

# PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS AND HEALTH MAINTENANCE ORGANIZATIONS: ARE THEY COMPATIBLE?†

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Health maintenance organizations (HMOs)<sup>1</sup> have demonstrated an ability to provide comprehensive health care of satisfactory quality at a cost significantly below that of providing similar care through the predominant "fee-for-service" system.<sup>2</sup> HMOs' success in this regard flows largely from their contractual undertaking with enrollees to provide comprehensive care in return for a fixed, prepaid premium. This commitment induces a level of cost-consciousness in the organization that is not matched in the fee-for-service sector, where services are paid for individually, in large part by health insurers or by government rather than by patients themselves. In general, HMOs have achieved their cost savings by departing from traditional resource utilization patterns in medical care, de-emphasizing acute care rendered in hospitals in favor of early treatment and ambulatory care. Amidst growing concern about the accessibility, quality, and rising cost of health care, the HMO concept has received much attention,<sup>3</sup> including a measure of congressional blessing in the Health Maintenance Organization Act of 1973.<sup>4</sup>

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1. See text accompanying notes 8-9 *infra*.

2. M. ROEMER, R. HETHERINGTON, C. HOPKINS, A. GERST, E. PARSONS & D. LONG, *HEALTH INSURANCE EFFECTS: SERVICES, EXPENDITURES, AND ATTITUDES UNDER THREE TYPES OF PLANS* 43-49 (1972); Donabedian, *An Evaluation of Prepaid Group Practice*, 6 *INQUIRY* 3, 16-17 (1969). *But see* note 30 *infra*, on how HMOs may be, or appear to be, a higher-cost alternative. Although doubts are still occasionally expressed as to the substantiality of HMOs' actual cost savings, the desirability of HMOs does not depend solely on empirical proof that existing plans are uniformly cheaper. Existing HMOs may offer qualitative benefits which make them a better buy at the same price. Or their cost-saving potential may not have been fully exploited because of professional conservatism, weak competitive pressures, poor management, or other factors. HMOs' incentive to conserve resources, together with evidence of their generally satisfactory performance, warrants conferring on them a degree of freedom which they have not yet been given.

3. See, e.g., Nixon, *National Health Strategy*, 7 *WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS* 244 (1971) (Message to Congress, Feb. 18, 1971), reprinted as *Health Message from the President of the United States*, H.R. Doc. No. 49, 92d Cong., 1st Sess. (1971). See also HEALTH SERVICES ADMINISTRATION, U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, *SELECTED ANNOTATED BIBLIOGRAPHY ON HEALTH MAINTENANCE ORGANIZATIONS AND ORGANIZED HEALTH CARE SYSTEMS* (1973).

4. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300 *et seq.* (Supp. III, 1973).

Attractive as they seem to be in theory, HMOs have had many problems in getting started or surviving in the marketplace.<sup>5</sup> Now, a new potential problem for HMOs has appeared in the form of Professional Standards Review Organizations (PSROs), recently conceived by Congress<sup>6</sup> in an attempt to stem the rising cost of federal health care programs. PSROs are representative groups of local physicians charged with reviewing the necessity for and quality of health services provided to federal beneficiaries in their areas. Their regulatory jurisdiction, initially limited to institutional care under federal programs, is potentially all-encompassing, and the sanctions available to back their judgments already seem sufficient to make a substantial impact on medical practice.

Although PSROs and HMOs will probably agree on the need to prevent over-utilization of expensive institutional services, conflict can be expected over what constitutes "quality," where and how services should be delivered, and when a comparison of costs with possible benefits may justify omission of particular tests or procedures. Moreover, PSRO standards can be expected principally to reflect the dominant fee-for-service practice rather than patterns developed in HMOs. Further, the PSRO statute and implementing guidelines give PSROs wide discretion in setting and enforcing standards, thus creating a potential for inadvertent or intentional interference with the internal affairs and priorities of HMOs and impairment of HMOs' efficiency and competitive effectiveness.

It would be unfortunate, and a bit ironic, if HMOs and PSROs, both giving promise of improving the functioning of the health services industry and lowering health care costs, should prove seriously incompatible. This article considers the probable interactions between PSROs and HMOs and the implications of these interactions for health policy<sup>7</sup> and concludes that PSROs will indeed impair HMOs' capacity to innovate and control costs, thus precluding HMOs from providing a needed stimulus for better performance by the fee-for-service sector and by PSROs themselves. This expectation rests on concerns more fundamental than on a simple fear that PSRO doctors will actively conspire against HMOs, although that is a possibility.

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5. See generally INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCES, HMOs: TOWARD A FAIR MARKET TEST 19-49 (1974) (policy statement); Rhein, *HMOs: Threat or Opportunity?*, 16 MED. WORLD NEWS 53 (Jan. 27, 1974); Holly & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644 (1972); Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971).

6. Social Security Amendments of 1972, 42 U.S.C. §§ 1320c *et seq.* (Supp. III, 1973).

7. Any reevaluation of relations between PSROs and HMOs drawing upon this article's analysis would be timely. Regulations under the PSRO law have not yet been issued, and the chapter on HMOs in the quasi-regulatory *PSRO Manual* now being used has not yet been written. See notes 39, 48, & 53 *infra*.

## I. HMOs AND HEALTH POLICY

A. *Ways of Thinking About HMOs*

The term "health maintenance organization" is a new name<sup>8</sup> for an old concept—the provision of comprehensive health care by one organization to a defined population for a fixed per capita price paid in advance.<sup>9</sup> HMOs can take many forms, but all share the essential, prepayment-induced incentive to economize by keeping subscribers healthy, curing them quickly, and using medical resources efficiently. As used herein, however, the term "HMO" excludes the so-called "foundations for medical care,"<sup>10</sup> as well as most plans under the HMO Act of 1973 which

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8. The term was coined and popularized by Dr. Paul M. Ellwood, Jr. See P. ELLWOOD, N. ANDERSON, J. BILLINGS, R. CARLSON, E. HAAGBERG & A. MCCLURE, *THE HEALTH MAINTENANCE STRATEGY* (1970), reprinted in 9 *MEDICAL CARE* 291 (1971) and 118 *CONG. REC.* 32,458 (1972). First the Nixon administration and later others adopted it for use in legislative proposals.

9. This article concentrates on HMOs which receive prepayment under the Medicare and Medicaid programs even though surprisingly little care now rendered by HMOs under these programs—and therefore subject to PSRO scrutiny—is in fact prepaid. Where HMOs serve federal beneficiaries, payment is frequently on a cost-reimbursement basis. Although the 1972 Social Security Amendments provided for prospective payments to qualified HMOs under the Medicare program, 42 U.S.C. § 1395mm (Supp. III, 1973); 2 *CCH MEDICARE & MEDICAID GUIDE* ¶¶ 13,945-80, 24,483 (1974) the restrictions imposed on HMOs participating in this way have discouraged nearly all HMOs from electing to accept federal prepayment. See McNeil & Schlenker, *HMOs, Competition, and Government*, 53 *MILBANK MEM. FUND Q.* 195, 213 (1975); Vohs, Anderson & Straus, *Critical Issues in HMO Strategy*, 286 *NEW ENG. J. MED.* 1082 (1972) (a prospective assessment of the then-pending legislation). The same legislation also permitted states to waive "statewide" and "comparability" requirements that had previously impeded their contracting for prepaid Medicaid services, 42 U.S.C. §§ 1396(a)(10), (23) (Supp. III, 1973); 2 *CCH MEDICARE & MEDICAID GUIDE* ¶ 14,515 (1974), and a number of states have begun to encourage HMOs to enroll Medicaid beneficiaries for a fixed fee paid by the state. See, e.g., Hester & Sussman, *Medicaid Prepayment: Concept and Implementation*, 52 *MILBANK MEM. FUND Q.* 415 (1974); Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, *Nw. U.L. Rev.* 90 (1975).

Less than half of all HMOs now serve federal beneficiaries. *HEALTH SERVICES INFORMATION 3* (InterStudy, Oct. 21, 1974). Only very recently, however, have such beneficiaries constituted a notable proportion of HMOs' membership. They now average about 15 percent of HMO enrollment, but half of these individuals are concentrated in eight plans which do not meet all the criteria of being an HMO. R. WETHERVILLE & J. NORDBY, *A CENSUS OF HMOs 8-9* (InterStudy, April, 1975). Moreover, it is not clear that all such care is in fact prepaid. McNeil & Schlenker, *supra*.

HMOs which are not prepaid for federal purposes will not face exactly the same potential conflicts with PSROs that prepaid HMOs can expect. Our concentration on the problems of prepaid HMOs reflects our belief that the other form of paying an HMO is anomalous and that only prepaid HMOs face the necessity and have the efficiency incentives to allocate medical resources which are central to HMOs' claims of superiority over fee-for-service care. In addition, we look ahead to national health insurance, under which HMOs will almost certainly be prepaid for all services.

10. "FMCs" are medical-society-sponsored plans designed to control utilization and costs more effectively than have Blue Shield plans, which they otherwise resemble. See C. STEINWALD, *AN INTRODUCTION TO FOUNDATIONS FOR MEDICAL CARE* (1971); Egdahl,

provide services through "individual practice associations,"<sup>11</sup> on the ground that those prepayment plans which are sponsored by local medical societies have substantially different implications from plans which are independently organized.<sup>12</sup>

Many observers believe that HMOs, if allowed to become an alternative available to most Americans, would contribute materially to the solution of the health care system's problems.<sup>13</sup> Supporters of the con-

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*Foundations for Medical Care*, 288 N. ENG. J. MED. 491 (1973); Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716, 769-77 (1970); Sasuly & Hopkins, *A Medical Society-Sponsored Comprehensive Medical Care Plan*, 5 MED. CARE 234 (1967). Some FMCs are legally committed to provide care on a prepaid basis and accept a real financial risk, not confining themselves simply to reviewing claims for health insurers. These FMCs share the HMO's incentive to economize and, indeed, have been called "HMOs without walls." Moreover, they can qualify as HMOs (providing services through an "individual practice association") under the HMO Act of 1973. 42 U.S.C.A. § 300e-1(5) (Supp. 1974).

Risk-bearing FMCs differ from HMOs in important respects, however. They are loosely organized and are therefore unlikely to achieve the advantages of the HMO model which flow from integration of services. Moreover, they may also differ fundamentally from HMOs in the strength of their incentive to control costs. Whereas HMOs are compelled to keep their enrollment fees competitive with health insurance premiums covering fee-for-service care, the local doctors sponsoring the FMC participate in fee-for-service practice generally and treat patients who are not FMC-plan members. They therefore may have no substantial stake in keeping premiums low to insure the FMC's success or growth at the expense of other insurance plans. Such a stake would arise only (1) if local doctors faced actual or potential competition from independent HMOs, which in turn would stimulate them to take collective action to keep down the cost of health insurance, or (2) if the FMC served, perhaps as a token of the profession's good faith, to forestall governmental efforts to deal with cost problems.

Far from resembling an HMO, the FMC which is primarily engaged in reviewing claims and which faces neither financial risk nor competitive challenge closely resembles a PSRO. Indeed, PSROs were modeled after FMCs. See, e.g., 116 CONG. REC. 29,603 (1970) (remarks of Senator Bennett). One important difference between such FMCs and PSROs is that PSROs' statutory power to regulate HMOs reduces the chances that HMOs will supply the kind of competitive stimulus to PSROs' effective cost and quality control which HMOs have on occasion given to FMCs. See Havighurst, *Speculations on the Market's Future in Health Care*, in REGULATING HEALTH FACILITIES CONSTRUCTION 249, 257-63 (C. Havighurst ed. 1974); Sasuly & Hopkins, *supra*.

11. 42 U.S.C.A. § 300e-1(5) (Supp. 1974); 42 C.F.R. § 110.101(j) (1974). "IPAs" are loosely organized physician organizations which pay doctors on a fee-for-service basis while imposing some controls on utilization and claims. Although foundations for medical care are the prototypical IPA-type plans, IPAs could be operated independently of local medical societies, perhaps by a health insurer. See note 10 *supra*.

12. The principal difference is their significantly weaker efficiency incentives, especially where, as is common, a medical society sponsored FMC or IPA has enrolled nearly all doctors in a region and there are no independent HMOs. See note 10 *supra*. Such groups cannot be expected to be or long remain innovative and cost-reducing; indeed, one may expect them to be quite conservative in serving the interests of fee-for-service medicine.

13. See, S. REP. NO. 93-129, 93d Cong., 1st Sess. (1973); *Hearings on S. 3, S. 191, S. 836, S. 987, S. 1376, S. 1490, S. 1598, & S. 1623 Before the Senate Comm. on Finance*, 92d Cong., 1st Sess., 229-50 (April 26-28, 1971) (testimony of H.F. Newman); P. ELLWOOD,

cept admire HMOs for their ability to provide a locus of responsibility for the subscriber's health, an accessible point of entry into the system, comprehensive coverage of a wide range of health needs, and a setting potentially conducive to good-quality care,<sup>14</sup> as well as for their cost-conscious emphasis on preventive care, patient education, early detection of disease, and appropriate use of paramedical personnel. Such HMO virtues result not only from the efficiency incentives of a fixed budget, but also from organizing the delivery of care so as to integrate disparate types of facilities, personnel, and services and to achieve available economies of scale.

Although HMOs' qualitative and economic virtues are supported by the experience of a number of prototypical HMOs,<sup>15</sup> proponents have been accused of overselling the concept. In particular, they are said to exaggerate both the availability of economies of scale in the rendering of personal services<sup>16</sup> and the value of most preventive care<sup>17</sup> and screening,<sup>18</sup> while underestimating both the possibility of diseconomies (in-

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*supra* note 8; INSTITUTE OF MEDICINE, HMOs, *supra* note 5; W. ROY, THE PROPOSED HEALTH MAINTENANCE ACT OF 1972 (1972); Havighurst, *HMOs*, *supra* note 10; MacLeod & Prussin, *The Continuing Evolution of Health Maintenance Organizations*, 288 N. ENG. J. MED. 439 (1973); Seward & Greenlick, *Health Policy and the HMO*, 50 MILBANK MEM. FUND Q. 147 (1972).

14. INSTITUTE OF MEDICINE, HMOs, *supra* note 5, at 52. In summarizing some of HMOs' "positive implications . . . for the quality of care," the Institute of Medicine has noted:

The grouping of physicians in an HMO setting provides both the environment and the incentives for effective peer review and continuing education, formal and informal. Close relationships and mutual advantage also encourage appropriate consultations and referrals, and opportunities for specialization within an integrated organization can increase quality assurance. Technical efficiencies are available in the maintenance of medical records, the prescription and dispensing of drugs, and the use of personnel and equipment, and should contribute to quality as well as economy. The economic incentives to practice preventive medicine also point toward potential improvement in the health of the enrollee population. In view of these considerations and actual performance of some existing HMOs, there is reason to expect that HMOs will give care of good quality.

*Id.* See also note 32 *infra*.

15. See, e.g., M. ROEMER, *supra* note 2; Donabedian, *supra* note 2, at 4-24; Roemer & Shonick, *HMO Performance: The Recent Evidence*, 51 MILBANK MEM. FUND Q. 271 (1973); *The Role of Prepaid Group Practice*, *supra* note 5, at 921-33.

