STATE HMO LAWS AND THE THEORY OF LIMITED REFORMMONGERING

*Philip C. Kissam**
*Ronald M. Johnson***

A health maintenance organization (HMO) may be defined as an organization that agrees to provide, directly or by contracts with other providers, a specified range of health services to a voluntarily enrolled population in exchange for prepaid per capita payments.[1] HMOs are thus both health care insurers and health care providers. Because in fact they contract to deliver relatively comprehensive services under a budget that is largely fixed in advance, HMOs are considered to be a promising policy instrument for implementing quality of care and economic reforms in the American health system.[2] Their fixed budgets, however, raise appropriate concern about the possibility of underservice that may result in the denial of needed care.[3]

In the past several years at least half of the states have enacted laws to promote and regulate the development of HMOs.[4] This activity has been accompanied by

* Associate Professor of Law, University of Kansas. B.A., Amherst College, 1963; LL.B., Yale University Law School, 1968.

** Member of the staff of the U.S. Senate Committee on Commerce. B.A., University of Kansas, 1973; J.D., University of Kansas, 1976.

[1] INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCES, HEALTH MAINTENANCE ORGANIZATIONS: TOWARD A FAIR MARKET TEST 2 (1974) [hereinafter cited as IOM REPORT]. The term "health maintenance organization" may be misleading in its implication that HMOs are likely to be substantially better than other providers at maintaining the health of patients through preventive rather than remedial care. *Id.* A more generic term such as "prepaid medical practice" might be preferable, but the term HMO has attained popular acceptance among policymakers and on balance its use would appear to reduce rather than add to semantic confusion. *Id.*

[2] *See, e.g.,* S. REP. No. 93-129, 93rd Cong., 1st Sess. .... (1973), *reprinted in* 1973 U.S. CONG. & ADMIN. NEWS 3033-49 (reporting out S. 14, the Senate version of the Health Maintenance Organization Act of 1973) [hereinafter cited as SENATE HMO REPORT]; Havinghurst, *Health Maintenance Organizations and the Market for Health Services,* 35 LAW & CONTEMP. PROB. 716 (1970) [hereinafter cited as Havighurst, *HMOs*]. It may be noted that plans for national health insurance programs of quite different types have included plans to promote HMOs on the theory that extra demand for health care services should not be added without simultaneous reforms that improve the efficiency of health care delivery. *See* 117 CONG. REC. 284, 284-85, 287 (1971) (speech by Senator Kennedy in the Senate to Introduce a Bill to Create a National System of Health Security, Jan. 25, 1971); 117 CONG. REC. 3119, 3120-21 (1971) (Message from President Nixon to Congress Relative to Building a National Health Strategy).

[3] *See, e.g.,* IOM REPORT, *supra* note 1, at 51-61; Havighurst, *HMOs, supra* note 2, at 754-56.

[4] As of June, 1976, at least 25 states had enacted HMO enabling acts. ARIZ. REV. STAT. ANN. §§ 20-1051 to -1068 (1975) (enacted 1973); ARK. STAT. ANN. §§ 66-5201 to -5228 (Supp. 1975) (enacted 1975); CAL. HEALTH & SAFETY CODE §§ 1340-1399.5 (West Supp. 1976) (enacted 1975); COLO. REV. STAT. ANN. §§ 10-17-101 to -129 (1974) (enacted 1973); FLA. STAT. §§ 641.17-.38 (1972) (enacted 1972); IDAHO CODE §§ 41-3901 to -3931 (Supp. 1975) (enacted 1974); ILL. ANN. STAT. Ch. 111½, §§ 1401-1417 (Smith-Hurd Supp. 1976) (enacted 1974); IOWA CODE ANN. §§ 514B.1-.32 (Cum. Pamphlet 1976) (enacted 1973); KAN. STAT. ANN. §§ 40-3201 to -3226 (Supp. 1975) (enacted 1974); KY. REV. STAT. ANN. §§ 304.38-010 to -200 (Supp. 1974) (enacted 1974); Law of Oct. 1, 1975, Ch. 503, §§ 4201-4226, [1975] Maine Laws 1546 (enacted 1975); MD. ANN. CODE art. 43, §§ 840-858 (Supp. 1975) (enacted 1975); MICH. COMP. LAWS ANN. §§ 325.901-.947 (1975) (enacted 1974); MINN. STAT. ANN. §§ 62D.01-.29 (Cum. Supp. 1976) (enacted 1973); NEV. REV. STAT. §§ 695C.010-.350 (1975) (enacted 1973); N.J. STAT. ANN. §§ 26:2J-1 to -30 (Supp. 1976) (enacted 1973); N.D. CENT. CODE §§ 26-38-01 to -35 (Supp. 1975) (enacted 1975); OKLA. STAT. ANN. tit. 63, §§ 2501-2510 (Supp. 1975) (enacted 1975); PA. STAT. ANN. tit. 40, §§ 1551-1568 (Supp. 1976) (enacted 1972); S.C. CODE ANN. §§ 37-1131 to -1136 (Supp. 1975) (enacted 1974); S.D. COMPILED LAWS ANN. §§ 58-41-1 to -97 (Supp. 1976) (enacted 1974); TENN. CODE ANN. §§ 56-4101 to -4105 (Supp. 1975) (enacted 1971); TEX. REV. CIV. STAT. ANN. art. 20A.01-.33 (Cum. Supp. 1975) (enacted 1975); UTAH CODE ANN. §§ 31-42-1 to -32 (1974) (enacted 1973); WASH. REV. CODE ANN. §§ 48-46.010-.920 (Spec. Pamphlet 1975) (enacted 1975). We have not included New York statutes concerning prepaid health care services because these statutes are not sufficiently comprehensive to be considered the equivalent of an HMO act. N.Y. INS. LAW §§ 250-60 (McKinney Supp. 1975) (enacted 1971); N.Y. PUB. HEALTH LAW §§ 4400-4423 (McKinney Supp. 1975) (enacted 1971). For a description of the New York scheme authorizing prepaid practice, *see generally* Albright & Vestner, *Prepaid Health Care Legislation in New York,* 36 ALBANY L. REV. 488 (1972).

substantial growth in the number of HMOs and their total subscriber enrollment, and HMOs now serve as the primary health care providers for perhaps as many as ten million Americans.[5] In an earlier article[6] we developed a general theory of HMO legislation and applied it to federal laws that affect HMO development. The purpose of this Article is to analyze the new state legislation in the context of our theory. State and federal HMO legislation tend to resolve common issues quite differently, and state legislation raises a number of new issues.

The first part of this Article summarizes some background information that seems necessary for an assessment of the state laws: the nature of HMO performance, different theories of HMO legislation, including our own, and the basic relationships between federal and state HMO legislation. The second part analyzes the new state HMO enabling acts and major issues that are faced by state legislators and administrators in regulating HMOs. In the third part we consider use of state Medicaid legislation as a device for promoting HMO development. The fourth part contains our overall assessment and recommendations for future rule-making concerning HMOs.[7]

I. THE BACKGROUND OF STATE HMO LEGISLATION

A. *HMO Performance*

The alleged advantages and disadvantages of HMOs in comparison with fee-for-service medicine may be analyzed in four separate categories.[8] First, both economic theory and empirical studies suggest that HMOs can deliver quality health care at a substantially lower total cost to consumers than can fee-for-service providers whose services are covered by traditional health insurance plans.[9] The financial incentive of HMOs to economize, in contrast to the financial incentives of fee-for-service providers,[10] and the possibility of economies of scale and integration from relatively

---

[5] *See* N.Y. Times, May 17, 1976, at 16, col. 5. As of July 1, 1975, the Department of Health, Education, and Welfare (HEW) reported that from 1965 to 1975 the number of HMOs in operation increased from about 20 to more than 175 and the number of HMO enrollees increased from about one and one-half million to six million. HEALTH SERVICES AD., U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH MAINTENANCE ORGANIZATIONS—SUMMARY OF FY 1975 ANNUAL REP. 5 (1975). This recent expansion is apparently due mostly to favorable market conditions, including rapidly increasing health care costs and related insurance premiums, and the expectation of HMO organizers that the federal government will provide subsidies and other benefits to promote HMO growth. McNeil & Schlenker, *HMOs, Competition, and Government*, 53 MILBANK MEM. FUND Q. 195, 195-207 (1975) [hereinafter cited as McNeil & Schlenker].

[6] Kissam & Johnson, *Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering*, 29 VAND. L. REV. 1163 (1976) [hereinafter cited as Kissam & Johnson].

[7] Other recommendations for state HMO legislation, which, however, do not analyze the new laws that have been enacted, may be found in IOM REPORT, *supra* note 1; Schneider, *Model Consumer Health Maintenance Organization Act and Commentary*, 6 RUTGERS-CAMDEN L.J. 265 (1974) [hereinafter cited as Schneider].

[8] The following discussion summarizes a more detailed treatment of HMO performance found in Kissam & Johnson, *supra* note 6, at 1167-83.

[9] For a recent review of the economic theory and performance of HMOs, see Auger & Goldberg, *Prepaid Health Plans and Moral Hazard*, 22 PUB. POLICY 353 (1974) [hereinafter cited as Auger & Goldberg]. Two other articles have reviewed the empirical studies of HMO performance. Donabedian, *An Evaluation of Prepaid Group Practice*, 6 INQUIRY 3 (Sept. 1969) [hereinafter cited as Donabedian]; Roemer & Shonick, *HMO Performance: The Recent Evidence*, 51 MILBANK MEM. FUND Q. 271 (1973) [hereinafter cited as Roemer & Schonick].

[10] *See* Auger & Goldberg, *supra* note 9. The financial incentives of fee-for-service providers are such that their income may be increased by providing additional or high value services without consideration of whether the additional quality obtained thereby is necessary or cost justified.

larger and more comprehensive HMO operations,[11] are major theoretical considerations that suggest more efficient performance by HMOs. Available empirical studies, which have compared the performance of HMOs with fee-for-service providers, have shown savings for HMO subscribers that range from about 10 percent[12] to 30 percent [13] of the total costs of providing medical care. These savings have been realized through subtantially lower out-of-pocket expenditures rather than reduced premiums. In fact, HMO premiums tend to be higher than premiums charged by other health insurers[14] because HMO policies generally cover more services than other policies, in particular more ambulatory services, and require fewer deductibles and coinsurance payments by subscribers.[15]

The primary sources of HMO cost savings appear to be reduced hospital utilization[16] and, to a lesser extent, reduced surgery[17] and reduced drug costs.[18] Although the reduction in drug costs can be substantial,[19] many HMOs do not offer full coverage for drug services, particularly outpatient drugs,[20] apparently because of the perceived need to maintain a competitive balance between their relatively high premiums and those of other insurers.[21] There also appears to be little evidence that HMOs have been aggressive innovators in introducing cost-reducing practices that relate most intimately to individual physician care and decision-making.[22] Such

---

[11] *See id.* at 354-58; Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations,* 24 STAN. L. REV. 644, 649-50 (1972) [hereinafter cited as Holley & Carlson]. Available empirical studies have neither demonstrated nor contradicted the claim that more efficient HMO operations are attributable in part to economies of scale or integration. *See* Auger & Goldberg, *supra* note 9, at 358; Roemer & Shonick, *supra* note 9, at 301.

[12] *See* M. ROEMER, R. HETHERINGTON, C. HOPKINS, A. GERST, E. PARSONS & D. LONG, HEALTH INSURANCE EFFECTS: SERVICES, EXPENDITURES, AND ATTITUDES UNDER THREE TYPES OF PLANS 46 (BUREAU OF PUBLIC HEALTH ECONOMICS, Research Series No. 16, 1972) [hereinafter cited as ROEMER] (reporting total expenditures of HMO subscribers to be 11% less than total expenditures of subscribers in commercial health insurance plans); Donabedian, *supra* note 9, Table 5 at 16 (summarizing the cost data from four different comparative studies).

[13] *See, e.g.,* ROEMER, *supra* note 12, at 46 (reporting total expenditures of HMO subscribers to be 28% less than total expenditures of subscribers in Blue Cross-Blue Shield plans); 2 REP. OF THE NAT'L ADVISORY COMM'N ON HEALTH MANPOWER 207 (1967) (estimating 20-30% savings for members of the Kaiser Permanent Plan HMO); Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis,* 84 HARV. L. REV. 887, 922 (1971) [hereinafter cited as HARVARD HMO Note] (reporting 33% savings for members of the Group Health Cooperative of Puget Sound HMO).

[14] *See, e.g.,* ROEMER, *supra* note 12, at 46.

[15] *See* HARVARD HMO Note, *supra* note 13, at 905-06. The reasons for this more comprehensive insurance coverage by HMOs have not been made entirely clear. *See, e.g., id.;* Phelan, Erickson and Fleming, *Group Practice Prepayment: An Approach to Delivering Organized Health Services,* 35 LAW & CONTEMP. PROB. 796, 800-02 (1970). Presumably, it results from an amalgam of sponsors' philosophies, consumers' market preferences, and the attractiveness to participating physicians of being able to provide a full range of services without worrying about substantial out-of-pocket expenditures for patients.

[16] *See* Auger & Goldberg, *supra* note 9, at 383-84; Roemer & Shonick, *supra* note 9, at 281-85.

[17] *See* Auger & Goldberg, *supra* note 9, at 384-85; Donabedian, *supra* note 9, at 13-16.

[18] *See* Auger & Goldberg, *supra* note 9, at 385-87; Donabedian, *supra* note 9, at 19-20.

[19] McCaffree & Newman, *Prepayment of Drug Costs Under a Group Practice Prepayment Plan,* 58 AM. J. PUB. HEALTH 1212 (1968), found a cost savings in one HMO's outpatient prescription drug program of 45% compared to nationwide outpatient drug costs, which figure they adjusted downward to 28% to account for taxes paid, profits of retail pharmacies, and drugs purchased outside the plan by the HMO's subscribers. They explain this dramatic difference by pointing to the HMO's use of a drug formulary including prices, its administrative controls over prescriptions including drug utilization reviews, and economies of size of the particular HMO (which had 95,000 members). *See also* Johnson, *Present and Projected Drug System Services in a Highly Developed HMO Structure,* 88 HEALTH SERV. REP. 873 (1973).

[20] Johnson, *supra* note 19, at 874; HARVARD HMO Note, *supra* note 13, at 905-06.

[21] Havighurst, *HMOs, supra* note 2, at 779-80.

[22] *See* 2 REP. OF THE NAT'L ADVISORY COMM'N ON HEALTH MANPOWER 206, 215-16 (1967); Roemer & Shonick, *supra* note 9, at 295-302. *But cf.* Lairson, Record & James, *Physician Assistants at Kaiser: Distinctive Patterns of Practice,* 11 INQUIRY 207 (Sept. 1974). Explanations for the failure of HMOs to implement these types of practices would appear to include the traditional emphasis of individual physicians on providing the highest quality of care possible without consideration of costs, *see* Havighurst &

practices might include, for example, substantial expansion of medical delegation by physicians to nonphysicians,[23] particularly if state medical practice laws are structured and interpreted in a way to allow delegation of medical acts to the maximum feasible extent.[24]

Second, the quality of health services under HMO plans has been found to be at least equivalent to the quality of services furnished under traditional insurance plans.[25] Indeed, in certain respects, HMOs may offer higher quality care than fee-for-service providers. For example, HMOs have a strong financial incentive to reduce unnecessary services, some of which, such as unnecessary surgery or drug services, may be quite harmful to patients.[26] As another example, HMOs' more comprehensive coverage of services may expand the use of preventive health services,[27] and there is evidence that some preventive services, especially prenatal and postnatal care for mother and infant[28] and well-child care,[29] may improve the health status of recipients.

Third, to the extent that HMOs become a major factor in the delivery of health care, competition between HMOs and other insurers and providers may be expected to produce economic and quality of care benefits for other health care consumers as well as for HMO subscribers.[30] The competitive benefits from substantial HMO expansion should include increased cost competition among insurers and providers. Arguably, certain HMO practices also will have favorable demonstration effects upon

---

Blumstein, *Coping With Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 Nw. U.L. REV. 6, 20-28 (1975) [hereinafter cited as Havighurst & Blumstein], understandable physician resistance and feared consumer resistance to dramatic departures in existing direct care practices, and the fear that innovative and cost-effective practices may cause imposition of additional malpractice liability if the customary standard of practice of fee-for-service providers should be applied to HMOs. *See* Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 4 DUKE L.J. 1375 (1975), suggesting that malpractice law should recognize and develop separate customary standards to apply to HMOs and fee-for-service providers in order to take account of HMOs' interest in making cost effective decisions.

[23] HMOs, at least those that operate in the form of group medical practices, present conditions conducive for much expanded delegation. These include the feasibility of close supervision of delegated acts by the physician, a relative lack of concern by him that his income position may be eroded, and, in the case of larger, self-sufficient HMOs, lessened fear of retaliation by competitors. Roemer & Shonick, *supra* note 9, at 297.

[24] For discussion of these laws and some evidence that they remain overly restrictive with respect to expanded medical delegation, see Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 KAN. L. REV. 1 (1975) [hereinafter cited as Kissam].

[25] *See* ROEMER, *supra* note 12, at 41-42, 50-58; Donabedian, *supra* note 9, at 7-10, 20-24; Roemer & Shonick, *supra* note 9, at 291-93, 302-09.

[26] For a recent survey of the kinds and estimated amounts of harmful, unnecessary surgery believed to occur in this country, *see* N.Y. Times, Jan. 27, 1976, at 1, col. 6. For a recent survey of the kinds and estimated amounts of harmful, unnecessary drug prescriptions believed to occur in this country, *see* N.Y. Times, Jan. 28, 1976, at 1, col. 7.

[27] The provision (and benefits) of expanded preventive services by HMOs is certainly a strongly held belief among some HMO supporters. *See, e.g.*, SENATE HMO REPORT, *supra* note 2, at 3034. Also, there is some objective evidence that HMOs do in fact provide expanded preventive services. ROEMER, *supra* note 12, at 41; Roemer & Shonick, *supra* note 9, at 293.

[28] INSTITUTE OF MEDICINE, NAT'L ACADEMY OF SCIENCES, INFANT DEATH: AN ANALYSIS OF MATERNAL RISK AND HEALTH CARE 1-3 (1973); Dott & Fort, *The Effect of Availability and Utilization of Prenatal Care and Hospital Services on Infant Mortality Rates*, 123 AM. J. OBSTET. GYNECOL. 854, 856-58 (1975). One empirical study of HMOs suggests that increased maternal and infant care by HMOs tends to reduce infant mortality rates. Shapiro, Weiner, & Densen, *Comparison of Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice, Medical Care Plan*, 48 AM. J. PUB. HEALTH 170 (1958); Shapiro, Jacobziner, Densen, & Weiner, *Further Observations on Prematurity and Perinatal Mortality in a General Population and in the Population of a Prepaid Group Practice Medical Care Plan*, 50 AM. J. PUBL. HEALTH 1304 (1960).

[29] *See* AM. ENTERPRISE INSTITUTE, NATIONAL HEALTH INSURANCE PROPOSALS, Legislative Analysis No. 19, 93rd Cong., 2d Sess. 11-12 (1974).

