

DISPELLING THE NEGATIVE MYTHS OF MANAGED CARE: AN ANALYSIS OF ANTI-MANAGED CARE LEGISLATION AND THE QUALITY OF CARE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS

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I. INTRODUCTION

Over the last several years, Florida and other states have made great strides toward improving the availability and quality of health care coverage for their citizens. Many of these improvements result from an increased use of managed care health plans, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs).¹ Health maintenance organizations are beginning to occupy a greater share of the health insurance market,² and studies indicate that the enrollment growth in these managed care plans is a primary factor in the rate of decline in the spiraling costs of health care coverage.³

Some interest groups, however, have promoted legislation that would heavily burden managed care plans by eliminating some of the essential

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1. "Managed care" is a broad term used to describe a variety of health plans which integrate the financing and delivery of health care services. Health maintenance organizations and PPOs are common managed care organizations. "Managed care organizations will generally use a variety of techniques such as utilization review, quality assurance programs, and preadmission certification to better manage the care that is delivered, with the goal of controlling utilization and cost, while still delivering quality care." FLA. H.R. COMM. ON HEALTH CARE, HEALTH CARE HANDBOOK 30-31 (1995).

2. In a survey of more than 250 of Florida's largest public and private sector employers representing more than 900,000 employees, 48% of these employers reported employees choosing managed care rather than indemnity coverage in the past year. Survey participants reported that plan configurations reflected a continuing shift toward managed care. Use of HMO plans increased from 5% in 1993 to 45% in 1994. WILLIAM M. MERCER, INC., 1994 FLORIDA HEALTH CARE COSTS AND BENEFITS: SURVEY RESULTS 2, 4, 6 (Sixth Annual Issue 1994). Nationally, current enrollment in HMOs is nearly 50 million, up from 3.6 million in 1973. Jerry Geisel, HMOs Ready To Give Up an Old Crutch, BUS. INS., Dec. 20, 1994, at 6, 6.

3. For example, the results of the Mercer survey indicate that the switch to managed care has produced cost reductions. Of those organizations where employee enrollment in managed care is now greater than enrollment in an indemnity plan, 80% reported that switching to managed care has helped reduce increases in health care coverage costs. WILLIAM M. MERCER, INC., supra note 2, at 4-6; see generally Geisel, supra note 2 (reporting that the rise in health care costs continued to be low in 1995).

concepts upon which managed care is based.⁴ Proponents of this anti-managed care legislation, including some physicians, claim that HMOs place "profits ahead of patients,"⁵ alleging that HMOs have achieved their cost savings at the expense of the quality of care provided to enrollees.⁶ Much of this proposed legislation is promoted on the basis that it would protect patients and increase the quality of care they receive.⁷ Managed care supporters, however, contend that this proposed legislation actually is designed to help doctors rather than their patients and would only drive up health care costs.⁸ This battle over managed care was waged in legislatures across the country during 1995 and is likely to continue at both the state and federal levels.⁹

The first part of this Article discusses managed care legislation. Specifically, it provides a summary of some of the last five years of Florida's legislative health care advancements incorporating managed care concepts. It then discusses some of the proposed legislation which targets HMOs and other managed care plans. The second part of the Article presents a comprehensive analysis of medical literature comparing the quality of care provided by HMOs to the quality of care provided to patients with traditional fee-for-service insurance.¹⁰ The available literature indicates that the quality of care provided by HMOs is as good as, if not better than, the quality of care provided in a traditional fee-for-service setting.¹¹ Finally, the Article concludes that, because studies show that the quality of care in HMOs is as good as the care provided under traditional insurance coverage, legislation which would cripple managed care in the name of preserving quality is unnecessary and counterproductive.

4. See *infra* notes 29-94 and accompanying text.

5. Craig S. Palosky, *Doctors Want Surgery on HMOs*, TAMPA TRIB., Mar. 27, 1995, Nation/World Section, at 1.

6. *Id.*

7. See Palosky, *supra* note 5, at 5; see also *infra* notes 29-94 and accompanying text.

8. See, e.g., *infra* notes 29-94 and accompanying text.

9. See George Anders & Laura Johannes, *Doctors Are Losing a Lobbying Battle to HMOs*, WALL ST. J., May 15, 1995, at B1, B2.

10. In a traditional fee-for-service health insurance setting the insured chooses the provider for his or her treatment, regardless of the appropriateness of the particular doctor's credentials or specialty (if any). There are few or no economic incentives for the provision of treatment in an efficient, cost-effective manner. See *Alphabet Soup*, TIMES UNION (JACKSONVILLE), Sept. 25, 1995, First Business, at 10. Generally, in a fee-for-service setting, providers are reimbursed based on the amount and type of care given. The more services utilized, the more the provider is reimbursed.

11. See *infra* notes 101-171 and accompanying text.

II. FLORIDA LEGISLATION

A. Legislative Advances in the Provision of Low-Cost Health Care

During the 1980s and early 1990s, the spiraling costs of health care threatened to bankrupt the country. In Florida alone, health care expenditures increased 278% between 1980 and 1991.¹² The state's total health care bill was \$35 billion in 1991 and \$38 billion in 1992.¹³ Without a major change in Florida's health care system, some estimated that Florida's total health care bill would reach \$90 billion by the year 2000.¹⁴ Nationally, as recently as the late 1980s, costs of group health care plans were increasing at more than 15% annually.¹⁵ As a result of these increasing health care costs, more people were forced to forego health insurance.¹⁶

In response, many states have enacted, or are enacting, legislation designed to make quality health care available to their citizens at an affordable price.¹⁷ In 1992, Florida increased its efforts to combat these ills by enacting a series of reforms designed to make health care less costly. The Florida Health Care Reform Act of 1992 contained provisions creating the Employee Health Care Access Act, which initiated reforms in the small group health insurance market;¹⁸ the Florida Health Plan, which developed strategies and implemented goals relating to access, cost containment, health care regulation, and insurance reforms;¹⁹ and the Agency for Health Care Administration, which streamlined the regulation of health care in Florida.²⁰

In the following year, the Florida Legislature enacted the Health Care and Insurance Reform Act of 1993.²¹ Among other provisions, this Act implemented the concept of "managed competition" in Florida through the creation of eleven Community Health Purchasing Alliances (CHPAs).²² Under managed competition, providers and payers join to-

12. HEALTHY HOMES 1994, THE FLORIDA HEALTH SECURITY PLAN 9 (Dec. 1993).

13. *Id.*

14. See *id.* at 10.

15. Jerry Geisel, Health Market Changes Spur 1% Drop in Costs, *BUS. INS.*, Feb. 13, 1995, at 1, 10.

16. HEALTHY HOMES 1994, *supra* note 12, at 7-8.

17. See ANNE R. MARKUS ET AL., SPECIAL REPORT: SMALL GROUP MARKET REFORMS: A SNAPSHOT OF STATES' EXPERIENCE 1 (Feb. 1995).