16. E.g., Bailey, *Economies of Scale in Medical Practice*, in *EMPIRICAL STUDIES IN HEALTH ECONOMICS: PROCEEDINGS OF THE SECOND CONFERENCE ON THE ECONOMICS OF HEALTH* 255 (H. Klarman ed. 1972).

17. See Group Health Association of America, *Proceedings of 23d Annual Group Health Institute* 53-64 (1973) (remarks of Drs. Smillie, Nesson, Gardner, Peterson, Packer, and Shapiro); *The Role of Prepaid Group Practice*, *supra* note 5, at 898.

18. See NUFFIELD PROVINCIAL HOSPITALS TRUST, *SCREENING IN MEDICAL CARE: REVIEWING THE EVIDENCE* (1968); Wilson, *Principles of Screening for Disease* & Pole, *The Cost-effectiveness of Screening*, in *Current Status and Value of Laboratory Screening Tests* [abridged], 64 *PROCEEDINGS ROYAL SOC'Y MED.* 1255-57 (1971); *Hearings*, *supra* note 13, at 240-41.

cluding increased depersonalization<sup>19</sup>) and the danger of undue commercialization and profiteering leading to overeconomizing at the expense of patients' health.<sup>20</sup> In general, however, there is wide agreement that, although HMOs are not a panacea, they are an important and salutary development, if only because of their ability to curb expensive hospital utilization.<sup>21</sup>

HMO supporters fall into two camps. The first, typified by proponents of the HMO Act of 1973, value HMOs as a model health care system, providing a large population with comprehensive services of good quality and plowing savings from efficiency in resource use back into improved accessibility, better care, and more extensive services.<sup>22</sup> Under this view, heavy subsidies are deemed appropriate to help create such large, multi-service HMOs. The HMO Act makes such subsidies available, but only for HMOs meeting very substantial requirements and restrictions designed to foster those aspects of HMOs thought to be desirable and to minimize potential bad aspects.<sup>23</sup> To those who hold this view, the HMO model is promising as a way of improving the quality of care and getting more health care to people, particularly those

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19. See, e.g., Halberstam, *Liberal Thought, Radical Theory and Medical Practice*, 284 N. ENG. J. MED. 1180 (1971).

20. See, e.g., H. SCHWARTZ, *THE CASE FOR AMERICAN MEDICINE* 177 (1972) (noting an HMO's "strong economic interest in having its seriously ill patients die quickly and inexpensively. Death is the ultimate economy."). But see Havighurst, *HMOs*, *supra* note 10, at 748-59. Medi-Cal, California's Medicaid program, which has experimented with HMO care, has been severely criticized for allowing profiteering and inadequate care. See generally COMPTROLLER GENERAL OF THE UNITED STATES, *BETTER CONTROLS NEEDED FOR HEALTH MAINTENANCE ORGANIZATIONS IN CALIFORNIA* (1974); Hester & Sussman, *supra* note 9; Schneider & Stern, *supra* note 9, at 126.

21. Earlier studies showing HMOs' large savings in hospital utilization, have recently been confirmed. E.g., Donabedian, *supra* note 2; RIEDEL, *FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: UTILIZATION STUDY 18-30* (HEW Pub. No. (HRA) 75-3125, 1975); M. ROEMER, *supra* note 2. The other supposed HMO advantages, such as greater preventive services, remain debatable, and some commentators contend that lower hospital use alone is not sufficiently important to justify embracing all-out federal promotion of HMOs. E.g., Brook, *Critical Issues in the Assessment of Quality of Care and Their Relationship to HMOs*, 48 J. MED. EDUC. 114 (1973). In general, however, it is difficult to deny the value of HMOs' cost-control incentives and reductions in hospitalization, so long as undue sacrifices of quality can be avoided, and experience does not suggest that HMOs consistently deliver lower quality care than fee-for-service providers. See notes 14 *supra* & 32 *infra*.

22. See, e.g., American Public Health Association, *Health Maintenance Organizations*, 61 AM. PUB. HEALTH 2528 (1971).

23. 42 U.S.C.A. § 300e (Supp. 1974). For critiques of the Act's requirements see *Hearings on Competition in the Health Services Market Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 93d Cong., 2d Sess., pt. 2, at 1036 (1974) (testimony of C. Havighurst); INSTITUTE OF MEDICINE, *supra* note 5; Dorsey, *The Health Maintenance Organization Act of 1973 (P.L. 93-222) and Prepaid Group Practice Plans*, 13 MED. CARE 1 (1975); Iglehart, *Heralded HMO Programs Beset By Unexpected Problems*, 6 NAT'L J. REP. 1826 (1974); McNeil & Schlenker, *supra* note 9, at 213-20; Starr, *The New Medicine: An Experiment Designed to Fail*, THE NEW REP. 15 (1975); Note, *The Health Maintenance Act of 1973*, 27 VAND. L. REV. 1043 (1974).

whose health needs have not been well served. Government support for HMOs is also embraced as a means of restructuring the health care delivery system along more rational lines. It is fair to say that, for this group of observers, the challenges of improving quality and meeting previously neglected health needs are paramount, and the problem of containing the total volume of health services and their cost to the nation is a secondary concern.

The other camp of HMO supporters is almost certainly a minority. These observers<sup>24</sup> respond to all of the positive quality and access benefits of the HMO, but see its cardinal virtue in its cost-consciousness and its consequent potential for restoring effective price, as well as quality competition, in the market for health services. They view such competition as supplying a needed brake on the health care system's capacity to consume, without considered justification, an ever-increasing share of the nation's resources.<sup>25</sup> They anticipate that fee-for-service providers, facing the active price competition which could be supplied by HMOs, would be induced to keep health insurance premiums competitive by curtailing overutilization of resources, perhaps through PSROs or PSRO-like mechanisms.<sup>26</sup> Supporters of HMOs as a new competitive force do not seek to obtain subsidies for them so much as freedom of entry and a "fair market test,"<sup>27</sup> from which might emerge a mixed system of fee-for-service providers and HMOs of many kinds, some emphasizing comprehensiveness and high quality and others offering somewhat lower quality, but adequate, care at less cost. Even imperfect market competition among delivery systems is seen as the best available way to steer a safe course between the Scylla of unnecessary care, overutilization, and extravagance, which too often characterize fee-for-service medicine, and the Charybdis of inadequate care, which might occur in an excessively cost-conscious HMO. Holders of this view are simultaneously dubious that governmental or professionally imposed controls can approach a proper balance between the cost and the value of health services consumed by Americans.<sup>28</sup>

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24. See, e.g., P. ELLWOOD, *supra* note 8; INSTITUTE OF MEDICINE, HMOs, *supra* note 5; Havighurst, *HMOs*, *supra* note 10; McNeil & Schlenker, *supra* note 9; *National Health Insurance and the Cost of Medical Care* (May 13, 1975) (address by Alain C. Entoven to the Detroit Academy of Medicine).

25. See generally Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6 (1975). In fiscal 1974, health care claimed 7.7 percent of the gross national product; in 1950, 4.6 percent; and in 1929, only 3.6 percent. Worthington, *National Health Expenditures, 1929-74*, 38 SOC. SEC. BULL. 3, 5 (1975).

26. See note 10 *supra* for an explanation of how FMCs, for example, have been employed by fee-for-service physicians for this purpose. See also Havighurst, *Speculations*, *supra* note 10, at 257-63.

27. See, e.g., INSTITUTE OF MEDICINE, HMOs, *supra* note 5.

28. E.g., Ellwood, *Models for Organizing Health Services and Implications of Legislative Proposals*, 50 MILBANK MEM. FUND Q. 73 (1972); Havighurst, *Regulating Health*

B. *The Hazards of HMO Quality Control by PSROs*

Whichever view of HMOs is taken, there are serious hazards in exposing them to possible domination by fee-for-service practitioners through the PSRO mechanism. Preservation of the HMO's capacity to allocate resources to their best uses and to conserve resources by substituting inputs and omitting expensive steps contributing little or nothing to better outcomes is essential to its success from any point of view. Yet this capacity might not survive close scrutiny by practitioners unaccustomed to comparing benefits and costs and indeed motivated by strong ethical and professional impulses to spare no expense which might benefit a patient, even slightly.<sup>29</sup> Under such regulation, HMOs may find their premiums prohibitive even for a basic benefit package,<sup>30</sup> or they may find themselves unable to allocate resources to preventive services, screening and "outreach" programs, and other things which believers in the virtues of very comprehensive HMO care value highly. The result

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*Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143 (1973); Havighurst & Blumstein, *supra* note 25; Noll, *The Consequences of Public Utility Regulation of Hospitals*, in CONTROLS ON HEALTH CARE 25 (1975) (Inst. of Medicine, Nat'l Acad. of Science); Enthoven Speech, *supra* note 24.

29. Fee-for-service doctors paid through a third-party insurer (private or government) have a strong incentive—many would say a duty—to seek every possible benefit for their patients, regardless of cost. In fiscal 1974, third-party payments constituted 89.6 percent of all personal health care spending for hospital care. Worthington, *supra* note 25, at 15. Where only 10 percent of cost is borne directly by patients, cost is not a significant constraint on the physician prescribing such care. By definition, all PSRO-approved care is eligible for federal payment in whole or in part.

30. Despite their basic potential cost advantage, HMOs may sometimes appear to be, or may be in fact, a higher-cost alternative. An HMO may seem overpriced, for example, if its benefits are more comprehensive than those of a competing health insurance plan or if such plan requires substantial out-of-pocket expenditures for deductibles and coinsurance. Although in such cases a higher HMO enrollment fee may simply mask what is in fact a better bargain, there are other possible inflators of HMO premiums which reduce the overall attractiveness of the HMO package. Thus, many HMOs have been formed under auspices (*e.g.*, medical schools) which guarantee such a high-quality orientation that, because of the high costs entailed, they have limited appeal even to middle-class consumers. Moreover, HMOs may be legally prohibited from competing effectively in price and value. For example, HMOs which qualify for federal funding and other benefits under the HMO Act of 1973, 42 U.S.C.A. § 300e (Supp. 1974), must offer a larger minimum benefit package than consumers have generally elected to purchase in health insurance plans, even though tax advantages have cheapened the true price. Further, federally qualified HMOs must establish a single "community" rate rather than pricing competitively for various groups (experience rating) as do health insurers, with the result that the price for healthier groups includes a kind of hidden tax supporting care for persons with greater demand for services. *Id.* § 300e(b)(1)(C), (b)(2). The HMO Act also includes a variety of organizational and other requirements which potentially increase HMO costs. See *Hearings on Competition*, *supra* note 23, at 1036. To a large extent, HMOs have not yet had an opportunity to show what they can do in giving the consumer what he wants, and no more than he wants, at an attractive price. This article suggests that PSROs may well also operate to deny HMOs this opportunity by requiring them to provide extra increments of quality which consumers might prefer not to buy.



could well be the elimination of many of those very features which distinguish the HMO from fee-for-service medicine and make it an attractive mechanism for expanding the range of services available to many populations.

Those who value the HMO as a competitive alternative to fee-for-service medicine would likewise deplore an undue loss of the HMO's cost advantage. Viewing the matter as a problem in maintaining competition, however, they would also see PSRO control over HMO practice as an intolerable opportunity for anticompetitive restraints.<sup>31</sup> The temptation to use PSROs to regulate HMOs in the interest of PSRO physicians will be very strong indeed.

The necessity for scrutinizing the quality of care in HMOs is itself not an issue in the ensuing discussion of the relations between HMOs and PSROs. Despite the many positive implications of HMOs for the quality of care,<sup>32</sup> an HMO's cost consciousness could easily lead, in some settings, to corner-cutting and even serious profiteering amounting to fraud on the enrollees.<sup>33</sup> Nevertheless, it is not inevitable that an identified quality problem in HMOs should be dealt with by PSROs.

## II. THE IMPLICATIONS OF PSRO REVIEW RESPONSIBILITIES FOR HMOs

### A. *The Legislative Charge*

PSROs were provided for in the Social Security Amendments of

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31. The argument, asserted as baldly as possible, is that there are only two possible outcomes of giving PSROs jurisdiction over HMOs . . . . One is that PSROs will regulate HMOs in the interest of fee-for-service medicine, requiring HMOs to adhere to quality norms developed in the fee-for-service sector and removing all significant likelihood of innovation, cost saving, and meaningful competition. The alternative possibility is that, with HMOs represented in its councils, the PSRO would be a forum in which the competing fee-for-service and HMO sectors would work out their differences, thereby eliminating competition and the likelihood of significant cost control or other benefits which would flow from competition between the two sectors. Adam Smith warned long ago that when competitors gather together for any purpose the probability of a conspiracy against the public interest is greatly enhanced, and the health sector will obey this law even if it may not obey other precepts which Smith enunciated.

INSTITUTE OF MEDICINE, HMOs *supra* note 5, at 69 (dissent of C. Havighurst).

32. HMOs' quality record is generally satisfactory. After a 1958 survey, the AMA's Larson Report recognized that "care of good quality" was provided by "closed-panel" group practice HMOs. Commission on Medical Care Plans, *Report: Findings, Conclusions and Recommendations*, 169 J.A.M.A. 44 (1959). Since then, what evidence has been developed shows that HMOs offer care at least comparable to that of the prevailing fee-for-service system. See, e.g., Donabedian, *supra* note 15, at 23-25; Roemer & Shonick, *supra* note 15, at 302-03. See also note 14 *supra*. But see note 20 *supra*; Brook, *supra* note 21, at 128-31.

33. Problems are most likely to be encountered where HMO developers seek short-run gains and have no concern for long-term consumer acceptance. Thus, abuses have been discovered in plans serving Medicaid populations exclusively. See note 20 *supra*. Although the care given by these HMOs may not have been greatly inferior to that which these populations were accustomed to receive, appropriate minimum quality levels need to be assured in some manner. See text accompanying note 136 *infra*.

1972 to ensure that no funds under the federal Medicare, Medicaid, or maternal and child health programs<sup>34</sup> would go to pay for medical services which were substandard or medically unnecessary or which could be provided more economically in a different type of facility.<sup>35</sup> PSROs represent a congressional adaptation of professional "peer review" to deal with the problems of overutilization of health care resources and, only secondarily from Congress's point of view, the quality of care. Since avoiding overutilization is also a prime HMO virtue, HMOs' inclusion under PSRO jurisdiction is explainable only by reference to this secondary quality-assurance function.<sup>36</sup> Indeed, the statute and its legislative history suggest that, HMOs aside, Congress's quality concerns were limited to first assuring the public that control of costs would not override quality considerations altogether and, second, strengthening professional controls over those providers who abuse Medicare and Medicaid by speeding up production of billable services while allowing the quality of those services to deteriorate.<sup>37</sup> Nevertheless, though cost control was Congress's main object, the quality assurance aspect of PSROs is clearly more popular (or less unpopular) with doctors, and the Department of Health, Education, and Welfare (HEW), in marketing the program to the medical profession, has expressly declared the law's primary purpose to be quality assurance.<sup>38</sup> As a result, PSROs have an increasingly

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34. The programs are Medicare, Social Security Act, 42 U.S.C. §§ 1395 *et seq.* (Supp. III, 1973); Medicaid, 42 U.S.C. §§ 1396 *et seq.* (1970); Maternal and Child Health programs, 42 U.S.C. §§ 701 *et seq.* (1970).

35. 42 U.S.C. §§ 1320c-4(a)(1)(A), (B), (C) (Supp. III, 1973).