[30] *See* Havighurst, *HMOs*, *supra* note 2, at 743-47.

consumers and providers in the fee-for-service sector that will encourage the introduction of quality improvements and specific efficiencies throughout the medical economy. That is, as a relatively large number of health care consumers become exposed and accustomed to such HMO practices as more comprehensive insurance coverage, reduced drug utilization, and increased use of paraprofessionals, they may begin to demand or at least accept more willingly such practices from other providers. Similarly, physicians may be encouraged to introduce some of these practices, given the example set by their professional colleagues working for HMOs. It may be argued of course that economic competition does not and cannot work in the health care market.[31] This argument, however, ignores the fact that much of the failure of competition in health care may be attributed to the medical profession's success in repressing market forces[32] and that if HMOs can be freed from such constraints the market may work. It also ignores the fact that much of HMOs' competitive influence will occur in health insurance markets, where some degree of competition already exists.[33]

Finally, any assessment of HMOs' future performance must consider the potential disadvantages of HMO performance. These include the risk of underservice, particularly by HMOs that serve primarily low-income groups with few alternatives to HMO care,[34] as well as the possibility that the clinic form of service by group practice HMOs may so disrupt the traditional professional relationship of trust between patient and physician that quality of care suffers.[35] However, in addition to possible legislative safeguards, which we discuss below,[36] there would appear to be a number of strong nonlegislative constraints on HMOs that should minimize these dangers. These include the potential of malpractice litigation for consequent injuries, market competition for subscribers between HMOs and other insurers, the possibility of outside evaluations by trade unions or employers who contract with HMOs for group insurance, and the ethical standards of HMO physicians.[37]

B. *Different Legislative Theories*

Commentators sympathetic to HMO development have proposed varying theories of HMO legislation.[38] Broadly, these theories may be characterized as either "reform-

---

[31] *See, e.g.*, Schneider, *supra* note 7, at 275.

[32] Havighurst, *HMOs*, *supra* note 2, at 739-40.

[33] *See* S. LAW, BLUE CROSS WHAT WENT WRONG? 11-12 (2d ed. 1976) [hereinafter cited as LAW]; Hanson, *The Private Insurance Industry and State Insurance Regulatory Activities as Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation*, 6 U. TOLEDO L. REV. 677, 691-95, 698 (1975) [hereinafter cited as Hanson].

[34] *See* Auger & Goldberg, *supra* note 9, at 388-90; Havighurst, *HMOs*, *supra* note 2, at 722-23, 754; Roemer & Shonick, *supra* note 9, at 309-11.

[35] Klarman, *Analysis of the HMO Proposal—Its Assumptions, Implications, and Prospects*, in HEALTH MAINTENANCE ORGANIZATIONS: A RECONFIGURATION OF THE HEALTH SERVICES SYSTEM 24, 33 (1971) (U. Chi. Center for Health Ad. Studies).

[36] *See* text at notes 186-224 *infra*.

[37] Auger & Goldberg, *supra* note 9, at 390-91; Havighurst, *HMOs*, *supra* note 2, at 755-56. *See also* Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U.L. REV. 69 (1975).

[38] Our division of other HMO supporters into two camps, and the following summary of their legislative positions, follow Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?* 1975 UTAH L. REV. 381, 386-87 [hereinafter cited as Havighurst & Bovbjerg]. For a more extended analysis of these positions and our own theory, see Kissam & Johnson, *supra* note 6, at 1183-98.

mongering"[39] or "fair market,"[40] depending on the degree of social engineering inherent in the proposed legislation.

The "reformmongering" theorists view the HMO as a model health care delivery system that is capable of achieving a broad variety of health care reforms.[41] Advocates of this view support legislation that would require all HMOs to implement these reforms. Under this approach, comprehensive coverage of services by HMO policies and direct consumer participation in HMO policymaking would be required of all HMOs as a means of improving the quality of health care. The use of a community rating system to establish premiums[42] and periodic open enrollment periods[43] also would be required in order to increase the availability of health insurance for high risk individuals and to help break down existing variances in the quality of care provided to the poor and the more well-to-do. Other suggested reforms include specific cost control measures such as requirements that HMOs assume nearly all financial risk for provision of their services and that HMOs make maximum feasible use of allied health personnel.

HMO supporters at the other end of the spectrum see the HMO primarily as a vehicle for improving the efficiency of health care delivery.[44] In this view, HMO legislation should be directed toward removal of legal, institutional, and other obstacles to HMO development in order to give HMOs a "fair market test" to determine if they can provide an increased degree of price and quality competition in the market for health services.[45] Proponents of this theory emphasize the need to promote both "model" and "nonmodel" HMOs in order to increase efficiency and consumer choice; in order to accomplish this, these HMO supporters argue against imposition of specific requirements on HMOs of the kind mentioned above.

Each of these approaches to HMO legislation has certain strengths and weaknesses. The "reformmongering" approach has the merit of recognizing that HMOs may be a powerful policy instrument, to which may be attached general health care reforms not otherwise attainable by operation of market forces or by direct regulation of the health care system. This technique of attaching reforms that are desirable for the entire health care economy solely to HMOs appears similar to some of the "reformmongering techniques" employed by economic planners in less developed countries,[46] and use of this technique seems appropriate in view of the relatively underdeveloped state of health care policymaking in this country.[47] Nonetheless,

---

[39] The term "reformmongering" is borrowed from the work on economic development planning of Professor Albert Hirschman, a Harvard economist. *See* A. HIRSCHMAN, JOURNEYS TOWARD PROGRESS: STUDIES OF ECONOMIC POLICY-MAKING IN LATIN AMERICA 225-97 (Norton Library ed. 1973). The similarity of techniques used by economic planners in less developed countries, as analyzed by Professor Hirschman, and by "reformmongering" HMO supporters is discussed in Kissam & Johnson, *supra* note 6, at 1191-93.

[40] The term "fair market" comes from the title of one of the major statements of this legislative position. *See* IOM REPORT, *supra* note 1.

[41] Leading statements of this position include SENATE HMO REPORT, *supra* note 2, at 3039-61; Schneider, *supra* note 7.

[42] A community rate is in essence a single rate for all subscribers that eliminates experience rating, which is the practice of charging different rates based on the varying health status and cost experience of specific subscriber groups. *See* SENATE HMO REPORT, *supra* note 2, at 3061.

[43] An open enrollment period is a period during which individual subscribers must be accepted in the order in which they apply and without regard to their health status or needs. *Id.*

[44] The leading statement of this position is IOM REPORT, *supra* note 1.

[45] *Id.* at 3-5.

[46] *See* A. HIRSCHMAN, *supra* note 39, at 229-35; Kissam & Johnson, *supra* note 6, at 1191-92.

[47] *See* Kissam & Johnson, *supra* note 6, at 1191-93.

the large number of reforms attached to HMOs by the model HMO approach may so increase costs that HMOs will be unable to develop in competition with other insurers and providers who are not burdened with similar requirements.[48] Furthermore, for many of these reforms there is little evidence available to suggest that they, in fact, will impove the health status of recipients[49] or even that legal requirements on HMOs are necessary to achieve all of the desired reforms.[50]

The "fair market" approach to HMO legislation has the strength of relying on economic market theory to point out the advantages to be gained by substantial development of a great variety of HMO types. Thus, for example, HMOs in rural areas may be financially viable only if they can offer a relatively limited range of services and obtain reinsurance for the costs of many of these services.[51] This approach also uses economic theory to point to a number of measures that might be undertaken to promote HMO development. These include limiting HMO requirements in general to those that are imposed on competing insurers and providers and avoiding forms of HMO regulation that are controlled by HMO competitors or are inappropriate to HMOs' unique economic incentives and operations. On the other hand, the fair market approach does not recognize the political utility of using the HMO as a policy instrument for promoting specific, desirable reforms throughout the health care economy.

We have proposed an intermediate strategy, which we call the theory of "limited reformmongering," as a more effective way of employing HMOs as a policy instrument.[52] This approach relies to a large extent on the principle of giving HMOs a fair market test, and thus, like the fair market theorists, we would place major emphasis on the use of HMOs to introduce greater competition and efficiency into American health care.[53] Our theory, however, qualifies the fair market principle by employing the reformmongering technique in limited instances where, based on

---

[48] For evidence of this proposition, see text at notes 89-105 *infra*.

[49] The Federal Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.* (1974), was originally based on the model HMO approach to HMO legislation. Yet the Senate Committee Report recommending adoption of this Act did not rely on any evidence that reforms such as very comprehensive insurance coverage by HMOs or consumer participation on HMO governing bodies would improve the health status of recipients. *See* SENATE HMO REPORT, *supra* note 2, at 3042-49. For a generally inconclusive answer to the question of whether increased health insurance coverage in general will have a favorable effect on health, *see* AMERICAN ENTERPRISE INSTITUTE, *supra* note 29, at 9-12.

[50] For example, the basic purpose of a requirement that consumers participate on HMO governing bodies is to ensure greater responsiveness by providers to consumer demands and needs. If health care consumers in fact desire increased provider responsiveness, it is unclear why some HMOs (and subsequently other competing providers) would not offer consumer participation on governing bodies in order to attract subscribers. *See* Kissam & Johnson, *supra* note 6, at 1206. For discussion of another apparently unnecessary reform requirement, see note 104 and accompanying text *infra*.

[51] *See* Havighurst, *State Regulation of HMO's: Arranging for a "Fair Market Test,"* in SUBCOMM. ON RURAL DEVELOPMENT OF THE SENATE COMM. ON AGRICULTURE AND FORESTRY, 93RD CONG., 2D SESS., RURAL HEALTH CARE DELIVERY: PROCEEDINGS OF A NATIONAL CONFERENCE ON RURAL HEALTH MAINTENANCE ORGANIZATIONS, LOUISVILLE, KENTUCKY, JULY 8-10, 1974, at 90, 92-93 (Comm. Print 1974).

[52] For a more detailed statement of our theory, *see* Kissam & Johnson, *supra* note 6, at 1196-98.

[53] The concern of the fair market theorists with inefficiency in our present health care delivery system and the consequent costs therefrom seems well founded to us. Since 1959, except for the period from August 1971 to April 1974, when mandatory federal price controls applied to the health sector, both hospital service costs and physician fees have increased at substantially higher rates than the prices for other consumer services. COUNCIL ON WAGE AND PRICE STABILITY, EXECUTIVE OFFICE OF THE PRESIDENT, THE PROBLEM OF RISING HEALTH CARE COSTS 5-9 (1976). During this period the percentage of GNP devoted to health services increased from 5.2% to 8.3%. *Id.* at 27. Of course, some of this spending has been for needed additional services and relatively unique cost increases, but much of it apparently must be attributed to the peculiarities of health economics which include, importantly, the widespread availability of third-party payments for services and the fact that physicians alone often determine the nature and extent of services. *See id.* at 9-21.

available evidence, a specific reform appears highly desirable, is unlikely to be achieved by operation of market forces alone or by comprehensive government regulation, and may be imposed on HMOs at relatively little risk of retarding HMO development.

More specifically, our theory contains three criteria for evaluating proposed HMO legislation. These criteria are designed to limit use of the reformmongering technique in HMO legislation to instances in which substantial social benefits may be obtained at little risk of retarding HMO development. The first criterion is the existence of evidence that a particular regulation may provide a substantial "payoff" in terms of improved health outcomes and/or efficiencies of a specific kind. The second is that the reform is not likely to be achieved generally by HMOs in the absence of regulation. The third is the existence of evidence that the regulation will not substantially jeopardize the competitive position of HMOs vis-à-vis other providers and insurers.

We have suggested that at least three types of HMO regulation satisfy the above criteria and should be included in HMO legislation. One type is to encourage HMOs to engage in substantially expanded medical delegation. This could be done by setting a statutory goal in general terms and by requiring HMOs to report periodically on their progress toward this goal and to provide education for their professionals and consumers that is designed to promote acceptance of expanded delegation. The other types of desired regulation are requirements that HMO policies cover on a prepaid basis all drug costs incurred in relation to other covered services and that all primary care HMOs cover complete prenatal and postnatal care for mother and infant, as well as well-child care. The major problem with these latter regulations, of course, is the possibility that they might so increase premium rates as to jeopardize HMOs' competitive position. However, most drug costs probably are incurred whether or not they are covered by insurance and an educational effort by HMOs should be able to overcome consumer resistance to higher premiums caused by expanded drug coverage. While the same situation may not exist with respect to maternity and well-child care, any problem of competitive jeopardy might be resolved by allowing this requirement to be waived upon a showing that the HMO's economic viability would otherwise be endangered.

C. *Federal HMO Law and the Continuing Need for State Legislation*

In the past several years, both the federal government and the states have been active in promulgating laws designed to both promote and regulate HMO development. This dual activity raises a need to sort out the actual and appropriate relationships between federal and state governments in the regulation of HMOs. More specifically, two questions must be addressed. Has the federal government so occupied the field that state HMO legislation is redundant and therefore possibly restrictive? If the federal government has not yet occupied the field, should it or is it likely to do so? We argue in this section that existing federal law leaves the states with ample opportunity to promote and regulate both federally qualified and other HMOs. They may do this by appropriate regulation of the financial conditions of and quality of care provided by all HMOs, by supplementing the federal law's benefits for HMOs through certain changes in state laws that are favorable for HMO development, and by providing clear legal authority and appropriate regulation for

the possibly substantial number of HMOs that may be unwilling or unable to qualify under federal law. Moreover, concurrent state regulation of HMOs seems appropriate even if the present scope of federal law should be expanded. State governments appear to have a comparative advantage over the federal government for certain types of HMO regulation, and states also may be able to provide particular benefits for HMOs that the federal government is either unwilling or constitutionally unable to provide.

Since 1972 the federal government has enacted three major laws designed specifically to promote and regulate HMOs: the Health Maintenance Organization Act of 1973[54] (the Federal HMO Act), an amendment to the Medicare law[55] that established conditions for HMO participation in the Medicare program on a prepaid basis,[56] and an amendment to the Medicaid law[57] that provided express authority for state Medicaid agencies to contract with HMOs on a prepaid basis.[58] Late in 1976, legislation was passed significantly amending all three major federal HMO laws (the 1976 HMO amendments).[59]

Federal HMO legislation has three basic features that suggest that states still have substantial scope and opportunity to promote and regulate HMOs. First, federal HMO law expressly preempts only a few aspects of state HMO regulation and concurrent state regulation of federally qualified HMOs clearly is contemplated.[60] The HMO amendments to the Medicare and Medicaid laws do not contain preemption provisions,[61] and the Federal HMO Act expressly preempts only three types of state regulation of HMOs that qualify under that Act.[62] The first type is any requirement that a medical society approve an HMO's organization, that physicians constitute some percentage of the HMO's governing body, or that participation in the HMO be open to all or some given percentage of physicians in the community.[63] The second type is any requirement that HMOs meet the initial capitalization or financial reserve requirements established for health care insurers

---

[54] 42 U.S.C. § 300e *et seq.* (1974). For analyses of this Act, all from somewhat different perspectives, see IOM REPORT, *supra* note 1; Kissam & Johnson, *supra* note 6, at 1203-24; Rosoff, *Phase Two of the Federal HMO Development Program: New Directions After a Shaky Start*, 1 AM. J. LAW & MED. 209 (1975); Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U.L. REV. 90, 101-10 (1975) [hereinafter cited as Schneider & Stern].

[55] Social Security Act, Title XVIII, 42 U.S.C. § 1395 *et seq.* (1974). A brief description of the Medicare program of health insurance for the elderly may be found in STAFF OF THE COMM. ON WAYS AND MEANS, 93RD CONG., 2D SESS., NATIONAL HEALTH INSURANCE RESOURCE BOOK 429-33 (1974) [hereinafter cited as RESOURCE BOOK].

[56] 42 U.S.C. § 1395mm (1974). For analyses of this amendment, see Kissam & Johnson, *supra* note 6, at 1225-29; Schneider & Stern, *supra* note 54, at 111-15.

[57] Social Security Act, Title XIX, 42 U.S.C. § 1395 *et seq.* (1974). For a summary of the Medicaid program of health care benefits for the poor, see Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7 (1974).

[58] 42 U.S.C. § 1396(a)(23) (1974) (enacted 1972). For analyses of this amendment, see Kissam & Johnson, *supra* note 6, at 1229-32; Schneider & Stern, *supra* note 54, at 115-22.

[59] Pub. L. No. 94-460 (Oct. 8, 1976).

[60] Regulations under all three federal HMO laws recognize concurrent state regulation. 42 C.F.R. § 110.603(b)(2)(xii) (1975) (Federal HMO Act regulations); 20 C.F.R. § 405.2003 (1975) (Medicare regulations); 45 C.F.R. § 249.82(b)(2) (1975) (Medicaid regulations).

[61] *See* 42 U.S.C. §§ 1395mm, 1396a(a)(23) (1974).

[62] 42 U.S.C. § 300e-10 (1974).

[63] *Id.* at § 300e-10(1)(A)-(C). These requirements typically are found in state "Blue Shield" enabling statutes that authorize nonprofit corporations to offer medical service insurance, HARVARD HMO Note, *supra* note 13, at 962-63, and can have the effect of limiting the operation of medical service plans not controlled by physicians. *See id.* at 963-69.

generally.[64] The third type of state regulation preempted by the Federal HMO Act is any prohibition against an HMO's advertising "its services, charges, or other non-professional aspects of its operation," although this does not authorize "advertising which identifies, refers to, or makes any qualitative judgment concerning any health professional who provides services for a health maintenance organization."[65] In addition, of course, any other state law that is deemed to conflict or be inconsistent with particular provisions or the overall regulatory scheme of any federal HMO law would be preempted implicitly by such law.[66]

Under this scheme of concurrent federal-state regulation, at least three kinds of state regulation of HMOs seem appropriate. Well-designed state regulation of the financial conditions, marketing practices, and quality of care of all HMOs would appear to offer several advantages. This approach, by retaining an important role for state governments, may be of some political advantage in obtaining support for more effective federal HMO laws. It also would permit reliance on state governments' considerable expertise in regulating the financial conditions and marketing practices of health insurance companies, and it would make use of the closer political relationship between state agencies and the public to help ensure effective regulation.

Second, existing federal law leaves the states with certain opportunities to help promote all HMOs by adding to the benefits available to HMOs that qualify under the Federal HMO Act. This Act offers three kinds of benefits for qualified HMOs: the possibility of obtaining developmental subsidies,[67] the preemption of certain restrictive state laws,[68] and the possibility of improved access to group health insurance markets. This latter benefit is achieved by the Federal Act's mandate that employers subject to the Fair Labor Standards Act, who employ at least 25 employees and offer health insurance as a fringe benefit to their employees, must include in any offer of health benefits the option of membership in a federally qualified HMO.[69] These benefits are clearly substantial,[70] but certain gaps exist that may be filled by appropriate state legislation applicable to both federally qualified and other HMOs.

---

[64] 42 U.S.C. § 300e-10(1)(D) (1974). Although HMO subscribers certainly deserve protection against financial difficulties of the HMO if such protection is provided for other health insurance subscribers, HMOs, unlike other health insurers, provide most of their benefits in the form of services rather than cash, and it is generally recognized that regulation of HMOs' financial condition should be more flexible than the conservative capital and reserve requirements that are applied to other health insurers. *See* IOM REPORT, *supra* note 1, at 23-24; HARVARD HMO Note, *supra* note 13, at 969-74. *But cf.* IOM REPORT, *supra* note 1, at 68 (a dissenting opinion claiming that the efficiency of alternatives to reserve requirements is not clear and deserves study).

[65] 42 U.S.C. § 300e-10(2) (1974). The common state prohibition against advertising by physicians arguably might limit all advertising by HMOs, Holley & Carlson, *supra* note 11, at 658, although to do so would ignore HMOs' sui generis nature as both insurers and providers. *See* text at notes 1-2 *supra*.

