The Health Maintenance Organization Act of 1973

How a Cost-Containment Experiment Became the Architecture of Corporate Medicine

Political and Economic Context

By the late 1960s, American healthcare expenditure was accelerating at a rate that alarmed both parties. National medical spending had climbed 170% in a decade, from $26 billion in 1960 to $70 billion by 1971, rising from 5.3% to nearly 7% of GDP [1]. Medicare and Medicaid, enacted in 1965, had injected enormous federal demand into a fee-for-service system with no structural cost discipline. Physicians billed per encounter; hospitals billed per bed-day. The incentive gradient pointed unambiguously toward volume maximization.

Simultaneously, Senator Edward Kennedy was building momentum for a single-payer national health insurance program — a proposal that threatened the private insurance industry and the Nixon administration's ideological commitment to market-based solutions. For Ehrlichman, the HMO concept represented an opportunity to develop a private-sector, profit-driven alternative to Kennedy's national health care proposal [2]. Nixon needed a counter-narrative: something that sounded reformist but preserved — and indeed deepened — private-sector control of healthcare delivery.

Enter Dr. Paul Ellwood, Jr., a rehabilitation physician and policy entrepreneur working through his Minneapolis-based think tank, InterStudy. In 1971, Ellwood published an article in *Medical Care* coining the phrase "Health Maintenance Organization" and proposing a national strategy of incentivizing HMO creation with federal funds while eliminating legal barriers to their proliferation [3]. Ellwood's theoretical pitch was elegant: if you capitate payment — pay a fixed amount per enrollee per month — you invert the fee-for-service incentive. The provider profits not by doing *more* but by keeping people *well*. Preventive care displaces acute intervention. Costs fall. Quality rises.

Ellwood's ideas caught the attention of liberal Republicans in the Nixon administration, including HEW Secretary Robert Finch and Assistant Secretary Lewis Butler. They encouraged President Nixon to use Ellwood's ideas as the model for a reform proposal [3].

The Ehrlichman Tape and Nixon's True Calculus

The idealized Ellwood model, however, was not what animated the White House. On February 17, 1971, domestic policy advisor John Ehrlichman briefed Nixon in a now-infamous Oval Office conversation (Conversation 450-23, University of Virginia Presidential Recordings Program). Ehrlichman told Nixon that Edgar Kaiser was running his Permanente operation for profit, and that he had gone into it in some depth: the incentives all ran toward less medical care, because the

less care they provided, the more money they made [2]. Nixon's response was approving. He announced his HMO-centered national health strategy *the following day* [2].

The distinction matters. Ellwood's vision was a *preventive-care* model — keep people healthy, and you reduce costly acute episodes, creating genuine savings. What Ehrlichman described to Nixon, and what Nixon endorsed, was a *care-denial* model: profit through rationing. These are structurally different propositions with radically different moral valences, though they share the same financial arithmetic at the level of capitated payment. The legislation that eventually emerged carried the DNA of both visions, but the institutional incentives it created would, over subsequent decades, overwhelmingly favor the Ehrlichman interpretation.

The Legislation: P.L. 93-222

The final bill, signed December 29, 1973, was a compromise between a House version (sponsored by Rep. Paul Rogers, closer to Nixon's proposal) and a Senate version shaped by Kennedy [4]. It appropriated $375 million over five years for HMO feasibility studies, planning grants, and loan guarantees [3]. Its operative provisions fell into three categories:

Federal qualification and subsidy. HMOs meeting specified requirements — community rating, open enrollment periods, a comprehensive basic services package — could obtain federal endorsement ("qualification"), unlocking access to grants and loans [4]. The requirements were sufficiently stringent that the bill was not expected to produce a major proliferation of HMOs unless similar standards were imposed on other insurers — a condition that never materialized [3].

The dual-choice mandate (§1310). Any employer offering health benefits to 25 or more employees was required to include the option of membership in a federally qualified HMO, if one operated in the service area and requested dual-choice inclusion [4], [5]. This was the provision that forced HMOs onto the national stage, giving them a guaranteed channel into employer-sponsored insurance markets. The mandate expired in 1995, but by then the managed-care revolution was self-sustaining.

Preemption of state law. This is the provision with the most far-reaching and least-discussed consequences. The legislation preempted state laws that restricted employer contributions to HMOs or prohibited the corporate practice of medicine in ways that impeded HMO formation [4], [5].