36. Federal medical program costs have far exceeded original estimates, and Congress's main goal in creating PSROs was to control cost by curtailing overutilization. *See generally* Havighurst & Blumstein, *supra* note 25, at 38. S. REP. NO. 92-1230, 92d Cong., 2d Sess. 54 (1972). In summarizing the PSRO amendment, Congress clearly stated that the "problem" PSROs were to solve was one of cost, with quality a lesser goal:

there are substantial indications that a significant amount of health services paid for by medicare and medicaid are in excess of those which would be found to be medically necessary under appropriate professional standards. Furthermore, in some instances services provided are of unsatisfactory professional quality.

*Id.* To the extent that this viewpoint concerns quality, it focuses on the low quality of services that are given, not on stimulating more and better services. *See also* note 37 *infra*.

37. PSROs' quality mandate is merely to determine "whether the [federally funded] services provided are sound and proper." 188 CONG. REC. H10,196 (daily ed. Oct. 17, 1972) (remarks of Representative Mills). The law anticipates withholding of federal payment if a service is substandard. 42 U.S.C. §§ 132c-7(a), -4(a)(1)(B) (Supp. III, 1973). (Senator Bennett, however, expressed concern about services not provided. *See* note 92 *infra*). Such an affirmative mandate contemplates not merely refusing payment for a substandard service but also evocation of more and better services and extensive upgrading of prevailing standards. *See also* note 36 *supra*. Preventing providers from claiming full payment for particular services of less than full quality is very different from HEW's current expectation that PSROs are to improve the quality of medical care generally through continuing education and the like. *E.g.*, Address by H. Simmons, Director, Office of Professional Standards Review, HEW, *PSRO and the Quality of Care*, Indiana Medical Association meetings, May 16, 1974 (duplicated).

38. In an explanatory pamphlet expressly aimed at physicians, HEW asked itself

clear mandate to define what arguable quality shortcomings are fair game and a broad license to pursue them. The HMO will clearly be viewed as a prime hunting ground.

Because only physicians were thought qualified to judge the medical necessity for or the quality of medical procedures, PSROs are to be run exclusively by practicing physicians<sup>39</sup> in their respective areas.<sup>40</sup> PSROs will judge care by standards of quality and medical necessity set through a blend of expert knowledge and local practice,<sup>41</sup> and "typical patterns of practice" in a PSRO area will serve as "principal points of evaluation and review."<sup>42</sup> PSRO disapproval of services will block federal payment for them.<sup>43</sup>

Under present law, PSRO review covers only the care of federal program beneficiaries, but, by agreement with PSROs, private insurers may also have PSROs review their beneficiaries' care.<sup>44</sup> Moreover, some

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the question, "Is the purpose of PSRO to assure quality or control cost?" and answered, "The primary emphasis of the PSRO program is on assuring the quality of medical care." OFFICE OF PROFESSIONAL STANDARDS REVIEW, U.S. DEP'T OF HEALTH, EDUCATION, & WELFARE, PSRO: QUESTIONS & ANSWERS (HEW Publication No. (OS) 74-50001, Dec. 1973), reprinted in 2 CCH MEDICARE & MEDICAID GUIDE ¶ 12,855.75 (1974); accord, Office of Professional Standards Review, OPSR Memo 3 (No. 4, Apr., 1974). In speeches to medical audiences, OPSR spokesmen are equally explicit. See, e.g., H. Simmons, *supra* note 37. See also text accompanying note 60 *infra*.

39. PSROs must be open to all practicing physicians in their areas, and be composed of a "substantial proportion" of those physicians. 42 U.S.C. §§ 1320c-1(b)(1)(A)(iii), -1(b)(1)(A)(v) (Supp. III, 1973). HEW has defined this proportion as twenty-five percent. Office of Professional Standards Review, U.S. Dep't of Health, Education, & Welfare, P.S.R.O. Program Manual § 500.15 (1974) (duplicated)[hereinafter cited as PSRO Manual]; see note 48 *infra*. Further, the law allows a majority of local physicians to veto as unrepresentative any organization HEW proposes to designate as their PSRO prior to January 1, 1976. 42 U.S.C. § 1320c-1(c)(1) (Supp. III, 1973). After that date, HEW may accept a less representative PSRO, but only in the unlikely event that no representative candidate exists or thereafter appears. *Id*.

40. A total of 203 PSRO areas have been established; twenty-eight of them give PSROs statewide jurisdiction. 39 Fed. Reg. 10,204 (1974). See also PSRO Manual, *supra* note 39, ch. 2.

41. 42 U.S.C. § 1320c-5(a) (Supp. II, 1973). The statute reveals concern that a PSRO's norms not merely average local practice but also reflect professional judgment about care, diagnosis, and treatment appropriate for conditions in the locality. The PSRO Manual is more explicit, calling for PSROs to develop and apply three kinds of standards: "norms" (typical practice), "criteria" (expertly developed quality requirements), and "standards" (the range of acceptable variation around a norm or criterion). PSRO Manual, *supra* note 39.

42. 42 U.S.C. § 1320c-5(a) (Supp. II, 1972).

43. 42 U.S.C. § 1320c-7(a) (Supp. II, 1972). Title V (Maternal and Child Health Program) services are exempt from PSRO denial of payment. *Id*. Such programs are funded differently from Medicare and Medicaid.

44. PSROs are required to review all care even partially paid by federal funds. 42 U.S.C. §§ 1320c-4(a), -7(a) (Supp. III, 1973). In addition, the pilot PSRO program in Utah already reviews care provided to many privately insured patients. Nelson, *Relation Between Quality Assessment and Utilization Review in a Functioning PSRO*, 292 N. ENG. J. MED. 671 (1975). According to one report, many private insurers are seeking PSRO

major national health insurance bills contemplate an expanded PSRO role.<sup>45</sup> In the long run, therefore, PSROs are likely to regulate all care for which the patient is not himself paying the entire bill. Their capacity to do this in a way which gives significant weight to the public's interest in controlling overall health care costs, as well as to providers' and patients' natural preference for more and better services in individual cases, remains to be demonstrated.<sup>46</sup>

### B. Jurisdiction

PSROs' review jurisdiction includes HMOs, along with all other providers of federally funded health care services. Initially, however, review is limited by statute to services provided "by or in institutions," and whether an HMO is an "institution" is not obvious.<sup>47</sup> Nevertheless, HEW's PSRO Manual<sup>48</sup> makes clear that *institutions* means only hospitals and other inpatient care facilities.<sup>49</sup> Moreover, PSROs' review jurisdiction over care provided "by" as well as "in" institutions has not been interpreted to cover outpatient care, even when rendered in the same facility as inpatient care.<sup>50</sup>

Once a PSRO has perfected its review of hospital and other institutional care, it may request and receive permission from the Secretary

review, and Dr. Henry Simmons, then OPSR Director and Deputy Assistant Secretary for Health, indicated that he expects PSROs and hospital utilization review committees to review inpatient care "for all, rather than just Medicare and Medicaid beneficiaries, even before the advent of a national health insurance program." *AM. MED. NEWS*, Feb. 17, 1974, at 1, cols. 1-2.

45. *E.g.*, S. 2513, 93d Cong., 1st Sess. (1973); H.R. 12,684, 93d Cong., 2d Sess. (1974). *See, e.g.*, Greenberg, *PSRO—On the Way, but to Where?* 290 *N. ENG. J. MED.* 1493 (1974).

"[I]t is certain that the PSRO system that is currently gestating is destined to be responsible for scrutinizing not merely a slice of the nation's medical services, but virtually the whole of the \$100-billion-a-year health-care enterprise."

*Id.* One bill introduced by Senator Kennedy, would have doctors accept PSRO review as a condition of receiving favorable malpractice insurance treatment. S. 215, 94th Cong., 1st Sess. §§ 1704(a), (c)(1) (1975).

46. *See generally* Havighurst & Blumstein, *supra* note 25.

47. 42 U.S.C. § 1320c-4(g) (Supp. II, 1972). "Institution" is not defined.

48. *Supra* note 39. As of June 1, 1975, HEW had issued only nine of twenty-four proposed chapters of the PSRO Manual which, though incomplete, nevertheless codifies much of the practice of prototype PSROs and represents HEW's current approach to PSROs. Although the Manual is the best available guide to PSROs, it is not definitive. HEW characterized the manual in its Foreword as "interim guidelines" to "be issued as proposed regulations" only after "experience is gained," thus avoiding the procedural requirements of the Administrative Procedure Act, 5 U.S.C. § 553 (1970).

49. PSRO Manual, *supra* note 39, § 102, provides: "The PSRO is required to review services furnished in and by hospitals and other health care institutions, such as skilled nursing facilities." *See also id.* § 700.3. The Manual thus far deals only with inpatient hospital review.

50. No current manual provisions cover outpatient care, nor does the proposed table of contents indicate that future chapters will deal with such care. *See* note 48 *supra*.

of HEW to review non-institutional care.<sup>51</sup> It is not clear, however, whether a PSRO could undertake review of HMO outpatient care without reviewing all other providers' noninstitutional care as well. A PSRO might be expected to attach high priority to full review of HMOs because of concerns about departures from traditional practice or because added power could help to suppress HMOs' competition, including competition for nonfederally supported patients. Moreover, logic would seem to support such a priority, since HMOs are more like "institutions" than are individual practitioners and are vulnerable to suspicions of overeconomizing on the quality of care. Further, PSRO efforts to upgrade HMO practice might be seen as having greater impact than comparable efforts directed at individual practitioners.<sup>52</sup>

Despite these arguments which PSROs might use to single out HMOs' outpatient care for special attention, there is weak evidence that HEW would resist such discrimination against HMOs. A recent draft HEW memo stated that "specific PSROs which ask for and receive [HEW's] approval to conduct ambulatory care review would include HMOs in that review, *along with all other providers.*"<sup>53</sup>

### C. Techniques of Utilization Review and Quality Assessment

At the outset, partly because data availability will be less of a problem in utilization review than in quality assessment, PSRO case-by-case review of inpatient care<sup>54</sup> will probably concentrate primarily on

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51. 42 U.S.C. § 1320c-4(g) (Supp. II, 1972). PSRO Manual, *supra* note 39, §§ 700.2-3.

52. Moreover, because HMOs are "quasi-institutions" which employ many doctors and usually apply uniform standards of practice through internal review, they are particularly susceptible to PSROs' provider profile analyses and Medical Care Evaluations. See text accompanying notes 68-71 *infra*. HMOs are more easily reviewed by techniques which focus on categories of patients rather than individual cases, since they have a larger volume of cases to which statistical norms may quickly be applied.

53. Department of Health, Education, & Welfare, PSRO-HMO-Relationships 5 (duplicated, undated draft) (emphasis added) [hereinafter cited as PSRO-HMO Relationships]. This draft was written as an issue paper for discussion by the National Professional Standards Review Council and is not authoritative. According to the PSRO Manual's Table of Contents, Chapter XII will deal with "PSRO Relationship[s] with Health Maintenance Organizations." PSRO Manual, *supra* note 39, at i (rev. ed. 1974).

54. Such review is to be of four types: (1)pre-admission certification of elective admission, (2)concurrent admission certification of elective admissions, (3)emergency admission certification, and (4)continued stay review. See PSRO Manual, *supra* note 39, §§ 705.11-.29. A fifth type, retrospective individual claims review, is only to be used where the others fail. *Id.* § 707.

In the course of these case-by-case reviews, PSRO "norms," "criteria," and "standards" (see note 41 *supra*) are to be used primarily for screening purposes. Nonphysician reviewers are to test individual cases against the applicable standards to determine medical necessity, allowable length of stay, and (eventually) quality of treatment to be given. *Id.* §§ 705.16, .17, .22, .26, 709. Cases not meeting screening standards are to be referred to physician reviewers, for "[o]nly physicians will be allowed to make final decisions on the care provided by physicians." *Id.* § 730.55; accord, 42 U.S.C. § 1320c-4(c) (Supp. III,

cost control through the prevention of medically unnecessary hospital admissions and overlong stays.<sup>55</sup> Because HMOs characteristically feature a low rate of hospital utilization,<sup>56</sup> they should not be significantly affected by these utilization-control efforts. Indeed, HMOs' prepayment features so discourage excessive use of inpatient facilities that such regulation of HMOs seems unlikely to justify its cost.<sup>57</sup> Moreover, because the HMO is prepaid, it, rather than the federal government, absorbs the costs of any overutilization, thus automatically achieving the chief goal of utilization review and making superfluous the PSRO law's principal sanction—denial of payment.<sup>58</sup> Although individual PSROs could exempt particular HMOs from this burdensome type of review, HEW has neither suggested a blanket exemption for HMOs nor as yet provided a formal appeal mechanism to assure that exemptions will be granted whenever warranted.<sup>59</sup>

Although starting with controls on overutilization, PSROs will quickly turn to regulating purported underutilization of services in hospitals pursuant to their quality mandate. Dr. Henry Simmons, then director of HEW's Office of Professional Standards Review, repeatedly noted that PSROs are primarily "quality assurance programs" and de-

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1973). Physician reviewers are then to make case-by-case determinations based upon more sophisticated PSRO standards and their own judgment. PSRO Manual, *supra* note 39, § 709. Because HMO practice is atypical, HMO cases are likely to face frequent in-depth examinations by physician reviewers. The consequences of reviewer disapproval of HMO care in an individual case is unclear; the usual disapproval of payment will probably not apply to HMOs. *See* note 62 *infra*; PSRO-HMO Relationships, *supra* note 53, at 12-14.

On the basic elements of review, *see, e.g.*, Flashner, Reed, Coburn & Fine, *Professional Standards Review Organizations*, 223 J.A.M.A. 1473 (1973); Frederick, *PSROs: How the First Ones Are Working*, 15 MED. WORLD NEWS 53 (1974); Goran, *The PSRO Hospital Review System*, 13 MED. CARE 1 (Supp. Apr. 1975); Lander, *PSROs: A Little Toe in the Door*, HEALTH PAC BULL. 1, 4-5 (1974).

55. Overlong stays are the target of the only "norm" the statute specifically calls upon PSROs to enforce—typical hospital length-of-stay by age and diagnosis. 42 U.S.C. § 1320c-5(a) (Supp. III, 1973). As envisaged by the PSRO Manual, *supra* note 39, §§ 705.11-.26, case-by-case hospital reviews will at first judge only the medical necessity of hospitalization and the maximum allowable length-of-stay, not quality. The use of quality criteria in current review of individual patients' care seems to be optional. *Id.* §§ 705.16, 706.25(c), 709.13. Quality seems mainly meant to be enforced through retrospective reviews of categories of cases. *See* text accompanying notes 68-77 *infra*.

56. *See, e.g.*, RIEDEL, *supra* note 21, at 18-30; Roemer & Shonick, *supra* note 15, at 287-91.

57. PSRO review of a typical case may cost ten to twenty dollars. Flashner, *supra* note 54, at 1483. Some cases, however, will be exempted from review. *See* note 59 *infra*; Frederick, *supra* note 51, at 56, 69.

58. *See* notes 62, 71 *infra*. Most HMOs are paid on a cost reimbursement basis under Medicare, however. *See* note 9 *supra*.

