980.

The results of empirical studies done on the effectiveness of CON laws have been mixed. CON laws have been effective in slowing the growth of capital expenditures. Furthermore, state government agencies have been able to steer capital expenditures into those hospital programs deemed most useful to the population in general. On the other hand, however, CON laws have done little to slow the overall growth of medical expenditures. While state agencies have influenced some investment decisions, the great majority- ninety percent of expenditure requests-

were approved as submitted (31). Despite the fact that CON's are intended to restrict expansion of hospital capacity, they have done little to reduce the excess capacity that already exists. Moreover, to circumvent this restriction on capacity expansion, hospitals have countered by increasing the capital concentration per bed unit by investing in capital not restricted by CON regulations and by increasing covered capital investments in increments below the CON review floor. Thus, although CON laws have been effective in restricting some types of inefficient capital formation, they have not sufficiently stemmed capital leakages to prevent the continuing explosion of medical expenditures.

Prospective Reimbursement:

A second and more recent option tried by the federal government has been the introduction of Prospective Reimbursement. Whereas Certificate-of-Need laws attempt to control costs by restricting hospital expenditures, Prospective Reimbursement attacks the problem directly by regulating the price of medical services purchased by the government. As 42.4 percent of all health care expenditures are made by the public sector, the federal government possesses considerable bargaining power when negotiating with individual hospitals (32). Therefore, in

1984 Medicare changed the manner by which it reimbursed hospitals for medical services provided to its beneficiaries. Instead of accepting whatever charges that the hospital billed it, Medicare began dictating what rates it was willing to pay for various medical services. This policy was developed when Medicare authorities discovered that Medicare was paying medical fees that were varying by as much as five hundred percent for identical operations. Medicare officials created a system of reimbursement centered on diagnosis related groups. Each diagnosis related group (DRG) represents a collection of medical services considered of equal value based on the amount of time and sophistication involved. In all, Medicare has designated four hundred and sixty-eight DRG's that encompass nearly all services provided by hospitals. As Medicare is one of the single most important consumers of medical services, most hospitals have reluctantly accepted the tenants of Prospective Reimbursement.

Since being enacted, Prospective Reimbursement seems to be relatively successful in controlling "medical inflation." Even though not all the success can be credited to Prospective Reimbursement, in the two years following its enactment the growth rate of medical expenditures declined from 18.5 percent annually in 1983 to

5.5 percent annually in 1985 (33). Yet another statistic, a reduction in the average length of a hospital stay from 9.3 days in 1983 to 7.7 days in 985, is cited as ample evidence that padding of medical fees has been significantly reduced by Prospective Reimbursement (34).

Unfortunately, Prospective Reimbursement is not without its problems also. Most obvious is the fact that under different circumstances, the same operation may indeed vary in cost. For example, urban medical services are notorious for being more costly to provide because of the density nature of the hospital's location. Furthermore, it is only logical that some operations will develop complications while others proceed routinely- yet it is obvious that more service is delivered in the former instance than the latter. Clearly, by assigning pre-determined and sometimes arbitrary values to generic medical services, the system fails to accurately compensate the provider.

A second and related criticism of Prospective Reimbursement involves the incentives that pre-determined rates give to hospitals. There have been numerous complaints that unscrupulous hospitals release Medicare patients prematurely and in general provide substandard service in a discriminatory manner to Medicare patients

(35). The rationale is simple: by skimping on service to Medicare patients, the hospital retains more of DRG fee in the form of profits. Medicare has tried to combat this trend by forming Peer Review Organizations (PRO) to act as private "watchdogs", but discrimination against Medicare patients still remains a serious problem.

Coerced Competitive Bidding:

A third choice left available to government policy makers is to attempt to reduce the extent to which hospitals exercise monopoly power as suppliers of medical services. By coercing competitive bidding among providers to serve major insurers, policy makers would hope that the interaction of supply and demand could restrict price increases to more realistic levels. Thus such large firms as Blue Cross, Kaiser-Permantente, and state Medicaid agencies would have the advantage of negotiating aggressively with providers. Conversely, at present, most hospitals refuse to negotiate comprehensive rate schedules with private insurers. Although the federal government has never instituted such a program mandating good faith bargaining, states such as Arizona and California have approved such programs and met with surprising success(36). For such a program to be instituted on the federal level would require overcoming a substantial hospital lobby that

would put up a vehement battle. Whether a nationally based plan would be successful or not remains unanswered, but experience from many state programs is very encouraging as at least a partial solution to the problem.

Government Policy: Long Term Care for the Elderly

In contrast to the containment of health care expenditures, a policy issue readily addressed by regulatory devices, the dilemma of providing long term health care to the elderly seems a problem unamenable to government manipulation. While cost control could be approached via non-revenue depleting measures, long term health care provision would require large scale spending increases by government- a highly unpopular idea in the eyes of most U.S. Congressman. At the crux of the problem is the fact that few people, for whatever reason, make plans to provide for long term nursing and medical services needed in their old age.

Most indicative of this tendency is the fact that nearly three out of every four elderly persons believe that Medicare covers nursing home costs (37). Because of this widely held misconception, many elderly find themselves entering nursing homes without any way of meeting the average yearly price tag of $22,000 (38). Although the

phrase "long term health care" also includes in-house nursing, this type of care is not as problematic because for the most part it is financed by relatives and friends. When it does become problematic is when in-home nursing costs become too great a financial burden on the family and forces the elderly person into a nursing home. The two policy alternatives available to government administrators, therefore are; 1) provide government assistance to pay for elderly nursing home care, or 2) create incentives for friends and relatives of the elderly to provide in-home nursing care.

Medicaid: Spending Down

The first aforementioned alternative, that of financing nursing home care out of government revenues is the most often cited remedy, but also the most vehemently opposed. Under the present system, Medicare, the federally sponsored assistance program for the elderly, covers approximately only two percent of nursing home costs (39). Thus, the only alternative left to many elderly is to "spend down" in order to qualify for state Medicaid assistance which will cover most nursing home expenses. Unfortunately, however, state Medicaid programs require that eligible recipients have no more than on average $2,700 in liquid assets and allow the non-institutionalized

spouse only an average of $240 in income per month to live on (40). The travesty in this process is that not only must the institutionalized individual exhaust all his savings, but his spouse must adjust to living on less than three thousand dollars a year- hardly sufficient to provide the bare necessities.

Pepper Bill (HR 3436)

In order to address this short coming therefore, two major subsidization bills have been recently introduced. The first and most radical was proposed by U.S. Rep. Claude Pepper (D. Fla.). Pepper's bill (HR 3436) calls for expansion of Medicare benefits to provide comprehensive reimbursement for nursing home care and for in-home care. This bill which is presently being debated in the House, has met stiff opposition for two principal reasons. First, the actual cost of such a program is likely to cost twenty-four billion dollars over a five year span (41). The relative cost of such a program is staggering when considering that it benefits slightly more than one million of the twenty-seven million present Medicare beneficiaries (42). The second point of opposition derives from the fact that in order to finance this program taxes would have to be increased through an elimination of the present cap on income subject to the Medicare payroll tax.

Clearly, while Pepper's bill would solve the long term health care problem, it would do so at a cost that completely offsets any benefit.