The Corporate Practice of Medicine: A Doctrine Gutted

To appreciate what the HMO Act dismantled, you need to understand the *corporate practice of medicine* (CPM) doctrine — a legal principle, rooted in state medical practice acts and decades of case law, holding that only licensed physicians may practice medicine, and that corporations may not employ physicians in ways that allow the corporation to control clinical decisions [5]. The CPM doctrine existed precisely to prevent the situation that now defines American healthcare: unlicensed corporate entities making binding determinations about what medical care a patient may receive.

The HMO Act did not expressly preempt or eliminate the CPM doctrine, but it did preempt state laws that could inhibit HMOs, including the prohibition on employing physicians [4], [5]. The Act is

seen as a definitive policy statement in favor of a corporate-based model of healthcare delivery. The 1973 act made HMOs exempt from state laws that kept medical decisions in the hands of doctors, and as a result, medical practice was subject to more corporate influence [5].

In California, for example, HMOs became exempt from the state's ban on physician employment, based on the federal HMO Act of 1973 [5]. Similar exemptions propagated across jurisdictions. The practical effect was to create a new class of entity — federally blessed, state-law-exempt — that could hire physicians, set formularies, impose treatment protocols, and make coverage determinations, all while operating across state lines under federal authority rather than state medical board jurisdiction.

This is the mechanism by which the HMO Act *de facto* authorized the interstate practice of medicine by non-physician corporate entities. A physician is licensed state-by-state and subject to that state's medical board. An HMO, by contrast, operates under federal qualification, preempts state CPM restrictions, and makes clinical determinations — formulary exclusions, prior authorization denials, step-therapy mandates — that bind physicians across every state in its service area. The entity making the clinical decision is not licensed to practice medicine in *any* state. It doesn't need to be: the federal framework exempts it [4].

The ERISA Amplifier

The HMO Act did not operate in isolation. One year later, Congress passed the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406), which created a federal regulatory framework for employer-sponsored benefit plans and included a sweeping preemption clause: ERISA's preemption clause, Section 514, makes void all state laws to the extent that they "relate to" employer-sponsored health plans [6]. ERISA was designed for pension plan uniformity, but its application to health benefits created a regulatory vacuum of extraordinary consequence.

Claims of negligence and breach of contract arising out of the alleged failure of an MCO to approve medically necessary treatment have been held preempted by ERISA [7], [5]. Self-insured employer plans — which now cover the majority of commercially insured Americans — are essentially immune from state insurance regulation. The combined effect of the HMO Act's CPM preemption and ERISA's liability shield is a system in which a corporate entity can override a physician's clinical judgment, cause patient harm, and face no meaningful legal accountability for doing so.

The Supreme Court cemented this architecture in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). The effective result of the decision was that state liability statutes holding managed care entities to a legal duty of care could not be enforced in the case of health benefit plans provided through private employers, because the state statute allowed compensatory or punitive damages that were not available under ERISA § 1132 [7]. Unless the treating physician is personally making the coverage decision, a plan gatekeeper's denial cannot give rise to a state-law malpractice suit. The patient can sue in federal court for the value of the benefit denied — a meaningful remedy if you pay out-of-pocket and seek reimbursement, but not if you forgo the treatment and are injured [7].

Justice Ginsburg, concurring, acknowledged the absurdity: the broad preemptive reach of ERISA, combined with its threadbare remedies, had created a regime in which patients harmed by wrongful denials had essentially no recourse [7].

Insurance Company Interference with Physician Prescribing

The operational manifestation of this legal architecture is the prior authorization system. When a physician prescribes a medication or orders a procedure, the insurer interposes itself as a gatekeeper — requiring pre-approval, imposing step-therapy protocols (the patient must fail on cheaper drugs before the prescribed one is authorized), applying formulary exclusions, or demanding peer-to-peer review in which the prescribing specialist must justify the decision to an insurance company employee who may be a nurse, a pharmacist, or a physician practicing in an unrelated specialty.

Non-physician insurer staff routinely make prior authorization decisions, and these decisions often interfere with providers' ability to adequately treat patients [8]. The legal fiction that permits this is the classification of coverage determinations as *administrative* rather than *clinical* acts. In Ohio, for example, activities conducted by health insuring corporations are defined in the Revised Code as being "not the practice of medicine" [8]. This definitional sleight-of-hand is replicated across jurisdictions: denying coverage for a prescribed treatment is not "practicing medicine"; it's merely deciding what the plan will *pay for*. The patient remains "free" to obtain the treatment at full cost — a distinction that is economically meaningless for most Americans.