59. Both the statute and the PSRO Manual allow a PSRO to exempt trustworthy providers from particular reviews. 42 U.S.C. § 1320c-4(a)(2) (Supp. III, 1973); PSRO Manual, *supra* note 39, §§ 705.14(a)(1), (2), (b)(3), .15(b), .23. Nowhere is there recognition that HMOs generally threaten little, if any, overutilization of institutional care. *But see* note 53 *supra*.

clared that "utilization review is probably the smallest part of what PSROs will be doing."<sup>60</sup> One form which a PSRO's quality-oriented regulation could take is the establishment of minimum lengths of hospital stay for different diagnoses. Although the PSRO Manual primarily emphasizes control of overutilization by setting maximum lengths of stay and does not expressly require minimums, many of its provisions imply that standards would also address the problem of too-short stays.<sup>61</sup> Nevertheless, utilization review is designed primarily to force patients out of the hospital, and there is no procedure for keeping a patient in the hospital when the physician wishes to have him discharged. The sanctions available to the PSRO are thus limited,<sup>62</sup> but a minimum length-of-stay standard would probably be followed by HMOs, if only to protect against malpractice suits alleging setbacks following premature discharge.<sup>63</sup>

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60. Simmons, *supra* note 37, at 2, 6. Dr. Simmons, OPSR's first, and thus far only, director, resigned effective June 1, 1975. AM. MED. NEWS, May 12, 1974, at 18, col. 3.

61. That PSROs may set minimum as well as maximum lengths of stay (and amounts of services) is implied by the very concept of a PSRO "standard" embodying a range of acceptable variation from a norm or criterion. See note 41 *supra*. Like the statutory definition, the PSRO Manual defines the term "norm" to include a "range" of "appropriate" treatment. 42 U.S.C. § 1320c-5(b)(1) (Supp. III, 1973). More specifically, the PSRO Manual, *supra* note 39, § 705.35(e), invites PSROs to specify, for example, "the optimal intervals" for "the length of pre and post-operative confinement" based upon results of its Medical Care Evaluations. See note 72 *infra* and accompanying text. This would create a minimum length of stay for surgery; minimum stays for other procedures or conditions are not conceptually different.

62. Withholding payment is an effective and logical sanction only for *too many* services. Where a PSRO thinks a service should have been given, but was not, no payment is due in any case. A PSRO might try to withhold payment for otherwise acceptable services on the ground that, without an omitted service, those rendered were substandard. That argument should fail, however, since Congress seems to have intended PSROs to judge each billed service on its own merits, not as part of a constellation of procedures that must stand or fall together. See 42 U.S.C. § 1320c-7(a) (Supp. III, 1973). With respect to HMOs, the discussion is moot insofar as they are paid in advance by federal programs and not service-by-service. See note 9 *supra*.

63. The statute attempts to immunize complying providers from malpractice liability, albeit not clearly. 42 U.S.C. § 1320c-16(c) (Supp. III, 1973); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 838-42 (1974); Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974). This, along with the norms' authoritative appearance and prestigious origins, may lead courts to imply negligence from noncompliance, despite the legislative history revealing an opposite intent. See S. REP. NO. 92-1230, *supra* note 36, at 267. ("Failure to order or provide care in accordance with the norms employed by the PSRO is not intended to create a legal presumption of liability.") One argument against judicial use of PSRO norms is that they may be promulgated with an eye to their principal function—screening many cases, rather than judging individual cases. The latter kinds of decisions will be made using more sophisticated norms and the reviewing doctor's own judgment. See note 54 *supra*.

HEW Secretary Caspar Weinberger recently expressed the hope that providers "who adhere to standards of care adopted by local PSRO's will be able [under state law] to assert this as a real defense to a malpractice suit." Malpractice Insurance Denials Spark

HMOs economize not only by shortening hospital stays but also by treating on an outpatient basis instead of hospitalizing.<sup>64</sup> Moreover, they have much lower frequency rates for certain kinds of surgery.<sup>65</sup> The PSRO, as long as it is limited to reviewing care of institutionalized patients, will have no direct opportunity to review cases in which HMO doctors elect not to hospitalize and will therefore be unable to police large portions of HMO practice where overeconomizing might be expected to occur. Of course, admission screening may identify cases where hospitalization or surgery has been excessively delayed.<sup>66</sup>

PSRO "criteria," another device for insuring high-quality institutional care, are apt to be far more important to HMOs than admission and length-of-stay norms. Criteria are supposed to identify "elements critical to the health care of the patient," including the "timing, frequency, and quantity" of "diagnostic or therapeutic services . . . which should be provided."<sup>67</sup> This mandate, which allows a PSRO to require providers to supply certain services to given categories of patients, could materially affect HMOs' hospital practices. Moreover, criteria might also be used to dictate the extent of the pre-admission workup or the regimen to be planned prior to discharge.

As another method to ensure high-quality care and to detect patterns of overutilization, PSROs are to develop, maintain, and review provider and patient "profiles" of care and services rendered and received.<sup>68</sup> If a provider's profile does not conform to PSRO norms, standards, or criteria,<sup>69</sup> the nonconformist may be singled out for special

Weinberger's Concern, PSRO Letter No. 35, at 3, 4 (Jan. 15, 1975). AMA President Malcolm Todd, M.D., strongly opposed even defensive use of PSRO norms in malpractice law because it "wrongly assumes there is a known therapy for every medical condition" and because it would raise the "spectre of cookbook medicine." *AMER. MED. NEWS*, Jan. 13, 1974, at 1, cols. 1-3. An editorial echoed Todd's views. *Id.* at 4, cols. 1-3.

64. See note 56 *supra*.

65. See, e.g., Donabedian, *supra* note 2, at 14-16.

66. The PSRO Manual, *supra* note 39, § 704.12(c), directs PSROs to check for "inappropriately delayed" admissions.

67. *Id.* § 709.14(c). See also *id.* § 705.16. PSROs were created to eliminate "unnecessary" and "excessive" medical services as well as over-long hospital stays. *E.g.*, S. REP. NO. 92-1230, *supra* note 36, at 263. But the very authority to define medical necessity includes the power not only to determine that some services are unnecessary and should not be rendered, but also to determine that others are necessary and must be rendered. Indeed, the Model PSRO screening criteria now being developed include a list of "critical diagnostic and therapeutic services" for each of the 300-odd conditions covered—accounting for seventy-five percent of hospital admissions. Screeners are routinely to ascertain whether particular services were in fact provided. American Medical Ass'n, Model Screening Criteria to Assist Professional Standards Review Organizations 11-12 (draft ed. 1975). Though such screening criteria are not binding on a PSRO review's final determination, they illustrate the direction PSROs will probably take. (The AMA's Criteria Development Project, undertaken under contract with HEW, formally enlisted the assistance of thirty-five other national medical specialty and professional societies and thus represents an emerging consensus on PSRO's mission.)

68. 42 U.S.C. § 1320c-4(a)(4) (Supp. III, 1973).

69. No standards are set for how or when profiles are to be reviewed, although the



case-by-case review,<sup>70</sup> or sanctions may be imposed.<sup>71</sup> HMOs, whose patterns are likely to differ from those of the fee-for-service sector, may encounter such scrutiny frequently and be forced to justify specific departures or to comply with PSRO-dictated standards and criteria. Acquiescence will undoubtedly be the course most often chosen.

"Medical Care Evaluations" (MCEs) are another type of quality-assurance project which PSROs must undertake. MCEs are "in-depth studies" of areas of "substandard quality." It is not required, however, that they be scientifically conducted, using accepted techniques of health services research, particularly the randomized, controlled trial.<sup>72</sup> Moreover, although the examples given in the PSRO Manual seem to indicate that MCEs should focus upon treatment of particular illnesses or the quality of particular services in the entire PSRO area,<sup>73</sup> nothing

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statute says they shall be "regularly reviewed on an outgoing basis." *Id.* The PSRO Manual contemplates profiles "screening" without as yet specifying a single detail about how it is to be done. PSRO Manual, *supra* note 36, §§ 705, 709.16.

70. Health care providers deemed particularly unreliable may be "black-listed" to permit continual and more thorough going case-by-case review. For most such providers, this means that they will have to carefully justify every admission and continual hospital stay. HMOs will probably have to justify instead their "low" level of quality or "too short" stays. *See* text accompanying note 76 *infra*. *See also* note 54 *supra*.

71. Although withholding payment for inadequate HMO services is probably not now possible, *see* note 62 *supra*, a PSRO might be able to recommend excluding a nonconforming HMO from federal programs and could seek other vaguely defined "professional" or "governmental" retribution against the HMO under 42 U.S.C. §§ 1320c-9(b), (c) (Supp. III, 1973). Section 1320c-9(b) permits suspension of a provider's "eligibility to provide such [federal program health care] services on a reimbursable basis" (emphasis added). Since HMOs provide services on a *prepaid* basis, this sanction seems inapplicable to them, but HEW may recommend granting "PSROs some form of authority relating to the [noncomplying] HMOs' continuing eligibility to enroll beneficiaries of Titles XVIII, XIX, and V." *PSRO-HMO Relationships*, *supra* note 53, at 13-14.

This uncertain effectiveness of PSROs' currently available formal sanctions against HMOs does not mean that PSROs will be unable to achieve HMO compliance, however. Not only will malpractice fears lead HMOs to follow PSRO standards, *see* note 63 *supra* and accompanying text, but PSROs also possess an impressive array of powers that may serve as informal sanctions. In addition to (1) withholding delegation of review powers to new HMOs or their hospitals, *see* notes 87-89 *infra* and accompanying text, and (2) requiring lengthy justification of review standards sought to be used by delegatee HMOs, *see* notes 81, 83 *infra* and accompanying text, PSROs directly reviewing HMO care could (3) "blacklist" a disfavored HMO, so that every case is reviewed in depth, *see* note 70 *supra*, (4) concentrate its medical care evaluations on suspected HMO weaknesses regardless of their relative importance, *see* notes 73-76 *infra* and accompanying text, and (5) impose heavy reporting requirements under 42 U.S.C. § 1320c-5(d)(1)(B) (Supp. III, 1973) or undertake detailed examinations of records or inspection of facilities under sections 1320c-4(b)(3) & (4).

72. PSRO Manual, *supra* note 39, § 705.34. MCEs are not mentioned in the statute. The PSRO Manual does not specify how rigorously scientific an acceptable MCE must be, *see* note 104 *infra*, but indicates the acceptability of the medical audit procedure of the Joint Commission on Accreditation of Hospitals and the quality assurance program (QAP) of the American Hospital Association. *Id.* § 705.33.

73. Examples of MCEs include "detailed analysis of the process of care for a particu-

expressly prevents a PSRO from aiming an MCE at the care given by a particular provider, such as an HMO. In fact, one MCE objective is to "assure that health care organization and administration support the timely provision of quality care,"<sup>74</sup> and, because "MCE studies will often identify needed changes in . . . organization," the PSRO is to "provide this information to those responsible . . . and help to assure that necessary action is taken."<sup>75</sup> MCEs, like profile analyses, can be used to determine on whom or what to concentrate other reviews.<sup>76</sup> PSROs have nearly complete discretion as to what and how many MCEs should be done.<sup>77</sup>

HMOs would seem likely targets for both profile analyses and MCEs, and this special scrutiny could be quite threatening, especially where the PSRO was not capable of total objectivity. Once again, however, the limitation to federally supported inpatient care may shield HMOs from major intrusions in the immediate future.

#### D. Delegation of Review Functions

Exactly how a PSRO will exercise its jurisdiction over HMO practice is not yet clear. A PSRO is empowered to delegate some of its review functions, and therefore actual case-by-case review of institutional care given by an HMO may be undertaken not by the PSRO but by the HMO itself or by an unaffiliated hospital or other institution in which the HMO places its patients. Although the statute and legislative history clearly contemplate delegation of review responsibility to HMOs,<sup>78</sup> the PSRO Manual now deals only with delegations to hospitals,<sup>79</sup> thus allowing only hospital owning HMOs to review their own care. HEW has not yet decided whether, or on what basis, to permit HMOs to review care of their patients in hospitals which they do not control.<sup>80</sup> In either

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lar diagnosis" and "[e]xamination of the length of time between the ordering and provision of a given radiologic procedure." *Id.* §§ 705.35 (a), (c).

74. *Id.* § 705.32(b).

75. *Id.* § 705.34(h).

76. *Id.* § 705.34(g).

77. The PSRO Manual specifies only that each PSRO must be performing at least one MCE at all times. *Id.* § 705.33. It does not even address the idea that MCEs should be employed nondiscriminatorily. To the contrary, selectivity, in choosing targets of "sub-standard quality" as "subjectively perceived" by a PSRO, is the essence. *Id.* § 705.34(c).

78. 42 U.S.C. § 1320c-4(e)(1) (Supp. III, 1973). The Senate Finance Committee Report specifically states that PSROs are to "accept . . . internal review activities of comprehensive prepaid group practice programs." S. REP. No. 92-1230, *supra* note 36, at 262.

79. The PSRO Manual's delegation provisions as yet cover only "The Hospital-PSRO Relationship with Respect to Medical Care Review." PSRO Manual, *supra* note 39, §§ 710-710.3. *But see* note 53 *supra*.

80. The draft memo on *PSRO-HMO Relationships*, *supra* note 53, at 20-23, discusses this issue without resolving it. Though recognizing that delegation of review to non-hospital-owning HMOs was contemplated, the draft advances some practical considerations against delegation—principally duplication of review systems within a single hospi-

event, the PSRO retains responsibility for overseeing such delegated review.<sup>81</sup>

The opportunity for self scrutiny is important to HMOs for a number of reasons. Where its own personnel review its care, an HMO can be certain that they will understand the unique HMO perspective on health care. Moreover, delegation would probably carry with it some funds to defray the costs of review.<sup>82</sup> Most important, however, the law holds out the possibility that delegates may develop their own review standards for use, with PSRO approval, in lieu of the PSRO's standards.<sup>83</sup> In seeking approval of its own standards, an HMO would have an opportunity to justify its practices to the PSRO and to argue that its special characteristics warrant departures from "typical patterns of practice" in the area.

Not only may the PSRO delegate the function of case-by-case review of hospital admissions and continued stays, but the delegatee may also be given primary responsibility for MCEs or profile analyses.<sup>84</sup> If an

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tal (i.e., the HMOs and the hospital's own). A kind of "semi-delegation" compromise is hinted at, with the non-hospital-owning HMO being "in charge of" its own review yet required to use PSRO or hospital reviewers. If the PSRO reviewers use PSRO standards, such review would be "delegated" to the HMO in name only.

81. PSRO Manual, *supra* note 39, § 720.01. Although this PSRO duty to supervise delegated review now applies only to hospitals (including those controlled by HMOs), see note 79 *supra*, a similar provision will probably govern any delegation to other HMOs. *PSRO-HMO Relationships*, *supra* note 53, at 22.

PSROs would lose the duty (and power) to supervise hospital self-review under a recent proposal by the AMA House of Delegates. According to AM. MED. NEWS, Dec. 9, 1974, at 9, col. 2, the proposal "called on local PSROs and similar agencies to accept a hospital's accreditation by the Joint Commission on Accreditation of Hospitals as sufficient to warrant that the [review] procedures are satisfactory." The JCAH is a private body representing six organized segments of American medicine, including the AMA. (Similarly, it might be argued that HMOs should be privately accredited rather than overseen by PSROs. The Group Health Association of America has long sought to establish such an accreditation system.)