18. 1992, Fla. Laws ch. 92-233, § 117, at 328 (codified at FLA. STAT. § 627.6699 (1995)).

19. *Id.* §§ 5-7, at 244 (codified at FLA. STAT. §§ 408.004-.006 (1995)).

20. *Id.* § 1, at 241 (codified at FLA. STAT. § 20.42 (1995)).

21. 1993, Fla. Laws ch. 93-129; see also Bruce D. Platt, A Summary of the Health Care and Insurance Reform Act of 1993: Florida Blazes the Trail, 21 *FLA. ST. U. L. REV.* 483, 483 (1993).

22. Fla. H.R. Comm. on Health Care, CS for SB 1914, SB 2006, SB 1784, SB 406 (1993) Staff Analysis 1 (final May 11, 1993) (on file with comm.).

gether to offer health care and insurance in a single package; together they compete for customers in a geographically defined health care market.²³ This Act also implemented health care coverage reforms for Florida employers with fewer than fifty-one employees.²⁴ These reforms include modified community rating, guarantee-issue requirements, and portability.²⁵

The Florida Legislature has continued to consider reforms. In 1994 and 1995, the Florida Legislature considered various versions of the Florida Health Security Act.²⁶ These Acts would have enrolled Medicaid participants in managed care plans and would have used the savings to assist low-income Floridians in purchasing health care coverage.²⁷ These proposals did not pass in the Legislature and are still the subject of rancorous debate.²⁸

B. Anti-Managed Care Legislation

Legislation also has been introduced in the Florida Legislature to limit severely the effectiveness of managed care plans in general, and HMOs in particular. During the 1995 session, legislation that targeted managed care plans included the Patient Protection Act,²⁹ the "Any Willing Provider" measure,³⁰ and legislation mandating direct access for patients to certain medical providers.³¹ None of these bills passed the Legislature.³² However, supporters indicate they will continue to fight for passage of these measures in the future.³³ A brief overview of some of the key provisions contained in this proposed legislation follows.

1. The Patient Protection Act

During 1995, more than twenty state legislatures considered bills designed to hinder managed care organizations.³⁴ Many of these bills were

23. See HEALTH LAW SERIES, HEALTH LAW HANDBOOK 51 (Alice G. Gosfield ed., 1994).

24. *Id.* at 52.

25. *Id.*; see also 1993, Fla. Laws ch. 93-128 (codified at FLA. STAT. § 627.6699 (1995)); see also Platt, *supra* note 21, at 495.

26. Fla. HB 1459 (1995); Fla. HB 2823 (1994).

27. *Id.*

28. FLA. LEGIS., FINAL LEGISLATIVE BILL INFORMATION, 1995 REGULAR SESSION, HISTORY OF HOUSE BILLS at 302, HB 1459; FLA. LEGIS., FINAL LEGISLATIVE BILL INFORMATION, 1994 REGULAR SESSION, HISTORY OF HOUSE BILLS at 392, HB 2823; see Diane Hirth, Health Reform Looks 'Deader Than Dead,' ORLANDO SENT., May 5, 1995, at B5.

29. Fla. HB 841 (1995).

30. Fla. HB 541 (1995).

31. Fla. HB 723 (1995).

32. FLA. LEGIS., FINAL LEGISLATIVE BILL INFORMATION, 1995 REGULAR SESSION, HISTORY OF HOUSE BILLS at 267, HB 841; *id.* at 244, HB 541; *id.* at 257, HB 723.

33. See Anders & Johannes, *supra* note 9, at B1.

34. *Id.*

patterned after the American Medical Association's Model Patient Protection Act, which was drafted in 1994.³⁵ The provisions contained in Florida's version of the Patient Protection Act, House Bill 841 (the Act),³⁶ are representative of nationwide proposals attempting to restrict managed care and give more power to physicians and patients.³⁷

a. Patient Information

The Act would have required managed care plans to provide prospective enrollees with detailed information on the plan's terms, conditions, and contracts with its providers.³⁸ Supporters of this provision contend that it would have put patients, rather than insurance companies, in control of care by providing them with additional information to enable them to make more informed choices when purchasing a health plan.³⁹

Health maintenance organization proponents contend that the most useful information to the consumer is already presented to HMO enrollees with their member handbook⁴⁰ and that the Act could have required HMOs to provide volumes of material which would overwhelm potential enrollees.⁴¹ For example, the Act might have been interpreted to require detailed lists of coverage provisions, benefits, and exclusions for each physician or provider in an HMO's network.⁴² For large HMOs with many physicians and provider contracts, this provision alone would have required hundreds of pages.⁴³ The increased expense of furnishing this in-

35. *Id.*

36. See Fla. HB 841 (1995); see also Fla. SB 1986 (1995).

37. *Id.*

38. Fla. HB 841, § 100 (1995). The Act would have required HMOs and other managed care plans to inform prospective enrollees of a plan's coverage provisions and exclusions, treatment policies and any restrictions or limitations on services, prior authorization or review requirements, any financial arrangements or contracts a plan has with hospitals, physicians or other providers that would limit services, referral or treatment, including any financial incentives not to provide services, an explanation of how plan limits would impact enrollees, loss ratios, and enrollee satisfaction with a plan, including statistics on re-enrollment and enrollees' reasons for leaving a plan. *Id.*

39. See, e.g., Letter from William E. Coletti, Exec. Dir., Pinellas County Medical Soc'y, Inc., to the Editor, *ST. PETE. TIMES*, June 17, 1994, at A17.

40. A plan's member handbook is the document distributed to the enrollee explaining what services are available and how to access those services. All such handbooks are reviewed by the Florida Department of Insurance to ensure that HMOs make the required information available. See FLA STAT. § 641.21(1)(f) (1995).

41. Interview with Ralph F. Scott, Ass't Gen. Counsel, State Affairs, Health Ins. Ass'n of Am., in Tallahassee, Fla. (Sept. 20, 1995).