Waxman-Schumer Bill (HR 1711)

A second proposal, the Waxman-Schumer bill (HR 1711), confronts the narrower problem of the impoverishment of the non-institutionalized spouse. Proponents of the bill feel that although it is not too much to ask the Medicare/Medicaid recipient to exhaust his funds in an effort to obtain long term health care, there is little justification in limiting the recipient's spouse to an income below the poverty level. The Waxman-Schumer bill, therefore proposes that the minimum needs allowance for the spouse be expanded from its present $240 per month to $925 per month. Furthermore, the bill would allow the spouse to retain one-half of the couple's remaining income if rent or mortgage minus utilities exceed one-third of this $925 needs allowance. Moreover, the spouse would also be able to keep up to twelve thousand dollars in liquid assets (43). Simply put the Waxman-Schumer bill is designed to relieve some financial burden from the spouse of a nursing home patient. (These benefits only apply to long term care, i.e. nursing homes, and are intended to compliment the Stark-Waxman bill which provides comprehensive Medicare

coverage for all medical expenses except long term care.) Although the Waxman-Schumer bill, which is presently before Congress, does help relieve some pressures of long term health care, it is only a first step and must be followed with more comprehensive reforms to completely deal with the problem. One problem with any future reforms of a comprehensive nature, however, is that they will require substantial funding; something that is unlikely to bode well with the present budget conscious Congress.

Government Incentives for In-Home Care

A second angle of attack for policy makers, one which has received little attention, is to provide tax incentives to those relatives and friends who finance home health care for the elderly. While one may feel that relatives have an obligation to support their elders in their old age, one must realize that these people are providing a positive externality by keeping the elderly off of the Medicaid rolls and therefore reducing costs borne by society. Few families, however, can afford the long run cost of providing twenty-four hour-a-day nursing services for an elderly relative. Because it is less expensive to provide this care at home than institutionally, it is societally desirable that a greater number of elderly are cared for at home. To correct this "externality" therefore, it is

necessary to give the home providers economic incentives to render more of this service to the elderly. By granting tax incentives to these families, the government can avoid actually increasing revenue expenditures while still providing adequate incentives. What remains to be seen is if the number of nursing home enrollees dependent on Medicaid can actually be cut and to what extent tax incentives must be granted to bring about the desired results. Truly, this proposal, while offering potential solutions to the problem, has many basic assumptions that remain to be proven.

Government Subsidized Health Care for the Poor

Undeniably the health care problem most urgently in need of improvement is the problem of providing medical services for the poor. While many elderly must endure great hardships to obtain long term health care, many of the poor have little or no access to health care. The Medicaid system, which is administered on the state level and funded by equal contributions from federal and state sources, is designed to aid the poor in obtaining health care. State Medicaid plans have relatively restrictive eligibility requirements. The most common eligibility criteria is that the potential recipient qualify for AFDC (Aid to Dependent Families with Children) benefits. To qualify for AFDC the

individual must be a member of a family that has an income that is classified as being below the poverty line. Furthermore, one-half of the states exclude two parent families from eligibility, while all states require that at least one parent be unemployed. Not only do these requirements exclude many families, but they also provide undesirable incentives to the poor. Not suprisingly, only fourty-five percent of those of those persons living below the poverty line actually receive Medicaid benefits. This compares to sixty-five percent of this group which received Medicaid benefits only a decade ago (44). Perhaps most responsible for this trend is the fact that while the actual poverty line has moved up as a result of inflation, few states have revised their statuatory poverty line to compensate for inflation. Thus, as a result of these restrictive policies, in 1988 there were thirty-seven million Americans who had no health insurance, public or private (45). To meet this crisis, the federal government has drafted three major pieces of legislation, the Hill-Burton Act, the "disproprtionate share" clause of the 1983 TEFRA amendment, and the recently proposed Kennedy bill.

Hill-Burton Act

The Hill-burton Act which dates back to 1946, has gone through many facelifts before arriving in its 1988 form.

The basic thrust of the Hill-Burton Act, as it stands today, is to require hospitals and other health care facilities to provide uncompensated health care to those persons unable to pay for them. Hill-Burton defines uncompensated services as "services made at no charge or at reduced charges" (46). Any health facilities that "received grants, or loans for construction, modernization, or equipment" from government sources are required to participate in Hill-Burton (47). What Hill-Burton does is to mandate that participating health facilities provide an annual amount of uncompensated services that is determined by the amount of federal aid that they received. Thus, a hospital must provide an annual amount of uncompensated services equal to the lesser of: 1) ten percent of federal assistance received, or 2) three percent of operating costs minus Medicare and Medicaid reimbursements. Furthermore, these services must be provided for twenty years following the completion of the financed project or until the loan is repaid, whichever is longer (48). Moreover, to insure that their quota for uncompensated service is met, hospitals must take active measures to notify eligible persons of its availability. Those persons that are eligible are defined as: 1) not being covered by a third party insurer or government program, 2) earning an income not more than

double the National Poverty Income guidelines, and 3) request services within the facility's allocation program (49). The design of the program, therefore, is government provision of subsidies to hospitals to insure that the poor are accorded some access to health care.

While Hill-Burton is successful in guaranteeing some health care for the poor, it falls short of arresting the indigent care problem because of two flaws. First, most hospitals have alternative sources of finance and can avoid Hill-Burton restrictions all together if they so choose. Although most hospitals do receive some form of government assistance, they can seek outside sources of capital to minimize their Hill-Burton obligation. Because of these outside sources, Hill-Burton has been unable to create the impact its draftees had envisioned. Second, Hill-Burton misfires because it has no mechanism to accurately control the amount of aid going to the poor. Rather, the hospitals control how much aid will be given to the poor. By choosing the amount of aid that they want to accept from the federal government, hospitals are in effect deciding how much aid will be given to the poor. Since Hill-Burton aid is arbitrary and bears little relation to the needs of the poor, it can not be used as an effective tool for meeting their medical needs. Thus, Hill-Burton is

successful as a stop-gap measure in guaranteeing limited access of the poor to health care but fall short of truly addressing the problem of opening health care access to the poor.

Disproportionate Share

A second measure enacted to lessen the plight of the poor was the "disproportionate share" clause of the 1983 TEFRA (Tax Equity and Fiscal Responsibility Act) act. It had long been argued that serving poor patients entailed significantly higher costs than for the average patient. This argument followed from the fact that on average poor patients arrive in worse physical condition because of their lower living standards and because they wait longer before seeking medical assistance due to their limited financial means. Therefore, the poor usually require more extensive treatment and take longer to recover from their illness. While serving a few welfare patients places no real burden on a hospital, enrolling a great number of them can drain the financial resources of a hospital. As a result, hospitals located in urban areas and which had patient bases consisting of greater than thirty percent welfare patients were suffering severe financial strains, some on the verge of closing. To relieve some of the burden, the federal government enacted

the "disproportionate share" clause which stated that any facility serving a disproportionate share of the welfare population was entitled to a higher reimbursement schedule to compensate for the added cost of serving a great number of welfare patients. Although many independent studies indicate that patient mixes exceeding twenty-five to thirty percent welfare patients inflict inordinate costs on the providing facility, the Department of Health and Human Services has been unable to develop a satisfactory definition of "disproportionate" and has therefore stalled the implementation of the clause (50). This provision does stand to improve the plight of the poor, but unless the Department of Health and Human services quits dragging its heels, the clause may never be effectively implemented.