82. Just how much of the cost of delegated review would be paid for is uncertain. 42 U.S.C. § 1320c-17 (Supp. III, 1973) provides for "fair and equitable" payment, "taking into consideration the costs attributable to the administration of this [PSRO] part," but the PSRO Manual, *supra* note 39, § 720.09, offers reimbursement to delegatee hospitals "only for those in-house review and continuing education activities which are unique requirements made by the PSRO program and which will need to be initiated as a supplement to present hospital activities." *PSRO-HMO Relationships*, *supra* note 53, at 27, uses similar language with respect to delegatee HMOs, which suggests that HMOs, which conduct reviews for non-PSRO purposes, see note 90 *infra*, may well not have their budgets supplemented significantly.

83. While the general rule is that delegates must use PSRO-established standards, delegates which act promptly to develop their own "norms," "criteria," and "standards" may use them at least until the PSRO promulgates different standards. Even then, delegates may continue to use their own standards instead of the PSRO's if the PSRO accepts them. In addition, for "valid reason," a delegatee hospital may even later seek and receive PSRO approval to use different standards. See PSRO Manual, *supra* note 39, §§ 709.15, .42.

84. *Id.* §§ 710.21, 720.1. With respect to MCEs, a PSRO retains the authority (and

HMO were delegated authority to undertake its own MCE's and profile analyses, it could use these important analytical techniques to show the effectiveness of HMO care.<sup>85</sup> Delegation of the conduct of MCEs and profile analyses would not, however, immunize the delegatee HMO from scrutiny under other MCEs which the PSRO might initiate.<sup>86</sup>

The statute leaves the decision of whether to delegate almost totally to each PSRO's discretion. Acceptance of hospital or HMO review committees' findings is required "only to the extent" that they have demonstrated "to the satisfaction of" the PSRO their ability to perform such review.<sup>87</sup> While appeals to HEW of decisions against delegation are permitted,<sup>88</sup> the ability of HEW to enforce fair treatment of HMOs under this provision is not clear.<sup>89</sup> Since most HMOs will be monitoring their own care for internal purposes in any case,<sup>90</sup> external review by a PSRO or a hospital would be largely duplicative. Furthermore, not all PSROs will be totally objective in their view of HMOs, and a PSRO's discretion to delegate case-by-case review or the conduct of MCEs and profile analysis could easily be used to reward compliance with its preferences regarding an HMO's growth and competitive aggressiveness. The best HEW policy would be to require automatic delegation, at least of hospital-admission and continued-stay review, to any HMO adopting appropriate procedures. Such delegation should, of course, be subject to subsequent revocation if inadequacy were established.<sup>91</sup>

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the duty) to conduct its own MCEs, even after delegating authority to an HMO hospital to conduct MCEs. *Id.* § 720.01. (The provisions on profile analyses are unclear, but the same may well be true of them also, though it seems anomalous to have separate reviews of the same providers' profiles. *See id.* § 710.21.) Thus, delegation of MCE authority does not prevent a PSRO's continuing to direct its own MCEs at an HMO. It would, however, give the HMO a formal means of self-justification.

85. Of course, any HMO could conduct MCE-like evaluative studies whether or not called upon by PSROs to do so. The results might carry more weight, however, if sanctioned by the PSRO, and PSROs would contribute to funding such studies.

86. PSRO Manual, *supra* note 39, § 720.01.

87. 42 U.S.C. § 1320c-4(e)(1) (Supp. III, 1973). The statute provides for no supervision of PSRO discretion. The PSRO Manual, *supra* note 39, §§ 720-720.5, sets standards for delegation decisions, with demonstrated organizational capability as the main criterion.

88. *Id.* §§ 720.07, .08. Chapter XII, on "Reconsideration, Hearings and Appeals," was issued on November 10, 1974, but deals only with appeals from denials of claims for federal payment, not refusal to delegate review duties. However, "procedures are being developed for reconsiderations [not appeals] of determinations regarding the effectiveness of institutional review mechanisms," which is the crux of any delegation decision. *Id.* § 1900 (rev. ed. 1974).

89. Review may be effective only to deal with abuse of discretion. There have, of course, been no appeals as of yet.

90. HMOs' fixed budgets induce internal utilization review, and quality assurance efforts are stimulated by physicians' ethics, competitive pressures, and federal and state legal requirements. *E.g.*, 42 U.S.C. § 1395mm(b)(8) (Supp. III, 1973); *id.* § 300e(c)(8).

91. One analysis of PSRO-like review under the Illinois Medicaid program concludes:

A fundamental principle of a prepaid health program is efficient and effective peer

### III. THE INCOMPATIBILITY OF PSROs AND HMOs

Allowing PSROs to review care rendered by HMOs may seem justified by a simple syllogism: PSROs are to assure the quality of care; HMOs present potential quality problems because of their prepayment feature; therefore, PSROs should regulate HMOs.<sup>92</sup> There are, nevertheless, good policy reasons for apprehension about PSRO supervision of the quality of care in HMOs. The problems stem from the statutory guarantee that PSROs will be representatives of local practitioners and from the inevitable domination of PSROs by fee-for-service practitioners by virtue of their greater numbers and their predominance in the medical societies likely to sponsor most PSROs.<sup>93</sup> Moreover, the statutory directive to PSROs to use "typical patterns of practice" as a touchstone in evaluating care also suggests the hazards to unorthodox providers such as HMOs. The incompatibility of HMOs and PSROs has both medical and economic dimensions.

#### A. Medical Perspectives

1. *Perceptions of Quality*—It is tempting, but wrong, to think that quality in medical care is well understood, at least by experts, and that departures from it are easily identified and corrected. In fact, the relationship between means and ends is frequently unclear.<sup>94</sup> The extent to which (if at all) medical intervention alters the natural history of partic-

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and utilization review. Any prepaid health program must be afforded an opportunity to opt out of PSRO and establish its own peer review methods.

Flashner, *supra* note 54, 1484.

92. Senator Bennett expressed this view in introducing the second version of his PSRO Amendment, noting that "any emphasis on the use of Health Maintenance Organizations as a cost control mechanism demands the existence of an effective quality review mechanism capable of monitoring underservicing." 118 CONG. REC. 1019 (1972). *See also Hearings on H.R. 1 Before the Senate Comm. on Finance*, 92d Cong., 1st & 2d Sess., pt. 5, at 2565-66 (1972), where, in resisting arguments similar to those advanced in this article, Senator Bennett emphasized the importance of having a single review mechanism (PSROs) for all care, on the assumption that different review for different care would involve merely self-review. Of course, the delegation provisions permit PSRO-supervised self-review for HMOs and other institutions and organizations.

93. Senator Bennett expected medical society sponsored organizations particularly foundations for medical care, *see* note 10 *supra*, to form most PSROs. 118 CONG. REC. 32,477 (1972). *See also* B. DECKER & P. BONNER, PSRO: ORGANIZATION FOR REGIONAL PEER REVIEW 64 (1973); *Federally Imposed Self-Regulation*, *supra* note 63, at 826. Most grants for conditional PSROs (none is yet operational) have been to FMCs and other medical society sponsored organizations. *See* OFFICE OF PROFESSIONAL STANDARDS REVIEW, U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, PSRO PROJECT DIRECTORY (2d ed. 1975).

94. For example, Ernest Saward, M.D., Professor of Social Medicine at the University of Rochester Medical School and Chairman of the National Professional Standards Review Council, recently stated: "I see medical knowledge as being islands in a sea of ignorance, a growing archipelago if you will, but unquestionably far more water than land." Address by Dr. Saward to Group Health Association of America, at 2, Oct. 23, 1974 (duplicated).

ular conditions or diseases is sometimes doubtful, and it is even more difficult to find affirmative evidence concerning the value of the myriad possible diagnostic or therapeutic steps which might be taken in each case.<sup>95</sup>

Because of the broad gaps in medical understanding, observers have come to lack confidence in the traditional quality assurance techniques of peer review and medical audit, dependent as they are on evaluations of "process"—that is, on comparing actual treatments rendered with more or less explicit norms prescribing specific steps to be taken for each diagnosis.<sup>96</sup> Such prescribed steps may involve great cumulative expense and may not all be necessary to achieve good results. For example, one study showed that, whereas only two percent of a set of cases could be said to have been handled satisfactorily under professionally developed process norms, sixty-three percent of the cases had produced satisfactory outcomes.<sup>97</sup> Of course, it is possible that one hundred percent compliance with norms would have yielded such benefits to the remaining thirty-seven percent of patients that the added cost would be justified, but one is entitled to doubt it. In any event, it is widely acknowledged that outcomes, where they can be measured, are the most valid indicator of quality of care. In addition to leading ultimately to better judgments about the efficacy of specific therapies, evaluation of care on the basis of outcomes would also register the effect of less scientific factors, such as patient education and doctor-patient rapport.

Analyzing outcomes of medical care is extremely difficult, in part because of professional traditions<sup>98</sup> and the fragmented structure of the

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95. Surprisingly few scientifically controlled studies (randomized or carefully standardized clinical trials) of medical results, or "outcomes," have been conducted to compare the merits of different therapies or therapeutic regimes. See, e.g., A. COCHRANE, *EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES* (1972); P. ELWOOD, *ASSURING THE QUALITY OF HEALTH CARE* (1973); L. MACMAHON & G. PUGH, *EPIDEMIOLOGY, PRINCIPLES AND METHODS* ch. 13 (1972); Brook & Appel, *Quality-of-Care Assessment: Choosing a Method for Peer Review*, 288 *NEW ENG. J. MED.* 1323 (1973).

96. Process oriented quality reviews have in the past seldom formulated explicit criteria for what constitutes acceptable care, relying instead on the reviewers' own subjective judgments. Such reviews, therefore, have typically lacked objectivity and reliability. Donabedian, *Promoting Quality through Evaluating the Process of Patient Care*, 6 *MED. CARE* 181, 187 (1968); Richardson, *Peer Review of Medical Care*, 10 *MED. CARE* 29 (1972). Because PSROs will set explicit norms and criteria, they may avoid the worst of these pitfalls. However, the reason for eschewing explicit criteria has often been substantial professional disagreement on how good results are achieved, and PSROs may be unable to bring about consensus where none now exists.

97. Brook & Appel, *supra* note 95.

98. Doctors typically see quality as skill in treating individual cases according to procedures they have learned; few have been educated to systematically assess quality on the basis of outcomes. There is also professional resistance on ethical grounds to investigating the efficacy of accepted therapies by withholding them from a "control" group of patients.

present delivery system,<sup>99</sup> and in part because of complexities of diseases and of patients which frequently confound statistical evaluations and invalidate comparisons.<sup>100</sup> Thus, although the HMO Act requires that each qualified HMO have a quality assurance program which "stresses health outcomes,"<sup>101</sup> the regulations impose the requirement only "to the extent consistent with the state of the art."<sup>102</sup> PSROs are also apparently expected to look at outcomes,<sup>103</sup> but the limitations of outcomes assessment and the conventions of the profession are such that that examination of process will be the dominant mode of PSRO review for some time to come. The potential problem with such process-oriented review is not so much that it concentrates on the diagnostic and therapeutic steps taken or not taken in a given case<sup>104</sup> as that it may well utilize process norms which have not been validated by outcome studies.<sup>105</sup> Many fee-for-service practitioners have themselves been con-

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99. Gathering outcome data through extensive follow-up of solo practitioners' patients is expensive. Moreover, a practitioner may see too few patients with any one disease to allow valid statistical measures of the success of his treatments. Multispecialty groups or hospitals have more patients, but they seldom have responsibility for all services to a given patient, especially over the long run. Further, since a provider's patients may not be a representative group, this factor impairs the comparability of their outcomes with those of other providers' patients. *See generally* P. ELLWOOD, *supra* note 95, at 36-38. On the other hand, HMOs, comprehensively serving reasonably large, stable, and representative populations over a long period, offer relatively good opportunities for outcome analysis. *See* Brook, *supra* note 21, at 131-33.

100. Because so many variables other than medical treatment affect a patient's health, it is very difficult to test the efficacy of a particular diagnostic or therapeutic step. *See* text accompanying note 95 *supra*. Definition and measurement of good outcomes also pose problems. *See* Starfield, *Measurement of Outcome: A Proposed Scheme*, 52 MILBANK MEM. FUND Q.—HEALTH AND SOCIETY 39 (1974). The effects of treatment can be separated from other factors only by painstaking experimentation, such as randomized controlled trials, e.g., A. COCHRANE, *supra* note 95, at 2, 22-25, or rigorous statistical regression analysis, e.g., Bush, *Health Indices, Outcomes, and the Quality of Medical Care*, in PROCEEDINGS OF THE CONFERENCE ON EVALUATION IN HEALTH SERVICES DELIVERY (R. Yaffe & D. Zalkind eds. 1975).

101. 42 U.S.C. § 300(e)(8)(A) (Supp. III, 1973).

102. 20 C.F.R. § 110.108(j)(1) (1974); 39 Fed. Reg. 37,315 (1974).

103. The PSRO statute does not mention outcomes, and the PSRO Manual requires no outcomes analysis, though some provisions seem to suggest judging procedures by their results. *See* PSRO Manual, *supra* note 39, §§ 701, 705.14(a), .15(a). *See also* note 105 *infra*.

104. For example, criteria for admissions review are to specify "the appropriate nature of a pre-admission work-up" and "the types of services" to be provided. PSRO Manual, *supra* note 36, § 705.16. The alternative to concentrating on specific services would be to use comparative outcome assessments to exempt providers whose results were deemed acceptable. While this mode of regulation is suggested for dealing with obstetrical admissions, *id.* § 705.14(a), there is no suggestion that HMOs might be exempted from case-by-case review generally on the basis of scientific outcomes assessment. *See also* note 59 *supra*. If workable, such regulation would be appropriate for all providers, and particularly so for HMOs. *See generally* P. ELLWOOD, *supra* note 95, ch. 4.

105. PSRO norms, criteria, and standards for reviewing individual care need not be scientifically justified by such recognized techniques as the randomized controlled trial. *See* PSRO Manual, *supra* note 39, §§ 709 *et seq.* Retrospective reviews like MCEs and

cerned that PSROs may propagate a "cookbook" approach, leaving little room for practicing the art as well as the science of medicine,<sup>106</sup> but it is clear that HMOs have the most to fear from process review based on a "one-right-way" approach to medical care.

A PSRO concentrates on reviewing individual services to individual patients and not on evaluating the overall services to a population.<sup>107</sup> Looked at through a PSRO's peephole, each tree in the HMO forest might seem less than perfect even though the forest itself might present a quite remarkable vista if viewed as a whole. The comparative strengths of HMOs do not lie in the acute, institutional care subject to PSRO review, and it is quite possible that any deficiencies in willingness to hospitalize or to do everything conceivable for the demanding inpatient might be more than offset by the HMO's many distinct qualitative advantages over the fee-for-service system.<sup>108</sup> As long as PSROs concentrate on reviewing individual services in accordance with the thrust of their statutory mandate, their quality assessments can give little or no weight to HMOs' comparative advantages in such areas as providing access to outpatient care, facilitating referrals and specialists' consultations, or maintaining a unitary record accessible to all medical personnel treating the patient. Further, a PSRO has no way of recognizing that high costs to the HMO involved in complying with quality dictates in one area could necessitate cutting back in other areas. Such cutbacks in quality would have to be made in areas that the PSRO does not monitor, which are just those areas where many of the HMO's special quality advantages lie—in preventive care, patient education, ease of patient access, and the like. Precisely because these services are not part of "typical patterns of practice" in the community at large, PSROs are unlikely to resist their sacrifice. The PSRO law does not recognize that quality can take many forms and that quality of care in an HMO includes components often absent in fee-for-service medicine and not measured by traditional methods of quality review.<sup>109</sup>

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profiles analyses might be expected to make more extensive use of outcomes analysis, and indeed MCE criteria "based on scientifically derived evidence of the efficacy of a given . . . procedure" are called for. *Id.* § 705.35(a). But such scientific evidence is not required; in its absence, the "best judgment of experts" suffices. *Id.* See also Simmons, *supra* note 37, at 7 (noting that MCEs would show, among other things, "unusual variations in . . . outcomes of care among providers"); *PSRO-HMO Relationships*, *supra* note 53, at 17-18 (calling for MCEs to "help validate criteria" by determining the impact of various factors on HMO enrollees' health) (emphasis added).