The AMA has characterized the situation bluntly: overly burdensome and opaque utilization management programs are increasingly harming patients, intruding in the patient-physician decision-making process, and undercutting the stability of physician practices [9].

What Nixon Hoped to Accomplish vs. What Resulted

Nixon's stated objective was cost containment through market competition. His actual objective, as the tapes reveal, was a private-sector alternative to Kennedy's national health insurance that would appeal to the insurance and hospital industries — core Republican constituencies — while creating the *appearance* of reform [2].

On the narrow political question, Nixon succeeded. Kennedy's single-payer proposal was neutralized. The HMO framework gave both parties a bipartisan talking point ("competition and choice") that persisted for decades.

On cost containment, the Act was a categorical failure — not merely in degree but in kind. U.S. healthcare costs at the time of the HMO Act were not wildly out of line with other Western industrialized democracies [1]. In 1970, the United States spent roughly 6.9% of GDP on health. The comparable figure for other wealthy nations was in the same range. The divergence begins *after* the managed-care apparatus was erected. By 2024, U.S. total health expenditure had reached approximately $14,900 per person (PPP-adjusted), representing 17.6% of GDP — no other high-income system comes close, with the EU averaging around 10% [10], [11].

Table 1. Health Expenditure: U.S. vs. Peer Nations

Metric	United States	OECD Average	Ratio
Per capita spending (PPP, 2024)	~$14,900	~$6,500	2.3×
Health spending as % of GDP	17.6%	~10%	1.8×
Admin costs per capita	~$1,078	~$245	4.4×
Admin costs as % of health spending	~8%	~3%	2.7×

Sources: OECD Health Statistics 2024 [1]; Peterson-KFF Health System Tracker [10]; Commonwealth Fund [12]; KFF International Comparison of Health Systems [13].

The managed-care revolution did not bend the cost curve. What it did was insert an enormous administrative intermediary between the clinician and the patient — and that intermediary now consumes resources on a scale that dwarfs the healthcare budgets of entire nations. OECD data puts U.S. administrative costs at 8% of total health spending, exceeding $800 per person [1] — but that figure counts only insurer overhead and governmental program administration. It excludes the administrative burden imposed on providers: the billing departments, the coding specialists, the staff dedicated to navigating prior authorization. When provider-side administrative costs are included, administrative complexity becomes the single largest component of excess U.S. health spending relative to peer nations, with higher insurer administration accounting for roughly 15% of the excess and higher provider administrative burden accounting for an additional 15% [12], [1]. A 2014 study in *BMC Health Services Research* estimated total billing and insurance-related costs at approximately $471 billion annually, of which $375 billion — nearly 80% — represented costs *added* by the multi-payer system relative to simplified financing benchmarks like Canadian single-payer or U.S. Medicare [14].

Table 2. Billing and Insurance-Related (BIR) Administrative Costs: Simplified Financing Benchmarks vs. Current U.S. Multi-Payer System

Metric	Simplified Benchmark	Current U.S. System	U.S. Multiple
System-wide BIR (annual)	~$96 billion	$471 billion	4.9×
BIR as % of health spending	~3.7%	~18%	4.9×
Per-encounter BIR costs:			
Inpatient surgical (vs. Canada)	$6	$215	35.8×
Inpatient surgical (vs. Netherlands)	$30	$215	7.2×
Inpatient general stay	—	$124	—
Primary care visit	—	$20	—
Excess BIR (multi-payer complexity)	*Baseline*	$375 billion	—

Sources: Jiwani et al., BMC Health Services Research (2014) [14]; Richman, Schulman et al., Health Affairs (2022) [15]. Benchmarks: Canadian single-payer for providers; U.S. Medicare for insurers.

The cross-national comparison at the encounter level is particularly instructive. It costs a Canadian hospital $6 in billing and insurance-related overhead to process an inpatient surgical admission. It costs a Dutch hospital — operating within a regulated *private* multi-payer system — $30. It costs an American academic medical center $215 for the identical administrative task [15]. The 35-fold differential between Canada and the U.S. is not attributable to differences in clinical complexity, documentation standards, or medical technology. It is the direct cost of the administrative apparatus that the managed-care system requires: eligibility verification, pre-authorization, coding to insurer-specific specifications, claim submission, denial processing, appeal, and rework.