Kennedy bill (S 1265)

The third and most promising reform put forth is the proposed Kennedy bill, drafted by Senator Edward Kennedy (D. Mass.). Of the thirty-seven million Americans without any form of health insurance in 1988, twenty-three million were employed or dependents of those in the workplace (51). Senator Kennedy's bill (S 1265) focuses on aiding the working poor by requiring employers to provide health insurance for all adult employees who work at least seventeen and one-half hours a week. Employees would be

required to pay at least eighty percent of the premium unless the worker earned less than one hundred and twenty-five percent of the poverty line, in which case the employer would be responsible for the entire premium. Furthermore, the health policy would have to cover at least eighty percent of all hospital expenses and would also have to have a catastrophic provision that limits out-of-pocket expenses to three thousand dollars a year (52). To increase the efficiency of the program , regional pools of small businesses would be created to purchase group plans and reduce administrative overhead costs. Clearly the effect of such a program would be to substantially and effectively reduce the number of uninsured Americans.

Like any policy proposal, however, Kennedy's bill is not without its negative aspects. The first and most obvious drawback of such a plan is its large price tag. The Congressional Budget Office estimates that such a plan will cost American business about 27.1 billion a year but offsets, including three billion in high-cost individual insurance policies that workers would drop as a result of this legislation, would reduce the net cost of the program to approximately fifteen billion dollars annually (53). A second complaint is that as a result of the added cost of health insurance, which would cost about fifty-two cents

per hour for a full time worker, nearly one hundred thousand jobs would be lost. Although the Congressional Budget Office estimates that most of the dislocated workers would eventually find work elsewhere, there is no doubt that this would greatly disrupt the economy. Moreover, this added cost to employers would at least partially be passed on to consumers in the form of higher retail prices, thus initiating potentially inflationary conditions. Lastly the bill would disproportionately fall on the shoulders of small business. While all U.S. firms with five hundred or more employees offer their some form of health insurance plan to their workers, only forty-two percent of those firms with nine or less employees provide insurance to their workers (54). Even though the bill calls for a gradual phase in period to alleviate some of the burden on the smaller businesses, opponents claim that such an added cost will cripple many small firms.

In analyzing the overall merit of the Kennedy bill, one must be left with a positive impression. First it seems quite capable of opening health care access to a large proportion of the population that is presently poor and uninsured. Secondly, it accomplishes its goal with minimal government administrative entanglement, and with minimal involvement of government revenues. There can be

little doubt that this plan will lay an added burden on the economy, but one cannot expect to provide health insurance for twenty-three million people without paying a substantial sum of money. Clearly, this bill comes closer to solving the health care problems of the poor than any other recently proposed alternatives; what is necessary is for Congress to become committed to solving this problem and to enact legislation such as that proposed by Senator Kennedy. At present, however, the economic recovery of the U.S. seems to be Congress's preoccupation and therefore the future of Senator Kennedy's bill looks dim.

Catastrophic Medical Costs

The last problem criteria set forth, catastrophic medical costs, is one which Congress, for the most part, has wholeheartedly refused to address. The reason that Congress has been so opposed to assuming responsibility for this problem is that Congress would most likely have to institute a national health insurance plan to fully abate the problem. There are several reasons why the idea of national health insurance is highly unpopular on Capitol Hill. First, the insurance lobby is an extremely effective lobby that could apply heavy pressure to defeat such a proposal. Second, although many studies have indicated

that Americans strongly favor a national health insurance program, eighty-three percent are covered by a private insurance policy and therefore are not likely to become actively involved in a push for such a reform (55). Lastly, but most importantly, financing a national health insurance plan, one comprehensive enough to cover catastrophic expenses, would require a substantial tax increase. In a time of severe government budget difficulties, Congress is unlikely to institute a tax hike simply to fund a national health insurance program. Instead of setting up such a comprehensive program, Congress has chosen to approach the problem on a significantly smaller scale, in an ad hoc manner. The result of this policy has been that legislators have chosen to provide aid to only those groups in most dire need of catastrophic health insurance, principally the poor and the elderly. Until recently there had been little Congressional action on the subject, but with the introduction of the Stark-Waxman bill (HR 2470), the scent of reform is once again in the air.

Medicare

Before explaining the changes posited by Stark-Waxman, it is first necessary to briefly explain how the present Medicare plan is designed. Medicare is divided into two

halves, Part A and Part B. Part A covers hospitalization and skilled nursing (not nursing home) expenses and is provided free of charge to all Medicare beneficiaries. Part B is optional and requires the payment of a small yearly premium. The services covered under Part B include reimbursement of eighty percent of all covered physician and outpatient charges after the beneficiary has met a seventy-five dollar deductible (56). The Stark-Waxman bill proposes changes that would greatly alter both sections of the Medicare program.

Stark-Waxman bill

Part A reforms include changes in coverage of both hospital inpatient services and skilled nursing services. Under present Part A guidelines, Medicare covers one hundred percent of the first sixty days of hospitalization except for a five hundred and twenty dollar deductible. After the first sixty days, the percentage of costs covered gradually declines until after one hundred and fifty days Medicare ceases coverage. Under Stark-Waxman, the beneficiary would only be required to pay an initial deductible and would then receive one hundred percent coverage of all inpatient services for 365 days a year (57). Moreover, under Part A, skilled nursing costs are covered for one hundred days with the beneficiary paying

approximately fifteen percent of the costs from day twenty until day one hundred and fifty, after which he must assume all of the costs. The proposed reforms would expand coverage to one hundred and fifty days and require the beneficiary to pay fifteen percent of the costs for the first ten days only.

Of the two major reforms to Part B of the Medicare plan, the proposal involving out-of-pocket costs is the most radical. Under current Medicare law, there is no limit to the amount of out-of-pocket expenses that the beneficiary must pay. Stark-Waxman would install a $2030 cap on covered Part B services. After the beneficiary had paid $2030 in out-of-pocket expenses for covered Part B services, Medicare would pay one hundred percent of all additional covered expenses (58). Secondly, while Medicare presently only covers eighty percent of costs of immunosuppressive drugs for organ transplant patients, Stark-Waxman would phase in over a five year period a measure that would cover eighty percent of all outpatient drug expenses after a six hundred dollar deductible was met.

Unlike many other health care reform bills, Stark-Waxman is considered to be "revenue-neutral." That is to say, Stark-Waxman would not add any financial strains to

the federal budget. It would be completely financed out of premium increases paid by Medicare beneficiaries. The House version of the bill would require an estimated forty percent of participants to pay a mandatory "supplemental premium" which would rise with income to a maximum of around $580 per year for 1988. The Part B premium would increase by twelve dollars a year, with an additional increase of about twenty-eight dollars per year for the drug benefits (59). The opponents of Stark-Waxman complain that there is no provision to cover long term health care, in particular, nursing home care. In response to this criticism the previously mentioned Pepper bill and Waxman-Schumer bill have been offered as compliments to Stark-Waxman. As it is, Stark-Waxman has passed both houses of Congress and is presently before a joint conference committee in an attempt to resolve the differences between each house's version of the bill. Stark-Waxman while not confronting the problem of catastrophic costs on a general basis, will provide protection from catastrophic costs for the nation's elderly- a first step down a long road.