106. See, e.g., AM. MED. NEWS, *supra* note 63; *id.* May 20, 1974, at 19-20, col. 1.

107. Although MCEs and profile analyses might take a larger view, even these are limited to care provided to classes of institutionalized patients not to entire populations, including outpatients and the nonsick, like those served by HMOs.

108. See notes 14 & 32 *supra*.

109. The inability of a PSRO to recognize such aspects of HMO quality to some extent results from limiting its review to inpatient care. Extending its review would not totally obviate the problem, however, since a PSRO necessarily views each type of patient and service in isolation. No particular HMO service is exactly comparable to its fee-for-



2. *The Relevance of Cost in Appraising Quality*—PSROs and HMOs will view quality differently not only because of their different approaches to medical care, but also because of their fundamentally different ways of looking at costs. An HMO, with a fixed budget, must persuade its doctors to consider the resource cost of each additional service they prescribe. In contrast, when a PSRO determines whether a treatment is “medically necessary” or whether additional services are needed to reach a professionally set standard of quality, it faces no resource constraint. The bottomless federal exchequer will pay if the PSRO approves.

In allocating its limited resources to meet the various needs of the entire population which it is obligated to serve, an HMO must decide among such options as extra diagnostic tests for surgery inpatients, more doctors for its outpatient clinics, longer recuperative hospital stays, and more time off for continuing professional education. Facing a choice between helping patients with condition *A* a little or helping patients with condition *B* a lot, it can choose the latter course in good conscience, perhaps also making an independent decision that providing the *A* benefit as well would not justify a higher enrollment charge—that is, would not be worth the cost to subscribers. Moreover, HMOs have a continuing interest in finding cheaper ways of achieving good medical results, and they will adopt new low-cost methods as a way of releasing resources for other uses. A small loss in quality might sometimes seem acceptable if the resources saved could achieve gains in other areas. Nowhere else in the health care system is anyone as consistently interested in comparing the costs and benefits of medical procedures as is the HMO.

In contrast to HMOs’ constant awareness of costs and the necessity for choice, PSROs can only view each case (or category of cases) in medical isolation, deciding whether procedure *X* will sufficiently benefit patient *A* (or patients with condition *A*) to be deemed “medically necessary.” This decision is made in absolute terms, not relative to patient *B*’s need for procedure *Y*, since, if the PSRO approves, both may be reimbursed under the open-ended federal financing program. Further, a PSRO has no mandate to determine how a limited number of federal health care dollars can buy the most health and no power to reallocate dollars among patients or treatments. In short, a PSRO need not rob Peter to pay Pauline and, indeed, cannot benefit Pauline by depriving Peter. So, from seemingly praiseworthy motives, the PSRO will approve giving both Peter and Pauline anything of medical benefit, regardless of cost, thus maximizing the “quality of care” for patients within its jurisdiction and the region’s claims on the federal treasury.

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service counterpart because it is part of an integrated system of comprehensive care. Further, such “structural” aspects of HMO quality as ease of access and unit medical record are not themselves “health care services” whose quality PSROs are directed to review.

HMOs' ability to balance costs and benefits could be quite thoroughly stifled by PSRO review, which stresses quality considerations to the almost total exclusion of cost factors. The fee-for-service doctors who will dominate PSROs have developed a strong ethical belief that "everything possible" should be done for a patient, and they tend to expect health insurers or the government to pay for everything which has some medical value. They also have a strong economic interest in maintaining demand for their services, and they will not easily be convinced that some of their ministrations are dispensable or replaceable by cheaper modes of treatment. Experience with municipal building codes, which may have been reasonable when first adopted but which later proved impregnable to needed change,<sup>110</sup> suggests that cheaper ways of doing things may not be easily adopted by self-regulatory bodies in medicine. In resisting economizing changes, PSROs will appear to be actively defending patients from poorer-quality methods of care and to be only incidentally securing the income of doctors and hospitals.

PSROs' inhibitions of HMOs' legitimate cost-saving innovations could occur for an even more fundamental reason than simply the different perspective of HMO and PSRO doctors. A cost advantage enjoyed by an HMO could make it an effective competitor in enrolling nonfederally supported patients as HMO enrollment fees become more attractive in comparison with health insurance premiums and other costs of equivalent fee-for-service care. There would surely be some temptation, and at least some opportunity, to use PSRO regulatory power over care rendered federal beneficiaries to minimize this competitive threat. Indeed, fee-for-service doctors in a PSRO could easily convince themselves that the suppressed competition was unfair and unethical, since it encouraged corner cutting and reductions in the quality of care, as fee-for-service doctors define it.

#### B. *PSRO Discrimination Against HMOs*

The foregoing hazards can be of course made to seem less than crucial by assuming an all-wise PSRO, capable of appreciating the strengths and weaknesses of HMOs and of maximizing the former while minimizing the latter. Although such a PSRO would have to suspend many of the predilections and prejudices of its participating doctors in order to accept the patterns of practice developed in HMOs and to introduce cost factors into its judgments concerning medical necessity, some PSROs may in fact achieve this level of detachment. The best prospects for fair treatment would probably exist in PSROs which enlist

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110. See, e.g., R. BABCOCK, *THE ZONING GAME: Municipal Practices and Policies* 16 (1966); NATIONAL COMMISSION ON URBAN PROBLEMS, *BUILDING THE AMERICAN CITY* 254-72 (1969). Building standards, like PSRO criteria, have also been criticized for not setting operationally meaningful performance levels and for not being justified in terms of their proven impact on public safety and health. See, e.g., Note, *An Analysis of the Probable Impact of the California Factory-Built Housing Law*, 23 *STAN. L. REV.* 978 (1971).

HMO physicians extensively in the review process and delegate large amounts of responsibility to the HMOs themselves. Federal vigilance against discrimination might also help,<sup>111</sup> and provable overt discrimination might give a frustrated HMO a treble-damage remedy against the PSRO under antitrust laws.<sup>112</sup>

Nevertheless, the PSRO mechanism will enable fee-for-service practitioners to discriminate against HMOs if they are so inclined. Most PSROs will be heavily dominated by fee-for-service practitioners because the number of HMOs remains small and the number of HMO physicians is appreciable in only a few PSRO regions.<sup>113</sup> Moreover, each PSRO has great discretion in defining quality<sup>114</sup> and in concentrating efforts to upgrade deficiencies it purports to find.<sup>115</sup> Further, HEW officials, in addition to lacking sanctions to enforce nondiscrimination effectively,<sup>116</sup> would find it difficult to establish the existence of discrim-

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111. The Senate Finance Committee recognized the dangers and condemned PSRO discrimination in strong language, S. REP. NO. 92-1230, *supra* note 36, at 267, but created no effective sanctions to prevent it. See note 116 *infra*. The PSRO Manual does not even rhetorically forbid it.

112. The battle would be an uphill one, however. See, e.g., Marjorie Webster Jr. College v. Middle Atlantic States Ass'n of Colleges & Secondary Schools, 432 F.2d 650 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970); Structural Laminates, Inc. v. Douglas Fir Plywood Ass'n, 261 F. Supp. 154 (D. Ore. 1966), *aff'd*, 399 F.2d 155 (9th Cir. 1968), *cert. denied*, 393 U.S. 1024 (1970). The leading precedent on the scope of antitrust liability for a statutory self-regulatory agency is *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963), which might impose certain procedural requirements on PSROs in dealing with HMOs, particularly if HEW's powers of review were seen as insufficient protection against abuse. The case suggested a "breathing space" for self-regulation so that not every mistake would necessarily result in treble damages. *But see id.* at 360. Even so, the courts should be attentive to the potential for using PSROs anticompetitively against HMOs and should be willing to apply antitrust remedies in an appropriate case. See *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *Group Health Cooperative v. King County Medical Soc'y*, 39 Wash. 2d 586, 237 P.2d 737 (1951); *cf. Hospital Bldg. Co. v. Rex Hosp.*, 1975 Trade Cas. 65,509 (4th Cir. 1975); *Doctors, Inc. v. Blue Cross*, 490 F.2d 48 (3d Cir. 1973).

113. By one count, there are only 181 operational HMOs in the entire United States. Almost half are in a single state (California), while nineteen states have only one or two HMOs, and fifteen states have none. R. WETHERVILLE & J. NORDBY, *supra* note 9, at 4.

114. Although the statute seems to contemplate overruling unreasonable local PSRO standards by the National Professional Standards Review Council, 42 U.S.C. § 1320c-5(a) (Supp. III, 1973), the PSRO Manual, *supra* note 39, § 709.12, gives final authority to each PSRO to accept, modify, or reject suggestions from the National Council. See also Havighurst & Blumstein, *supra* note 25, at 47-51.

115. The PSRO Manual as currently written, gives each PSRO total discretion as to what diagnoses, physicians, or institutions will be subject to or exempted from individual reviews. See PSRO Manual, *supra* note 39, §§ 705.14(a)(2), .14(b)(3), .15(b), .23. Likewise, MCEs' retrospective review of categories of diagnoses, treatments, or physicians is entirely discretionary. The only requirement is that each PSRO (or delegatee) perform at least one MCE at all times. *Id.* § 705.33. Requirements for profile analysis have not been issued. See *id.* § 710.2.

116. The only available sanction is the ultimate one of terminating the PSRO con-

ination if all that had occurred was the application of a uniform standard to all providers of care.<sup>117</sup> In view of these circumstances, the potential for discrimination cannot be discounted even if PSRO insensitivity to HMOs' special characteristics can be overcome.

The historical antagonism of organized medicine towards HMOs<sup>118</sup> reinforces doubts about PSROs' ability to discharge their public responsibilities in regulating the quality of care in HMOs. It is true that in recent years HMOs have achieved a certain "nervous respectability"<sup>119</sup> and that the American Medical Association (AMA) has now endorsed the concept of "pluralism" in health care delivery.<sup>120</sup> Nevertheless, antagonisms continue to flare from time to time,<sup>121</sup> and are particularly likely to occur where there exists a foundation for medical care or a broad-based individual practice association whose doctors dominate the PSRO and perceive themselves as being in direct competition with the HMO. A wide variation in the degree of harmony between local PSROs and HMOs can therefore be anticipated. The AMA's guarded acceptance of the HMO concept, as spokesman for the profession nationally,<sup>122</sup>

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tract. 42 U.S.C. § 1320c-1(d)(2) (Supp. III, 1973). Given the extreme nature of this sanction and HEW's strong desire to make PSROs work, it is very unlikely that it will even be imposed. Further, if one PSRO is disbanded and another formed, the same people will be involved—the area's physicians. See note 39 *supra*.

117. For ways in which PSRO standards applicable to all providers take inadequate account of valuable HMO attributes and raise HMO costs, see text accompanying notes 107-09 *supra*. On the other hand, HMO advocates have frequently complained of special requirements imposed on HMOs but not on other providers or prepayment plans. See, e.g., INSTITUTE OF MEDICINE, HMOs, *supra* note 5, at 55-56; *Hearings on Competition*, *supra* note 23, at 1468.

118. See generally *Prepaid Group Practice*, *supra* note 5, at 954-75; Comment, *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 938, 977-96 (1954).

119. Group Health Association of America, *supra* note 17 (addressed by Senator Bennett). This characterization of HMOs' status in the medical world was the most encouraging Senator Bennett could offer, even in a speech designed to win HMO support for PSROs.

120. The AMA House of Delegates recently gave the AMA Board of Trustees a vote of confidence on guidelines for national health insurance, including "Maintenance of pluralism in health delivery systems." AM. MED. NEWS, Dec. 9, 1974, at 1, col. 1. See also *American Medical Ass'n, Principles of Medical Ethics*, § 1(4), in OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL (1971), stating:

Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives . . . .

121. See, e.g., *Hearings on Competition*, *supra* note 23, at 99, 1597 (testimony of J. Bernal and Exhibit 3 following testimony of J. Riley).

122. See, e.g., *Hearings on H.R. 5615 & 11,728 Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 92d Cong., 2d Sess., ser. 92-89, pt. 2, at 333-41 (1972) (statements of Drs. Kernodle & Roth for the AMA), suggesting that, despite the long term existence of prepaid group practice, the HMO was an untested form of medical practice whose existence should not be fostered

will not necessarily carry great weight at the local level, where PSROs are organized, nor will it prevent opposition to particular HMOs which could be deemed, for one reason or another, to fall outside the limited AMA endorsement.

C. *The Deceptive Character of Apparent Harmony*

PSROs may further the dominance of fee-for-service medicine, thus reducing diversity in medical practice and raising costs, whether or not they engage in actual overt discrimination against HMOs. Indeed, harmonious relations between PSROs and HMOs, though seeming to prove that their incompatibility is merely a theoretical problem, could easily hide a situation no less objectionable than overt repression but far more difficult to identify, let alone to alter.

It is, of course, conceivable that PSRO-HMO harmony could result from PSRO doctors' allowing HMOs nearly total autonomy, accepting the consequent philosophic and economic competition, and interfering in both HMO and fee-for-service practice only when abuses are clear. Nevertheless, given fee-for-service practitioners' traditional suspicions and hostility toward HMOs, their potential power under PSRO law, and the law's bias toward uniformity in medical practice, an absence of overt conflict is more likely to be due to existing HMOs' "knuckling under" and to discouragement of market entry by potential nonconformists. The mere existence of PSROs' substantial powers, even though unexercised, is likely to have a chilling effect which produces harmony, but only at the hidden cost of discouraging HMOs from being too innovative or enterprising. The stifling effect of PSRO control might well reach beyond the federal programs directly affected, causing setbacks to the promise of the HMO concept which would probably be undetectable even by sophisticated observers. HEW would in all likelihood be helpless to rectify matters through supervision or appellate review.

The chilling effect of PSRO quality regulations would be felt by both existing HMOs and potential HMO developers. Delegation of review responsibility would serve as the ultimate reward to induce existing HMOs' good behavior, as defined by PSRO doctors. On the other hand, new HMO entrants, lacking a track record, would probably be denied the privilege of self-monitoring in a presumptively reasonable exercise of PSRO discretion. More subtly, the PSRO's discretionary power to impose burdensome reporting requirements, to require in-depth reviews and site visits, and to initiate threatening MCEs, all of which could certainly be done without more than anecdotal evidence or a showing of deviation from traditional standards, would be substantial intimidating factors, likely to foster compliance with the PSRO preferences and fee-for-service-style norms and to discourage entry by HMOs which en-

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except on an experimental basis. Compare, e.g., Iglehart, *Intense Lobbying Drive by Medical Group Dims Prospects for HMO Legislation*, 4 NAT'L J. REP. 1404 (1972).

tertain different ideas. At all points, there would be great pressure on HMOs to accommodate their practices to PSRO standards rather than to press their case for different standards or greater autonomy. Resistance to particular impositions would entail not only the costs of prosecuting a difficult appeal to HEW in the face of the usual presumption of administrative regularity, but also costs which might attend heightened tensions and vulnerability to the PSRO's informal sanctions.