[66] *See generally* Holly & Carlson, *supra* note 11, at 677-81. The common-law rule against the corporate practice of medicine, which has been applied recently to forbid an HMO to operate, *see* Garcia v. Texas State Bd. of Medical Examiners, 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd mem.*, 421 U.S. 995 (1975), would appear to be a good example of a state law that could not be applied to a federally qualified HMO under the preemption doctrine. For an analysis of some additional preemption questions, see text at notes 239-41, 264-65 *infra*.

[67] 42 U.S.C. §§ 300e-2 to 300e-4 (1974).

[68] *Id.* § 300e-10. *See* text at notes 62-66 *supra*.

[69] 42 U.S.C. § 300e-9(a) (1974).

[70] The Federal HMO Act's benefits, in particular its mandate upon many employers to offer employees the option of insurance coverage by a qualified HMO, *id.*, may be sufficient to attract many HMOs despite the apparently substantial extra costs involved in meeting the qualifying conditions. *See* McNeil & Schlenker, *supra* note 5, at 216-17; Schneider & Stern, *supra* note 54, at 104-05.

In addition to providing subsidies, for which there is both justification and need,[71] there are several areas in which progressive state legislation could support HMO development by adding to the benefits available under federal law. The Federal HMO Act partially frees qualified HMOs from restrictive state laws against medical advertising, by authorizing HMO advertising exclusive of quality of care issues.[72] This provision does not seem to go far enough. Because of consumer inertia to this relatively new form of practice, HMOs may find it useful to provide potential subscribers with information about the quality of care they render, and they should be allowed to so advertise subject to the usual strictures against deceptive and misleading advertising by insurers.[73]

The Federal HMO Act also encourages qualified HMOs to engage in expanded medical delegation,[74] but it does not preempt application to those HMOs of state medical practice laws, which are often unduly restrictive.[75] The typical structure of state medical practice laws raises significant questions about the legality of much expanded delegation.[76] Although most states recently have enacted "physician's assistant" and "nurse practitioner" laws to promote and regulate expanded delegation, by and large these laws seem incomplete and overly restrictive.[77] In particular, they tend to unduly limit or leave unresolved the scope of authorized expanded delegations[78] and to limit eligible nonphysicians to persons with relatively comprehensive training,[79] who must obtain approval from state licensing boards that are dominated by organized medicine and organized nursing.[80] As HMOs have particular incentives and capacity to engage in expanded delegation,[81] it would seem desirable for state HMO legislation to provide an alternative and more favorable scheme for regulating expanded delegation by HMOs.[82]

The Federal HMO Act's mandate that an HMO option be included in employers' offers of health benefits to employees does not, at present, apply to state and local governments, and there is a constitutional question as to whether such a requirement can be applied. In *National League of Cities v. Usery*[83] the Supreme Court held that aplication of the minimum wage and overtime provisions of the Fair Labor Standards Act to most operations of state and local governments is not authorized by the commerce clause of the United States Constitution.[84] An immediate although incidental effect of this decision was to exempt state and local governments from the

---

[71] The arguments for subsidizing HMO development are summarized in Kissam & Johnson, *supra* note 6, at 1185. It may be noted that federal subsidies under the Federal HMO Act do not appear to be overly generous. *See id.* at 1221-22. We do not focus much on this issue in this Article, however, because of the unlikely availability of state resources. *See* Schneider, *supra* note 7, at 276-77.

[72] *See* text at note 65 *supra.*

[73] *See* IOM REPORT, *supra* note 1, at 42-43. Of course such advertising itself will be of a new kind and may offer new possibilities for deception. Some states have guarded against this by requiring prior state approval of HMO advertising material, which is a less restrictive alternative than a per se rule against discussing quality of care issues. *See* text at notes 194-200 *infra.*

[74] *See* text at notes 103-05 *infra.*

[75] Such a preemption provision was included in the Senate's proposed Federal HMO Act, SENATE HMO REPORT, *supra* note 2, at 3058, but was dropped in the final version. 42 U.S.C. § 300e-10 (1974).

[76] *See* Kissam, *supra* note 24, at 11-13.

[77] *Id.* at 1, 29-59.

[78] *Id.* at 44-51. *See* Lairson, Record & James, *Physician Assistants at Kaiser: Distinctive Patterns of Practice,* 11 INQUIRY 207, 216 (Sept. 1974).

[79] Kissam, *supra* note 24, at 37-43.

[80] *Id.* at 52-55.

[81] *See* text at notes 10-23 *supra.*

[82] *Cf.* IOM REPORT, *supra* note 1, at 28-29.

[83] 96 S. Ct. 2465 (1976).

[84] *Id.* at 2472-76.

Federal HMO Act's HMO option mandate that applies only to employers subject to the Fair Labor Standards Act. *National League of Cities* also raises some question about the constitutionality of any mandate of an HMO option on state governments because this too would involve a federal requirement that impinges on the states' power to determine compensation of their employees.[85] The 1976 HMO amendments attempt to reinstitute the HMO option mandate on state and local governments by providing that certain federal grants under the Public Health Service Act be denied to any state that does not arrange for inclusion of an HMO option (for federally qualified HMOs) in health benefits plans offered to its state and local government employees.[86] This provision attempts to strengthen the claim of constitutionality for imposition of an HMO option on states by attaching it to the federal spending power. However, in view of the somewhat indirect relationship between the HMO option and the purposes of the grants to which the option provision would be attached, it appears possible, if not probable, that the Supreme Court might ignore this linkage and treat the question directly as one of the extent of the commerce power under the *National League of Cities* doctrine.[87]

It thus is possible that only states have the constitutional power to arrange for the offer of an HMO option to their state and local government employees. A state requirement that such an option be provided would be justified by the same reasons that support the Federal HMO Act's option provision. These include resistance to HMO insurance by employers and union leaders because of inertia, fear of additional administrative costs, and fear of additional pressure from employees for the employer to pay additional amounts needed to cover HMOs' generally higher premiums. The access of new HMOs to group health insurance markets also may be obstructed unfairly by the entrenched position of existing insurers, whose management may enjoy personal ties with employers and union leaders and who have the economic strength to engage in unfair methods of competition such as offering below-cost premiums.[88]

Last, each federal HMO law regulates by establishing qualifying conditions that HMOs must satisfy in order to obtain certain benefits. As indicated in the following paragraphs, several of these conditions appear quite restrictive and likely to impose substantial additional costs on HMOs, even after the generally liberalizing changes of the 1976 HMO Amendments become effective.[89] If these costs outweigh the benefits to be obtained from federal qualification, many HMOs may be unable or unwilling to qualify under the federal laws.[90] These HMOs deserve the develop-

---

[85] *See* Kissam & Johnson, *supra* note 6, at 1202 n.245. One potentially significant difference between imposition of minimum wage and overtime requirements and imposition of an HMO option, however, is that the latter requirement need not increase costs to state and local governments as employers, as the Federal HMO Act's option provision currently provides. 42 U.S.C. § 300e-9(c) (1974).

[86] Pub. L. No. 94-460, § 110(a) (Oct. 8, 1976).

[87] *See* Kissam & Johnson, *supra* note 6, at 1216-17.

[88] These reasons are discussed in more detail in *id.* at 1185-86.

[89] The brief summary of restrictive qualifying conditions in federal HMO law that follows is based on our analysis in Kissam & Johnson, *supra* note 6, at 1199-1232.

[90] At present this certainly seems to be the case. As of July 1, 1976, after two and one-half years of operations under the Federal HMO Act, only 18 HMOs had qualified. Telephone Interview with Peter Kirsch, Public Health Advisor, HMO Program, Public Health Service, HEW, July 22, 1976. As of the same date, only two HMOs had qualified for prepayment contracts under the HMO amendment to Medicare and about 20 had applications pending. Telephone Interview with Wayne Fowler, Director, Group Health Plan Operations, Social Security Administration, HEW, July 22, 1976. Under the more flexible Medicaid scheme, a larger number of HMOs have qualified for prepayment contracts with state Medicaid agencies, but most of this contracting has occurred in California and the recent failure of many HMOs

mental assistance that state HMO legislation can provide, and their subscribers deserve the benefit of specially tailored safeguards against the risk of underservice. Such legislation also may provide the social benefits obtained from HMO regulation under the theory of limited reformmongering.

As examples of the financial and administrative burdens imposed by the Federal HMO Act, HMOs, to qualify, must offer subscribers a basic policy that covers a rather comprehensive range of services on a prepaid basis,[91] many of which are not generally covered by existing HMOs or other insurers.[92] A second quality of care reform imposed by the Federal HMO Act is the requirement that subscribers constitute at least one-third of the HMO's policymaking body.[93] These coverage and consumer participation requirements seem likely to retard HMO development under the Federal Act, the former by increasing HMO premiums unduly[94] and the latter by deterring nonconsumer-oriented institutions from sponsoring HMOs.[95] Moreover, as we have noted, there appears to be little evidence available to support the hypothesis that either of these requirements will, in general, significantly improve the health status of HMO subscribers.[96]

Additionally, the Federal HMO Act requires qualified HMOs to establish their premiums by community rating[97] and to conduct annual open enrollment periods during which individual subscribers must be accepted in the order in which they apply without regard to their health status or health care needs.[98] These provisions may jeopardize HMOs' competitive position because of the costs of serving high

---

there has reduced the total number of Medicaid HMOs to about 55. *See* Kissam & Johnson, *supra* note 6, at 1225 n.415. Moreover, growth in the number of Medicaid HMOs may be limited by the requirement of the 1976 HMO Amendments that Medicaid HMOs must qualify under the Federal HMO Act. Pub. L. No. 94-460, § 202(a) (Oct. 8, 1976); *see* Kissam & Johnson, *supra* note 6, at 1230.

[91] 42 U.S.C. §§ 300e(b)(1), 300e-1(1) (1974), *as amended,* Pub. L. No. 94-460 (Oct. 8, 1976). These services include not only physician, hospital inpatient, and hospital outpatient services, but also short-term mental evaluations and crisis intervention, treatment and referrals for the abuse of or addiction to alcohol and drugs, home health services, and preventive services (including family planning and children's eye examinations). *Id.* § 300e-1(1). In addition, a qualified HMO may charge its subscribers only "nominal" copayments for specific services, 42 U.S.C. § 300e(b)(1)(D) (1974), and HEW's regulations limit such copayments to no more than 50% of the cost of any specific service and, in the aggregate, to no more than 20% of the total cost of providing all basic health services. 42 C.F.R. § 110.105(a)(4)(i) (1974).

[92] *See* note 94 and accompanying text *infra.*

[93] 42 U.S.C. § 300e(c)(6) (1974).

[94] The breadth of the Federal HMO Act's coverage requirements and consequent expansion of coverage and extra costs that are involved are one of the two major reasons given by many existing HMOs for their unwillingness or inability to qualify under the Act. McNeil & Schlenker, *supra* note 5, at 216-17; *see* N.Y. Times, Feb. 14, 1974, at 30, col. 3; Wall Street Journal, Feb. 11, 1975, at 1, col. 1, 31, col. 2.

[95] *See* Schneider, *supra* note 7, at 298-301. These institutions, such as existing health insurance companies, physicians, and profitmaking entities, are likely to be an important source of private capital and management expertise for new HMOs.

[96] *See* note 49 and accompanying text *supra.* We have suggested above reasons for believing that selected expansion of insurance coverage to include drugs, maternity care, and well-child care may improve the health status of recipients, *see* text at notes 26-29 *supra,* but the Federal HMO Act's expanded coverage requirements are much more comprehensive than this.

[97] 42 U.S.C. §§ 300e(b)(1), (2) (1974). The Federal HMO Act does allow HMO rates to reflect different administrative costs from collecting payments from different groups, and it also allows HMOs to charge different rates for subscribers whose premiums are paid by Medicare and Medicaid. *Id.* § 300e-1(8)(A), (B).

[98] *Id.* § 300e(c)(4). The open enrollment requirement may be waived by HEW for reasons of economic viability or impairment of an HMO's capacity to satisfy the requirement that it enroll persons who are broadly representative of the population groups in the area it serves. *Id.*

risk individuals who subscribe at the community rate during open enrollment.[99] The 1976 HMO amendments made significant changes in these requirements. Imposition of the community rating requirement has been delayed for four years after an HMO has qualified under the Federal HMO Act[100] and, more significantly, only a limited form of open enrollment requirement has been retained for relatively mature and expanding HMOs.[101]

As specific measures of cost reform, qualified HMOs under the Federal HMO Act must assume nearly all the financial risk involved in providing services covered by their basic policies,[102] and they are required to utilize available nonphysician health personnel in a manner that is "appropriate for the effective and efficient delivery of . . . services."[103] The first provision limits the HMO's ability to obtain substantial reinsurance of its costs, and it is designed to ensure that an HMO faces maximum economic incentive for efficient operations. This provision may be unnecessary, and in any event it will have the unfortunate effect of obstructing development of new and smaller HMOs.[104] The requirement that HMOs utilize allied health personnel efficiently seems desirable, although HEW's regulations implement it in a weak fashion by merely restating the statutory language.[105]

The federal qualifying conditions for HMO participation in the Medicare and Medicaid programs on a prepaid basis were in general somewhat less onerous than those under the Federal HMO Act,[106] but the 1976 HMO amendments have changed this by requiring that an HMO qualify under the Federal HMO Act as a condition of participation in these programs on a prepaid basis.[107] The ability and incentive of HMOs to participate in Medicare on a prepaid basis also is circumscribed by certain conditions that limit the retention of cost savings by HMOs under prepaid Medicare contracts.[108] Urban HMOs must have a current membership of at least 25,000 in order to participate on a prepaid and risk sharing basis.[109] Furthermore,

---

[99] *See* McNeil & Schlenker, *supra* note 5, at 217-18. These requirements are the second major reason given by existing HMOs for their unwillingness or inability to qualify under the Federal HMO Act. *See id.;* Schneider & Stern, *supra* note 13, at 104 n.65. Although available data on the extent of cost increases that would be imposed by these requirements is scarce (few HMOs have qualified under the Federal HMO Act to date, *see* note 59 *supra*), one HMO has reported 50% higher costs for serving subscribers joining during open enrollment, McNeil & Schlenker, *supra* note 5, at 217-18, and others have experienced utilization increases of 35% to 140% from such subscribers. S. REP. No. 94-844, 94th Cong., 2d Sess. 9 (1976).

[100] Pub. L. No. 94-460, § 105(a) (Oct. 8, 1976).

[101] *Id.* § 103(b). The new open enrollment requirement applies only to an HMO (1) that has been in existence five years, or has an enrollment of 50,000 subscribers, and (2) that has not incurred a financial deficit in its most recent fiscal year. Furthermore, such an HMO can close its open enrollment after taking 3% of its new increase in enrollment during the preceding year, exclusive of increases under existing group contracts.

[102] 42 U.S.C. § 300e(c)(2) (1974).

[103] *Id.* § 300e-1(4)(C)(iv), (5)(B)(i).

[104] *See* Kissam & Johnson, *supra* note 6, at 1212-13. This provision may be unnecessary because HMOs should have adequate incentive to reduce the costs of reinsured services in order to keep their reinsurance policy costs at a minimum. Thus the avowed purpose of the provision, to ensure efficient operation, should be achieved without the requirement.

[105] 42 C.F.R. § 110.101(i)(3)(iv), (j)(ii)(A) (1975). See text following note 53 *supra* for our recommendations on how this requirement should be implemented.

[106] *See* Kissam & Johnson, *supra* note 6, at 1225-30.

[107] Pub. L. No. 94-460, §§ 201(a), 202(a) (Oct. 8, 1976).

[108] Few HMOs have done so to date. *See* note 90 *supra.*

[109] 42 U.S.C. § 1395mm(i)(2)(A) (1974). The requirement that urban HMOs must have a membership of 25,000 or more in order to participate on a risk sharing basis, though inconsistent with the allowance of much smaller rural HMOs to so participate, apparently was intended to protect the Medicare program and beneficiaries from smaller HMOs becoming insolvent under a risk sharing contract. *See* S. REP. No. 1230, 92d Cong., 2d Sess. 231-32 (1972) (explaining this requirement as necessary to determine valid HMO prepayment rates). In 1972 it was commonly believed that HMOs needed enroll-

any risk sharing HMO may retain only one-half of any cost savings it generates in comparison with comparable fee-for-service costs,[110] but the HMO must absorb all losses except for half of any losses that can be offset against future savings.[111]

In summary, this brief survey of federal HMO law reveals that states have substantial opportunities for promoting effective HMO development under well-designed state legislation. Concurrent regulation of federally qualified HMOs is contemplated, and such regulation, as well as the provision of additional assistance to these HMOs, seems appropriate. In particular, the provision of additional assistance to HMOs by states may help HMOs overcome the extra costs involved in qualifying under federal laws. States also appear to have a substantial opportunity to promote and regulate a broader variety of HMOs than those able and willing to qualify under the federal laws.

II. STATE ENABLING ACTS

As of June 1976, at least 25 states had enacted new laws that specifically enable HMOs to operate and provide for regulation of their operations.[112] In this Part we consider a number of major issues addressed by this legislation and assess the relative merits of different approaches that have been or might be taken within the context of our theory of limited reformmongering.

It is appropriate at the outset to ask whether enabling legislation is necessary or helpful to HMO development in view of the fact that a number of HMOs have established themselves successfully without the aid of enabling acts.[113] These HMOs have been allowed to organize and operate in three different ways. Some have been organized as nonprofit corporations and operated free of state health insurance regulation, either because they were deemed not to be health insurance companies[114] or

---

ments of 20,000 or more to be economically feasible, but it now appears that much smaller HMOs with enrollments of 5,000 are generally feasible. *See* Kissam & Johnson, *supra* note 6, at 1173 n.61. Another explanation for imposition of the size requirement on risk sharing HMOs might have been the belief that these HMOs will generate larger cost savings for the government by reason of economies of scale. We have noted above that this belief is not yet well documented. *See* note 11 *supra*.

[110] 42 U.S.C. § 1395mm(a)(3)(A)(i) (1974). Retained savings by the HMO also are subject to a maximum limit of 10% of the estimated cost of service by other providers. *Id.*

[111] *Id.* § 1395mm(a)(3)(A)(ii).

[112] *See* note 4 *supra*.

[113] *See* McNeil & Schlenker, *supra* note 5, at 198-200; HARVARD HMO Note, *supra* note 13, at 964-69. One national census of HMOs reported that 181 HMOs were operating as of July 1, 1975. R. WETHERVILLE & J. NORDBY, A CENSUS OF HMOs: JULY 1975, at 8 (1975) [hereinafter cited as HMO CENSUS] (this work is available from Interstudy, 123 East Grant Street, Minneapolis, Minn. 55403; the July 1975 report, however, contained the last HMO census data collected by Interstudy. Letter from Robert E. Schlenker, Senior Health Economist, Interstudy, to Philip Kissam, Oct. 3, 1975). Of these 181, at least 25 were operating in states without enabling acts in effect at that time. Even in states with HMO legislation, some HMOs operate outside of the HMO law because they were organized prior to the enactment of an HMO law, are outside the scope of their state's HMO law, or are allowed to organize under some other state law. Pennsylvania's HMO Act, for example, is limited to nonprofit HMOs. Consequently, for profit HMOs have had to organize and be licensed as stock insurance companies under the state's insurance law. Letter from Thomas J. Chepel, Rate and Policy Examiner, Pennsylvania Insurance Department, to the authors, December 2, 1975. HMOs sponsored by Blue Cross or Blue Shield may be licensed under the state's enabling acts for those organizations rather than the state's HMO law. This has been the experience in Illinois and Pennsylvania. Telephone conversation with Joe Garrett, Regulatory Division, Illinois Insurance Department, July 8, 1975; Letter from Thomas J. Chepel, *supra*. Moreover, entities that offer prepaid health care services may choose to organize under a law other than an HMO law because of perceived advantages under the former. For example, in Illinois some organizations have chosen to organize under the Voluntary Health Services Plans Act, ILL. ANN. STAT. ch. 32, §§ 601-622 (Smith-Hurd Supp. 1976), rather than the HMO Act, ILL. ANN. STAT. ch. 111½, §§ 1401-1417 (Smith-Hurd Supp. 1976). Telephone conversation with Joe Garrett, *supra*.