Health Maintenance Organizations:

After examining some of the major policy options open

to the federal government, both proposed and practised, a look a those alternatives offered by the private sector will complete the spectrum of viable remedies to the U.S.'s health care woes. During the last twenty to thirty years, the greatest advances in health care organization have come from the private sector. Greatly slowed by government lethargy, the private sector has propelled its two major organizational innovations, the Health Maintenance Organization (HMO) and the Preferred Provider Organization (PPO), into the forefront of the health care debate. Although still foreign terms to many Americans, HMO's and PPO's have, since the late 1970's and continuing through the present, gained an increasingly large share of the health care market. Before moving on to a discussion of the past successes and future prospects of HMO's and PPO's, it is first necessary to define just what they are, and how they differ from each other.

HMO: Defined

The older of the two organizational forms and presently the most popular is the Health Maintenance Organization. The origins of the HMO date back to the Kaiser-Permantente Foundation created in 1946 (60). The Permantente Foundation was the successor to Kaiser industry's prepaid employee health care plan. Kaiser's

health plan had been so successful and had expanded to such a degree that in 1946 it was opened to the general public as the Permantente Foundation. Although it never gained a significant share of the insurance market, Kaiser-Permantente remained a relatively successful venture.

The basic organizational characteristics of an HMO are actually quite simple. The first important characteristic, and the one that sets HMO's apart from all other health care insurers, is that it is set up on a capitation system rather than a fee-for-service basis. More simply put, members of an HMO pay one yearly premium and all subsequent medical services are free of charge. Moreover, instead of being reimbursed on a per service basis, physicians are salaried relative to the number of patients that they serve.

An equally important characteristic of the HMO is the manner in which it negotiates with staff physicians to assure that the costs to the consumer are kept low while quality is preserved. The major problem with the existing health care market is that the suppliers, the hospitals and physicians, have monopoly power. With the emergence of large HMO's, however, health care providers can be made to bargain with consumers on an equal basis. Furthermore, HMO's have the time and resources to obtain information

regarding the prices and qualifications of the entire field of health care providers. This further enhances the position of the consumer, as few individuals have the resources to accurately discriminate among the various health care providers.

The last, but nonetheless the most critical, characteristic of an HMO is the manner in which management approaches policy objectives. As HMO's are for-profit institutions and must compete against rival HMO's for members, they have strong incentives to keep premiums at a minimum while maintaining a reputation for excellence in service. In order to perpetuate this balance, management gives physicians incentives to keep excess costs and unnecessary services to a minimum. Although this may at first seem as if management is cutting back on service, this not so. Doctor's are notorious for tacking unneeded services and hospital days on to a patient's bill so as to earn more money. Moreover, the HMO has sufficient incentives not to cut significantly into quality of care, the threat of a fall in membership coupled with numerous malpractice suits serves that purpose.

PPO: Defined

Preferred Provider Organizations are in many ways

similar to HMO's but differ on some important points. A more recent innovation, the first true PPO was developed in Colorado in 1980 (61). The PPO has risen as a viable alternative to not only traditional fee-for-service health care, but also to HMO's. There are five basic characteristics which distinguish PPO's from other institutions (62). First, every PPO has a provider panel of selected physicians and hospitals contracted to serve PPO members. The PPO searches for the most cost efficient providers and then negotiates strenuously to obtain the lowest rates for its members. Secondly, whereas HMO physicians are more strongly associated with the HMO organization, PPO physicians are unattached doctors who simply contract services to a given number of PPO members are therefore not truly part of the PPO organization. Moreover, PPO physicians are reimbursed on a fee-for-service payment system. This contrasts with HMO doctors who are in effect salaried employees of the HMO. Thirdly, PPO are not restricted to PPO providers in seeking medical services. If they choose, PPO members are free to solicit treatment from non-PPO physicians. However to encourage member use of PPO physicians, the PPO does create incentives toward that end. Thus, while all services provided by PPO doctors are completely covered, services

provided by non-PPO doctors are reimbursed only to the fee level that PPO doctors are paid. Therefore, if an outside provider charges fifty dollars for an office visit but the PPO providers have contracted that service for twenty-five dollars a visit, the member must pay twenty-five dollars out of his own pocket. The fourth characteristic, a characteristic shared by HMO's, is that of utilization review. More simply put, the PPO management reviews the services provided by its contracted physicians to ascertain if the virtues of efficiency were practised. If a doctor fails to minimize costs, he will be warned and eventually dropped from the provider panel if he fails to take heed. The last, and least significant characteristic of PPO's is the rapid pace at which they settle claims. Of concern probably only to doctors, the efficient manner in which most PPO's are organized allows for swift processing and billing. On the most basic level, PPO's are modified insurance companies which simply act as middle men in forming service contract between provider and patient. In contrast, an HMO can be described as a provider within itself as it employees doctors and actually acts to organize the health care product for use by the member.

Medi-Cal

Before moving on to discuss the applicability of the HMO

and PPO to the solution of the four previously stated health care dilemmas, it may beneficial to highlight the development and implementation of HMO's and PPO's in California which has been a leader in this field. Throughout the late 1970's and early 1980's, California suffered through a severe health care crisis. Medical costs rose at such an alarming rate that the lower income groups had a hard time paying their ever-increasing insurance premiums. Moreover these sky-rocketing costs were putting severe strains on the state Medicaid plan. Therefore, in 1982 California enacted legislation that enabled health care purchasers, such as private insurers and the state Medicaid plan, to negotiate contracts for the provision of health care to their respective beneficiaries (63). Thus as PPO's were allowed to negotiate with health care providers, new forces were brought to bear on the health care market. The two major implementors of this legislation were the PPO's and the state Medicaid plan, better known as Medi-Cal.

Perhaps most significant were the steps taken by Medi-Cal in revolutionizing government provision of health care. Medi-Cal approached its problems on two fronts: first it took advantage of the 1982 legislation and organized itself into one giant PPO. Secondly, it created incentives for

California based HMO's to actively recruit Medi-Cal eligible members to be sponsored by Medi-Cal itself.

By organizing itself into a "giant PPO", Medi-Cal transformed itself from a passive consumer into an active participant in the health care market. In contrast to the past, when Medi-Cal simply swallowed the inflated charges of hospitals and physicians, Medi-Cal, by virtue of of its large enrollment, could force medical care providers to do business on its terms. Not surprisingly, once Medi-Cal began its negotiations for medical care contracts, most hospitals succumbed to the need of Medi-Cal's patronage; by 1983 seventy-two percent of all California hospitals were participating in the contracting process and sixty-seven percent had been awarded contracts (63). The remarkable success of this program is illustrated in Medi-Cal's obtaining, on average, twelve percent discounts in 1984 over 1983 rates (64). Many critics charged that Medi-Cal's strategy would greatly reduce the quality of health care available to its patients but the initial results show otherwise. A study completed in 1985 found that due to the wide dispersion of Medi-Cal contracted providers, there was no measurable reduction in access to health care. Moreover, the actual quality of care available to Medi-Cal patients also remained stable (65). So what accounted for

the hospitals ability to cut fees by twelve percent ? Basically the twelve percent cut in fees was compensated for by efficiency measures such as increasing occupancy rates from a state average of sixty percent in 1983 to a more practical seventy percent in 1984 (66).

The second approach adopted by Medi-Cal, farming out Medicaid contracts to HMO's, is clearly the most revolutionary of the two tactics. What it did was to offer reater than normal premiums to HMO's to compensate for the greater costs associated with caring for the poor. The program was successful in that the proportion of eligible Medi-Cal patients actually receiving regular medical care significantly increased (67). Moreover, since Medi-Cal only had to pay the recipient's yearly premium, its administrative costs associated with processing medical bills were substantially reduced. The plan was not without its defects, however. Medi-Cal investigators found that the HMO's were selectively enrolling only the healthier Medi-Cal recipients, thus attempting to reduce costs associated with treating Medi-Cal patients. Furthermore, there a few documented cases of HMO's reducing services to Medi-Cal clients. These problems seem to have resulted from a lack of governmental oversight rather than an inherently flawed program.