HMOs most likely to be scrutinized by PSROs would be those most inclined to compete aggressively with existing providers. These would include, in particular, profit-making plans, which conveniently enough, would also be plausible targets for opposition on quality-of-care grounds. On the other hand, if an HMO of similar quality were organized primarily to serve the poor, it might seem somewhat less threatening to PSRO physicians serving primarily middle-class patients. By the same token, HMOs controlled by a local hospital or medical school or by the local Blue Cross plan might seem from past experience to be more amenable to reaching understandings with the fee-for-service sector. Although such plans might not encounter great difficulty from PSROs, their success would mask the absence of cost-saving initiatives by plans seeking to compete on the basis of prices as well as quality.

It is far from clear that active participation by HMO doctors in PSRO affairs would ameliorate these problems significantly.<sup>123</sup> Although HMO physicians might educate their fee-for-service colleagues in some useful respects, collaboration might well facilitate arrival at a cartel-like division of markets and agreements by both sectors not to compete too energetically or in certain specified ways. Moreover, there is no reason to think that existing HMOs, any more than fee-for-service providers, would welcome new HMO competition in the community or would strive to protect the right of new plans to innovate.

Those who are attracted to HMOs for their own sake, but who attach little importance to the goal of a more competitive system, might be quick to accept apparent PSRO-HMO harmony as evidence that all was well. Even though many unique features of HMOs, including their price advantage, might have been sacrificed to accommodate PSRO physicians or the PSRO's fee-for-service-style norms, these observers would probably be content to discover the existence of a "pluralistic" system in which some form of comprehensive prepaid care was available and in which quality concerns had been largely put to rest. In approving this state of affairs, these HMO advocates would share the view of the AMA, whose endorsement of "pluralism" is an implied rejection of meaningful competition focusing on price as well as on the quality of care and the comparative strengths of different delivery systems.

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123. Senator Bennett's view was that participation by HMO physicians in PSRO review activities would guarantee fairness and nondiscrimination. See, e.g., *Hearings on H.R. 1*, *supra* note 92. However, HMOs are at best a minority form of practice even where they are established and would probably have little influence in PSRO councils.

Advocates of HMOs as a source of needed competition would regard HMOs which were locked into an explicit or implicit PSRO-sponsored cartel with fee-for-service doctors as being only slightly preferable to no HMOs at all. Their interest lies in preserving HMOs' ability to evolve and to offer a different style of care and a range of alternative plans, including some of somewhat lower quality and substantially lower cost. They believe that such market choices are necessary with regulatory protection, to introduce an appropriate degree of cost-consciousness into the health care system.

#### IV. CONCLUSIONS: DIVORCE OR ACCOMMODATION?

The hazards posed by PSRO review of HMOs, while real, are more prospective than immediate. For one thing, PSROs face a long start-up period and, even after becoming operational, will continue to expand and intensify their review efforts, reaching their full potential for good or ill only at some indefinite future date. Moreover, so long as PSROs review only institutional care, HMO doctors will be largely free to substitute outpatient care for some inpatient care; but such substitution, which is vital to HMOs' success both medically and economically, would remain vulnerable to PSROs' eventual election to cover outpatient care and impose standards based on "typical patterns of practice." Finally, HMOs are not currently dependent in large measure on Medicare and Medicaid beneficiaries, whose care alone is legally subject to PSRO review. HMOs have been slow to enroll participants in these programs on a prepaid basis because of nonconductive federal and state reimbursement policies and failure of the programs themselves to encourage beneficiaries to seek out efficient providers.<sup>124</sup>

At present, therefore, the problems of PSRO control over HMOs may seem insignificant in comparison with the many other obstacles which currently face HMOs. Indeed, HMOs and their supporters have themselves not yet identified PSROs as a major problem, in part because, like everyone else, they have found it hard to envision just how PSROs will operate.<sup>125</sup> In recognition of the need for better prognostication, this article has attempted to predict PSRO performance with respect to HMOs, finding grounds for concern which range from the danger of inadvertent homogenization of medical practice to the worrisome opportunities presented for anticompetitive or other intentional misuse of PSRO power. How serious these concerns are, of course, depends greatly on the ultimate extent of PSRO control and influence. But, even in the short run, malpractice fears and voluntary arrangements with health insurers may expand PSRO impact well beyond federally funded inpatient care; and, in the long run, PSROs are very likely to be relied

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124. As to federal program beneficiaries enrolled in HMOs, see note 9 *supra*.

125. See, e.g., INSTITUTE OF MEDICINE, HMOs, *supra* note 5, at 31-32.

upon as the principal utilization and quality monitor under national health insurance.<sup>126</sup>

While it is necessarily speculative to predict the loss of HMOs' special cost and qualitative advantages under PSRO supervision, the risks are great enough to suggest that excessive confidence has been placed in PSROs. Not only is PSRO-HMO compatibility in doubt, but there is as yet no proof of PSROs' effectiveness as operational self-regulatory mechanisms even in their natural habitat—the fee-for-service sector. Many of the PSRO prototypes being relied upon, however promising, were launched voluntarily as demonstration projects by elite elements of the medical profession or by more typical physician groups acting on their best behavior, while other models, including some of the most successful, were prompted primarily by competition from independent HMOs. Generalizing the successes of these prototypes is therefore difficult in any event, but it will be even more difficult if the prod of future HMO competition can be dulled by the efforts of PSROs themselves.

The conclusions which emerge from this analysis of PSRO-HMO interactions relate both to PSROs' role under existing law and to their likely increased future role. It is ironic that the effect of subjecting HMO care to PSRO review could well be not only to impair another promising mechanism for improving the health care system, but also to weaken an important potential guarantor of good performance by PSROs themselves. Policymakers should seriously consider the advantages of allowing HMOs a substantial degree of independence from PSRO supervision.

#### A. *The Case for Divorce on the Ground of Incompatibility*

Because PSROs are charged with overseeing all Medicare and Medicaid spending, it may seem logical that they should supervise the utilization practices and quality of care of all providers alike. But all providers are not alike. With fee-for-service providers, the chief hazard, which more than anything else prompted enactment of the PSRO program, is costly overutilization of resources in pursuit of questionable or small health benefits. On the other hand, underutilization, leading to low quality, is the danger apprehended in economy-minded HMOs.<sup>127</sup> Assigning two such distinct problems as controlling cost and upgrading quality to a single agency is a dubious policy in light of experience with other regulatory agencies charged with regulating an entire industry, while also promoting its basic service. In such cases, one view of the

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126. See notes 44 & 45 *supra*.

127. Both types of health care provider could of course be guilty of providing services of unacceptable quality. However, PSROs' sanctions are designed to deal effectively with this problem only in the fee-for-service sector (by withholding payment) and not in prepaid HMOs.



agency's prime mission, usually the one favored by the industry in question, has tended to predominate over the other.<sup>128</sup> Correspondingly, PSROs' assumed mandate to improve the overall quality of health care seems certain to win out (if it has not already) over cost control, and HMOs—never the best understood providers or the most popular with physicians—are likely to have their costs escalated and their qualitative advantages impaired in the process. For these reasons, PSROs should be relieved of their regulatory jurisdiction over HMOs.<sup>129</sup>

Although HMOs' quality-of-care record is generally good,<sup>130</sup> all HMO proponents recognize the need to guard against possible overeconomizing, shortrun profiteering, and other failings. The best means of meeting this need is not by subjecting HMOs to review by PSROs, but by a separate quality assurance program established at either the state or federal level to monitor HMO deficiencies. The appropriate scope of such HMO regulation is debatable, however. Many observers would subject HMOs to extensive statutory and regulatory requirements similar to or more extensive than those of the 1973 Act.<sup>131</sup> Others favor greater diversity and would leave more to consumer choice with improved information, relying in part for quality assurance on HMOs' need to provide an attractive service in order to compete successfully with high quality oriented fee-for-service medicine.<sup>132</sup> Strict regulation presents the hazard that—as is practically guaranteed under PSROs—HMOs would be required to adapt to traditional input and process standards, since such standards would be the easiest for the regulators to adopt and defend. Use of detailed specification of inputs and case-by-case review of the process of care could easily raise HMOs'

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128. Such inconsistent dual mandates to the Civil Aeronautics Board and the Atomic Energy Commission, for example, have allegedly led to favoring the regulated industry's interest at the expense of the public's, even though the CAB and AEC (unlike PSROs) were ostensibly independent of their respective industries. *See, e.g.*, W. JORDAN, AIRLINE REGULATION IN AMERICA, EFFECTS AND IMPERFECTIONS (1970); Gillette, *Nuclear Safety (III): Critics Charge Conflicts of Interest*, 177 SCIENCE 970 (1972); Pillai, *The CAB as Travel Regulator*, in THE MONOPOLY MAKERS 159 (M. Green ed. 1973). Partly in recognition of this problem, The Energy Reorganization Act of 1974 divided the AEC's promotional and regulatory duties between the Energy Research and Development Administration and the Nuclear Regulatory Commission. 42 U.S.C.A. §§ 5801 *et seq.* (Supp. 1975). Of course, "capture" by its industry is a recognized occupational hazard for any regulatory agency, regardless of its mandate. *E.g.*, R. NOLL, REFORMING REGULATION 33-46 (1971).

129. Although a PSRO regulating only fee-for-service providers might continue to overemphasize quality assurance at the expense of cost control, a dual mandate is less troublesome where the regulated sector faces competition. *See notes 139-41 and accompanying text infra.*

130. *See notes 14, 32 supra.*

131. *See* 39 Fed. Reg. 37,315 (1974) (HMOs under the 1973 Act); 39 Fed. Reg. 30,935 (1974) (HMOs prepaid under Medicare); 40 Fed. Reg. 20,516 (1975); 40 Fed. Reg. 20,954 (1974) (HMOs prepaid under Medicaid). For a full discussion favoring heavy regulation see Schneider, *Model Consumer Health Maintenance Organization Act and Commentary*, 6 RUTGERS-CAMDEN L.J. 265 (1974).

132. *E.g.*, INSTITUTE OF MEDICINE, HMOs, *supra* note 5, at 7-18, 51-61.

costs unnecessarily and impair their unique ability to allocate resources to their most productive uses. On the other hand, more than minimal regulation of HMOs is needed to compensate for unaided consumers' inability to detect many qualitative deficiencies, and for the limits which market structure and other circumstances frequently place on their range of choice.<sup>133</sup>

An HMO quality assurance agency should strive to assure that a full range of appropriate quality-cost options is made available to consumers—range of choice such as would be unlikely to emerge under a PSRO's regulatory aegis. Of course, such a variety of competing quality-cost combinations will not be appropriately weighed by beneficiaries of federal financing programs so long as such beneficiaries perceive only limited benefit to themselves in electing a more economical plan.<sup>134</sup> For this reason, Medicare and Medicaid beneficiaries should be given substantial incentives to economize in their choice of health care plans.<sup>135</sup> If these prescriptions were followed, the presence of independently regulated HMOs would allow increased reliance on consumers' choices to

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133. One developed non-PSRO quality assurance scheme would have a "Health Outcomes Commission" monitor both HMOs and other providers on an elective basis. P. ELLWOOD, *supra* note 95, at 89-125.

134. Like PSROs, federal beneficiaries currently have little financial stake in how federal program resources are used and, therefore, small reason to weigh the cost and quality of health services. However, the opportunity to escape the deductibles or coinsurance requirements of Medicare, the coverage limits of both Medicare and Medicaid, and the surcharges of some Medicare providers might induce some nonindigent beneficiaries to join a prepaid HMO which applied its cost savings to reducing cost-sharing requirements or expanding benefits. (Nevertheless, HMOs have accepted prepayment for federal beneficiaries only to a limited extent. *See* note 9 *supra*.) Indigent beneficiaries are less likely to be influenced by the need for out-of-pocket expenditures either because Medicaid will pay them or because excess costs will be absorbed by providers.

135. One way of strengthening incentives, without requiring cash outlays by low-income consumers (*see* note 134 *supra*), would be to allow an HMO to pay to its federally supported subscribers a cash rebate or year-end dividend based on experience. Although to some extent this would allow needy federal beneficiaries to take cash in lieu of health care benefits, this should not seem inappropriate provided adequate minimum standards are maintained. Indeed, less than the highest standard of care is probably optimal for most Americans, given the limits of personal and national resources, the limited efficacy of much medical care, and the fact that other things may rationally be valued above "spare-no-expense" medicine.

Despite objections to the rebate or dividend approach on the ground that some program dollars would be spent on things other than increasing medical care for the formerly underserved, it seems philosophically preferable to allow the dollar savings from possibly reduced quality to accrue to the affected patients themselves, rather than to providers or the government, as would occur under the limited cost-saving incentive allowed HMOs under the Social Security Act Amendments of 1972. 42 U.S.C. § 1395mm(a)(3)(A) (Supp. III, 1973). These amendments allow certain HMOs to retain half of the first twenty percent of the savings they may achieve over the costs of other Medicare providers and gives the government, not enrollees, the other half. *Id.* § 1395mm(a)(3)(A)(i)(I). In any event, such incentives for middle-income participants under federal programs or national health insurance should prompt no concern. Whether national health insurance will preserve such incentives (*e.g.*, by mandating private purchase of coverage) remains to be seen.

determine, within regulated limits, the appropriate balance between the quality and the cost of health care. This would be a promising means of achieving the cost-control as well as the quality-assurance goals of the PSRO legislation, which PSROs themselves might well sacrifice in pursuit of professional objectives if not prodded to examine fee-for-service sector costs by consumers' interest in potentially lower-cost HMO alternatives. Indeed, the design of national health insurance would profit from recognition of the importance of preserving consumers' incentives and opportunities to select a health care plan on the basis of cost as well as quality, convenience, amenities, and other factors.

If cost-conscious consumers were to be encouraged to choose among a wide range of quality-cost options, concern might properly be raised about improvident choices, particularly by low-income persons who might be unduly tempted to "cash in" their government-provided health benefits. A requirement that all plans enroll a substantial proportion of middle-income consumers who have freely chosen the plan on the basis of comparative quality, cost, and other factors would assure that each plan had passed, and could continue to pass, the test of a marketplace in which no purchaser was unduly necessitous.<sup>136</sup> With this basic safeguard, regulators of the quality of care in HMOs could concentrate on assuring that appropriate minimum quality standards were being met in those phases of HMO operation where consumers are least able to assess HMO performance<sup>137</sup> and where there are only weak protections of other kinds.<sup>138</sup> HMO regulators should also take steps to assure fair

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136. See Havighurst, *HMOs*, *supra* note 10, at 729-32. The 1972 Social Security Amendments imposed a similar requirement that at least one-half of the membership of an HMO enrolling Medicare beneficiaries must consist of people under age sixty-five. 42 U.S.C. § 1395mm(b)(7) (Supp. III, 1973). Medicaid regulations specify that no more than half the members can be Medicare or Medicaid beneficiaries. 40 Fed. Reg. 20,518 (1975). See also 42 U.S.C. § 300e(c)(3) (Supp. III, 1973).