42. See Fla. HB 841, § 100(5)(b)1 (1995).

43. The authors understand that HMOs contract with many physicians to form the HMO's network. To list each service each physician could perform and each service each physician could not perform, would necessarily lead to hundreds of pages.

formation to consumers would not have been matched by any additional value to the enrollee.⁴⁴

Health maintenance organization representatives also are concerned that this provision would have been interpreted to require them to make available confidential information about the terms of their contracts with their hospitals and doctors.⁴⁵ Health maintenance organization representatives contend that much of this information is of little use to patients but could be used by competitors and adverse parties in contract negotiations.⁴⁶ These representatives argue that this information is proprietary and that making some of this information public would necessarily hinder future negotiations with providers; providing such information, which has no bearing on the quality of care, would thus increase the cost of providing care.⁴⁷

b. Physician Due Process

The Act would have provided increased due process rights to physicians who were denied admittance to or terminated from a managed care plan.⁴⁸ It would have required each plan to establish a credentialing system for physicians⁴⁹ and would have allowed all physicians within a plan's geographic area to apply for the plan's credentials.⁵⁰ The Act also would have required HMOs to hire or contract with all qualified doctors who applied for credentials, even if the HMO had a surplus of doctors in relation to its number of patients.⁵¹ These provisions of the Act would have placed severe restrictions on an HMO's ability to select its own physicians.⁵²

44. At a minimum these expenses would have included the cost of preparing the reports, the material needed for the reports, and the cost of storage.

45. See Fla. HB 841, § 100(5)(b)4 (1995); see also Interview with Ralph F. Scott, *supra* note 41.

46. For example, the Act would have required the HMO to disclose every specific medical exclusion, including the names of every drug not included in the HMO's formularies. See Fla. HB 841, § 100(5)(b)2 (1995). Such a list could consume many volumes and would be cumbersome and costly to publish. Moreover, pharmacies and drug manufacturers would find this information extremely valuable in their negotiations with HMOs. A patient or potential subscriber who needs this information can obtain it by calling the HMO. Interview with Ralph F. Scott, *supra* note 41.

47. Interview with Ralph F. Scott, *supra* note 41.

48. Fla. HB 841, § 100(5)(d)9 (1995).

49. *Id.* at § 100(5)(d).

50. *Id.* The Act would have further provided that if economic considerations were a factor in the decision to grant or deny credentials, any economic profiling of a physician would have to take into account features of the physician's practice which could account for costs which are higher or lower than expected, such as case mix and age of patients. *Id.* Decisions regarding granting or denying an application would have been required to be on the record. *Id.*

51. The effect of this legislation would be virtually the same as that of the proposed "Any Willing Provider" legislation. See discussion *infra* notes 81-87 and accompanying text.

52. See *id.* A plan could not have denied, reduced, or withdrawn credentials without providing the physician notice, an opportunity for a hearing before an arbitrator or hearing off i-

Managed care opponents contend that this provision would have protected patients by removing the threat that an HMO could terminate a physician for economic reasons, or for having provided a patient with necessary care not authorized by the HMO.⁵³ This provision would have given physicians statutory job security not provided to any other profession.⁵⁴ Supporters of managed care view the measure as a virtual guarantee that every physician in Florida would have had an unprecedented right to obtain and keep a job.⁵⁵

Furthermore, HMOs argued that they would have been prevented from quickly terminating doctors who were making mistakes.⁵⁶ Under the Act, an HMO could not have removed a doctor from its network unless the HMO had been able to prove the physician had caused "imminent harm to patient health[,] or [there had been] an action by the Board of Medicine or other government agency that effectively [impaired] the physician's ability to practice medicine within the jurisdiction," even if the HMO believed that the physician was not providing a suitable level of care.⁵⁷ Such a measure, HMO proponents contend, actually would have provided physicians with more protection than their patients.⁵⁸

Health maintenance organization supporters also note that an HMO needs the ability to determine the number of physicians in its network.⁵⁹ One of the bedrock principles of managed care is that HMOs negotiate discounts with physicians in exchange for a certain patient volume.⁶⁰ Requiring an HMO to accept and retain all physicians who meet the credential requirements would eliminate an HMO's ability to provide its physicians with this volume. Thus, HMO supporters argue that the measure would have eliminated a provider's economic incentive to accept a lower

cer, and an opportunity to complete a "corrective action plan." *Id.* These due process requirements could only have been denied in cases where "imminent harm to patient health" existed, or where the physician was unable to practice medicine due to action by the Board of Medicine or another government agency. *Id.* A physician would have had the right to appeal the decision of the arbitrator or hearing officer. *Id.*

53. Your Right To Select Your Doctor and Hospital-Patient Freedom of Choice, MED. HEALTH CARE ALLIANCE (on file with authors); see generally *Legislature: Protect Patients, Act To Curb Growing HMO Power*, TALL. DEM., Feb. 15, 1995, at A8.

54. See *DeMarco v. Publix Super Markets*, 384 So. 2d 1253, 1254 (Fla. 1980). As an "at-will" employment state, Florida employers are not generally required to furnish specific reasons for firing employees.

55. See generally Martin Dyckman, *Self-Serving Doctors*, ST. PETE. TIMES, Mar. 16, 1995, at A19.

56. *Id.*

57. Fla. HB 841, § 100 (1995); see also *infra* notes 81-87 and accompanying text.

58. See generally Dyckman, *supra* note 55, at A19; see also BLUE CROSS BLUE SHIELD OF FLORIDA, PATIENT PROTECTION ACT POLICY STATEMENT (1995) (on file with authors).

59. See Telephone Interview with Richard F. Dorf, Exec. Dir. of Fla. Ass'n of HMOs (Sept. 20, 1995); Interview with Ralph F. Scott, *supra* note 41.

60. See e.g. John Dunbar, *HMOs Fight Patient Choice*, TIMES UNION (JACKSONVILLE), Apr. 25, 1995, at A1, A4.

rate and would have undermined one of the basic concepts of managed care.⁶¹

c. Treatment Decisions

Supporters of the Act allege that HMO administrators, rather than the physicians, make the decisions regarding treatment of patients.⁶² They believe that HMO employees may not always have the best interest of the patient in mind. Under the Act, only physicians would have been allowed to recommend denial of coverage or services or to make decisions about the necessity or appropriateness of treatment.⁶³ Any claimant who had a claim denied as "not medically necessary" would have been entitled to a due process appeal.⁶⁴

Health maintenance organization proponents argue that this provision of the Act could have been interpreted to apply to two separate issues: treatment denial decisions and coverage decisions.⁶⁵ They note that HMOs already are required to have treatment denial decisions reviewed by a physician.⁶⁶ However, they are concerned that the Act would have been interpreted to apply to decisions concerning whether the treatment is covered under the HMOs' health plans as well.⁶⁷ This might have resulted in a requirement that all claims adjusters be licensed physicians.⁶⁸

Health maintenance organization supporters further argue that this provision was unnecessary because all HMOs already are required to have grievance procedures through which HMO enrollees can challenge

61. *Id.*

62. The American Medical Association has emphasized this concern in its advertising campaign promoting its anti-managed care proposals. One such ad warned, "Would you rather trust your life to an MD or an MBA?" See John Fairhall, *Clash of the Titans: Doctors, HMOs, Insurers on Health Care*, BALTIMORE SUN, July 3, 1994, at E1. Much of the rhetoric surrounding the AMA's model of this provision depicts managed care plans as placing medical decision making "in the hand of corporate clerks and government bureaucrats." Steven Brostoff, *AMA Backing "Anti-HMO" Legislation*, NAT'L UNDERWRITER, LIFE & HEALTH INS., May 30, 1994, at 1. "If we don't keep the health plans honest," the AMA warns, "some anonymous clerk sitting at the end of a 1-800 number is going to take over for your doctor." Adrienne Appel, *AMA Tries Pressure on HMOs: Ad Campaign Seeks Support for Legislation That Would Require More Health-Plan Information*, PEORIA J. STAR, May 29, 1994, at C15 (quoting Dr. Lonnie Bristow, Chairperson of the AMA Board).