[114] *See, e.g.*, California Physicians' Servs. v. Garrison, 28 Cal. 2d 790, 172 P.2d 4 (1946).

because of the absence of such regulation.[115] Others have benefited from flexible interpretations of state health insurance laws and have been allowed to incorporate and operate under these statutes.[116] More recently, a number of states have amended their health insurance laws to allow insurance organizations generally, including HMOs, to offer combined hospital and medical insurance policies.[117]

These alternative modes of recognizing and regulating HMOs may be useful and attractive if there is a danger that an HMO enabling act will impose onerous burdens on all HMOs[118] or on new HMOs desiring to enter the market.[119] Nonetheless, these modes seem less than optimal means of promoting and regulating HMO development for three reasons. First, under traditional state health insurance and medical practice laws, HMO entry may be deterred by uncertainty about the legal authority of HMOs to operate,[120] potential litigation resulting therefrom, and possible substantial costs involved in negotiating administrative waivers. Second, these modes ignore the unique insurance aspects of HMOs. On the one hand, HMOs may not be regulated as insurers, thus increasing the risk of HMO defaults and consequent harm to subscribers. On the other hand, HMOs may be regulated solely as health insurers and thereby subjected to unduly restrictive initial capital and reserve requirements,[121] as well as inappropriate rate regulation.[122] Third, the alternative modes fail to provide legislative safeguards against the potential for medical underservice by HMOs.[123] These deficiencies suggest that enabling legislation is desirable if undue restrictions on HMOs can be avoided.

A. *Fundamental Patterns*

Although the HMO enabling laws contain varied substantive provisions, a few central patterns can be detected. Many of the statutes replicate a model act proposed by the National Association of Insurance Commissioners (NAIC Model Act) and others appear to be mark-ups of the NAIC Model Act with local variations.[124] California and Washington, which already have a substantial number of HMOs, have

---

[115] HARVARD HMO Note, *supra* note 13, at 965-66 n.77.

[116] *Id.* at 964-69. Flexible interpretations of state health insurance laws to accommodate HMOs, however, are not always available. *See* Stone, *State Board of Insurance HMO Regulations Ruled Invalid,* 70 TEX. MED. 113 (Sept. 1974).

[117] *See, e.g.,* Mo. ANN. STAT. §§ 354.010-.175 (Vernon Cum. Supp. 1976) (enacted 1973); WASH. REV. CODE ANN. §§ 48.44.010-.250 (Spec. Pamphlet 1975) (enacted 1947).

[118] Existing enabling acts appear to contain some undue restrictions on HMOs. *See, e.g.,* text at notes 129-31 *infra.*

[119] This will be a danger in states where HMOs already exist and are able to influence the nature of an HMO act in such a way that it unfairly restricts new entrants.

[120] This uncertainty will arise from the existence of state laws of the type preempted by the Federal HMO Act for federally qualified HMOs. *See* text at notes 63-65 *supra.*

[121] *See* note 64 *supra.*

[122] State rate regulation of HMOs and its potentially restrictive nature are discussed in text at notes 266-82 *infra.*

[123] These HMOs, of course, remain subject to the nonlegislative constraints against underservice discussed in text at notes 34-37 *supra.*

[124] NAT'L ASS'N OF INS. COMM'RS, MODEL HEALTH MAINTENANCE ORGANIZATION ACT (1972) [hereinafter cited as NAIC MODEL ACT]. The NAIC Model Act has had a substantial impact upon the content of more than half of the state HMO laws enacted to date. Excepting some minor deviations, three states have adopted the NAIC Model Act verbatim. ARK. STAT. ANN. §§ 66-5201 to -5228 (Supp. 1975); COLO. REV. STAT. ANN. §§ 10-17-101 to -131 (Supp. 1975); Law of Oct. 1, 1975, Ch. 503, §§ 4201-4226, [1975] Maine Laws 1546. Six state acts are closely patterned after the NAIC Model Act. *See e.g.,* N.D. CENT. CODE §§ 26-38-01 to -35 (Supp. 1975); TEX. REV. CIV. STAT. ANN. art. 20A.01-.33 (Cum. Supp. 1975). Seven other states have followed the Model Act in lesser varying degrees.

enacted their own relatively unique statutes.[125] Finally, three states simply have delegated broad regulatory power to an administrative agency.[126]

In general, state enabling acts avoid many, but not all, of the unduly restrictive conditions of the Federal HMO Act. For example, only two states appear to require that HMOs cover much more than basic inpatient and outpatient services,[127] and only a few mandate consumer participation on HMO governing bodies.[128] Only Idaho requires community rating to establish HMO premiums, and this is required only in areas where most competing insurers are not using experience rating for groups.[129] On the other hand, many states require open enrollment periods if HMOs do not limit themselves to group contracts,[130] and a few require that HMOs assume nearly all the financial risk of their insurance coverage.[131] State enabling acts, moreover, provide little positive government assistance to promote HMO development. Only six states have promulgated rules to improve HMO access to the group health insurance market for public and private employees,[132] only one enabling act provides for developmental subsidies,[133] and none of the acts provide for special regulation of expanded medical delegation by HMOs. Nor do these statutes make much use of the reformmongering technique to require drug coverage or to encourage maximum feasible use of expanded delegation. In the discussion that follows we analyze these and other issues, paying particular attention to specific provisions in the statutes, and available regulations thereunder,[134] that vary from the general form.

B. *Preliminary Issues*

In designing an HMO enabling act, state legislatures are faced with two important preliminary issues: the choice of state agency or agencies to administer the act and a decision about the kinds of organizations that may sponsor HMOs. The

---

[125] CAL. HEALTH & SAFETY CODE §§ 1340-1399.5 (West Supp. 1976); WASH. REV. CODE ANN. §§ 48.46.010-.920 (Spec. Pamphlet 1975).

[126] OKLA. STAT. ANN. tit. 63, §§ 2501-2510 (Supp. 1975); S.C. CODE ANN. §§ 37-1131 to -1136 (Supp. 1975); TENN. CODE ANN. §§ 56-4101 to -4105 (Supp. 1975). One of the earliest HMO acts, the Tennessee law does little more than authorize the formation of HMOs. The Tennessee Insurance Department has issued regulations that require an HMO to demonstrate that it has adequate working capital, file semi-annual financial statements, and make other formal filings before entering into contracts with enrollees. TENN. INS. DEP'T Rule No. 47 (1974). The regulations were approved over objections that the department had exceeded its statutory authority. Letter from J. H. Allen, Staff Attorney, Tennessee Insurance Department, to the authors, December 3, 1975.

[127] *See* text at notes 227-35 *infra.*

[128] *See* text at notes 242-46 *infra.*

[129] IDAHO CODE § 41-3915(5) (Supp. 1975).

[130] *See* text at notes 253-56 *infra.*

[131] MICH. COMP. LAWS ANN. § 325.929 (1975); MINN. STAT. ANN. § 62D.04(f) (Cum. Supp. 1976); S.D. COMPILED LAWS ANN. § 58-41-17(5) (Supp. 1976).

[132] *See* text at notes 287-91 *infra.*

[133] MINN. STAT. ANN. § 62D.27 (Cum. Supp. 1976) (grants and technical assistance). At least one other state, California, provides financial and technical assistance to developing HMOs under a separate act. CAL. HEALTH & SAFETY CODE § 1177 (West Supp. 1976) (loans and technical assistance).

[134] In November and December 1975, the authors requested copies of HMO regulations from the responsible administrative agencies under state HMO enabling statutes effective at that time. Some state agencies had not issued any regulations because an HMO act had only recently been enacted or there had not been any HMO activity in the state. Regulations were received from ten states, and these were in effect as of January 1, 1976. Some of these HMO regulations were promulgated jointly by a state's insurance and public health department, and consequently have parallel citations to both agencies' regulations. We, however, have cited only the insurance department regulation when the regulations were identical. "Insurance department" is abbreviated "I.D." and "public health department" as "H.D." Idaho I.D. Reg. No. 26 (1974); Ill. I.D. Rule 55.01 (1976); Ill. H.D. Regs. 1.00.00-7.01.00 (1975); Iowa I.D. Rules 12.1-.10 (1974); Ky. I.D. Regs. 38.010-050 (1975); Mich. I.D. Rule R325 (Proposed 7/17/75); Minn. H.D. Regs. 366-76 (1974); N.J. H.D. Rules 8:33-1.1 to -4.2 (1974); S.C. I.D. Reg. R6-75 (1975); Tenn. I.D. Rule No. 47 (1974); Utah I.D. Reg. 74-1 (1974).

general uniformity among existing state laws in resolving these issues suggests that they have not received a great deal of attention in the legislative process, although each issue raises interesting and difficult questions about the nature of HMO development and regulation.

1. *The Choice of Administrative Agency.* A majority of states divide the responsibility for administering their HMO enabling acts between the insurance department, which is given responsibility for regulating HMOs' financial condition, and the health department, which is given responsibility for regulating HMOs' quality of care.[135] This division of responsibility follows a provision in the NAIC Model Act.[136] The rest of the states, for the most part, delegate all responsibility to the insurance department,[137] although the insurance department may be given express authority to rely on the state health department's expertise and resources to perform quality of care reviews of HMOs.[138] Only two states deviate from this pattern of reliance on state insurance and health departments. California places responsibility for HMOs with the corporation commissioner,[139] and Oklahoma has entrusted HMO regulation to its health planning commission, which consists of the directors of the public welfare, health, and mental health departments.[140]

The obvious and perhaps major advantage in the prevailing reliance on insurance and health agencies is that this allows direct use of existing expertise and resources in state government.[141] On the other hand, these agencies may be captives of the fee-for-service insurers[142] and providers [143] that they already regulate, and these insurers and providers clearly have an economic interest in limiting HMO development.[144] Furthermore, the experience of these agencies has been predominantly with regulation of insurers that pay cash benefits or with regulation of health care quality without need to consider costs. Such experience might lead insurance departments to impose unduly restrictive financial controls on HMOs[145] and health departments to apply fee-for-service quality standards that do not allow HMOs the freedom to make cost-effective decisions.[146] Either the captured agency situation or the prevailing

---

[135] *See, e.g.,* COLO. REV. STAT. ANN. § 10-17-104 (1973). Most of these states vest primary responsibility in the insurance commissioner, *see, e.g., id.,* but three give primary authority to the health department. MICH. COMP. LAWS ANN. § 325.910 (1975); MINN. STAT. ANN. § 62D.03 (Cum. Supp. 1976); N.J. STAT. ANN. § 26.2J-3 (Supp. 1976). Since these two types of statutes divide the substance of regulatory responsibility between the insurance and health departments in the same fashion, primary responsibility merely indicates the agency responsible for coordinating regulatory activities and issuing the license.

[136] NAIC MODEL ACT, *supra* note 124, at § 4.

[137] *See, e.g.,* IDAHO CODE §§ 41-3901 to -3931 (Supp. 1975); KAN. STAT. ANN. §§ 40-3201 to -3226 (Supp. 1975); KY. REV. STAT. ANN. §§ 304.38-010 to -200 (Supp. 1974); WASH. REV. CODE ANN. §§ 48.46.010-.922 (Spec. Pamphlet 1975).

[138] *See, e.g.,* KAN. STAT. ANN. § 40-3211(b) (Supp. 1975).

[139] CAL. HEALTH & SAFETY CODE § 1341 (West Supp. 1976). Formerly the attorney general had jurisdiction over HMOs. Ch. 880, § 1, [1965] Cal. Stats. 2485.

[140] OKLA. STAT. ANN. tit. 63, § 2508 (Supp. 1975). The composition of the Commission is outlined in *id.* § 1-112.

[141] *See* NAIC MODEL ACT, *supra* note 124, at § 4, Comment.

[142] *See, e.g.,* LAW, *supra* note 33, at 14-18.

[143] *Cf.* Havighurst, *Regulation of Health Facilities and Services by "Certificate-of-Need,"* 59 VA. L. REV. 1143, 1178-88 (1973) [hereinafter cited as Havighurst, *Certificate-of-Need Regulation*]; Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change,* 35 LAW AND CONTEMP. PROB. 305, 308-10 (1970).

[144] See text at notes 30-33 *supra.*

[145] For some evidence that this has happened, see text at notes 172-85 *infra.*

[146] *Cf.* Havighurst & Bovbjerg, *supra* note 38, at 401-11.

experience of existing state agencies could result in unduly restrictive administration of HMO enabling acts.

Larger states, which are likely to experience more substantial HMO development and to have a broader range of regulatory agencies, probably can create new and effective HMO regulatory units without exorbitant expense. This would seem advisable if the insurance and health agencies do not appear to be supportive of HMO development. Admittedly, a new HMO agency might in turn be captured by its regulated constituency, which could lead to unduly lax regulation. The danger of serious abuse by such capture, however, is limited by the fact that HMOs collectively may suffer greatly from any bad public image engendered by abuses of a few, and the advantages of more responsive regulation may outweigh such danger.[147] It also may be advisable to consider delegating HMO regulation to an administrative agency that already spends government funds for health services, which usually will be a health department with responsibility for Medicaid expenditures.[148] Such agencies are most likely to be conscious of escalating health care costs and the need to control them. As HMO regulators, these agencies may be more likely to give appropriate recognition to the need of HMOs to make quality/cost trade-offs in providing efficient care. A partial implementation of this idea may be seen in Oklahoma's decision to locate HMO regulation in its health planning commission,[149] which includes the state director of public welfare, who has overall responsibility for Medicaid expenditures.

2. *The Choice of Eligible Sponsors.* The great majority of state HMO enabling acts, like the Federal HMO Act,[150] place no apparent limitation on HMO sponsorship, thus recognizing for profit as well as nonprofit HMOs, medical care foundations (MCFs) as well as closed-panel HMOs,[151] and HMOs sponsored by Blue Cross, Blue Shield, and commercial insurers. Three acts, however, apply only to nonprofit HMOs[152] and one of these acts does not recognize MCFs,[153] although MCFs and for profit HMOs may be able to organize under the insurance laws of these states.[154] Kansas expressly has forbidden Blue Cross and Blue Shield from

---

[147] *Id.* at 416.

[148] *See* Havighurst, *Certificate-of-Need Regulation, supra* note 143, at 1178-83, 1230.

[149] OKLA. STAT. ANN. tit. 63, § 2508 (Supp. 1975).

[150] The Federal Act does limit the provision of developmental subsidies to for profit HMOs; these HMOs may obtain only loan guarantees and only if they serve medically underserved populations. 42 U.S.C. §§ 300e-2(c), -3(a), -4(a) (1974). For profit HMOs, however, may qualify fully for the Act's market access and preemption benefits. *Id.* §§ 300e(a), 300e-9, -10.

[151] These two basic types of HMOs have been described and labelled as "medical care foundation" and "closed-panel" by Auger & Goldberg, *supra* note 9, at 358-63. The critical difference between the two types lies in their different mechanisms for reimbursing participating physicians. MCFs reimburse their participating physicians on a fee-for-service basis, although such fees are subject to the total prepayments collected from subscribers. This form of reimbursement allows the MCF to operate more easily with solo practitioners as participating physicians. As a matter of fact, MCFs have been sponsored by county medical societies and are open for participation by all physician members of the county society who agree to accept various controls over their practice (including maximum fees, claims and peer review, and certain risk-sharing). Closed-panel HMOs, on the other hand, reimburse their physicians on a salaried or capitation basis and tend to operate in the form of group practices. *See id.;* Egdahl, *Foundations for Medical Care,* 288 NEW ENG. J. MED. 491, 491-93 (1973).

[152] MINN. STAT. ANN. § 62D.02(4) (Cum. Supp. 1976); PA. STAT. ANN. tit. 40, § 1554(a) (Supp. 1976); S.D. COMPILED LAWS ANN. § 58-41-2 (Supp. 1976).

[153] PA. STAT. ANN. tit. 40, § 1566(2) (Supp. 1976).

[154] Pennsylvania, for example, has allowed a for profit HMO to operate as a stock insurance company licensed under the insurance code and might recognize MCF's under its Blue Shield law. Letter from Thomas J. Chepel, Rate and Policy Examiner, Pennsylvania Insurance Department, to the authors, December 2, 1975. South Dakota also might allow a for profit HMO to operate as a licensed insurer. Letter from South Dakota Insurance Department, to the authors, December 29, 1975.

operating HMOs.[155] Only ten HMO acts, moreover, following a recommendation of the National Association of Insurance Commissioners,[156] expressly authorize the formation and operation of HMOs by the "Blues" and other commercial insurers.[157] The absence of such a provision may be significant if other state laws that govern these insurers are deemed to limit their operations to providing cash benefit insurance plans.[158]

Two arguments may be made to support exclusion of certain entities from HMO sponsorship. First, profitmaking HMOs arguably will have particularly strong incentives to overeconomize, an argument undoubtedly fueled by recent bad experience with proprietary nursing homes[159] and by the recent marketing and service abuses of Medicaid HMOs in California.[160] This argument, however, ignores the considerable complex of legislative and nonlegislative constraints against HMO underservice. It also ignores the fact that profitmaking HMOs may be a particularly suitable vehicle for promoting HMO development because they offer the opportunity for equity investment and are less likely to refrain from strenuous competition with existing insurers and providers.[161]

Second, antitrust type arguments might be used to exclude MCFs, other insurers, and perhaps existing hospitals from HMO sponsorship on the theory that these institutions are likely to use HMOs on behalf of fee-for-service providers and insurers as a defensive tactic to preempt the field and avoid true HMO competition.[162] The quite recent development of MCFs in states that already have experienced HMO development[163] may be evidence supporting this hypothesis. On the other hand, any statutory prohibition of HMOs sponsored by these institutions runs the danger of unduly limiting available capital and expertise for HMO development.[164] Such a prohibition also limits the opportunity of fee-for-service providers and insurers to participate fully in a pluralistic health care delivery system, which can rightfully be considered a value in and of itself.[165] Moreover, even defensive use of HMOs

---

[155] KAN. STAT. ANN. §§ 40-1803, -1903 (Supp. 1975). Because the Kansas HMO Act does not provide express authority for Blue Cross and Blue Shield to operate HMOs, in 1975 the Kansas Blues sought amendments to their own enabling acts that would make clear their authority to operate nonprofit HMOs. 1 REPORT ON KANSAS LEGISLATIVE INTERIM STUDIES TO THE 1975 LEGISLATURE 245 (1974). The legislature, however, took the position that the Blues should not operate HMOs and adopted instead amendments that forbid such corporations from forming, owning, controlling, or investing in HMOs. KAN. STAT. ANN. §§ 40-1803, -1903 (Supp. 1975). The apparent reasons for this action were a belief that the Blues had an unfair advantage over others who would establish HMOs and the fear that the Kansas Blues might jeopardize the welfare of their subscribers under Blue Shield and Blue Cross policies by venturing into HMO development.