137. See INSTITUTE OF MEDICINE, *HMOs*, *supra* note 5, at 51-61. Distinctions can be drawn between technical quality questions and qualitative factors related to access, convenience, rapport, and patient satisfaction with the handling of particular problems. Emphasis should be placed on regulating those technical aspects of care about which good understanding exists but of which patients as a group are relatively ignorant and those measures which are used so infrequently that they minimize the educational value of repeated dealings and word-of-mouth. Regulatory standards imposed on HMOs should be equivalent—which is not to say identical—to those imposed on fee-for-service providers so that HMOs will not be placed at a competitive disadvantage by being held to a higher standard. See *id.* at 56. See also UTAH CODE ANN. § 31-42-6(b)(ii) (1974) (requiring that HMO regulations be based upon "prevailing standards for quality assurance for other forms of health care delivery in the state of Utah").

138. Potential tort or other liability can frequently supply adequate incentives for good quality products or services even if consumer ignorance precludes consumer choice under a principle of caveat emptor from serving this purpose. See, e.g., G. CALABRESI, *THE COSTS OF ACCIDENTS* (1970); Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK MEM. FUND Q. 125 (1973); Symposium, *Products Liability: Economics and the Law*, 38 U. CHI. L. REV. 1 (1970).

marketing and financial responsibility, to provide accurate cost and quality-related information to consumers, and to enforce performance of HMOs' contractual commitments. HMO quality assurance efforts should transcend the service-by-service approach of PSROs, avoid domination by traditional fee-for-service providers, and eschew process-oriented review and detailed specification of structure and inputs in favor of outcome measurement wherever possible.

Like many other regulatory bodies, a separate agency for HMO supervision might well come to identify with and promote the interests of its regulated constituency. Assumption of such a promotional role would not be inappropriate in these circumstances, however, since a desirable balance between quality and cost considerations would be prompted not by mere legislative directive, but by HMOs' need to attract consumers to an unfamiliar mode of health care delivery. In such a competitive setting, HMO regulators could be expected to foster, rather than curb, HMOs' competitive effectiveness by allowing flexibility and cost-saving innovations on the one hand and by maintaining quality standards and the HMO sector's reputation on the other. Moreover, since the interest of the HMO sector in offering a variety of reputable plans with different quality-cost mixes coincides closely with the public's interest in diversity and innovation in health services delivery, regulators sympathetic to HMO development would not be forced to choose between serving the industry and serving the public.<sup>139</sup>

If PSROs were not in a position to minimize HMO competition by imposing costly regulatory requirements or by strategic harassment, such competition could be expected in time to stimulate better performance by the fee-for-service sector itself.<sup>140</sup> The most likely mechanisms for coordinating the fragmented fee-for-service system's response to HMOs' competitive challenge are PSROs, whose review functions might be extended beyond federally supported care and exerted to keep private health insurance premiums and other fee-for-service costs at more com-

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139. See notes 128, 129 *supra* and accompanying text. R. NOLL, *supra* note 128, at 38, notes that regulation which espouses the regulated industry's interests may be successful where the public interest happens to coincide. One such example is the Federal Aviation Administration, which implements the joint interest of the public and air carriers in high safety standards, at least at the prevailing prices.

140. Patterns of hospital use, for example, are quite different in the only United States area where HMOs cover a substantial proportion of the population, the western states. Although strongly suggestive of the impact of even limited HMO competition, the data have never been analyzed to eliminate the impact of non-HMO factors. The West has the nation's lowest ratio of hospital beds to population, and also the lowest utilization rate per population. NATIONAL CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, HEALTH RESOURCES STATISTICS: HEALTH MANPOWER AND HEALTH FACILITIES 368 (1974). Of course, the general averages reflect the direct influence of HMOs' own lower utilization rates, but they may reflect HMOs' competitive influences as well. The major fee-for-service insurer's hospital utilization per enrollee population is twenty-seven percent lower in the Pacific region than nationwide. BLUE CROSS ASS'N, THE USE OF HOSPITALS BY MEMBERS OF BLUE CROSS PLANS IN 1973, at 6 (1975).

petitive levels. Although such extension of PSRO supervision could be expected to occur voluntarily wherever HMOs were competing effectively,<sup>141</sup> any national health insurance legislation is quite likely to mandate such broadened review responsibility for all PSROs.

Voluntary or compulsory extension of PSRO jurisdiction beyond the Medicare and Medicaid programs poses the danger that their promotional, quality-enhancing mandate will override their cost-control responsibilities. This hazard would be lessened, however, where HMO competition effectively limited PSROs' discretion and provided them with an incentive to put teeth in their utilization reviews and to incorporate a cost factor in their quality standards. Nevertheless, some might still object to PSRO monopolization of cost and quality control functions within the fee-for-service sector. It is possible to prefer instead the additional competition and further decentralization of decision making which would come about if competing health insurers were free, under HMO stimulus and with professional cooperation induced by competitive pressures, to introduce cost-control and quality-assurance measures of their own.<sup>142</sup>

Faith in HMOs' potential competitive impact on PSROs and the fee-for-service sector must be qualified by recognition of major barriers to HMO market entry which prevent prompt development of a competitive health services marketplace.<sup>143</sup> Nevertheless, PSROs in areas without HMOs might be compelled by active HEW supervision<sup>144</sup> to adopt and enforce those standards of fee-for-service practice which emerge in areas where competition is effective. Moreover, HMOs freed of PSRO control would independently judge the relative value of different kinds of care, develop procedures to identify diagnostic or therapeutic steps which could be omitted with little or no adverse effect, and implement their findings in practice. Appropriately adapted, such findings and the procedures developed for deriving and implementing them could well prove useful to PSROs in improving performance in the fee-for-service sector.

In these ways, a "dual" health care system with separate HMO and PSRO regulation could be expected to come much closer to realizing the objectives of PSRO legislation than PSROs with monolithic power. It is as important to escape Scylla as to avoid Charybdis.

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141. See note 44 *supra*. The expectation that PSROs would respond to HMO competition in the manner suggested is not unreasonable in light of the spontaneous development of foundations for medical care—the forerunners of PSROs—in response to earlier HMO competition. See note 10 *supra*. More comprehensive than health foundations and having a legislative mandate and broad powers, PSROs are well equipped to coordinate the fragmented fee-for-service sector's response to HMO competition.

142. See Havighurst, *Speculations*, *supra* note 10, at 260-62; Enthoven Speech, *supra* note 24, at 20-23. Insurers could, for example, operate HMOs on the "individual practice association" model under the HMO Act. See note 11 *supra*.

143. See authorities cited note 5 *supra*.

144. But see note 114 *supra*.

*B. Ground Rules for Continuing the Relationship*<sup>145</sup>

It is unlikely that an independent quality assurance program for HMOs will soon be established to replace PSRO supervision.<sup>146</sup> Certainly the desire for speedy implementation of some kind of quality and cost monitoring prior to enactment of national health insurance, the sense that HMOs should not seem to get "preferred" treatment, and political pressures from organized medicine all militate against divestiture of PSRO jurisdiction over HMOs. Even without complete HMO independence, however, some of the benefit of relatively autonomous HMOs may be obtainable through adjustments in the present PSRO regulatory framework.

First, HMOs need no PSRO assistance in curbing costs. Any PSRO effort to prevent overutilization by HMOs will almost certainly be unproductive and wasteful. HEW should therefore insist that HMOs be routinely exempted from such utilization review.

PSROs' second mandate, to maintain the quality of care, warrants some PSRO action with respect to HMOs. But quality norms, criteria, and standards should not be used, without careful and specific justification, to force HMOs to deliver fee-for-service-style care, nor should they be employed to harass legitimate providers merely because of a theoretical danger of low quality or underutilization. To avoid these dangers, HEW should require that HMOs be automatically delegated authority to review their own care,<sup>147</sup> with continued delegation dependent to the fullest extent possible upon an HMO's record in keeping subscribers healthy, and not upon its dutifully creating mini-PSRO-style process review using PSRO-approved criteria. Although, ideally, detailed PSRO

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145. This section deals with only the most salient problems of PSRO-HMO coexistence. More detailed comments on many aspects of PSRO-HMO relations must await publication of HEW policies implementing PSRO control over HMOs. See notes 7, 53 *supra*. Although actual experience may prove enlightening, it may also be deceptive and slow to accumulate. Meanwhile, however, some less salient concerns may also be noted. In addition to difficulties previously highlighted, see notes 80, 82, 87, 104, 105, 111, 115 *supra* and accompanying text, these concerns include such problems as: (1) whether PSROs will be directed to monitor HMO care from a broader perspective than isolated individual services (see also notes 108 *supra*); (2) whether HEW will require PSROs to adopt internal procedures giving minority views recognition which they could not get under simple majority rule; (3) whether the statute's provision calling for PSROs to use "professional" and "governmental" influence against nonconformists will be limited to educational as opposed to punitive measures (see also note 71 *supra*); (4) whether HMOs will be allowed to offer, within a single PSRO jurisdiction, different styles of care for different premiums; and (5) what to do in case of conflicting MCE results on the validity of particular PSRO standards.

146. Such an agency could emerge from a thoroughgoing revision of the 1973 HMO Act, however. Many commentators have called for amendments, and some action is pending. *E.g.*, S. 1926, 94th Cong., 1st Sess. (1975); H.R. 7847, 94th Cong., 1st Sess. (1975). See Iglehart, *Health Report-Coalition Pushes for Changes in Faltering HMO Program*, 7 NAT'L REP. 875 (1975).

147. See notes 75-77 *supra* and accompanying text.

supervision of HMO review procedures or direct PSRO review of HMO care should be initiated only where an HMO achieves comparatively poor results as judged by objective outcomes criteria, such total reliance upon the fledgling art of outcomes analysis is visionary.<sup>148</sup> Nevertheless, this should be clearly established as the ultimate goal, and, where lack of knowledge or insuperable methodological difficulties force reliance on more traditional supervision and review measures, HEW should be vigilant against inappropriate requirements and discrimination reflecting the re-emergence of traditional anti-HMO attitudes.

Third, where PSROs directly apply minimum quality standards to HMO care, they should be allowed to impose only outcomes-validated quality criteria except in unusual cases.<sup>149</sup> Basing potentially expensive quality criteria solely on what each PSRO considers expert opinion (or, worse, on typical local practice) is unwarranted if rigorous proof of effectiveness is possible. Because surprisingly little is now known about the efficacy of much of the medical care which claims our society's every thirteenth dollar, PSROs should be required, not merely encouraged, to act vigorously to expand scientific knowledge before establishing their minimum criteria. But, since total reliance on outcomes analysis to validate review standards will never be possible, unvalidated process criteria will sometimes have to be employed. HEW must be alert to their possible misuse.

Finally, HEW should create a special grievance procedure designed for HMOs. In the fee-for-service sector, provider complaints against a PSRO can be aired relatively easily within PSRO membership and on appeal from nonpayment for a disputed service.<sup>150</sup> Because HMOs do not face the sanction of nonpayment for individual services and comprise no more than a small minority of physicians in any PSRO area,

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148. PSRO review could, however, be result-oriented and compare HMOs' success with that of other providers' without having to analyze all possible outcomes. For example, some diseases or conditions might be reviewed as "tracers," a surrogate for monitoring all care. See, e.g., Kessner, Kalk & Singer, *Assessing Health Quality—The Case for Tracers*, 288 NEW ENG. J. MED. 189 (1973). Sampling methods might also be used.

149. See Fifer, *Cost Containment and Quality Assurance: An Adversary Relationship*, HEALTH SERV. INFO. 4 (1974). It would be preferable to require PSRO standards to be not merely effective (to generate good outcomes), but also efficient in order to achieve outcomes that are worth more than the cost of meeting the standards. See generally Havighurst & Blumstein, *supra* note 25, at 60-68; Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141, 1161-63 (1975). It is not certain that this could be achieved under current legislation which does not seem to contemplate such explicit trading-off of costs and benefits in standard setting, and it would be undeniably difficult for PSROs, since it would call for weighing health benefits in dollar terms.

150. This statement is not meant to endorse the PSRO appeals procedure as a perfect mechanism. Fee-for-service providers are rightly concerned, for example, that appeal may be too costly, may be ineffective for small claims, and may not solve many formal problems not crystallized in nonpayment. HMOs would face even more difficult problems in overcoming the presumptions which would probably attach in any appellate review to local practice and practitioners' judgments concerning the quality of care.

they will have no practical way of objecting to PSRO actions.<sup>151</sup> In consultation with representative HMOs, HEW should provide an effective means of protecting HMOs against unfair or inappropriate treatment, perhaps by appointing a tribunal to which such issues could be referred.

HMO supporters who value HMOs primarily for their comprehensiveness and qualitative and organizational strengths and for their emphasis on preventive and primary care, accessibility, and internal efficiency would probably be generally satisfied if the foregoing adjustments in the PSRO program could be effected. Such changes would allow sufficient HMO autonomy to permit consumers a meaningful choice among different styles of delivery, thus securing the benefits of "pluralism"—namely, somewhat greater responsiveness to consumer preferences and a better allocation of resources within the health sector of the economy. Thus, a system featuring autonomous HMOs should realize qualitative advantages and improved access and should provide more value for each health dollar. Of course, substantial steps to facilitate HMO development in other ways would also be desirable if HMOs' promise in those regards is ultimately to be realized.<sup>152</sup>

On the other hand, supporters of HMOs as a new and needed competitive force would view the suggested adjustments in the PSRO program and steps to remove obstacles to HMO growth as necessary, but by no means sufficient prerequisites to realizing HMOs' value in restoring an appropriate level of cost consciousness in the health care system. Achievement of this added benefit would also require attention to preserving or restoring consumers' incentives and opportunities to select a health care prepayment plan with a view to its cost as well as its qualitative features.

Settling for the more limited role for consumers and HMOs contemplated by the notion of "pluralism" would be to place excessive reliance on PSROs to face important resource-allocation issues. Not only do PSROs, as currently structured, lack the incentive to address these issues directly and effectively, but they are in a position to impair both

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151. Currently, PSROs have no effective formal sanctions against HMOs, though they may be able to recommend excluding HMOs from participation in Medicare and Medicaid. *See* notes 62, 71 *supra*. Perhaps PSROs should be able to confront HMOs, as they can other providers, with a somewhat less extreme and more credible penalty than exclusion from federal programs. One such sanction for poor-quality care might be recommendation of retroactive reduction of an HMO's per capita federal prepayments in the fiscal proportion that unacceptable HMO care bears to total HMO care. HMOs would object to the uncertainty introduced by the potential for such retroactive adjustment as an interference with their commitments. Moreover, the existence of a workable minor sanction might facilitate anti-HMO discrimination which would otherwise be politically difficult if a PSRO's only sanction were to totally bar an HMO from federal programs. Nevertheless, HMOs would be somewhat better off if the availability of a clear and appropriate remedy for allegedly deficient quality made it less legitimate for PSROs to turn to more troublesome informal sanctions or harassment.

152. Proposed amendments to the HMO Act currently promise to make some improvement in HMO prospects. *See* note 146 *supra*.



the internal allocative efficiency of HMOs and HMOs' ability to offer consumers good-quality health care for less. In the absence of clearly reliable mechanisms for balancing medical expenditures against the results achieved, it would seem undesirable to foreclose a role for HMOs and consumer choice in dealing with such allocative problems. Moreover, HMOs and consumers can together exert badly needed pressure on the fee-for-service sector and PSROs to improve the former's performance. PSRO-HMO relations should be re-examined in the light of these considerations.