63. Fla. H.B. 841, § 100 (1995).

64. *Id.*

65. Interview with Ralph F. Scott, *supra* note 41; Telephone Interview with Richard F. Dorf, *supra* note 59.

66. HMO accreditation agencies require that these review decisions be made by a physician. Standards for the Accreditation of Managed Care Associations, in NCQA MANUAL 1995 EDITION, 25, 25 (1995) (on file with authors). Currently, Florida law requires all HMOs to be accredited within one year of obtaining their certificate of authority to operate. FLA. STAT. § 641.512 (1995).

67. Interview with Ralph F. Scott, *supra* note 41; Telephone Interview with Richard F. Dorf, *supra* note 59.

68. See Telephone Interview with Richard F. Dorf, *supra* note 59.

denial of authorization, and these grievance procedures provide a thorough review of all contested actions.⁶⁹ Under current law, these grievance procedures must be approved by the state⁷⁰ and meet national accreditation standards.⁷¹ If the enrollee is not satisfied with the outcome of the HMO's grievance procedure, an independent statewide subscriber assistance program is available to review the denial.⁷² This actually provides more safeguards for HMO enrollees, as such a statewide review of decisions is not always available for traditional indemnity policyholders.⁷³

d. Antitrust Exemption

The Act would have granted physicians an exemption from antitrust laws in order to "combine into sufficiently large networks" to negotiate and compete with managed care plans.⁷⁴ The American Medical Association depicts the antitrust exemption as a way for physicians to "even the playing field" with insurers and HMOs.⁷⁵ However, insurers maintain that an antitrust exemption would cause boycotts and price-fixing by physicians.⁷⁶ They contend that this would be anticompetitive and result in increased health care costs.⁷⁷ Health maintenance organization proponents note that similar antitrust protections are not available for any other industry or employer group, and they question why only medical providers should obtain such protections.⁷⁸

In addition, the Federal Trade Commission and the Federal Department of Justice already have developed health care provider antitrust

69. See FLA. STAT. § 641.511 (1995); see also NCQA MANUAL, *supra* note 66, at 33-34; Phil Galewitz, As HMOs Proliferate, So Do Complaints About Them, PALM BCH. POST, Oct. 15, 1995, at E4 (interview with Linda Enfinger of AHCA explaining the grievance process).

70. See FLA. STAT. §§ 641.495(8), 641.21(1)(e) (1995). The grievance procedure must be contained in the HMO's contract offered for its subscribers. See *id.* § 641.495(8). The master contract must be approved by the Department of Insurance. See *id.* §§ 641.21(1)(f), 641.31(3).

71. See *id.* § 641.512.

72. See *id.* § 641.511.

73. Interview with Ralph F. Scott, *supra* note 41; Telephone Interview with Richard F. Dorf, *supra* note 59.

74. Fla. HB 841, § 17 (1995) (codified at Fla. Stat. § 408.7054 (1995)). The Act stated that creation of "health care provider networks" would "enhance competition" by allowing independent health care providers and small group practices to participate in the market alongside the large corporate networks. *Id.* The Act intended to exempt these networks of independent physicians from state antitrust laws and to provide immunity from federal antitrust laws so that they could engage in collective activity with respect to disseminating information on cost and pricing data, payment procedures, patient referral protocols, administrative matters, and dispute resolution mechanisms. *Id.*

75. See, e.g., Fairhall, *supra* note 62, at E1.

76. *Id.*

77. See generally FLORIDA ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS ANTITRUST POLICY STATEMENT (1995) (on file with authors).

78. Telephone Interview with Richard F. Dorf, *supra* note 59; see also Palosky, *supra* note 5, at 5 (quoting Carl Homer speaking generally about the Patient Protection Act).

“safety zones.”⁷⁹ Health maintenance organization proponents contend that these safety zones should be given an opportunity to work and that the necessity of an antitrust exemption should be independently examined before carving out such exemptions for specific groups.⁸⁰

2. Freedom of Choice/Any Willing Provider

One of the most controversial pieces of legislation directed at managed care would have required an HMO to allow any physician to become a service provider for the HMO so long as the physician agreed to accept the HMO's reimbursement rates and to comply with the HMO's guidelines.⁸¹ Referred to as the “Any Willing Provider” measure, House Bill 541 reciprocally provided that enrollees in HMOs would be entitled at all times to “absolute choice” in the selection of their providers.⁸² Health maintenance organizations would be “expressly forbidden” from requiring or coercing enrollees to use any provider other than one the enrollee selected.⁸³

“Any Willing Provider” legislation defeats the entire concept of managed care. Health maintenance organizations and other managed care entities currently contract with only the number of physicians needed to serve their patients. By offering physicians an increased patient volume and a set income, HMOs are able to negotiate lower rates.⁸⁴ Requiring HMOs to allow any qualified physician to join the plan would drive up operating costs and reduce the HMO's bargaining power to negotiate

79. In 1993 the Department of Justice and the Federal Trade Commission (together, the “Agencies”) set forth six policy statements regarding the enforcement of antitrust policies relating to the health care industries. In 1994, these were revised and new policy statements were added. The statements describe certain health care antitrust “safety zones,” which are circumstances under which the Agencies will not challenge conduct under the antitrust laws. These “safety zones” are: I) “Mergers Among Hospitals,” II) “Hospital Joint Ventures Involving High Technology or Other Expensive Health Care Equipment,” III) “Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Health Care Services,” IV) “Providers’ Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services,” V) “Providers’ Collective Provision of Fee-Related Information to Purchasers of Health Care Services,” VI) “Provider Participation in Exchanges of Price and Cost Information,” VII) “Joint Purchasing Arrangements Among Health Care Providers,” VIII) “Physician Network Joint Ventures,” and IX) “Analytical Principles Relating to Multiprovider Networks.” See generally U.S. DEP’T OF JUSTICE AND THE FTC, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST (Sept. 27, 1994).