[156] NAIC MODEL ACT, *supra* note 124, at § 17.

[157] *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-117 (1974).

[158] *See* note 155 *supra.*

[159] *See, e.g.*, Regan, *Quality Assurance Systems in Nursing Homes,* 53 J. URBAN LAW 153, 210-14 (1975); Shulman & Galanter, *Reorganizing the Nursing Home Industry: A Proposal,* 54 MILBANK MEM. FUND Q. 129, 129-39 (1976).

[160] *See,* Schneider & Stern, *supra* note 54, at 126-38.

[161] Havighurst, *HMOs, supra* note 2, at 749-54. As of July 1, 1975, 26 of 181 operating HMOs were classified formally as for profit HMOs by HMO CENSUS, *supra* note 113, at 12.

[162] Havighurst, *HMOs, supra* note 2, at 759-77, 789-90; Schneider, *supra* note 7, at 299-302.

[163] MCFs apparently have developed largely in response to closed-panel HMO development in the same or neighboring areas. *See* Egdahl, *supra* note 151, at 491; Havighurst, *HMOs, supra* note 2, at 769-70; McNeil & Schlenker, *supra* note 5, at 202. This development has been particularly evident in California, a state in which much HMO development in general has occurred. As of July 1, 1975, 70 of 181 operating HMOs in the United States were located in California, but 17 of 34 MCFs were located there, and most MCFs in California had opened since 1972. *See* HMO CENSUS, *supra* note 113, at 8-11.

[164] *See, e.g.*, Schneider, *supra* note 7, at 301.

[165] *Cf.* SENATE HMO REPORT, *supra* note 2, at 3039-40.

is likely to provide some increased efficiencies.[166] To the extent that such use does not in fact preclude other more efficient HMOs, additional efficiency gains may be obtained by allowing MCFs, other insurers, and hospitals to sponsor HMOs. The better approach to this issue would seem to be to allow these institutions to sponsor HMOs and rely on vigorous enforcement of federal and state antitrust laws in specific cases where these HMOs are used to exclude others.[167] If profitmaking HMOs, MCFs, and HMOs sponsored by insurers are not to be prohibited by state law, it also would be preferable to regulate them under the HMO enabling act, in order to extend the benefits of more flexible financial controls to them and to apply the legislative safeguards against HMO underservice that are provided by HMO enabling acts generally.[168]

C. *Consensus Regulations*

All HMO supporters appear to agree that HMO legislation should protect HMO subscribers from unexpected loss of insurance coverage due to an HMO's financial difficulties and from the risk of inferior quality of care, in particular the risk of underservice.[169] States, moreover, are particularly well suited for carrying out these regulatory tasks for federally qualified as well as other HMOs.[170] In this section we analyze the three basic kinds of state regulation that have been designed to accomplish these purposes.

All state enabling acts require that HMOs be licensed by a state agency.[171] Almost all acts establish explicit requirements aimed at guarding against HMO insolvency and ensuring that potential and actual subscribers are provided with accurate information about the nature of HMO operations and policies. Most acts also attempt to provide more direct safeguards against an inferior quality of care. In general, the regulations that have been established seem unobjectionable and appropriate, although a few states have established financial requirements and quality of care regulations that may be overly restrictive.

1. *Financial Controls.* State controls over the financial condition of HMOs follow three different models. First, many acts are patterned after the Federal HMO Act[172] and grant broad discretion to the regulatory agency to monitor the financial sound-

---

[166] *See* Havighurst, *HMOs, supra* note 2, at 772.

[167] *See id.* at 767-81; Schneider, *supra* note 7, at 302. The application of federal antitrust law to use of HMOs as an exclusionary device may face two preliminary obstacles. If defensive use of HMOs is employed by existing insurers, these companies may raise defenses based on the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1970), that limits the application of federal antitrust laws to the insurance business to agreements or acts of boycott, coercion, or intimidation, *id.* § 1013(b), and otherwise to the business of insurance only "to the extent that such business is not regulated by State law," *id.* § 1012(b). Other defendants may claim that their acts have no effect on interstate commerce. Havighurst, *HMOs, supra* note 2. at 778-81. This claim, however, may be met with the argument that the excluded HMO would have had a significant impact either on interstate health insurance transactions or on interstate drug traffic. *See* Kissam & Johnson, *supra* note 6, at 1200 n.241. *See also* Havighurst, *HMOs, supra* note 2, at 778-81.

[168] *See* text at notes 172-224 *infra.*

[169] *See, e.g.,* IOM REPORT, *supra* note 1, at 23-24, 55-61; SENATE HMO REPORT, *supra* note 2, at 3062-65, 3087.

[170] *See* text at note 66 *supra.*

[171] Note, however, that prepaid medical practices which fit the statutory definition of an HMO still may seek to organize under other state laws and be allowed to do so. *See* note 113 *supra.*

[172] 42 U.S.C. § 300e(c)(1) (Supp. IV 1974) requires merely that a qualified HMO "have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary." HEW's regulations call for a full reporting of the HMO's financial conditions and contract arrangements but do not require any specific initial capitalization or reserve requirements. 42 C.F.R. § 110.603-.604 (1975).

ness of the HMO. Typically, the agency is directed to consider such factors as the adequacy of an HMO's working capital, its back-up arrangements for providing services in the case of insolvency, and any surety device that the agency may require in particular cases.[173] Some regulations under these statutes may impose more specific requirements such as a minimum net worth or surety bond in a minimum amount.[174] California generally follows this model, but recently has required that new HMOs contract with an unrelated provider to deliver services in the event the HMO discontinues service during the period of subscriber contracts.[175] Second, several other states grant broad discretion to the regulatory agency but also require submission of a surety bond or deposit of cash or securities to guarantee performance, unless such submission is waived by the insurance commissioner.[176] Last, four states require that HMOs maintain reserves of a specified minimum amount,[177] and two of these states also require that a cash deposit of at least 50,000 dollars be maintained with the insurance department as a surety device.[178]

There is some evidence that reserve and surety requirements of this sort have deterred HMO formation under state HMO acts.[179] In any event, specifying minimum reserves by statute seems inconsistent with the service nature of HMO insurance.[180] The grant of broad discretion to a regulatory agency to assure itself of an HMO's financial soundness would seem to be a better way to balance the need to encourage HMO development against the need to protect HMO subscribers from financial loss,[181] although the possibility remains for abuse of discretion either for or against HMOs.[182] California's requirement of a back-up arrangement for all new HMOs also may be attractive,[183] but this would seem likely to impose sub-

---

[173] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1372 (*West* Supp. 1976); UTAH CODE ANN. § 31-42-6 (2)(b) (1974); WASH. REV. CODE ANN. § 48.46.040(3) (Spec. Pamphlet 1975).

[174] *See, e.g.*, Utah Ins. Dep't Reg. 74-1(II)(J) (1974).

[175] CAL. HEALTH & SAFETY CODE § 1375(a) (West Supp. 1976) (enacted 1975) requires an HMO to contract with an unrelated provider to provide payment for the originally contracted health care services between the HMO and its enrollees, or to provide the services themselves, should the HMO go out of business. After five years of operation, the HMO can apply for an exemption from this requirement. The corporation commissioner must grant the request if the HMO has operated trouble-free for the previous two years and, if the HMO was operating prior to this section's enactment, has maintained a tangible net equity of at least $750,000 for the previous 12 months. The net equity requirement can be waived by the commissioner. *Id.* § 1375(d).

[176] *See, e.g.*, COLO. REV. STAT. ANN. §§ 10-17-104(2)(d), 114 (1974). This scheme follows NAIC MODEL ACT, *supra* note 124, at §§ 4(2)(d), 14. Typically, the HMO is required to maintain a surety bond or deposit of cash or securities in an amount satisfactory to the commissioner. The Colorado Insurance Department has not allowed anything less than a $50,000 surety bond. Letter from J. Richard Barnes, Insurance Commissioner, to the authors, January 6, 1976.

[177] ARIZ. REV. STAT. ANN. § 20-1056(A) (1975) ($100,000); IDAHO CODE § 41-3925 (Supp. 1975); ILL. ANN. STAT. ch. 111½, § 1406 (Smith-Hurd Supp. 1976) (after 1 year grace period, HMO must accumulate reserves at annual rate of 2% of its annual net income until it has reserves equal to 55% of its average annual net income for previous 5 years); MICH. COMP. LAWS ANN. § 325.912(a) (1975).

[178] ARIZ. REV. STAT. ANN. § 20-1055(A) (1975); IDAHO CODE § 41-3926 (Supp. 1975).

[179] McNeil & Schlenker, *supra* note 5, at 207-08.

[180] *See* note 64 *supra*.

[181] *See* NAIC MODEL ACT, *supra* note 124, at § 4(2)(d), Comment.

[182] Nevada grants broad discretion to its insurance commissioner to determine the financial soundness of HMOs, NEV. REV. STAT. § 695C.270 (1975), but McNeil & Schlenker, *supra* note 5, at 208, report that the commissioner, in the absence of regulations, has established such high financial requirements that two potential HMOs were driven from the market and the continued operation of a third was threatened.

[183] A particularly attractive feature of California's subsequent provider requirement is that it is imposed on the HMO only when the HMO's solvency is uncertain. After the HMO has demonstrated that it can deliver services, it can be exempted from the requirement. Contrast this with reserve requirements that require the HMO to gradually build up reserves until a target figure is reached. *See, e.g.*, ILL. ANN. STAT. ch. 111½, § 1406 (Smith-Hurd Supp. 1976). "Creeping" reserve requirements can be criticized because they leave enrollees unprotected during the HMO's start-up period and burden the

stantial entry costs. Perhaps this requirement should be considered to be a special reaction to California's recent and unique experience with Medicaid HMOs, in which the state attempted to promote Medicaid HMOs on a crash basis,[184] leading to a substantial number of Medicaid HMO failures.[185]

2. *Consumer Information Controls.* New HMOs, like any new insurance company, have an economic need to build up their subscriber enrollment quickly in order to achieve the minimum feasible enrollment for risk pooling and thereby reduce initial operating losses. The need to build initial enrollments rapidly may be even greater for new HMOs to the extent that HMOs have substantial fixed costs due to investment in capital facilities.[186] More generally, HMOs' solicitation of subscribers is likely to face considerable consumer resistance to this new form of practice[187] and to necessitate explanation of the qualitative differences between HMO services and fee-for-service medicine.

These factors suggest that state HMO enabling acts should deal with possible marketing abuses by HMOs. Furthermore, ensuring that potential and actual HMO subscribers receive accurate information about the nature of HMO operations should help guard against the risks of inferior quality care, as well as aid HMO development by encouraging consumers to enroll in relatively effective HMOs.[188] To these ends, state acts have adopted a number of advertising and freedom-of-information provisions.

Virtually all state HMO acts impose marketing disclosure requirements similar to those imposed on health insurers generally. Thus, an HMO's policy forms and other documents provided to subscribers and potential subscribers must be reviewed and approved by a state agency to ensure that they provide clear and complete statements of the policy's benefits and costs,[189] an HMO's sales agents must be licensed by the state,[190] and HMOs are prohibited from engaging in false, misleading, or deceptive advertising.[191] These classic forms of insurance disclosure regulation appear unobjectionable and unlikely to impose undue burdens on HMOs, as long as they are applied equally to other insurers.

A few states also require that HMOs furnish all potential subscribers with a state-approved prospectus that summarizes the major benefits, services, and financial provisions of the HMO's policies in terms that are "understandable to the layman" and that "facilitate comparisons" between the HMO's and other health insurance policies.[192] This measure of limited reformmongering certainly may promote better

---

HMO with a reserve requirement in its later years without retard to the success of its operation. Telephone conversation with Joe Garrett, Regulatory Division, Illinois Insurance Department, July 8, 1976.

[184] *See* Schneider & Stern, *supra* note 54, at 126-38.

[185] About 20 such HMOs have failed recently. Telephone interview with H. R. Jolley, Director, Office of Program Innovation, Social and Rehabilitation Service, HEW, July 22, 1976.

[186] *Cf.* IOM REPORT, *supra* note 1, at 32-38.

[187] *See* Donabedian, *supra* note 9, at 4-7.

[188] IOM REPORT, *supra* note 1, at 53-55, 59.

[189] *See, e.g.,* COLO. REV. STAT. ANN. § 10-17-108(1)(b) (1974).

[190] *See, e.g., id.* § 10-17-116.

[191] *See, e.g., id.* § 10-17-115(1).

[192] *See, e.g.,* CAL. HEALTH & SAFETY CODE § 1363 (West Supp. 1976). At least one state has imposed such a requirement by regulation. S.C. INS. DEP'T REG. R6-75, § 5(j) (1975).

informed consumer choice among competing insurance plans if such a prospectus can be drafted.[193]

It is true that HMO advertising, unlike that of other insurers, should and will have a medical component if HMOs are to be able to explain the nature of their services in order to attract subscribers. In recognition of this need, many state HMO acts provide broadly that solicitation of enrollees by an HMO will not be a violation of any law relating to solicitation or advertising by health professionals.[194] Arguably, however, lack of experience with medical care advertising might result in new forms of deceptive advertising. To guard against this possibility, a number of states require that all advertising by HMOs be approved in advance by the regulatory agency.[195] Several other states follow the Federal HMO Act[196] and prohibit HMO advertising from making qualitative judgments about its health professionals[197] or competing forms of health care,[198] or even from identifying or listing the credentials of its professionals.[199] Because of the experimental nature of medical advertising, prior approval of such material may be appropriate if HMOs are given broad authority to advertise. On the other hand, per se rules against discussion of quality of care issues in HMO advertising seem unnecessarily restrictive and likely to limit unfairly the ability of HMOs to inform consumers fully of the nature of their operation.[200]

Last, more than half of the state HMO acts require that present and potential subscribers be given access to "applications, filings, and reports" by or about the HMO.[201] Such documents include an HMO's annual financial statements, growth figures, and reports on the number and nature of consumer grievances and settled malpractice cases. In most cases, state agency reports of financial and quality of

---

[193] Easily understood summary statements of health insurance policies apparently are not required of other health insurers. *See* Hanson, *supra* note 33, at 699-701 (discussing current developments in regulation of health insurance advertising). Nonetheless, if an easily understood statement that accurately summarizes an HMO's policies can be prepared at relatively little expense, the imposition of this requirement on HMOs would appear to be consistent with the criteria for limited reformmongering stated above. *See* text following note 53 *supra*. One author, Philip Kissam, doubts, however, whether such a statement can be drafted as a result of his experience with attempts by the New York City Health Services Administration in 1970-71 to draft legislation that would require this kind of prospectus for all health insurance policies. In his view, existing health insurance policies are too complex to allow reduction to effective summary statements.

[194] *See, e.g.*, FLA. STAT. ANN. § 641.30(2) (1972); KAN. STAT. ANN. § 40-3214 (Supp. 1975); NEV. REV. STAT. § 695C.050(2) (1975); TEX. REV. CIV. STAT. ANN. art. 20A.26(b) (Cum. Supp. 1975).

[195] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1361 (West Supp. 1976); UTAH CODE ANN. § 31-42-17(1) (1974).

[196] 42 U.S.C. § 300e-10(b) (1974).

[197] *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-1067 (1975); ILL. ANN. STAT. ch. 111½, § 1409 (Smith-Hurd Supp. 1976); MICH. COMP. LAWS ANN. § 325.924 (1975).

[198] MICH. COMP. LAWS ANN. § 325.924 (1975).

[199] ARIZ. REV. STAT. ANN. § 20-1067 (1975); ILL. ANN. STAT. ch. 111½, § 1409 (Smith-Hurd Supp. 1976); KAN. STAT. ANN. § 40-3214 (Supp. 1975); MICH. COMP. LAWS ANN. § 325.924 (1975); UTAH CODE ANN. § 31-42-17(1) (1974).

[200] Arguably, overrestrictive limitations on HMO advertising violate the first amendment after Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Counsel, Inc., 96 S. Ct. 1817 (1976). In that case, the Supreme Court found that state statutes prohibiting advertisement of prescription drug prices by pharmacists were unconstitutional.

[201] Thirteen states make filings and reports that are required under their HMO acts public documents. Typically, these freedom of information provisions are patterned after NAIC MODEL ACT, *supra* note 124, at § 26, which reads as follows: "All applications, filings and reports required under this Act shall be treated as public documents." Ten HMO acts have incorporated a provision similar to that just quoted. *See e.g.*, ARK. STAT. ANN. § 66-5226 (Supp. 1975); MINN. STAT. ANN. § 62D.23 (Cum. Supp. 1976). Four other HMO acts have substantially adopted this provision, but have excepted one or more classes of information from its reach. *See e.g.*, TEX. REV. CIV. STAT. ANN. art. 20A.27 (Cum. Supp. 1975) (examinations by insurance commissioner and health department).

care examinations of the HMO are also included. Most of these acts also require that HMOs affirmatively provide its enrollees with more limited information, including the HMO's financial statement, but excluding quality of care reports by the HMO and state agency reports.[202] These freedom of information and affirmative disclosure provisions seem well-designed to help consumers make a rational choice among insurers and providers and thereby to help protect themselves against the risk of underservice by HMOs.[203] It also seems appropriate to give consumers access to quality of care reports by HMOs and state agencies but to exclude these reports from the affirmative disclosure obligation. These kinds of documents probably deserve interpretation by HMO officials and thus should be made available only upon request.

3. *Direct Quality of Care Controls.* In addition to consumer information controls, most state HMO acts require three kinds of regulatory procedures that are designed to ensure adequate quality of care in a more direct manner. First, under about half of the acts, HMOs must report statistics relating to the pattern of utilization of its services to the state health department,[204] and under most acts the state health department is directed to conduct quality of care audits of HMOs on a periodic basis.[205] Utilization statistics, which can be compared with service utilization patterns of populations that are comparable to the HMO's members, would seem to be particularly useful for detecting at least gross cases of overeconomizing and underservice by HMOs.[206] Occasional onsite audits by a state agency may be less likely to detect underservice, particularly if they are carried out in the same manner as typically understaffed state health facility licensing surveys.[207]

Second, most state HMO acts require that HMOs establish some ongoing quality assurance procedure.[208] This provision is often defined by statute or regulation to

---

[202] Eleven HMO acts require an HMO to annually provide to its enrollees information pertaining to the operation of the HMO. Typically, this information must include the most recent financial statement of the HMO, a description of the operation of the health care plan offered by the HMO, a description of services and where to obtain them, and a description of the complaint system. *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-110 (1974); N.J. STAT. ANN. § 26:2J-10 (Supp. 1976). An HMO could probably satisfy this provision by making this information available at its principal office and at the offices of its providers. *See* KY. REV. STAT. ANN. 6 304.38-080(2) (Supp. 1975) (principal office).

[203] Even if similar requirements are not imposed on other providers, their imposition on HMOs may be justified on two grounds: the relatively unique risk of underservice by HMOs and the apparent consistency of these requirements with the criteria for limited use of the reformmongering technique.

[204] *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-104(1)(b)(III) (1974); MINN. STAT. ANN. § 62D.04 (1)(b)(c) (Cum. Supp. 1976). This provision follows both the Federal HMO Act, 42 U.S.C. § 300e(c)(11)(B) (1974), and NAIC MODEL ACT, *supra* note 124, at § 4(1)(b)(iii).