Although the 1982 legislation provided the same incentives to private PPO's as it did to Medi-Cal, the private firms were less enthusiastic in negotiating contracts during the first year. The slowness with which the PPO's initially grew was most likely due to the provider's reluctance to accept the new arrangement. Whereas Medi-Cal comprised a large proportion of demand for health care, it possessed near monopsony power in negotiating with the various health care providers. Private PPO entry into the market was hindered because few PPO's had large enough memberships to either entice or intimidate physicians and hospitals into taking part in the plan. Despite these aforementioned barriers and those put up by consumers who were wary of PPO safeguards, PPO's eventually achieved success comparable to that enjoyed by the Medi-Cal program. After a PPO managed to win over a hospital or medical practice, the other providers soon fell in quick succession so as to avoid losing patients to more flexible competitors. In this manner, PPO's slowly "conquered" California, community by community. Thus, by 1985 Blue Cross PPO had contacted with nearly one hundred and fifty hospitals and nine thousand physicians while enlisting one million Californian members (68). Furthermore, as in the Medi-Cal study, the quality of the

medical service was demonstrated to be as high as it had been before the 1982 legislation had been enacted. Even more, PPO members were paying ten to twenty percent less in 1985 for medical services than they had in 1982, purchasing these services through the traditional avenue (69). Despite the potential for radical medical reform in California's health care base, that state, like all other states, is still troubled by deep-seeded flaws in its health care system. Is the HMO/PPO the salvation of our health care system or is it just a passing fad ? By analyzing the benefits that the HMO/PPO has to offer with regard to each of the previously mentioned health care problems, we will be able to determine in which areas and to what extent HMO/PPO's present a solution to our health care woes. (For brevity's sake "HMO/PPO" will be shortened to simply "HMO")

HMO's: Cost Containment

The first criteria by which the HMO is to be measured is that of cost containment. HMO's were designed with the primary goal of cost containment in mind, and therefore, as perhaps their most appropriate application, will be analyzed first.

Most obvious and most beneficial are the operational efficiency characteristics of the HMO. First and foremost

among these characteristics is the HMO's emphasis on cost-benefit analysis. HMO managers carefully review medical services provided by HMO physicians to insure that all costs are legitimate and not unnecessary use of medicine or equipment. HMO managers are not trying to deprive members access to the latest med-tech analysis, only trying to eliminate medical school habits of over-reliance on expensive diagnostic equipment without adequately judging its true necessity.

The second cost cutting advantage of HMO's is that by guaranteeing physicians and medical centers of a certain volume of patients, it enables both to cut down on excess capacity. Whereas physicians and especially hospitals were always faced with an uncertain demand curve- uncertain both in the quantity of service demanded and uncertain in the demographics of those demanding the service- HMO's allow health care providers to be more confident in the numbers and types of patients that they are likely to be treating. Moreover, while excess capacity and bed space were costs passed on to consumers to help "guarantee" hospitals the ability to meet unpredictable types and levels of demand, HMO's, by insuring hospitals of a given demand, allow hospitals to tailor their supply to more neatly fit the consumer's demand. Thus, HMO's act as "medical

wholesalers" trading patient volume for discounted medical fees.

A third and not unrelated feature of HMO's that augments their ability to restrict cost increases is the apparent economies of scale that derive to the medium and large HMO's. The traditional method by which rival hospitals would compete against one and another was through quality competition. Rather than using price incentives or advertisements to attract clients, they would attempt to develop specialized care facilities that were superior to their rival's. Such rivalry led to the overabundance of relatively little used equipment like radiology labs, chemotherapy units, and CAT scan machines. HMO's, by the simple fact that they link together networks of doctors and hospitals, can greatly reduce such economic waste. Thus, if an HMO network consists of two hospitals in a given city, there is no need for both facilities to duplicate specialized capital; rather one could concentrate in a designated field such as pre-natal care, while the other invests in an intensive coronary care unit. In this manner, both hospitals would maintain a satisfactory share of patients yet there would be less waste of medical resources. Even more, general practioners, via their affiliation to the HMO could share costly X-ray equipment

and lab facilities, and further reduce costs. Therefore, because of their large client membership and their ability to link physicians and facilities together into efficient networks, HMO's are able to generate higher returns on their capital investments.

Although as demonstrated, HMO's have many features that make them inherently more efficient than their traditional rivals, HMO's can actually improve the cost containment practices of their traditionally organized rivals. By introducing price competition into the health care market, HMO's can cause non-participating (non-HMO) providers to reform their fee structure without actually forcing them to merge with an HMO. The injection of price competition presents with three choices: sustain a significant decrease in patient volume, merge with an HMO, or reform their fee schedule so as to bring provider fees into line with the prevailing market rate. Despite the difficulties experienced by many hospitals and group practices in obtaining voluntary fee reductions, most hospitals have been able to adjust their rates to at least some extent. This reasoning is supported by the fact that although HMO's compose only ten to fifteen percent of the health are market, the rate of health care expenditure increases fell nationally by an average of twenty percent

from 1982 to 1985 as a result of national legislation that for the first time effectively gave incentives to HMO formation (70). Furthermore, California, a state with higher than average HMO concentration, witnessed a fifty percent decrease in medical expenditure inflation after the first year of its 1982 HMO legislation (71). Clearly, not only do HMO's have characteristics that make them more efficient than their rivals, but HMO's, because they inject price competition into the market, create a strong incentive for transitional providers to minimize costs.

Of course the cost containment criticism of HMO's is not without its critics. The first and most pronounced criticism of this policy is that Americans may well not want to reduce health care expenditures. Today's society may value health care at an increasing rate equal to the growth of health care costs. Undeniably, Americans are more health conscious today than ever before. Moreover, as new medical tests and services have been developed, Americans have welcomed their arrival. Although these assumptions may very well be true, however, it is still necessary to put these choices back into the consumers hands and not just to assume that the health care profession is capable of determining what the consumer wants. Thus, while it is easy to believe that Americans

place a high value on medical care, it is equally difficult to believe that they truly value it to such an extent that it should absorb in excess of ten percent of the GNP. The idea of cost containment therefore, is not to arbitrarily restrict health care expenditures, but to project cost-benefit analysis into the resource allocation process.

A second and more accurate complaint leveled against HMO's as vehicles of cost containment is that they aren't capable of restricting price increases on their own. This criticism is also a complaint voiced by HMO proponents who claim critics judge HMO's too harshly. The truth is that alone, HMO's are not yet numerous enough or powerful enough to single-handedly hold down expenditure increases. Even if they did compose a large share of the health care supply, it is doubtful that they would possess the power, both economic and political, to do so. The decision to slow medical expenditure increases must be made by the people and carried out in the form of consumer participation and government legislation; HMO's can only be one tool toward this end.