80. See generally GROUP HEALTH POLICY, PRUDENTIAL ANTITRUST POLICY STATEMENT & PRUDENTIAL ANTI-MANAGED CARE LAWS POLICY STATEMENT (Mar. 1995).

81. Fla. HB 541, § 1 (1995).

82. *Id.*

83. *Id.*

84. See *supra* notes 59-60 and accompanying text.

physician fees. Cost savings generated by HMOs would be lost, and higher premiums would result.⁸⁵

Finally, and perhaps most importantly, "Any Willing Provider" legislation could cripple the HMO's ability to ensure the quality of care provided by the physicians in its networks. While only minimal oversight is required in a traditional fee-for-service setting, HMOs are required to evaluate physicians' credentials before they are able to join the network and are required continually to monitor the quality of care provided once the physicians are members.⁸⁶ Health maintenance organization proponents argue that requiring HMOs to accept providers and making it difficult to terminate them from the HMO network will necessarily hinder HMOs' ability to ensure high-quality health care.⁸⁷

3. Direct Access

Another buzzword in the battle over managed care is "direct access." "Direct access" allows patients to receive services from certain health care providers without prior approval from their primary care physician.⁸⁸ Currently, HMOs operate under a "gatekeeper system," whereby the primary care physician, the "gatekeeper," usually must refer patients to a specialist before the HMO will cover the cost of the specialist's services.⁸⁹ The gatekeeper system assures that unnecessary services are avoided and that high-cost services are not overutilized by making one physician responsible for the coordination of the subscriber's treatment, medications, and other health care needs.⁹⁰ Health maintenance organization proponents argue that the gatekeeper's knowledge about the patient's medical history puts the gatekeeper in the best position to determine the most appropriate and cost-efficient care.⁹¹

85. Blue Cross and Blue Shield estimated that premiums would increase by as much as 14% if "Any Willing Provider" legislation passed. Dunbar, *supra* note 60, at A1. In its fiscal evaluation of Florida's proposed "Any Willing Provider" legislation, Arthur Anderson and Associates concluded that the economic impact of this provision would be significant. See Fla. H.R. Comm. on Health Care, HB 541 (1995) Staff Analysis 5 (Feb. 27, 1995) (on file with comm.). The fiscal evaluation also predicted that administrative expenses would increase due to greater network size. *Id.*

86. See FLA. STAT. § 641.512(4) (1995); see also NCQA MANUAL, *supra* note 66, at 27-31.

87. See FLORIDA ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS, ANY WILLING PROVIDER POLICY STATEMENT 2 (1995) (on file with authors); see also BLUE CROSS BLUE SHIELD OF FLORIDA, *supra* note 58.

88. See Dunbar, *supra* note 60, at A4.

89. See, e.g., CAPITAL HEALTH PLAN MEMBER HANDBOOK 4 (Mar. 1992) (on file with authors); see also Susan J. Stayn, Securing Access to HMOs, 94 COLUM. L. REV. 1674, 1679-80 (1994); see also FLA STAT. § 641.21(1)(f) (1995).

90. See Stayn, *supra* note 89, at 1679-82; see also FLORIDA DEPT. OF INS., 1994, 1995 HEALTH MAINTENANCE ORGANIZATION CONSUMERS' GUIDE 1-2 (1994).

91. See generally FLORIDA ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS, DIRECT ACCESS POLICY STATEMENT (1995) (on file with authors).

House Bill 723⁹² would have allowed HMO subscribers direct access to board-certified optometrists, ophthalmologists, and dermatologists under contract with the HMO.⁹³ The bill also would have prohibited HMOs from establishing disincentives to inhibit subscribers from seeking direct access to these three types of providers.⁹⁴ Allowing the patient direct access could have resulted in unnecessary utilization of these providers by HMO enrollees; such utilization would have increased health care premiums without necessarily increasing the quality of care.

III. IS SUBSTANTIAL REFORM REALLY NECESSARY? AN ANALYSIS OF THE QUALITY OF CARE PROVIDED BY HMOs

Before legislation is passed which would, in many respects, eliminate managed care as a low-cost health care alternative, it is necessary to examine objectively the performance of HMOs and the care they provide. Supporters of the proposed curbs on managed care cite quality of care as one of the primary reasons such legislation is required.⁹⁵ Sponsors of these bills have attempted to link the cost savings HMOs generate to a decrease in the quality of the care provided to enrollees.⁹⁶ As one Florida Representative stated, “[A]ny time you squeeze price, squeeze price, squeeze price, quality is going to go down, go down, go down.”⁹⁷ The Patient Protection Act itself cites that “potential and actual abuses by insurance companies and other managed care organizations, including making inappropriate decisions to refuse or terminate health care and other decisions which negatively affect patients’ health,” are evidence of the need for tough reforms which will protect patients from mistreatment.⁹⁸

Recent studies, however, demonstrate that HMOs across the country are providing care which is not only of high quality but is, in many cases, better than the care provided to patients in non-managed care plans.⁹⁹

92. Fla. HB 723 (1995).

93. *Id.*

94. *Id.*

95. Palosky, *supra* note 5, at 5 (quoting Rep. Everett Kelly, D-Tavares); see also Dan Morgan, HMO Trend Squeezes Big-Fee Medical Specialists, WASH. POST, July 17, 1994, at A1.

96. Palosky, *supra* note 5, at 5 (providing an example of these attempts).

97. *Id.* (quoting Rep. Everett Kelly, D-Tavares).

98. Fla. HB 841, § 100 (1995).

99. This analysis examines several recent studies published in medical journals such as the *Journal of the American Medical Association*, the *New England Journal of Medicine*, and the *Annals of Internal Medicine*. In an attempt to limit subjective biases, the publications listed in this analysis primarily concentrated on the difference in reported outcomes between HMOs and fee-for-service providers, as well as comparisons of the likelihood of receiving specific services and diagnostic tests that are demonstrated to be indicators of quality health care. These studies conclude that, in an examination of specific health outcomes measured, the quality of care provided to patients enrolled in HMOs is generally as good as, perhaps better than, the quality of care received by patients enrolled in traditional fee-for-service insurance plans. This

These studies have reviewed the quality of care provided in many settings and to many different types of patients.¹⁰⁰ Thus, the question arises whether there is a legitimate reason to pass legislation which would substantially alter, if not destroy, the managed care system.

The following section of this Article will focus upon medical literature comparing the treatment provided by HMOs to the treatment provided by traditional fee-for-service plans in the following areas: preventive care and health promotion in general, early diagnosis of diseases, care of the elderly, care of children, care in acute situations, and efficiency in medical treatment. It also will address comparative data relating to survival and mortality rates.