[205] Sixteen state HMO acts require the health department to conduct quality of care audits of HMOs. The health department is usually authorized to carry out quality examinations as often as necessary, but at least once every three years. *See, e.g.*, IOWA CODE ANN. § 514B.24 (Cum. Pamphlet 1976); S.D. COMPILED LAWS ANN. § 58-41-70 (Supp. 1976). HMOs also may be subject to quality of care audits by HMO act regulation, *see, e.g.*, S.C. Ins. Dep't Reg. R6-75, § 9(b) (1975), or to more general state "hospital" licensing audits in states where hospital licensure laws cover ambulatory clinics as well as inpatient facilities.

[206] IOM REPORT, *supra* note 1, at 58-59.

[207] A general criticism of state hospital licensure has been that only a few state health agencies have adequately superintended institutional medical care. A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 108-15 (1969); Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305, 309-10, 317-19 (1970). In Kansas, for example, state hospital inspection teams consist only of a sanitation engineer and public health nurse, Telephone interview with Mr. Swanson, Director of Hospital Program, Kansas State Health Department, February 5, 1974, and accordingly, these surveys focus primarily on the hospital's physical plant and nursing service, Conversation between Philip Kissam and Donald Lenz, Administrator, Lawrence Memorial Hospital, Lawrence, Kansas, April, 1974.

[208] *See, e.g.*, ILL. ANN. STAT. ch. 111½, § 1404(a)(2) (Smith-Hurd Supp. 1976); N.J. STAT. ANN. § 26:2J-4(2)(b) (Supp. 1976); S.D. COMPILED LAWS ANN. § 58-41-12(2) (Supp. 1976).

require that the HMO establish a system of internal peer review.[209] This requirement seems useful,[210] although HMOs are likely to establish internal peer review systems on their own as an outgrowth of their institutional need to resolve goal conflicts between the organization and the individual physicians.[211] Maryland and Iowa also require that HMOs annually contract for external peer review audits.[212] This may be a preferable alternative to state agency quality of care audits, if the state agency is understaffed and if the external auditors will not be as likely to be biased towards fee-for-service medicine. Iowa, however, requires that the external review be performed by any available regional Professional Standards Review Organization (PSRO).[213] PSROs are physician organizations that have been established under the Social Security Act to monitor the costs and quality of Medicare and Medicaid services.[214] Because these organizations will be dominated by fee-for-service providers,[215] they would appear to be potentially biased, and therefore inappropriate, regulators of HMO care. Iowa's requirement that HMOs be audited by the regional PSRO is thus subject to the same objection (but in stronger terms) that we have advanced above about HMO regulation by captive state health departments.[216]

Third, state HMO acts generally require HMOs to establish procedures for resolving enrollee grievances.[217] State requirements often are more specific than those of the Federal HMO Act[218] in providing how enrollees are to be informed about

---

[209] Five state HMO acts require HMOs to have a system of internal peer review. IDAHO CODE § 41-3905(6)(a) (Supp. 1975); KAN. STAT. ANN. § 40-3203(b)(7)(B) (Supp. 1975); MD. ANN. CODE art. 43, § 844(a)(8) (Supp. 1975); UTAH CODE ANN. § 31-42-6(2)(f) (1974); WASH. REV. CODE ANN. § 48.46.040(5)(a) (Spec. Pamphlet 1975). The HMO regulations of at least three other states also require an internal peer review system. Ill. Pub. Health Dep't Reg. § 4.04.04 (1975) (if HMO has more than 3,000 enrollees); Iowa Ins. Dep't Rule 12.5(11)(a)(1974); S.C. Ins. Dep't Reg. R6-75, § 9(a) (1975). These regulations typically require the following of any peer review system: (1) standing committee composed of health professionals, (2) regular meetings, (3) review of processes and outcomes, and (4) written records of meetings are to be kept.

[210] Note, however, that serious questions may be raised about whether medical peer review can be a cost-effective means of controlling quality of care. *See* 2 AMERICAN PUBLIC HEALTH ASSOCIATION, A GUIDE TO MEDICAL CARE ADMINISTRATION—MEDICAL CARE APPRAISAL 121-22 (1969); Donabedian, *Promoting Quality Through Evaluating the Process of Patient Care,* 6 MED. CARE 181, 191 (1968).

[211] These goal conflicts center around the HMO's institutional goal of low cost service and personal goals of individual physicians that are cost-inducing. Auger & Goldberg, *supra* note 9, at 378-82. Resolution of these conflicts will require internal utilization controls that involve physician review of work by other physicians. *Id.* If such review is implemented, it seems likely that utilization review would be expanded naturally into review of quality of care as well. *Cf.* Havighurst & Blumstein, *supra* note 22, at 38-68.

[212] MD. ANN. CODE art. 43, § 844(a)(7) (Supp. 1975). The HMOs internal peer review procedure may be employed in lieu of an external audit if approved by the public health director. The Iowa external peer review requirement was imposed by regulation. Iowa Ins. Dep't Rule 12.5(11)(b) (1974). Iowa also requires the commissioner of public health to make periodic quality audits of HMOs. IOWA CODE ANN. § 514B.24 (Cum. Pamphlet 1976). Maryland authorizes, but does not require, the Department of Health and Mental Hygiene to make quality audits. MD. ANN. CODE art. 43, § 847(g) (Supp. 1975).

[213] Iowa Ins. Dep't Rule 12.5(11)(b) (1974).

[214] 42 U.S.C. § 1320c *et seq.* (Supp. 1976).

note 22.

[215] *See* Havighurst & Bovbjerg, *supra* note 38 at 401-11. *See generally* Havighurst & Blumstein, *supra*

[216] *See* text at notes 142-46 *supra.*

[217] Eighteen state HMO acts require an HMO to have a procedure for resolving enrollee grievances. *See, e.g.,* ARK. STAT. ANN. § 66-5212(1)(a) (Supp. 1975); COLO. REV. STAT. ANN. § 10-17-112(1)(a) (1974). At least one state insurance department has imposed this requirement by exercise of its rule making power. S.C. Ins. Dep't Reg. R6-75, § 13 (1974).

[218] 42 U.S.C. § 300e(c)(7) (1974). HEW's regulation on grievance procedures essentially restates the statutory provision that "meaningful procedures" be established. 42 C.F.R. § 110.108(i) (1975).

these procedures[219] and in providing for reporting of grievance procedure results to a regulatory agency.[220] Michigan and Illinois also have established requirements for the conduct of grievance procedures. Michigan authorizes the state health agency to hear and resolve grievances after an enrollee has exhausted his or her remedies with the HMO[221] and also requires HMOs to hold annual meetings where complaints can be raised about the HMO's operation.[222] Illinois, by regulation, requires that HMOs have a grievance committee with at least 50 percent enrollee membership. This committee may hear any complaints except malpractice claims.[223] Such procedures may serve as useful deterrents to underservice and other forms of inferior quality care.[224] If consumers and providers know of a forum in which consumer grievances may be discussed, in particular a forum that is subject to review by a regulatory agency, providers should have additional incentive to practice quality medicine and be more open with consumers in order to avoid complaints.

D. *Specific Reform Issues*

In this section we analyze the states' response to the claim that a variety of specific requirements should be attached to HMOs in order to achieve quality of care, distributional, and specific cost reforms generally throughout the American medical economy. The response to these issues by the 25 states with HMO enabling acts has, of course, been variable, but in general has been more liberal and more appropriate than the response of the federal government.

1. *Quality of Care Reforms.* Some HMO supporters have recommended that legislation require all HMOs to provide comprehensive insurance coverage and to include subscribers on their governing bodies.[225] As we have noted, these requirements seem likely to retard HMO development by imposing substantial additional costs, and it is not clear that these requirements in general will provide substantial improvement in the health status of HMO subscribers.[226] By comparison with the Federal HMO Act, state acts in general appear liberal with respect to the quality of care reforms that they attach to HMOs.

Virtually all state acts require HMOs to cover "basic health care services,"[227] but

---

[219] HMOs generally are required to provide enrollees with information on how to initiate complaints. Such information is often required to be included in the enrollee's evidence of coverage. *See, e.g.*, KAN. STAT. ANN. § 40-3209(d) (Supp. 1975). The HMO may also be required to post grievance procedures in its clinics and to send a copy of such procedures to enrollees at the time of their enrollment. *See, e.g.*, Utah Ins. Dep't Reg. 74-1, II(F) (1974).

[220] Typically, the HMO is required to keep a record of enrollee complaints and submit an annual report to the responsible agency concerning the number and causes of complaints during the previous year. The HMO may also be required to include in this annual report the number and disposition of malpractice suits settled by the HMO or any of its providers. *See, e.g.*, ARK. STAT. ANN. § 66-5212(1)(b) (Supp. 1975); COLO. REV. STAT. ANN. § 10-17-112(b) (1974).

[221] MICH. COMP. LAWS ANN. § 325.941 (1975).

[222] *Id.* § 325.934.

[223] Ill. Ins. Dep't Rule 55.01, § 4(B) (1976).

[224] *See* IOM REPORT, *supra* note 1, at 60.

[225] *See, e.g.*, SENATE HMO REPORT, *supra* note 2, at 3042-45, 3048; Schneider, *supra* note 7, at 273-75, 297-302.

[226] *See* text at notes 91-96 *supra*.

[227] Only Kentucky and Oklahoma do not include such a requirement in their HMO acts. California has a basic services requirement for multi-service HMOs, but its act also authorizes the formation of specialty HMOs that offer services in a single area of health care such as dentistry or pharmaceutical services. CAL. HEALTH & SAFETY CODE § 1345(m) (West Supp. 1976). There is an apparent absence of experience with specialty HMOs, but California's explicit authorization for experimental development of them seems useful. *See* HOUSE SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS, 94th Cong., 2d Sess., COST AND QUALITY OF HEALTH CARE: UNNECESSARY SURGERY 6-7 (Subcomm. Print 1976) (recommending

these services usually are defined by statute and regulation to include only inpatient hospital and physician services, outpatient medical services, and emergency care,[228] and, in many cases, preventive health care services.[229] Kansas has an even more liberal provision, requiring only that the basic policy must cover services "which are determined by the commissioner to be generally available on an insured or prepaid basis in the geographic area served."[230] In addition, HMO supplemental services are permitted but generally not required.[231] Only a few states deviate substantially from this pattern and impose broader coverage requirements on HMOs. Nevada requires that vision care, mental health services, dental care, and drugs be included in the basic policy,[232] thus closely following the Federal HMO Act's requirements.[233] Michigan requires HMOs to offer these services, but only on an optional supplemental basis for additional premiums or payments.[234] Three acts, including Michigan's, require HMOs to cover home care services in the basic policy.[235]

With the limited exceptions noted above, state HMO enabling acts in general, and Kansas' act in particular, appear to have avoided damaging HMOs' competitive position vis-à-vis other insurers by not imposing sweeping coverage requirements. These acts, moreover, appear at least implicitly to require HMOs to cover full

---

that HEW undertake a comprehensive study and fund demonstration projects involving prepaid surgical care); Schoen, *Dental Care and the Health Maintenance Organization Concept*, 53 MILBANK MEM. FUND Q. 173 (1975) (recommending that dental HMOs be promoted).

[228] All of the states that do require HMOs to offer basic health care services define that term to include as a minimum the following: (1) inpatient hospital and physician services, (2) outpatient medical care, and (3) emergency services. A typical definition follows the NAIC Model Act, which defines "basic health care services" as those "health care services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services." NAIC MODEL ACT, *supra* note 124, at § 2(2). About half of the acts that require comprehensive services have definitions identical or similar to the NAIC Model Act. *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-102(1) (1974); TEX. REV. CIV. STAT. ANN. art. 20A.02(a) (Cum. Supp. 1975). Nine acts further define basic health care services to include one or more of the following: x-ray, diagnostic, or laboratory services. *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-1051(1)(c) (1975) (x-ray, diagnostic, and laboratory services); COLO. REV. STAT. ANN. § 10-17-102(1) (1974) (x-ray and laboratory services); IDAHO CODE § 41-3903(2) (Supp. 1975) (x-ray). In other states, however, these services seem likely to be required by administrative regulations or interpretations of simpler statutory definitions of basic services. Iowa, for example, defines "outpatient medical services" by regulation to include laboratory and x-ray services. Iowa Ins. Dep't Rule 12.1(8) (1974).

[229] Although mandatory coverage of "outpatient medical services" might easily be interpreted to include many preventive as well as remedial services, 11 state enabling acts explicitly require HMOs to provide preventive health care services as part of their basic package of benefits. *See, e.g.*, KAN. STAT. ANN. § 40-3203(b) (Supp. 1975); N.J. STAT. ANN. § 26:2J-(2)(b) (Supp. 1976); S.C. CODE ANN. § 37-1132(b) (Supp. 1975). At least one state, Utah, includes preventive health care in the minimum services that an HMO must offer to its enrollees by regulation. Utah Ins. Dep't Reg. 74-1 (1974). Preventive services are not generally defined by statute, but they have been defined by administrative regulations to include physical examinations, pap smears, children's eye examinations, immunizations, sterilization, health education, and referrals to services other than those in the basic package, such as mental health services. *See, e.g.*, Mich. Ins. Dep't Rule R325-1(16) (Proposed Rules 1975); S.C. Ins. Dep't Reg. R6-75, § 1(d)(1) (1975); Utah Ins. Dep't Reg. 74-1 (1974).

[230] KAN. STAT. ANN. § 40-3202(f)(1) (Supp. 1975).

[231] *See, e.g.*, S.C. CODE ANN. § 37-1132(b) (Supp. 1975).

[232] NEV. REV. STAT. § 695C.060(2) (1975).

[233] For a description of the federal requirements, *see* note 91 and accompanying text *supra*.

[234] MICH. COMP. LAWS ANN. § 325.912(d) (1975). This requirement is effective only after the HMO has been in operation for three years and can be waived or modified if the HMO can show that inclusion of these services would cause financial hardship. *Id.*

[235] ARIZ. REV. STAT. ANN. § 20-1051(1)(c) (1975); CAL. HEALTH & SAFETY CODE § 1345(b)(4) (West Supp. 1976); MICH. COMP. LAWS ANN. § 325.903(2)(g) (1975).

maternity and well-child care[236] as proposed by our theory of limited reformmongering. On the other hand, only two states require that HMOs offer comprehensive drug coverage on a prepaid basis as part of the basic policy,[237] and only one state requires such coverage to be offered as a supplemental service.[238] These last provisions in fact require broader coverage of drugs than does the Federal HMO Act, which mandates only that HMOs include inpatient drugs in their basic policies.[239]

A preemption question may be raised, of course, by application to a federally qualified HMO of any state coverage requirement that is broader than that of the federal law. If the broader state requirement substantially increases HMO costs and jeopardizes the HMO's competitive position vis-à-vis other insurers, the state requirement may justifiably be deemed to be inconsistent with federal law and therefore preempted by such law. Nonetheless, the basic structure of federal HMO law, which contemplates concurrent state regulation and contains only a few express preemption provisions,[240] and a strong state interest in any particular coverage requirement would appear to justify a balancing approach and careful scrutiny of any claim that the state requirement would jeopardize the development of federally qualified HMOs. For example, a state's interest in reducing drug costs and the argument that comprehensive drug coverage and resulting higher premiums could be made acceptable to HMO subscribers[241] might be held to justify a requirement of comprehensive drug coverage. Furthermore, acceptable compromises between conflicting federal and state policies might be struck by allowing federally qualified HMOs to charge higher deductibles or co-insurance payments than usual for the additional service required by state law, or by allowing them to offer the service as a supplemental one that individual subscribers may or may not choose to buy. Either of these accommodations would weaken the argument that the broader state requirement is likely to jeopardize the competitive position of federally qualified HMOs.

State HMO enabling acts also appear more liberal than the Federal HMO Act with respect to consumer participation in HMO governance. Only seven states require consumer participation on the HMO governing body,[242] a provision that

[236] The usual open-ended nature of the statutory definition of "basic health services," *see* notes 227-29 and accompanying text *supra*, supports this interpretation, and at least two states by regulation have interpreted "basic health care services" to include maternity care, including prenatal and post-natal care. Ill. Ins. Dep't Rule 55.01, § 13(E) (1976); N.J. Pub. Health Dep't Rule 8:33-1.2(a)(1)(iii) (1974). Colorado has recently amended its HMO act to require HMOs to offer coverage for maternity care. COLO. REV. STAT. ANN. § 10-17-131 (Supp. 1975) (enacted 1975). It is unclear whether maternity care is to be offered as a basic or a supplemental service. One may assume that it is only required to be offered as a supplemental service because the amendment was not added to the basic services requirement.

[237] NEV. REV. STAT. § 695C.060(2) (1975). Minn. Pub. Health Dep't Regs. 367(e)(2), (5) (1974). The Minnesota HMO regulations, however, permit an HMO to place limitations on the provision of outpatient prescription drugs, but not on inpatient drugs. *Id.* at 369(c)(2)(mm). Regulations of at least two states interpret "inpatient services" to include drugs. Ill. Ins. Dep't Rule 55.01, § 13(C) (1976); N.J. Pub. Health Dep't Rule 8:38-1.2(a)(2)(1) (1974). Regulations of other states take the position that coverage of drugs prescribed in connection with basic or supplemental services is a supplemental service. *See, e.g.*, Utah Ins. Dep't Reg. 74-1 (1974). When not required to be included in the basic coverage, inpatient and outpatient drugs could, of course, be contracted for as a supplemental service.

[238] MICH. COMP. LAWS ANN. § 325.912(d) (1975).

[239] 42 U.S.C. §§ 300e(b)(2), 300e-1(2) (1974), *as amended*, Pub. L. No. 94-460 (Oct. 8, 1976) leaves qualified HMOs free to determine whether or not they will offer "prescription drugs" to their subscribers as a supplemental service. HEW's regulations in effect define "prescription drugs" as drugs that are related to outpatient care. 42 C.F.R. §§ 110.102(a)(2), (b)(4) (1975).

[240] *See* text at notes 61-65 *supra*.

[241] *See* text after note 53 *supra*.

[242] MICH. COMP. LAWS ANN. § 325.933 (1975) (⅓); MINN. STAT. ANN. § 62D.06(1) (Cum. Supp. 1976) (40% after first year); PA. STAT. ANN. tit. 40, § 1557 (Supp. 1976) (majority); S.D. COMPILED

may deter non-consumer oriented institutions from entering the HMO field.[243] More than half of the acts do require more limited consumer participation in HMO policymaking by mandating that the HMO establish some vehicle by which enrollees can express their views on matters of policy and operation. These statutes often suggest consumer advisory panels or consumer referenda on policy matters as appropriate outlets for consumer expression.[244] Selection of a consumer participation mechanism is left to the HMO,[245] although this decision is subject to review by the regulating agency.[246] Consumer advisory panels may be potentially less costly than referenda and thus a better compromise between the interest of consumer groups in ensuring HMO responsiveness to subscribers and the need to ensure efficient HMO operations.

2. *Distributional Reforms.* The more reform-minded among HMO supporters have recommended that HMO legislation require HMOs to use a community rating method for establishing their premiums and to hold periodic open enrollment periods during which subscribers are accepted on a first-come, first-serve basis.[247] A more general requirement that might serve the same purpose of redistributing health care resources to the relatively needy would be a requirement that an HMO obtain subscribers who are representative of the population in the area served by the HMO.[248] Although this use of the reformmongering technique may be attractive as a matter of policy if adequate direct subsidies to the relatively needy are not available,[249] these requirements may impose unacceptably high costs on HMOs,[250] damaging their competitive position in the marketplace.