Yet another complaint leveled against HMO's, one with more serious ramifications, is the criticism that competition among HMO's could drive some firms to such financial straits as to necessitate significant reductions

in the quality of medical care provided. Critics fear that just as unrestricted price competition has reduced air travel to an adventure in survival, so too will it pose a threat to the health of potential patients. Although most HMO's have the foresight to realize that unnecessary risks reduced membership and costly malpractice suits, a few unethical HMO managers might be inclined to cut corners in order to earn short run profits. To prevent such occurrences, an effective monitoring agency should be developed following federal guidelines to foster uniformity but administered on the state level as such a project would most effectively be carried out by local agencies. These agencies could periodically inspect HMO's to insure that medical standards were not being sacrificed in favor of profits. Thus, even though it is probably safe to say that quality decline is not likely to be an industry-wide problem- as research evidence has proven- it may be necessary to create a regulatory agency, federally structured but locally administered, to assure that standards of quality are respected by all licensed HMO's.

HMO: Care for the Poor

Government involvement becomes even more important when evaluating HMO's on their ability to meet the second

of the four problem criteria, providing care for the poor. In this field, the HMO holds perhaps one of the brightest hopes. While one of this country's most lamentable problems, the health condition of the poor could be greatly improved if the HMO was utilized as the government tool for delivering health care to the poor. The advantages of the HMO stem from its ability to smoothly bring the poor into the health system used by the rest of the United States.

The first of these advantages is the ability of HMO's to bring eligible Medicaid recipients into the actual health care system. Although all Medicaid recipients are obviously eligible for government reimbursed health care, some percentage well over fifteen percent of the Medicaid population has no regular access to health care system (72). Given adequate incentives by the federal government, HMO's could greatly increase the participation of Medicaid recipients in the health care system. They could do so by utilizing the already well organized advertising departments to go out and seek Medicaid enrollees. On the local level, HMO's have vastly greater manpower resources to insure Medicaid participants have access to the medical system than does the federal or state governments. Thus in 1985, Congress amended the contents of the Tax Equity and Fiscal Responsibility Act of 1982 to provide incentives for

HMO's to enroll Medicare members. The incentives included government agreement to reimburse HMO's on a capitation basis and recognition that Medicare patients incur higher than average medical costs. The first incentive involved the government's willingness to reimburse HMO's on a capitation basis, a yearly premium arrangement, rather than on a per case method. It was inefficient for HMO's to operate a billing department simply to care for Medicare patients when all other patients were billed on a yearly premium basis. Moreover, by allowing HMO's a larger capitation rate for Medicare patients on an at-risk basis, the government made serving Medicare patients a profitable venture. (An at-risk basis is one in which the government gives the HMO a fixed amount of money to cover the patient's medical expenses; if the HMO spends more than that amount it loses money, if it spends less than that amount it can keep the difference in the form of profits.) Within a few years of its implementation, this act brought the Medicare enrollment in HMO's from four percent in 1982 to eleven and a half percent in 1985 (72). Although this act affected only the low income elderly, a similar plan could easily be enacted and implemented to drastically increase the Medicaid enrollment in HMO's. As for the millions of "working poor", HMO's could not act to help

these people unless state or federal officials pass legislation, such as the Kennedy bill, widening Medicaid coverage to include this group.

A second advantage of government enrollment of Medicaid patients would be to solve the problem of inequality in medical care. At present, a large percentage of the poor receive medical care in public clinics and hospital outpatient facilities while most of the rest of America receives medical care in physicians' offices. Not only is the second type of treatment more desirable, it is also of a higher quality. In the California case, Medi-Cal patients were enrolled in HMO's used by the rest of the population. No HMO's took on exclusively Medi-Cal patients, instead each participating HMO enrolled a mix of patients to create an optimal utilization of its facilities. Thus, by enlisting welfare recipients in HMO's, the government would in effect be merging the poor into a medical system shared equally by all. Not only would better medical care benefit the poor, but would also lead to a better overall level of health as the poor are ill-famed for spreading society's most dreaded diseases. Lastly, this level of medical equality for low income patients is unlikely to cost the taxpayer because HMO's are not only more efficient than most public clinics, but

recent evidence shows that overstatement of Medicaid and Medicare charges has cost government approximately two hundred million dollars a year (73).

Yet another advantage of HMO enrollment of welfare recipients derives from the fact that HMO's make easy tools for policy implementation. Whereas now there is no simple channel that government could utilize to quickly and effectively implement policy concerning Medicaid or Medicare patients, if all welfare patients were enrolled in HMO's the process could be greatly simplified and expedited. Because all HMO's must be licensed, they are easily identifiable and accessible to government policy. Moreover, as HMO's are tightly and efficiently organized, they could be readily utilized as an effective means of implementing policy goals without fear of objectives being lost in the bureaucratic quagmire that plagues many hospitals. Clearly then, HMO's could prove to be efficient vehicles of Medicaid policy by virtue of their easy accessibility and streamlined administrative structure. On a somewhat different angle, HMO service of welfare patients could well benefit the rest of society financially. As was previously discussed, all public and many private hospitals serve patients who are in dire need regardless of their ability to pay. As a result, these

hospitals must pick up the tab of various poor people who either aren't eligible for Medicaid or haven't been signed up. Furthermore, these hospitals discover that in numerous cases they lose money on Medicaid patients because their forms were either lost or never sent in to the government. These costs are not simply absorbed by the hospital, but are either passed on in the form of higher fees for paying customers, as is the case of private hospitals, or in the form of higher taxes, as is the case of public hospitals. By removing the poor from this unenviable position and actively enrolling them in HMO's, where their costs can be paid by the government rather than by other consumers, the burden of financing health care for the poor is at least shifted to the appropriate bearer. This distinction is important, for as long as care of the poor is subsidized by medical payments of the middle and upper income classes, it remains an externality and is therefore not receiving the attention or resources a problem of its nature truly requires for satisfactory resolution.

The problems associated with instituting a federally sponsored program of enrolling Medicaid/Medicare recipients are nonetheless several and potentially serious. The first problem involves the extra tax burden such a program is likely to cause. Although the per capita cost of providing

for welfare patients is not likely to rise significantly, such a program of encouraged enrollment is likely to increase the number of patients being sponsored by the government. Despite the fact that this added revenue burden is not a direct consequence of the proposed shift to HMO enrollment of the indigent, it still remains an obstacle to the development of such a plan. The gravity of the problem becomes more clear when one considers that state governments spend several hundred dollars for each Medicaid patient. To institute a program on the state or federal level that causes incentives such as the 1982 TEFRA legislation, could bring several million additional active participants in the Medicaid program. Not only will the aggressive recruitment tactics of HMO's result in additional Medicaid clients, but the promise of quality medical care will also draw some people that were not motivated to participate in Medicaid in the past. Undeniably, this is a question not of the potential effectiveness of HMO's in this function, but rather, whether or not the country is capable and willing to allocate substantially greater resources to the care of the indigent- a question that can only be answered by heated debate in the U.S. Congress.

Another obstacle likely to forestall speedy enactment

of indigent HMO legislation is the problem in guaranteeing the Medicaid patients are treated fairly and equitably by HMO's. Ideally all HMO's would treat their Medicaid clients like any paying-clients. However, Medi-Cal experience has illustrated that reality is often unrelated to theory. In the Medi-Cal experiment, HMO's tried to cut costs by only enrolling the healthiest Medi-Cal clients, provided levels of care that were substandard, and terminated patients that demonstrated sickly trends. The only solution to this problem, and the one eventually adopted by Medi-Cal, is to create a government oversight commission to monitor participating HMO's to insure good-faith execution of contractual obligations. In addition to this regulatory agency, an ombudsman could be appointed to open channels of communication for Medicaid patients to voice their complaints against the system. No matter what regulatory structure is employed, it is obvious that there is a need to protect the rights of the poor from those who would exploit them.