A. Preventive Care and Health Promotion in General

There is general agreement that one of the most effective and affordable means of providing quality health care is to make available, and encourage the use of, preventive care and health-promotion services. Research shows that HMOs are more effective at providing preventive care and health-promotion services than traditional fee-for-service indemnity plans. A recent literature analysis of managed care performance since 1980 published in the *Journal of the American Medical Association* cites six studies which have found that HMO plan enrollees receive more preventive tests, procedures, examinations, and health-promotion services than indemnity plan enrollees.¹⁰¹

Among the six reviewed studies, one published in the *Annals of Internal Medicine* compared the quality of care provided to patients with common ambulatory conditions in an HMO setting with care provided in a traditional fee-for-service setting.¹⁰² The authors found that HMO patients were more likely to undergo screening for breast cancer and cervical cancer and had better blood pressure control than fee-for-service patients.¹⁰³ The study also found that HMO patients were equally as likely to undergo screening for colon cancer as fee-for-service patients.¹⁰⁴ Interestingly, the authors' initial hypothesis was that financial incentives to limit treatment in a network model HMO would reduce the number of services

observation is not new. A 1980 article reviewing 1958-1979 literature on the quality of health care in HMOs concluded that the quality of care delivered by HMOs was generally better than, or comparable to, fee-for-service care. See generally Frances C. Cunningham & John W. Williamson, *How Does the Quality of Health Care in HMOs Compare to that in Other Settings? An Analytic Literature Review: 1958 to 1979*, 1 *GROUP HEALTH J.* 4 (1980).

100. See *infra* notes 101-71 and accompanying text.

101. Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980*, 271 *JAMA* 1512, 1516 (1994).

102. I. Steven Udvarhelyi et al., *Comparison of the Quality of Ambulatory Care for Fee-for-Service and Prepaid Patients*, 115 *ANNALS INTERNAL MED.* 394, 394 (1991).

103. *Id.* at 397-98.

104. *Id.*

provided to HMO patients and potentially reduce the quality of care received.¹⁰⁵ However, they determined from their data that HMO patients “received equal or better quality of care than fee-for-service patients treated by the same physicians” for the treatment of uncomplicated high blood pressure “and for the provision of preventive services to middle-aged women without chronic diseases.”¹⁰⁶ The authors concluded that “incentives for physicians to limit the use of medical services did not compromise the quality of ambulatory care” received by HMO patients.¹⁰⁷

Researchers with the Centers for Disease Control and the National Center for Health Statistics reached a similar conclusion in a cancer screening study of women.¹⁰⁸ In this study, female HMO enrollees aged fifty to sixty-four were found to receive more mammographies, clinical breast exams, and Pap tests than women with fee-for-service coverage.¹⁰⁹ Using data from the 1992 National Health Survey, the authors of this study found that among women aged fifty to sixty-four with twelve years of education or less, 62.8% of female HMO enrollees had received a mammogram within the year preceding this study, compared with only 48.1% of women with fee-for-service coverage.¹¹⁰ Almost 71% of the total HMO enrollees had recently received a clinical breast examination and nearly 63% had received a Pap test within the past year.¹¹¹ In comparison, less than 64% of women with fee-for-service coverage had received a clinical breast exam in the past year, and only 56% had received a Pap test in the past year.¹¹² For all women aged sixty-five and older, use of mammography and Pap testing was approximately 13% higher for HMO enrollees than for women with fee-for-service coverage.¹¹³

As these representative studies indicate, HMO patients are more likely to receive preventive care and screening than patients with fee-for-service coverage.

B. Early Diagnosis of Disease

For many diseases, the effectiveness and degree of treatment vary depending upon the stage of the disease at the time of diagnosis. An earlier diagnosis means easier and more successful treatment. Thus, the quality

105. *Id.* at 398.

106. *Id.*

107. *Id.* at 399.

108. Diane M. Makuc et al., *Health Insurance and Cancer Screening Among Women*, in *ADVANCE DATA FROM VITAL AND HEALTH STATISTICS OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION*, NATIONAL CENTER FOR HEALTH STATISTICS, No. 254 (Aug. 1994).

109. *Id.* at 5.

110. *Id.* at 4.

111. *Id.*

112. *Id.*

113. *Id.* at 5.

and the cost of care are directly related to the extent of the disease at the time of detection.

Recent research indicates that HMOs provide superior cancer screening and preventive services than fee-for-service providers. For example, a study published in the *American Journal of Public Health* compared the stage of cancer diagnosis in Medicare beneficiaries enrolled in HMOs to the stage of cancer diagnosis in fee-for-service patients.¹¹⁴ This study found that providers diagnosed HMO enrollees with melanoma, female breast, cervix, and colon cancer at significantly earlier stages in the disease.¹¹⁵ The largest differences were found in women with cervical cancer and in patients with melanoma.¹¹⁶ Health maintenance organizations diagnosed 58% of enrollees with cervical cancer at the "in situ," or local stage, as opposed to regional or distant stages.¹¹⁷ Only 38.8% of fee-for-service patients were diagnosed at this local stage.¹¹⁸ In melanoma patients, 39% of HMO enrollees were diagnosed when the cancer was at the local stage, compared to only 23.8% of fee-for-service patients.¹¹⁹

The research indicates that the earlier diagnosis of these cancers may be attributable to HMO coverage of screening procedures such as mammographies, Pap tests, fecal occult blood tests, and physical examinations.¹²⁰ However, in most cancers that lack these routine screening procedures, the researchers still found no difference in the stage of diagnosis between HMO and fee-for-service patients.¹²¹ These cancers studied include prostate, rectum, buccal cavity and pharynx, bladder, uterus, kidney, and ovary.¹²² Thus, the research indicates that HMO providers diagnose cancers at a stage which is at least equal to, and sometimes significantly earlier than, the stage of diagnosis for fee-for-service patients.

C. Care of the Elderly

At least one critic of managed care has expressed concern that HMOs may be insensitive to patients with special needs, such as the elderly.¹²³

114. Gerald F. Riley et al., *Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees*, 84 *AM. J. PUB. HEALTH* 1598, 1600 (1994).

115. *Id.*

116. *Id.*

117. *Id.* at 1600-01.

118. *Id.*

119. *Id.* at 1601.

120. *Id.* at 1602.

121. *Id.*

122. *Id.* at 1601. An exception was found in patients with stomach cancer, where HMO enrollment was associated with distant stage disease. *Id.*; see also Howard P. Greenwald & Curtis J. Henke, *HMO Membership, Treatment, and Mortality Risk Among Prostatic Cancer Patients*, 82 *AM. J. PUB. HEALTH* 1099, 1100 (1992) (finding that the stage at diagnosis of prostate cancer did not systematically vary among HMO and fee-for-service patients).