The distributional reforms attached to HMOs by state enabling acts are relatively liberal by comparison with the Federal HMO Act. First, no state prohibits the use of experience rating for identifiable groups of HMO subscribers,[251] although Idaho restricts the use of experience rating to areas in which this is a common practice among health insurers generally.[252] If other insurers may employ experience rating and any one of them does, HMOs should be allowed to use this system to establish group premiums in order to be fully competitive. From this point of view, Idaho's

---

LAWS ANN. § 58-41-23 (Supp. 1976) (20% after first year); WASH. REV. CODE ANN. § 48.46.070 (Spec. Pamphlet 1975) (⅓). At least two states require consumer representation on the governing body by regulation. Iowa Ins. Dep't Rule 12.4 (1974) (30%); S.C. Ins. Dep't Reg. R6-75, § 7 (1975) (⅓ after first year).

[243] *See* text at note 95 *supra.*

[244] *See, e.g.,* COLO. REV. STAT. ANN. § 10-17-106(2) (1974); UTAH CODE ANN. § 31-42-11 (1974).

[245] *See, e.g.,* MINN. STAT. ANN. § 62D.06(2) (Cum. Supp. 1976); NAIC MODEL ACT, *supra* note 124, at § 6(2).

[246] *See, e.g.,* COLO. REV. STAT. ANN. § 10-17-104(2)(e) (1974); KAN. STAT. ANN. § 40-3203(b)(4) (Supp. 1975); NAIC MODEL ACT, *supra* note 124, at § 4(2)(e).

[247] *See, e.g.,* SENATE HMO REPORT, *supra* note 2, at 3060-61; Schneider, *supra* note 7, at 318-24.

[248] The Federal HMO Act contains such a requirement, 42 U.S.C. § 300e(2)(c) (1974), in addition to the community rating and open enrollment requirements, although this provision was originally intended as a compromise alternative to the open enrollment requirement. *See* CONF. REP. No. 93-621, 93d Cong., 1st Sess. .... (1973), *reprinted in* 1973 *U.S.C. Cong. & Ad. News* 3121-52.

[249] *See* Kissam & Johnson, *supra* note 6, at 1210.

[250] *See* note 99 and accompanying text *supra.*

[251] Fourteen state HMO acts expressly authorize experience rating. Typically, provisions authorizing experience rating allow an HMO to charge different rates for different groups of enrollees. They do not, however, permit the HMO to base an individual enrollee's rate upon his or her health. *See, e.g.,* COLO. REV. STAT. ANN. § 10-17-108(2)(b) (1974). HMO acts that are silent on rating methodologies have been interpreted by the responsible administrative agency to allow experience rating. Letter from W. Joe Garrett, Regulatory Division, Illinois Insurance Department, to the authors, February 10, 1976; Letter from Kenneth A. Tannenbaum, Assistant Commissioner, Michigan Insurance Bureau to the authors, January 28, 1976.

[252] IDAHO CODE § 41-3915(5) (Supp. 1975).

provision seems deficient in that it would allow HMOs to use experience rating only if this method is a "common practice" among insurers and not merely employed by a minority of the insurers.

Second, although more than half of the state acts require that HMOs conduct annual open enrollment periods,[253] the typical state provision is considerably less restrictive than the Federal HMO Act's open enrollment requirement in several respects. Under state acts, the open enrollment requirement generally applies only after the first two years of operation, and the state agency may approve "such underwriting restrictions upon enrollment as are necessary to preserve [the HMO's] financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage."[254] More significantly, most state open enrollment requirements do not mandate that HMOs serve the public generally; if HMOs serve only group subscribers the requirement applies only to those subscribers.[255] In any event, the absence of a complementary community rating mandate, which allows a special group rate for enrollees from the public at large,[256] should reduce, if not eliminate, the problem of high costs for all HMO subscribers that might be caused by serving high risk individuals who join during open enrollment.

Last, no HMO enabling act requires that HMOs obtain subscribers who are representative of the area's population. The absence of this requirement is under-

---

[253] Fourteen states require open enrollment periods. Common to all open enrollment provisions are two features patterned after NAIC MODEL ACT, *supra* note 124, at § 11(1). First, an HMO must have an annual open enrollment period of at least 30 days during which it accepts new enrollees on a first-come, first-serve basis. Second, HMOs are exempted from this requirement during the first two years of operation. *See, e.g.*, KAN. STAT. ANN. § 40-3223(a) (Supp. 1975); N.J. STAT. ANN. § 26:2J-11(a) (Supp. 1976). During periods of open enrollment, most states require an HMO to accept new enrollees without restriction as to their age or health. *See, e.g.*, IDAHO CODE § 41-3919(2) (Supp. 1975); KAN. STAT. ANN. § 40-3223(a) (Supp. 1975). Minnesota, however, allows HMOs to impose reasonable underwriting restrictions and to require a physical examination. MINN. STAT. ANN. § 62D.10(2) (Cum. Supp. 1976). Michigan allows HMOs to impose waiting periods for preexisting conditions that required treatment for the 180 days prior to enrollment and for maternity and obstetrical services. MICH. COMP. LAWS ANN. § 325.928(3) (1975).

[254] *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-111(1) (1974); KAN. STAT. ANN. § 40-3223(a) (Supp. 1975). Michigan, however, limits the power of the regulator to grant waivers of the open enrollment requirement to three consecutive years. MICH. COMP. LAWS ANN. § 325.928(1) (1975). Under the Federal HMO Act, waivers of the open enrollment requirement may be obtained if the HMO can demonstrate satisfactorily that a disproportionate number of high risk individuals already have enrolled or will enroll as a consequence of open enrollment and that such enrollment "will jeopardize [the HMO's] economic viability." 42 U.S.C. § 300e(c)(4)(A) (1974). Thus the federal and state waiver provisions for open enrollments are similar, but the Federal HMO Act does not provide for an automatic two year grace period at the beginning and appears to define the conditions for waiver in a somewhat more limited manner and place a greater burden of proof on the HMO seeking a waiver.

[255] *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-111(2) (1974); IDAHO CODE § 41-3919(2) (Supp. 1975). The fate of enrollees who enrolled with a group and whose HMO membership lapses either because the group contract expires or they leave the group is uncertain. Under existing statutes, the HMO that caters exclusively to groups apparently could refuse to renew contracts on an individual basis with enrollees who were no longer members of such groups. Statutory restrictions forbid cancellation or nonrenewal on the basis of age or health status, but do not speak to whether the HMO with group contracts must only allow conversion from group to individual membership. *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-115(3) (1974); IDAHO CODE § 41-3915(3) (Supp. 1975). The HMO regulations of at least one state, however, require HMOs with group and individual contracts to grant the option to enroll as an individual to persons whose group contracts have been terminated. Iowa Ins. Dep't Rule 12.10(2) (1974). The regulation seems to say that the HMO that has only group contracts would not have to offer conversion privileges.

[256] Although state HMO acts generally permit experience rating, they prohibit skimming of poor health risks by determining the premium of an individual on the basis of his or her health status. An enrollee's premium must be determined by actuarial principles for various categories of enrollees. *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-108(2)(b) (1974); TEX. REV. CIV. STAT. ANN. art. 20A.09(b)(2) (Cum. Supp. 1975).

standable in view of the fact that the nature of HMO services to the elderly and poor will be largely controlled by the provision of such services under the Medicare and Medicaid laws.

3. *Cost Reforms.* State HMO enabling acts currently do not parallel the Federal HMO Act with respect to specific measures of cost reforms that may be attached to HMOs. First, only three states require HMOs to assume nearly all the financial risk of covered services,[257] and in one of these states the insurance commissioner has authority to modify this requirement in specific cases.[258] Indeed, many state acts expressly authorize HMOs to contract for reinsurance,[259] as recommended by the National Association of Insurance Commissioners.[260] In accordance with our earlier analysis, the general absence of assumption of risk requirements is desirable inasmuch as reinsurance contracts will aid HMO development in general, and the development of smaller HMOs in particular.[261]

Second, only California attempts to encourage HMOs to make maximum feasible use of expanded medical delegations. California's Act requires that HMOs employ allied health personnel "to the extent permitted by law and consistent with good medical practice."[262] This absence of expanded delegation requirements unfortunately ignores the opportunity to help ensure that HMOs lead the way in introducing this specific efficiency reform into American medical practice.[263] Of course, application to a federally qualified HMO of a state requirement that HMOs engage in expanded medical delegation to a greater extent than that required by federal law might raise a preemption question.[264] Given, however, the immediate cost-reducing nature of expanded delegation and the fact that the Federal HMO Act does require some such effort,[265] this preemption argument does not appear to be very persuasive.

4. *HMO Rate Regulation.* As an additional measure of cost control, if not reform, a majority of state HMO acts provide for direct regulation of HMO premium rates[266] as recommended by the National Association of Insurance Commission-

[257] MICH. COMP. LAWS ANN. § 325.929 (1975); MINN. STAT. ANN. § 62D.04(f) (Cum. Supp. 1976); S.D. COMPILED LAWS ANN. § 58-41-17(5) (Supp. 1976). All three require an HMO to assume full financial risk on a prospective basis for the provision of health services, except that an HMO can make insurance arrangements "for the cost of providing to an enrollee health maintenance services the aggregate value of which exceeds $5,000.00 in a year," and for the costs of out-of-area emergency services. *Id.* §§ 58-41-17(5), -19. Minnesota and South Dakota also permit an HMO to make insurance arrangements for not more than 95% of the amount by which the HMO's costs for any year exceeds 105% of its income for such year. MINN. STAT. ANN. § 62D.04(f) (Cum. Supp. 1976); S.D. COMPILED LAWS ANN. § 58-41-19 (Supp. 1976).

[258] MICH. COMP. LAWS ANN. § 325.929 (1975).

[259] *See, e.g.,* COLO. REV. STAT. ANN. § 10-17-105(1)(c) (1974); KAN. STAT. ANN. § 40-3208(4) (Supp. 1975).

[260] NAIC MODEL ACT, *supra* note 124, at § 5(1)(e).

[261] *See* note 104 and accompanying text *supra.*

[262] CAL. HEALTH & SAFETY CODE § 1367(f) (West Supp. 1976).

[263] *See* text after note 53 *supra.*

[264] *See* text at note 66 *supra.*

[265] *See* text at notes 102, 105 *supra.*

[266] Seventeen HMO acts confer express authority on the responsible regulatory agency—usually the insurance commissioner—to regulate premium rates. *See, e.g.,* FLA. STAT. § 641.22(4) (1972); IDAHO CODE §§ 41-3915(a),(b) (Supp. 1975); MICH. COMP. LAWS ANN. § 325.925(1) (1975). In states without express statutory authority to regulate premium rates, the insurance commissioner may nonetheless imply that power from other sources. The Illinois HMO Act, for example, does not grant rate regulating authority to the insurance commissioner. This has not deterred the Illinois Insurance Department from issuing HMO regulations claiming the power to regulate HMO premiums. ILL. INS. DEP'T RULE 55.01, § 6 (1976). There are several arguments that support an "implied" power to regulate premiums. For example, many HMO acts require prior approval of the "form" of subscriber contracts, *see, e.g.,* UTAH CODE ANN. § 31-42-12 (1974), and the premium arguably is an element of the "form" of the contract.

ers.[267] The typical statute provides that HMO premiums must be approved by the state insurance department and may not be excessive, inadequate, or discriminatory.[268] A few acts also authorize the insurance department to approve HMO contracts with its providers such as hospitals and physician groups,[269] although such power might be implied in any case by the power to limit premium rates. The appropriateness of HMO rate regulation by any particular state should be judged in part by consideration of HMOs' unique nature and role in health insurance markets and in part by consideration of the scope and effectiveness of the prevailing regulatory scheme for other health insurers in that state. Rather than make the latter assessment on a state-by-state basis, the following discussion is limited to outlining theoretical considerations relevant to this issue.

Typically, states regulate the premium rates of Blue Cross and Blue Shield under a statutory scheme similar to that which has been imposed on HMOs.[270] On the other hand, only about 20 states regulate premium rates of commercial health insurers,[271] and this regulation at best is limited because the costs of commercial health insurers usually involve indemnity payments to subscribers rather than direct reimbursement of provider costs.[272] Admittedly HMOs, like the Blues, have more direct leverage over provider costs than do commercial insurers, a fact that might seem to justify HMO rate regulation in the interests of controlling provider costs. This argument, however, ignores at least four considerations that suggest that HMOs should not be subject to a comprehensive scheme of rate regulation. The first consideration is that the procedure for obtaining rate approvals may be unnecessary and therefore unnecessarily costly. Rate regulation of the Blues may be justified by reason of their relatively dominant market positions, but individual HMOs seem much more likely to keep their premiums down in order to compete with other insurers and providers.[273] A second consideration is that traditional state regulation of health insurers has focused on keeping premium rates at the minimum feasible level, a level which often may fail to provide adequate funds for capital growth that is important to HMO development.[274] At least some insurance departments appear willing to recognize a capital growth component in HMO premium rates, but their apparent difficulty in developing specific standards for this component[275]

[267] NAIC MODEL ACT, *supra* note 124, at §§ 8(2)(a),(b). Many of the rate regulation provisions are patterned after the NAIC Model Act. *See, e.g.*, ARK. STAT. ANN. §§ 66-5208(2)(a),(b) (Supp. 1975).

[268] *See, e.g.*, KY. REV. STAT. ANN. § 304.38-050(1) (Supp. 1974); NAIC MODEL ACT, *supra* note 124, at § 8(2)(b).

[269] Four acts have provisions regulating contracts between HMOs and other providers. The Pennsylvania HMO Act requires an HMO to file contracts between the HMO and other providers with the insurance commissioner. The commissioner can require the HMO to renegotiate a contract if he or she thinks that it calls for excessive payments by the HMO or fails to include reasonable incentives to control costs. PA. STAT. ANN. tit. 40, § 1558(A) (Supp. 1976). The Texas HMO Act authorizes the insurance commissioner to disapprove an exclusive management contract between an HMO and another entity if it subjects the HMO to excessive payments. TEX. REV. CIV. STAT. ANN. art. 20A.18(b)(1) (Cum. Supp. 1975). Finally, Minnesota and South Dakota prohibit HMOs from incurring expenses that are unreasonably high in relation to the value of the services or goods received. MINN. STAT. ANN. § 62D.19 (Cum. Supp. 1976); S.D. COMPILED LAWS ANN. § 58-41-57 (Supp. 1976).

[270] *See, e.g., Law, supra* note 33, at 13-14.

[271] Hanson, *supra* note 33, at 698.

[272] *Id.* at 698, 702.

[273] *See* HARVARD HMO Note, *supra* note 13, at 974.

[274] *Id.*

[275] The authors sent inquiries about rate regulating methodologies to the administrative agencies of 15 states with HMO acts. Of nine responses that addressed the issue of a capital growth component, seven indicated that they were permitted, but no standards were indicated other than the standard of reasonableness. *See, e.g.*, Letter from Emmet Ferrell, Administrator, Health Maintenance Organization Section, Florida Insurance Dept., to Ronald Johnson, Dec. 3, 1975.

may lead one to question whether regulatory second-guessing of HMO decisions on this matter is workable. A third consideration is that much state regulation of the Blues' premiums has avoided the difficult question of regulating underlying provider costs,[276] although this would seem essential for effective regulation. HMO rate regulation, on the other hand, almost necessarily must consider underlying provider costs, inasmuch as each HMO is a provider. If HMO rate regulation is effective at keeping premiums down, but similar regulation is not applied to other insurers, this might unfairly jeopardize HMOs' quality of care in contrast to other providers.[277] Finally, to the extent that existing insurance departments are captives of traditional health insurers, these insurers may find HMO rate regulation a useful device for limiting competition by forcing HMO rates, particularly rates for employee groups, to an unnecessarily high level on the basis of claims that proposed HMO rates are inadequate or discriminatory.

Notwithstanding these objections to general HMO rate regulation, individual states may find more limited forms of regulation desirable in certain instances. Regulation of HMO premiums to ensure that they are adequate to cover costs might be considered a necessary safeguard against financial insolvency. Also, if all other health insurers must obtain prior approval of group contract rates to guard against unfair price discrimination, it would seem only fair to subject competing HMOs to similar control. The possibility also exists that some HMOs, particularly HMOs controlled by the only hospital in a small community, might obtain control of a natural monopoly market in which it is economically infeasible for other insurers and providers to compete.[278] In this case it might be appropriate to regulate an HMO's premiums after an administrative agency has determined that the HMO occupies such a natural monopoly market.[279] Last, one commentator has argued that HMOs and their subscribers might benefit from state regulation of the rates that an HMO pays to contracting hospitals and physician groups to obtain services for the HMO's subscribers.[280] This argument is that new HMOs are likely to have relatively weak bargaining positions vis-à-vis well-established providers and therefore need help from state regulators in negotiating these contracts. The basic problem with both of the latter two arguments is that state regulation of excessive health care provider rates has not yet proven to be successful[281] and that, should it prove successful, the quality of care may diminish, and HMOs will have no incentive to continually reduce costs.[282]

---

[276] *See Law, supra* note 33, at 13-18.

[277] Diminished quality under effective rate regulation is always a concern, but this problem seems particularly troublesome in health care because of the relatively unstandardized product being sold and the related difficulty of measuring quality. Havighurst, *HMOs, supra* note 2, at 762-63.

[278] *Id.* at 759-61.

[279] HARVARD HMO Note, *supra* note 13, at 974. *Contra,* Havighurst, *HMOs, supra* note 2, at 762-66. Note that regulation of HMOs' premiums after administrative determination of a natural monopoly position would be akin to the "deregulation" provision in the Railroad Revitalization Act of 1976 that requires the Interstate Commerce Commission to determine that a railroad has "market dominance" over the traffic in question prior to establishing any maximum rate for that traffic. Pub. L. No. 94-210, § 202(b) (Feb. 5, 1976).

[280] Schneider, *supra* note 7, at 312-15.

[281] *See* Lewin, Somers & Somers, *State Health Cost Regulation: Structure and Administration,* 6 U. TOLEDO L. REV. 647, 657-61 (1975).

[282] Havighurst, *HMOs, supra* note 2, at 762-74. The reason for special concern about inducing diminished quality of care by rate regulation of health care providers is given in note 277 *supra.* Effective rate regulation may induce inefficient performance because it will deny the opportunity of earning long-term extraordinary profits from more efficient operations.

5. *Government Assistance to Qualified HMOs.* State HMO acts do provide limited kinds of assistance to HMOs, although it appears that much more could be done by state legislation to promote HMO development. By qualification under these acts, an HMO can free itself from any undue legal restrictions under other state health insurance laws[283] and from a rule against the corporate practice of medicine.[284] As noted above, most state acts also explicitly free HMOs from medical practice act prohibitions against advertising by physicians, although advertising material often must be approved by a regulatory agency and a number of states prohibit HMOs from discussing quality of care issues.[285]

Only a few state acts provide additional benefits for qualified HMOs. No act exempts a licensed HMO from restrictions on expanded medical delegation under state medical practice laws, and only one act provides developmental subsidies.[286] Six acts contain rules designed to improve the access of HMOs to employee groups, but only Washington requires both public and private employers to include an HMO option in health benefits plans offered to employees.[287] Michigan requires private employers of a certain size to offer an HMO option,[288] and four other states mandate this option for public employees.[289] Market access rules of this type are desirable in general because they should help HMOs overcome the resistance of employers, union leaders, and other insurers to HMO competition.[290] State market access rules are desirable because they may benefit a much larger number of HMOs than those that qualify under the more restrictive conditions of the Federal HMO Act. Furthermore, a state HMO option rule for state and local government employers will be especially desirable if the similar federal rule contained in the 1976 HMO Amendments should be declared unconstitutional.[291]

One significant limitation on the states' authority to benefit HMOs by market access rules should be noted. A state requirement that an HMO option be offered

---

[283] *See, e.g.*, KAN. STAT. ANN. § 40-3214 (Supp. 1975).