HMO's: Catastrophic Health Care Costs

A third dilemma plaguing the health care system is the phenomena of catastrophic health care costs. As mentioned earlier, catastrophic health care costs are not defined by

some fixed dollar value, but are variable and relative to a person's income or ability to pay. Thus, for example, medical expenses exceeding twenty percent of income might be considered might be considered to inflict "catastrophic" expenditures on his/her financial resources. By this measure, HMO's are among a choice of alternatives proposed to alleviate the problem. The ideal solution is to develop an insurance plan that has a very low deductible and covers almost all medical costs. Many traditional comprehensive insurances policies strive toward this ideal. The HMO might be the best solution available, however, as it has many exclusive features that enable it to react most efficiently to potentially expensive operations. From the consumer's standpoint, once the yearly premium is paid, all medical services are free of charge with the exception of very minimal charges for prescription medicine. This very low patient charge threshold is very attractive in that it guarantees that no one will suffer potentially severe financial problems as a result of medical bills. Secondly, while even the most comprehensive insurance plans pay out only a maximum reimbursement value, HMO coverage is based on time not money. Furthermore, there are some operations that are so rare and expensive that most insurance programs will not cover them. Therefore, there may be some

operations that are so costly that they become potentially catastrophic regardless of the conventional insurance policy held. From an HMO standpoint, one can see how HMO's are able to provide this "unconditional" health coverage. Because HMO's have a large membership base and because they collect annual premiums rather than per service payments, they must allocate funds to provide their doctors and individual must be a member of a family that has an income that is classified as being below the poverty line. Furthermore, one-half of the states exclude two parent families from eligibility, while all states require that at least one parent be unemployed. Not only do these requirements exclude many families, but they also provide hospitals with resources to meet all the needs, both the normal and the extreme, that an average population is expected to develop over a year. Moreover, as all employees of the HMO, including the physicians are salaried rather than being paid on a fee-for-service basis, it costs the HMO the same regardless of what operations its surgeons perform. Thus, as far as the HMO is concerned, the patients medical costs are taken care of once the yearly fee has been paid. The distinction between HMO's and comprehensive insurance plans, therefore, rests on the fact that HMO's have direct control over the medical resources

needed for service while the private insurer must contract out for these services on a fee-for-service basis. (In this aspect, HMO's are superior to PPO's because PPO's contract for physicians services in a manner not unlike that of private insurers.) In summation, because of tneir organizational innovations, HMO's are perhaps best suited to reduce the threat of financially catastrophic medical care costs.

The role of HMO's in restricting financially catastrophic medical is not without limitation, however. The first and most apparent barrier is the yearly premium. For many, the HMO premium is paid by their employer as fringe benefit, but for the poor a yearly premium of several hundred to a few thousand dollars may be prohibitive indeed. Unfortunately, the nature of the HMO requires that all member pay a fixed fee that will support the HMO in its yearly operations. Once again however, the flaw is not necessarily of the HMO's making, rather it is one that could readily be cured if state and local government acted to subsidize the poor in their endeavor of seeking financial security from medical costs. Until such actions are taken, however, the HMO premium may act as a barrier preventing the lowest income classes from obtaining protection from financially catastrophic medical

expenditures.

HMO's: Long Term Health Care for the Elderly

The last problem criteria, long term health care, is a topic just being explored by the HMO field. As previously argued, the present system of long term health care, principally Medicaid reimbursement of nursing home care, is undesirable both from the standpoint of the recipient's "spending down" to qualify for Medicaid and from the standpoint of the poor and sometimes unhealthy conditions found in too many nursing homes. An alternative system, one not fully developed yet, could be the Social HMO. Technically, the Social HMO "is a managed system of health and long term care services. Under this model a single provider entity assumes responsibility for a full range of personal care services under a fixed premium that is prospectively determined." (74). The Social HMO has the advantage that it coordinates all the health services needed by the member. Thus, the S/HMO will either provide or arrange the provision of any health care service needed. Moreover, the S/HMO, because it can effectively "pool" the risk of a great number of members, can hold down costs. Therefore, the premiums are estimated to range from five thousand to twelve thousand dollars a year.

There are several flaws in S/HMO's that reduce their potential feasibility. Most importantly, the four experimental S/HMO's presently offer limited services. Although they all guarantee the provision of all health services, many services, such as nursing home care must be paid for by the member. As there are presently only four experimental S/HMO's under government supervision (based in Portland, Oregon; Brooklyn, New York; Minneapolis, Minnesota; and Long Beach, California), it is difficult to gauge how serious this problem is. Secondly, S/HMO's do not resolve the problem of financing care before retirement. More clearly, S/HMO's require a yearly premium but many elderly, believing that Medicare covers long term care, fail to save sufficient funds to pay for such premiums. What is needed, therefore, is a system by which people can pay for long term care far in advance of old age. Lastly, as S/HMO's are community-based, there is no way for a member to take benefits with him if he decides to move to another part of the country.

Although there are several serious problems with S/HMO's, it is too early to make a decision regarding their relative benefits. The four government sponsored S/HMO's, the only existing S/HMO's, were created in 1986 and are guaranteed sponsorship until 1991. No studies have been

done on their potential feasibility; the first expected to be completed in 1990 (75). Thus, despite several potential flaws, S/HMO's do offer hope that an effective alternative to the present long term health care system may soon be developed.

Conclusion

In summation, it can be seen that while HMO's are not a cure-all solution to America's health care problems, they can be used as a tool of government policy for more effectively achieving its goals. In the realm of cost containment, HMO's have proven their organizational structure gives great incentives for efficient operation. Government promotion of HMO's as the preferred mode of health care delivery would be at least as successful at holding down costs as Certificate-of-Need requirements and Prospective Reimbursement. Furthermore, the ability of HMO's to "pool" risk of a given population group and to provide comprehensive health care ideally suites them to caring for the Medicare and Medicaid populations. The present system of caring for the poor and the elderly is an ad hoc mish-mash, split between federal and state agencies, which fails miserably to provide any uniformity in policy implementation. By utilizing HMO's as units for providing

health care, government could more easily control policy implementation and uniformity. Lastly, long term health care is a puzzle which at the present time neither the public or private sectors seems capable of solving. Nursing home care financed by Medicaid is a scary proposition, while Social HMO's remain a big question mark. It is clear that HMO's will play a role in the future; to what extent and how effectively they will be integrated into government policy depend on Congress's commitment to solving America's health care woes and its willingness to use new and innovative tools in implementing that policy.