123. Nicole Lurie et al., *The Effects of Capitation on Health and Functional Status of the Medicaid Elderly*, 120 *ANNALS INTERNAL MED.* 506, 506 (1994).

While it would seem that the supposed financial incentives to limit treatment in HMOs would be especially strong among high-cost enrollees such as the elderly, current research indicates otherwise.¹²⁴ A recent study published in the *Annals of Internal Medicine* compared the health and functional status of elderly Medicaid recipients in prepaid plans to the status of elderly patients enrolled in traditional fee-for-service Medicaid.¹²⁵ The authors of this study found that elderly patients enrolled in prepaid plans reported better general health and well-being scores than those enrolled in fee-for-service plans.¹²⁶ The study reported no differences between the two insurance groups as to number of deaths, the proportion in fair or poor health, physical functioning, activities of daily living, visual acuity, blood pressure, or diabetic control.¹²⁷ The authors concluded that “there was no evidence of harmful effects of enrolling elderly Medicaid patients in prepaid plans, at least in the short run.”¹²⁸

Another study found similar results when it compared the quality of care received by elderly patients with high blood pressure in Medicare HMOs to those in fee-for-service plans.¹²⁹ Of 685 elderly hypertensive patients studied, those enrolled in HMOs were more likely than those in fee-for-service plans to have their medications, alcohol history, and smoking history documented.¹³⁰ These HMO patients were three times more likely to have their orthostatic blood pressures checked both at their initial visit and in follow-up visits.¹³¹ The authors also found “significant differences” between the two settings in referrals to sub-specialists.¹³² Medicare HMO patients were more likely to receive a fundoscopic examination and more likely to be referred to an ophthalmologist for examination.¹³³ Cardiac examinations were “consistently more frequently evaluated” in the Medicare HMO patients than in the fee-for-service patients.¹³⁴

Hypertensive patients enrolled in Medicare HMOs also were significantly more likely to undergo screenings of electrolytes and renal parameters and tests for diabetes mellitus, and they were more likely to receive a chest roentgenogram.¹³⁵ While this study found that the Medicare HMO patients received fewer medication adjustments in response to new mental

124. *Id.*

125. *Id.*

126. *Id.* at 508.

127. *Id.* at 506.

128. *Id.*

129. Jeanette A. Preston & Sheldon M. Retchin, *The Management of Geriatric Hypertension in Health Maintenance Organizations*, 39 *J. AM. GERIATRICS SOC'Y* 683, 683 (1991).

130. *Id.* at 686.

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

status changes and were less likely to have electrolytes monitored if they were on diuretics,¹³⁶ the authors concluded that elderly hypertensive patients in Medicare HMOs received “equal or better quality of care for most criteria,” compared with those in fee-for-service settings.¹³⁷

D. Care of Children

Children comprise another segment of the population that is particularly vulnerable to inadequate care.¹³⁸ Research conducted in response to this concern demonstrates that children enrolled in HMOs receive care which is at least comparable to the care received by children enrolled in fee-for-service plans.¹³⁹

In a study conducted in conjunction with the RAND Health Insurance Experiment, 693 children ranging in age from newborn to thirteen were randomly assigned to either a staff model HMO or to one of several fee-for-service plans.¹⁴⁰ A comparison of the two groups found no difference in total health expenditures or in individual health outcomes.¹⁴¹ However, children assigned to an HMO had a 40% greater number of routine preventive examinations and had a 50% greater number of office visits than children assigned to a fee-for-service plan.¹⁴² The authors concluded that these results indicate that “no serious negative health effects exist for children receiving care in the staff model prepaid group practice compared to those receiving fee-for-service care.”¹⁴³

E. Care in Acute Situations

Additional concerns about HMO coverage may arise in acute care settings; these concerns include accessibility of HMO enrollees to medically necessary acute care and the quality of care HMO enrollees receive in these acute situations. However, recent research shows HMO enrollees actually may receive superior care in acute situations, compared to patients with fee-for-service insurance.

A 1994 study published in the *New England Journal of Medicine* found that patients with acute appendicitis who had fee-for-service coverage were more likely to suffer a ruptured appendix, which is associated with

136. *Id.* at 689.

137. *Id.* at 683; see also Ron Winslow, *Elderly Get Similar Quality At HMOs As At Traditional Settings, Study Says*, WALL ST. J., May 18, 1994, at B4.

138. See R. Burciaga Valdez et al., *Prepaid Group Practice Effects on the Utilization of Medical Services and Health Outcomes for Children: Results From a Controlled Trial*, 83 *PEDIATRICS* 168, 168 (1989).

139. *Id.* at 179.

140. *Id.* at 168. The cost sharing in the fee-for-service plans varied from 0% to 95%. *Id.*

141. *Id.*

142. *Id.* at 175 (comparing children assigned to an HMO with children assigned to a co-pay fee-for-service plan).

143. *Id.* at 179.

elevated mortality, than those patients enrolled in HMO plans.¹⁴⁴ The researchers suggested that “insurance-related delays in seeking medical care”¹⁴⁵ might be responsible; they noted that “[d]eductibles and higher co-payments in fee-for-service plans may contribute to delays by patients in seeking care.”¹⁴⁶ Furthermore, they commented that “large staff-model HMOs often provide urgent care facilities that are separate from the hospital emergency room; such facilities may increase the likelihood of an early evaluation for abdominal pain.”¹⁴⁷

Additional research demonstrates that HMO members are actually more likely than fee-for-service patients to be admitted to a hospital in some acute situations.¹⁴⁸ A 1994 study of 3,006 patients who sought treatment at a hospital emergency department for acute chest pain found that HMO patients were more likely to be admitted to the hospital than patients in other insurance groups.¹⁴⁹ These results were true for patients at low risk and medium risk of acute myocardial infarction.¹⁵⁰ For patients at high risk of acute myocardial infarction, where the decision to hospitalize is less discretionary, hospital admission rates did not differ.¹⁵¹ The “percentage of patients who suffered acute myocardial infarction and who were inadvertently discharged from the emergency department” also was the same for HMO patients and other patients.¹⁵²

In their study, the authors acknowledged that salaried HMO primary physicians, “although at minimal direct financial risk, certainly would not receive financial rewards for hospitalizing their patients.”¹⁵³ They noted that their explanations were uncertain for why they had found “unexpectedly higher”¹⁵⁴ admission rates for HMO patients with chest pain.¹⁵⁵ They contend the unexpected results suggested that “[o]rganizational factors beyond financial incentives ... may exercise a more powerful influence on physicians’ decision making, potentially leading to increased hospitalization of HMO patients.”¹⁵⁶

144. Paula Braveman et al., *Insurance-Related Differences in the Risk of Ruptured Appendix*, 331 *NEW ENG. J. MED.* 444, 446 (1994).