The prior authorization apparatus — the primary operational mechanism through which insurers override clinical judgment — exemplifies this pathology. The AMA's 2024 survey found that responding physicians completed an average of 39 prior authorization requests per week, with 75% reporting that denials had risen, in many cases significantly, over the preceding five years [9]. Handling those requests for a single physician requires 13 hours of physician and staff time per week [9]. That is a third of a full-time employee's labor, per physician, devoted not to clinical care but to justifying clinical decisions to an insurance bureaucracy. Forty percent of surveyed physicians have been forced to hire staff who work exclusively on prior authorization; 82% reported that patients commonly abandon their recommended course of treatment due to prior-authorization delays; and 29% reported that the process has caused serious adverse events — hospitalization or permanent bodily damage — to a patient in their care [9].

Table 3. Prior Authorization: Pre-Managed-Care Baseline vs. Current Regime (AMA 2024 Survey; n = 1,000)

Metric	Pre-Managed-Care Baseline (pre-1973)	Current System (2024)
PAs per physician/week	0 — concept did not exist; physician prescribed, insurer reimbursed	39
MD + staff hours/week on PA	0	13
Dedicated PA-only staff	None required	40% of practices
Insurer denial of MD-ordered care	Rare; indemnity plans paid covered claims without pre-approval	31% of PA requests often/always denied
PA denials overturned on appeal	*N/A*	81.7%
Patients abandoning Rx due to PA	*N/A*	82% of MDs report this is common
Serious adverse events from PA	*N/A*	29% of MDs report at least one
PA delays patient care	*N/A*	93% of MDs report this
PA contributes to MD burnout	*N/A*	89% of MDs report this
PA denial trend (5-	*N/A*	75% report denials increasing

year)		
MD concern AI will increase denials	*N/A*	61%

Sources: AMA Prior Authorization Physician Survey, 2024 [9]. Pre-1973 baseline reflects the fee-for-service indemnity model in which utilization review and prior authorization did not exist as standard insurer practices. "N/A" indicates the metric had no pre-managed-care analogue.

The perverse irony is that this system does not even achieve its stated cost-reduction objective on its own terms. Among denials that were appealed, 81.7% saw the initial prior authorization denial fully or partially overturned [9] — meaning that four out of five denials were clinically unjustified by the insurer's own criteria. The denials do not prevent care; they *delay* it, degrade it, and shift costs downstream. Patients whose treatment is delayed present later with more advanced disease, require more intensive intervention, and generate higher acute-care expenditures. The insurer that denied the $200 medication ends up paying for the $40,000 hospitalization — or, more precisely, passes that cost to the employer and ultimately to the premium pool. The savings are illusory. The administrative costs are real. The United States spends over $1,000 per person on administrative costs alone — approximately five times more than the average of other wealthy countries — yet performs worse on common health metrics including life expectancy, infant mortality, unmanaged diabetes, and maternal safety [11].

What the HMO Act created, then, was not a cost-containment mechanism but a *cost-redistribution* mechanism: it transferred economic risk from insurers to patients and physicians, transferred clinical authority from the examining room to the corporate boardroom, and layered a vast administrative apparatus over the entire system — an apparatus whose primary function is not to improve care but to interpose friction between the physician's order and the patient's receipt of treatment. The friction is the product. The savings accrue to the insurer's quarterly earnings; the costs are externalized to patients, providers, employers, and taxpayers.

What the HMO Act actually accomplished was a structural transformation of American medicine: it shifted clinical authority from the examining room to the corporate boardroom, created federal preemption pathways that insulated managed care from state medical practice regulation, and — in concert with ERISA — constructed a liability shield that allows managed care entities to deny care without facing the legal consequences that any individual physician would face for the same act [4], [6], [7]. The physician who fails to prescribe a necessary medication commits malpractice. The insurance company that prevents the patient from obtaining that medication commits an *administrative act* — and is, under ERISA, substantially immune from tort liability for the consequences.

The irony, from Ellwood's perspective, is severe. When Nixon signed the HMO Act in 1973, it had been so diluted by the political process from Ellwood's ideas that Kaiser Permanente — the central model at the outset — did not even qualify as an HMO under the Act until it was amended four years later [3]. The integrated, preventive-care model that inspired the concept was marginalized from the start. What proliferated instead were IPA-model and network-model HMOs that functioned primarily as cost-reduction instruments for employers and profit vehicles for insurers — precisely the entities Ellwood had hoped to displace.

References

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