Endnotes

1. National Health Care Expenditure Study, "Usual Sources of Health care." pg. 2

2. Weaver, pg. 23

3. Luft, pg. 81

4. Jones, pg. 6

5. Davis, pg. 87

6. National Health Care Expenditure Study, "Usual Sources of Health care." pg. 2

7. Ibid

8. Davis, pg. 137

9. Davis, pg. 138

10. Luft, pg. 35

11. Weaver, pg. 16

12. United States. Finance Committee. Economic Problems Facing Hospitals Serving the Poor. pg. 6

13. Ibid pg. 84

14. Ibid pg. 12

15. United States. Labor and Human Resources. Health Care Cost Containment Strategies. pg. 11

16. United States. Labor and Human Resources. Health Care Cost Containment Strategies. pg. 11

17. Inquiry, Winter 1983, pg. 4

18. Ibid pg.6

19. United States. Labor and Human Resources. Health Care Cost Containment Strategies. pg. 16

20. Moss, pg. 9

21. Ibid pg. 8

22. United States. Department of Health and Human Services. Long Term Health Care Policies. Washington: GPO, 1987.
pg. 9

23. Inquiry, Winter 1986, pg. 391

24. Inquiry, Spring 1985, pg. 7

25. Moss, pg. 24-31

26. Ibid

27. Ibid pg. 55

28. Inquiry, Winter 1986, pg. 383

29. Ibid pg. 385

30. Christianson, pg. 41

31. Ibid pg. 62

32. Ibid pg. 21

33. CQ, "Congress Takes Ball and Runs After State of the Union Punt." pg. 206

34. Ibid pg 207

35. Ibid

36. Christianson, pg. 65

37. CQ, "Congress Takes Ball and Runs After State of the Union Punt." pg. 207

38. Ibid

39. Ibid

40. CQ, "New Bid Made to Expand Medicaid Eligibility." pg. 571

41. CQ, "Catastrophic Costs Conference Irked by Lobbying Assault." pg. 780

42. CQ, "Catastrophic Costs Conference Irked by Lobbying Assault." pg. 777

43. CQ, "New Bid Made to Expand Medicaid Eligibility." pg. 571

44. Inquiry, Winter 1986, pg. 385

45. CQ, "Senate Labor OK's Mandated-Benefits Measure." pg. 363

46. Provider Guide ..., pg. 1
47. Ibid

48. Ibid pg.4

49. Ibid

50. United States. Finance Committee. Economic Problems Facing Hospitals Serving the Poor, pg. 14

51. CQ, "Senate Labor OK's Mandated-Benefits Measure." pg. 363

52. CQ, "House Panel Approves Catastophic Care Plan." pg. 917

53. CQ, "Senate Labor OK's Mandated-Benefits Measure." pg. 363

54. Ibid pg. 367

55. Ibid pg. 363

56. CQ, "Major Provisions of Catastrophic-Insurance Bill." pg. 1640

57. Ibid

58. Ibid

59. CQ, "House Panel Approves Catastophic Care Plan." pg. 918

60. Falkson, pg. 19

61. Inquiry, Summer 1985, pg. 331

62. Inquiry, Spring 1986, pg. 7-8

63. Inquiry, Spring 1985, pg. 25

64. Inquiry, Winter 1986, pg. 421

65. Ibid

66. Ibid pg. 422

67. United States. Department of Health and Human Services. Private Sector Iniatives. pg. 12

68. Inquiry, Spring 1985, pg. 27

69. Inquiry, Spring 1985, pg. 28

70. Inquiry, Winter 1985, pg. 29

71. Inquiry, Winter 1985, pg. 27

72. National Health Care Expenditures Study. "Usual Sources of Health Care and Their Characteristics." pg. 3

73. New York Times February 11, 1988, pg.1

74. United States. Department of Health and Human Services. Long Term Health Care Policies. pg. 26

75. Ibid pg. 15

References

Banta, David H. Resources for Health. New York, NY: Praeger. 1982.

Blue Cross and Blue Shield Association. Inquiry. v. 20. Chicago IL. 1983.

Blue Cross and Blue Shield Association. Inquiry. v. 22. Chicago IL. 1985.

Blue Cross and Blue Shield Association. Inquiry. v. 23. Chicago IL. 1986.

Blumenstein, James F. Uncompensated Hospital Care. Baltimore, MD: Johns Hopkins University. 1986

Christianson, Jon B. Current Strategies for Containing Health Care Expenditures. Jaimamca, NY: Spectrum Publications. 1985.

"Bill Would Make Employers Provide Insurance." Congressional Quarterly. May 23, 1987. pg. 1081-1082.

"Catastrophic Costs Conference Irked by Lobbying Assault." Congressional Quarterly. Mar. 26, 1987. pg. 777-780.

"Congress Takes Ball and Runs After State of the Union Punt." Congressional Quarterly. Jan. 31, 1987. pg. 206-208.

"House Panel Adds Drug Benefit to Catastrophic Insurance Bill." Congressional Quarterly. June 13, 1987. pg. 1263-1264.

"House Panel Approves Catastophic Care Plan." Congressional Quarterly. May 9, 1987. pg. 915-919.

"Kennedy Off and Running with Liberal Agenda." Congressional Quarterly. Jan. 17, 1987. pg. 117-119.

"Major Provisions of Catastrophic-Insurance Bill." Congressional Quarterly. July 25, 1987. pg. 1640-1642

"New Bid Made to Expand Medicaid Eligibility." Congressional Quarterly. March 28, 1987. pg. 571-572.

"Senate Labor OK's Mandated-Benefits Measure." Congressional Quarterly. Feb. 20, 1988. pg. 363-365

"Two Panels Add Drug Coverage to Medicare." Congressional Quarterly. June 20, 1987. pg. 1327-1328.

Davis, Edith M. Health Care for the Urban Poor. Totowa, NJ. Rowman and Allenheld. 1983.

Falkson, Joesph L. HMO's and the Politics of Health System Reform. Chicago, IL: American Hospital Association. 1980.

Havinghurst, Clark C. Regulating Health Facilities Construction. Washington: American Enterprise Institute for Policy Studies. 1974.

Luft, Harold S. Poverty and Health. Cambridge, MS: Ballinger. 1978.

Moss, Frank E. Too Old. Too Sick. Too Bad. Germantown, Maryland: Aspen Systems Corp. 1977.

Pear, Robert. "Hospitals Linked to Discrepencies in Medicare Pay." New York Times February 11, 1988, pg.1

Rabin, David L. Long Term Care for the Elderly. Oxford, England: Oxford University Press. 1987

Rice, Mitchell F. Black American Health. New York, NY: Greenwood Press. 1987.

United States. House Select Committee on Aging. Catastrophic Costs: Broad Problem Demanding Equally Broad Solution. Washington: GPO, 1971

United States. Finance Committee. Economic Problems Facing Hospitals Serving the Poor. Washington: GPO, 1986

United States. National Academy of Sciences. For-Profit Enterprise in Health Care. Washington: National Academy Press. 1986.

United States. Finance Committee. Health Care for the Economically Disadvantaged. Washington: GPO, 1984.

United States. Labor and Human Resources. Health Care Cost Containment Strategies. Washington: GPO, 1985.

United States. Judiciary Committee. High Cost of Hospitalization. Washington: GPO, 1971

United States. Department of Health and Human Services. Long Term Health Care Policies. Washington: GPO, 1987.

United States. Department of Health and Human Services. National Health Care Expenditures Study. "Private Health Insurance Coverage of the Medicare Population." Washington: GPO, 1984.

United States. Department of Health and Human Services. National Health Care Expenditures Study. "Usual Sources of Health Care and Their Characteristics." Washington: GPO, 1982.

United States. Department of Health and Human Services. Private Sector Iniatives. Washington: GPO, 1984.

United States. Department of Health and Human Services. Provider's Guide to Hill-Burton Uncompensated Services Regulations. Washington: GPO, 1988.

Weaver, Jerry F. National Health Policy and the Underserved. St. Louis: C.V. Mosby. 1976.