145. *Id.* at 447.

146. *Id.* at 448.

147. *Id.*

148. Steven D. Pearson et al., *The Impact of Membership in a Health Maintenance Organization on Hospital Admission Rates for Acute Chest Pain*, 29 *HEALTH SERVS. RES.* 59, 59 (1994).

149. *Id.* at 64-66.

150. *Id.*

151. *Id.* at 64-65.

152. *Id.* at 70.

153. *Id.* at 71.

154. *Id.* at 72.

155. *Id.*

156. *Id.* at 71.

F. Efficiency in Medical Treatment

A driving force in health care today is elimination of waste while maintaining quality. Research indicates that HMOs are highly effective in achieving this goal. The Journal of the American Medical Association published a comprehensive review of studies conducted since 1980 comparing managed care with indemnity plans; it found that, in eighteen of twenty comparisons from nine different studies, HMO plans used 22% fewer procedures, tests, or treatments that were considered expensive and/or had cheaper alternatives.¹⁵⁷ At the same time, sixteen studies conducted since 1980 have shown either better or equivalent quality-of-care results for HMO patients compared to fee-for-service patients. These studies reviewed a broad range of medical conditions, diseases, or interventions, including congestive heart failure, colorectal cancer, diabetes, hypertension, colon cancer, and cerebrovascular accident.¹⁵⁸

One such study compared clogged artery treatment decisions for Medicaid patients, patients covered by fee-for-service plans, and patients enrolled in HMOs. This 1988 study found that fee-for-service patients were approximately 2.3 times more likely than HMO patients to undergo coronary bypass surgery or angioplasty than Medicaid patients, while HMO patients were only about 1.5 times more likely to undergo coronary bypass surgery or angioplasty than Medicaid patients.¹⁵⁹ However, mortality rates for HMO patients were slightly lower than those of fee-for-service patients; the lower mortality rates suggest that some of the coronary bypass surgery may have been unnecessary, which may have increased patient mortality.¹⁶⁰ The authors noted that the rate at which discretionary procedures were performed on HMO enrollees was lower than that on patients with fee-for-service coverage and suggested that this indicated “a more appropriate use of procedures in HMOs.”¹⁶¹

At least one other study appears to indicate that HMOs provide more effective and efficient care. This study, comparing the treatment and mortality risk of prostate cancer patients covered by fee-for-service plans to such patients enrolled in HMOs, found that the HMO patients were less likely to receive surgery, but more likely to receive radiation therapy, than patients in fee-for-service settings.¹⁶² Mortality risk was also lower for the HMO patients than for the fee-for-service patients, especially in

157. Miller & Luft, *supra* note 101, at 1515.

158. *Id.* at 1516.

159. KENNETH M. LANGA & ELLIOT J. SUSSMAN, *The Effect of Cost-Containment Policies on Rates of Coronary Revascularization in California*, 329 *NEW ENG. J. MED.* 1784, 1787 (1993).

160. *Id.* at 1788.

161. *Id.* at 1789.

162. Greenwald & Henke, *supra* note 122, at 1100.

low-income patients.¹⁶³ The authors stated that the finding of less frequent surgery, but more frequent radiation therapy, was consistent with previous findings that HMOs favor outpatient care.¹⁶⁴ However, the authors stated that the results of their study “contradict the belief that HMOs undertreat their patients” and “should encourage policy makers to continue viewing the HMO as a desirable alternative to traditional fee-for-service plans, particularly for low-income persons.”¹⁶⁵

G. Survival and Mortality Rates

The ultimate indicators of the quality of health care coverage are survival and mortality rates. Again, research suggests that survival and mortality rates for HMO patients are at least equal to, if not better than, the rates for fee-for-service patients. Coverage of preventive services, such as cancer screening, appears to have a positive effect on the stage at which cancer is diagnosed; early detection is “strongly associated” with survival and mortality rates.¹⁶⁶ Furthermore, a study comparing the treatment and survival of prostate cancer patients in HMO and fee-for-service settings found that the mortality risk was lower for HMO patients than for patients with fee-for-service plans, with the difference being greatest among patients with low incomes.¹⁶⁷ The authors noted other research indicating that treatment in an HMO setting also may increase survival rates for low-income patients with other cancers.¹⁶⁸ From their own research and available literature, the authors concluded that HMOs “enable persons predisposed to seeking appropriate care to do so,” and that HMOs “promote access to basic medical services”; these factors “appear conducive to survival.”¹⁶⁹

A year-long study comparing the health status outcomes of elderly Medicaid recipients enrolled in fee-for-service plans to those enrolled in prepaid plans also documented equally favorable survival rates for managed care enrollees.¹⁷⁰ In a study of 800 Medicaid beneficiaries aged 65 or older, there was no difference in the number of deaths between those enrolled in fee-for-service plans and those who received prepaid care.¹⁷¹

163. *Id.* at 1102.

164. *Id.* at 1103.

165. *Id.*

166. Riley et al., *supra* note 114, at 1602-03.

167. Greenwald & Henke, *supra* note 122, at 1102.

168. *Id.* at 1103-04.

169. *Id.* at 1104.

170. Lurie et al., *supra* note 123, at 506.

171. *Id.*

IV. CONCLUSION

Proponents of anti-managed care legislation argue that the quality of care HMOs provide is, or will be, poorer than the quality of care provided in the traditional fee-for-service settings. However, as shown by the research cited in this Article, the quality of care in an HMO setting is often equal to or better than that provided in a traditional fee-for-service setting. Additionally, HMOs provide this equivalent or superior medical care at a lower cost.

Managed care plans tend to offer better access to screening and preventive care services. Thus, they are better at keeping their enrollees healthy, and their physicians are often able to diagnose conditions at an earlier, more manageable stage. For these and other reasons, managed care plans can be more efficient and effective than fee-for-service plans. The studies clearly indicate that HMOs are a viable means for providing low-cost, quality health care.

This review of the objective medical literature indicates that there is no legitimate reason to eliminate HMOs as a health care alternative. Studies demonstrate that increased enrollment in managed care plans is beginning to slow the runaway increases in health care costs. However, physicians and others have proposed, and continue to propose, legislation that strikes at the foundation of HMOs and managed care plans. The authors believe the proponents of such legislation are either not aware of these objective studies or may have been unduly swayed by anecdotal evidence of abuse. After an analysis of proposed anti-managed care legislation and a thorough review of the available literature, the authors conclude that legislation which seeks to eliminate the very concepts on which managed care is based is unnecessary and will deprive Florida citizens of their ability to choose this option for high-quality, low-cost health care.