[284] Some acts explicitly make the rule against the corporate practice of medicine inapplicable to HMOs. *See, e.g.*, COLO. REV. STAT. ANN. § 10-17-125(3) (1974); MD. ANN. CODE art. 43, § 857(b) (Supp. 1975). The very existence of an HMO enabling act, however, by implication, certainly repeals this rule for qualified HMOs.

[285] *See* text at notes 194-200 *supra.*

[286] MINN. STAT. ANN. § 62D.27(2) (Cum. Supp. 1976). Under this section, the state board of health can make planning grants to an eligible HMO for up to $50,000 per year for two years. If an HMO is to qualify for financial assistance, it must propose to serve a medically underserved area and have a governing body with a majority of consumers. *Id.* § 62D.28. *See also,* CAL. HEALTH & SAFETY CODE § 1177 (West Supp. 1976), a statute that is separate from California's HMO enabling act, which authorizes the public health director to make loans to eligible HMOs for start-up costs.

[287] Washington requires both public and private employers that make a health benefits plan available to their employees to include an HMO option. To be subject to this requirement, an employer must have more than 50 employees and at least 25 employees must desire to enroll in an HMO. The option provision also has a proviso that reconciles this requirement with federal labor laws concerning collective bargaining by requiring that the HMO option be offered only to the collective bargaining agent of organized employees. WASH. REV. CODE ANN. § 48.46.180 (Spec. Pamphlet 1975).

[288] Michigan requires employers with 25 or more employees that are subject to the federal minimum wage law to include an HMO option in any health benefits plan offered to their employees. MICH. COMP. LAWS ANN. § 325.943 (1975).

[289] Three of these option provisions are very similar and authorize "any employee" to enroll in an HMO. IOWA CODE ANN. § 514B.21 (Cum. Pamphlet 1976); N.J. STAT. ANN. § 26.2J-29 (Supp. 1976); PA. STAT. ANN. tit. 40, § 1568 (Supp. 1976). Utah, however, seems to require an HMO option only if the entire group, or a substantial portion of such group, of public employees expresses a desire to enroll in an HMO. UTAH CODE ANN. § 31-42-32 (1974).

[290] *See* text at note 88 *supra.*

[291] The possibility of this happening is discussed in text at notes 83-87 *supra.*

directly to employees organized under the Labor Management Relations Act,[292] without prior approval of the collective bargaining agent, would appear to be preempted by that federal law.[293] On the other hand, mandating only that the option be offered to the collective bargaining agent might be upheld as a reasonable accommodation between federal labor and state health insurance policies.[294] This would at least provide HMOs with the same limited kind of access to organized employees as the Federal HMO Act provides.[295]

Last, two state HMO acts attempt to protect HMO physicians from denial or loss of staff privileges at hospitals due to their HMO association.[296] This exclusionary practice, which has been employed historically against HMO physicians,[297] could retard HMO development by discouraging physicians from working for HMOs or by limiting the ability of nonhospital HMOs to obtain hospital services for their subscribers. Antitrust laws[298] and a variety of state judicially created rules that prohibit arbitrary denial of hospital staff privileges[299] may minimize this danger. There is, however, uncertainty about the application of federal antitrust law to medical providers,[300] and state courts generally have hesitated to review admitting privilege decisions by private hospitals other than those with monopoly positions.[301] Furthermore, these rules must be enforced in the courts, which could involve delays, expenses, and unfavorable publicity that might be especially costly to developing HMOs. A clear legislative rule that prohibits hospitals from denying staff privileges to HMO-associated physicians due to the association and that provides for administrative, as well as judicial, remedies would be a desirable extension of the policies underlying these other laws.

---

[292] 29 U.S.C. §§ 141-187 (1970). The duty of the employer and union to bargain collectively in connection with conditions of employment is regulated by *id.* § 158(d). Health insurance coverage is considered to be a mandatory subject of bargaining under *id.* § 158(d). *See, e.g.,* McLean v. NLRB, 333 F.2d 84, 87 (6th Cir. 1964).

[293] In Teamsters Local 24 v. Oliver, 358 U.S. 283, 295-97 (1959), *aff'd on rehearing,* 362 U.S. 605 (1960), the Supreme Court held that a union agreement properly entered into under the Labor Management Relations Act could not be held to violate state antitrust laws. The Court distinguished the case of a conflict between a collective bargaining agreement and a "local health or safety regulation," noting that the conflict in the instant case "is between the federally sanctioned agreement and state policy which seeks specifically to adjust relationships in the world of commerce." 358 U.S. at 297. A state law that required offer of an HMO option directly to employees in contravention of a bargaining agent's refusal would appear to be a state policy which also "seeks specifically to adjust relationships in the world of commerce," and is therefore preempted under the rule of *Teamsters Local 24.*

[294] Washington's mandate of an HMO option attempts to achieve such an accommodation. *See* note 287 *supra.*

[295] *See* 42 C.F.R. § 110.805 (1975). For discussion of the issue whether the HMO option should be offered directly to organized employees or only to their collective bargaining agents as a matter of federal law, *see* Kissam & Johnson, *supra* note 6, at 1214-15.

[296] IDAHO CODE § 41-3920 (Supp. 1975); TEX. REV. CIV. STAT. ANN. art. 20A.14(c) (Cum. Supp. 1975). *See also* N.Y. PUB. HEALTH LAW § 2801-b (McKinney Supp. 1975), which makes denial of staff privileges by the governing body of a hospital for reasons unrelated to quality of care an improper practice.

[297] *See, e.g.,* Group Health Cooperative of Puget Sound v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951); Kessel, *Price Discrimination in Medicine,* 1 J. LAW & ECON. 20, 30-32, 34-42 (1958).

[298] *See* Havighurst, *HMOs, supra* note 2, at 767-69.

[299] *See* Holley & Carlson, *supra* note 11, at 660-62.

[300] This uncertainty arises because of the need to establish an effect on interstate commerce from an act by a medical provider against an HMO. Havighurst, *HMOs, supra* note 2, at 778. One argument to establish such an effect is that antitrust violations against an HMO will have a harmful effect on interstate drug traffic. *Id.* at 778-80. Another argument might be that HMOs have an effect on interstate insurance transactions, *see* note 167 *supra,* and that antitrust violations by medical providers against them thereby effect interstate commerce.

[301] Holley & Carlson, *supra* note 11, at 661-62.

III. STATE MEDICAID PROGRAMS AND HMOs

The federal-state Medicaid program provides, on a nationwide basis, publicly financed health care benefits for approximately ten percent of America's population[302] at an annual public cost in excess of 14 billion dollars.[303] This program clearly can be an important source for funding HMO operations on a prepaid basis, although the frequently limited choice of health care providers for Medicaid beneficiaries also raises special concern about the possibility of marketing and service abuses by HMOs.[304]

State legislators, particularly those in larger, more urbanized states, should be interested in the nature of Medicaid-HMO contracts in their states for three separate reasons. One reason is that prepayment contracts with HMOs for Medicaid services could be used to promote effective HMO development in general, with consequent advantages for the entire population of health care consumers.[305] Prepaid contracts, in contrast to the usual Medicaid cost reimbursement system, offer HMOs two potentially significant benefits: the possibility of improving their cash flow, which may be particularly important for new HMOs,[306] and the possibility of retaining at least some of the cost savings generated by HMOs' more efficient performance.[307]

The second reason for legislative attention to Medicaid-HMO contracts is that effective contracting may improve services to Medicaid beneficiaries. Improved service may result from higher quality provision of existing Medicaid services by HMOs.[308] It may also result from HMOs offering Medicaid subscribers additional services that are not presently covered by the state Medicaid plan.[309] HMOs may need to offer such additional services because otherwise Medicaid beneficiaries may have little incentive to subscribe in that they pay only a small fraction of the costs of their health services.[310] Of course, HMOs will not be able to provide such additional services effectively if they are unable to retain cost savings under prepaid contracts that cover existing Medicaid services.

The third reason for legislative attention to Medicaid-HMO contracts is that more efficient HMO performance can generate immediate cost savings in public expenditures by reducing both service payments and the substantial administrative costs associated with state Medicaid programs.[311] This goal, of course, could conflict with the two previously stated. In the remainder of this section we outline some general considerations that a state legislature should take into account in reviewing the Medicaid situation in its state, and we then analyze California's attempt to govern Medicaid-HMO contracts by statute.

---

[302] *See* RESOURCE BOOK, *supra* note 55, at 491.

[303] *See* HEW, SOCIAL AND REHABILITATION SERVICES, MEDICAL ASSISTANCE (MEDICAID) FINANCED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT 39 (DHEW Pub. No. (SRS) 76-03150 April, 1976).

[304] *See* Schneider & Stern, *supra* note 54, at 115-38.

[305] *See* text at notes 9-33 *supra*.

[306] *See* Schneider & Stern, *supra* note 54, at 118-19.

[307] HMOs can and do serve Medicaid beneficiaries on a retroactive cost reimbursement basis, as fee-for-service providers do, and adequate cost reimbursement also can support HMO development. Such reimbursement, however, does not offer the advantages mentioned in the text, and in fact it will eliminate the incentive for HMOs to economize on Medicaid services. *See* Havighurst & Bovbjerg, *supra* note 8, at 383 n.9.

[308] Schneider & Stern, *supra* note 54, at 117.

[309] The amendment to the federal Medicaid law that authorizes prepaid contracts with HMOs provides for this possibility. 42 U.S.C. § 1396a(a)(23) (1974).

[310] *See* Havighurst & Bovbjerg, *supra* note 38, at 414 (in particular n.134).

[311] Schneider & Stern, *supra* note 54, at 116-17.

A. *General Considerations*

A state's options in controlling the nature of HMO contracting with its Medicaid program are limited by relevant requirements of the federal Medicaid law and federal regulations promulgated thereunder. In an earlier article, we analyzed federal Medicaid law as it pertains to HMOs.[312] We concluded that this law, as originally designed, left considerable discretion to the states on such matters as required service coverage, open enrollments, assumption of risk, and apportionment of cost savings generated by HMOs in comparison to fee-for-service providers. Unfortunately, the 1976 HMO Amendments, by requiring that Medicaid HMOs qualify under the Federal HMO Act,[313] require these HMOs to provide quite comprehensive coverage and community rating for their other enrollees, to include subscribers on their governing bodies, and to assume almost all financial risk of coverage for their other enrollees. These amendments also require a Medicaid HMO to include family planning and home health care services in its basic policy for Medicaid beneficiaries and to offer as supplemental services all other Medicaid benefits that are generally available in the area served by the HMO.[314]

Nonetheless, even after the 1976 HMO Amendents, state Medicaid programs are left with some important choices in implementing prepaid contracts with HMOs. Among these decisions, the most important would appear to be the choice of whether to enter into prepaid contracts or not,[315] the financial arrangements of such contracts,[316] the nature of controls to ensure adequate quality of care and fair marketing practices, and the manner in which expanded medical delegation might be promoted and regulated in accordance with the Federal HMO Act's very general requirement.

The present federal Medicaid law, as recently amended, does not require state Medicaid agencies to contract with HMOs on a prepaid basis.[317] State Medicaid agencies should have ample incentives for contracting with HMOs, in particular the opportunity to realize cost savings. These agencies, however, may refrain from doing so due to new demands on their resources to regulate HMO quality and to guard against duplication of payments to both an HMO (on a prepaid basis) and fee-for-service providers (on a cost reimbursement basis) for the same beneficiary.[318]

---

[312] Kissam & Johnson, *supra* note 6, at 1229-32.

[313] Pub. L. No. 94-460, § 202(a) (Oct. 8, 1976).

[314] *Id.*

[315] "At the end of 1974, between 300,000 and 400,000 Medicaid eligibles were enrolled in 74 HMOs in 13 states and the District of Columbia." Schneider & Stern, *supra* note 54, at 120 n.149. Fifty-four of these HMOs, with a total Medicaid enrollment in excess of 250,000, were in California. *Id.* at 128-29. In July 1976, however, the total number of Medicaid eligibles enrolled in HMOs had probably declined from its peak because of the failure of about 20 HMOs in California. Telephone interview with H. R. Jolley, Director, Office of Program Innovation, Social and Rehabilitation Service, HEW, July 22, 1976. Possible reasons for the failure of other states to implement prepayment contracts with HMOs are given in text at note 318 *infra*.

[316] HEW's regulations on Medicaid-HMO contracting merely require that any prepayment contract "specify how any 'savings' (excess of premiums over allowable costs) will be apportioned between the [HMO] and the State agency." 45 C.F.R. § 249.82(c)(2)(v) (1975).

[317] The discretion given to the states on this most important question is consistent with the simple nature of the 1972 HMO amendment to the Medicaid law, 42 U.S.C. § 1396a(a)(23) (1974), which merely authorizes states to enter into prepayment contracts for Medicaid beneficiaries, and with the general structure of the Medicaid law, which gives broad discretion to states to formulate and administer their Medicaid plans. *See generally,* Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations,* 8 CLEARINGHOUSE REV. 7 (1974). HEW also has claimed that any federal mandate upon the states to offer an HMO option to Medicaid beneficiaries would create considerable administrative difficulties in some states. *See* Schneider & Stern, *supra* note 54, at 117 n.133.

[318] *See* Schneider & Stern, *supra* note 54, at 116-17.

When state agencies do contract with HMOs, they also may focus excessively on obtaining immediate cost savings to the detriment of both HMO development and Medicaid beneficiaries[319] or impose unduly rigid quality of care standards based on experience with regulating fee-for-service providers.[320] Depending upon the present situation, a state legislature may well find it desirable to establish a statutory framework for Medicaid-HMO contracting that serves to promote HMO development, to benefit Medicaid beneficiaries, and to limit public expenditures (at least over the long-run).

If a state chooses to contract with Medicaid HMOs on a prepaid basis, the most difficult question to be faced is the nature of the financial arrangements between the state and HMOs. State governments have a natural interest in minimizing public expenditures, but if this interest is pressed too far, the attractiveness of such contracting to HMOs will be diminished and their Medicaid enrollees may be subjected to unnecessary risks of underservice.

We recommended in an earlier article[321] that Medicaid HMOs should be paid a flat premium in advance, with HMOs bearing the full risk of any losses and retaining all cost savings. The premium amount should be equivalent to what it costs to pay other providers for equivalent services to similar beneficiaries. This very liberal provision might be objected to as providing HMOs with unjust "windfall" profits (and also involving administrative costs in calculating the equivalent amounts), although we would characterize such profits as extraordinary profits justified by HMOs' more efficient performance and the need to attract more HMOs into the market. If the windfall objection is considered persuasive, however, the HMO premiums should be made equivalent to the market-established premiums that the HMOs charge other enrollees,[322] with adjustments to reflect the extent that different services are provided to different groups. This approach would allow the forces of market competition for other enrollees to determine the "fair" premium for services to Medicaid beneficiaries, and it should work as long as HMOs do not serve primarily Medicaid and Medicare beneficiaries. HEW's regulations under Medicaid limit HMOs generally to a 50 percent enrollment covered by Medicare and Medicaid, although this requirement may be waived by HEW for "good cause."[323] For cases where an HMO obtains such a waiver and does serve primarily Medicare and Medicaid beneficiaries, we recommended that the Medicaid agency should be authorized to negotiate "reasonable" premiums with the HMO that are

---

[319] For example, in implementing cost saving provisions in HMO prepayment contracts, Oregon requires that an HMO must absorb all losses and can keep none of its savings. McNeil and Schlenker, *supra* note 5, at 210. California is attempting to limit any cost savings retained by HMOs to those generated under annual contracts in which the prepaid amount is set substantially below the amount calculated for fee-for-service providers. *See* text at notes 341-46 *infra*. Furthermore, the cost savings requirements of the Medicare HMO provision, which allow the HMO to retain only half of the savings up to a limit, *see* text at notes 108-11 *supra*, may serve as an attractive model for many state Medicaid agencies.

[320] For example, a proposed HMO prepayment contract for Medicaid services developed by New York City's Health Department in 1973-74 contained detailed structural and process quality of care standards that were based on the Department's experience with regulating all providers in the City. *See* Hester & Sussman, *Medicaid Prepayment: Concept and Implementation*, 52 MILBANK MEM. FUND Q. 415, 434-36 (1974). Such standards might easily create the same problems for effective HMO performance as PSRO regulation. *See* text at notes 213-16 *supra*.

[321] Kissam & Johnson, *supra* note 6, at 1231.

[322] *See* Havighurst, *HMOs*, *supra* note 2, at 729-32.

[323] 45 C.F.R. § 249.82(c)(5)(ii) (1975).

between 95 percent and 100 percent of the amount that otherwise would be paid to fee-for-service providers for such services.[324]

Prepaid contracts between HMOs and Medicaid programs also must consider appropriate quality of care and marketing practice controls and should consider encouraging expanded medical delegation, at least if all HMOs in the state are subject to a similar requirement.[325] We analyze the nature of these issues in the following discussion of California's Medicaid HMO law.

B. *California's Medicaid HMO Law*

California's Waxman-Duffy Prepaid Health Plan Act[326] represents a major legislative attempt to promote and regulate Medicaid-HMO contracting by the state in which most of this contracting has occurred.[327] Significant provisions of this Act may be divided into three categories as follows: those that are designed to promote specific reforms called for by the limited reformmongering theory, those designed to guard against marketing and service abuses, and a financial provision that appears to be unnecessarily restrictive. First, the Waxman-Duffy Act requires that HMOs must cover prescription drugs in their basic policy for Medicaid enrollees[328] and that these HMOs must "employ allied health personnel . . . to the extent that it is reasonable and consistent with good medical practice."[329] Both of these provisions are desirable requirements, and we have suggested above ways in which this type of expanded delegation provision could be strengthened.[330]

Second, the Waxman-Duffy Act establishes a variety of provisions to guard against potential marketing and service abuses. The state Medicaid agency is directed to prepare and make available to all Medicaid beneficiaries information that summarizes "the benefits and restrictions to beneficiaries enrolled in prepaid health plans as opposed to the fee-for-service system."[331] The agency also is given extensive control over all marketing material and procedures employed by HMOs to obtain Medicaid enrollees,[332] and is authorized to levy a variety of sanctions for marketing misrepresentations.[333] The Act also requires that Medicaid HMOs establish enrollee grievance procedures, for which there must be a written finding of fact furnished to

---

[324] Kissam & Johnson, *supra* note 6, at 1232 n.456. The 95% figure admittedly provides for an arbitrary division of cost savings between the government and HMO, although it is not a new suggestion. The House of Representatives initially proposed an amendment to the Medicare law that would have authorized all HMO premiums to be set at an amount equal to 95% of the amount that otherwise would be paid to other providers. *See* S. REP. No. 1230, 93rd Cong., 2d Sess., 230 (1972).

[325] It would seem unfair to Medicaid beneficiaries to require expanded delegation only of Medicaid HMOs, although perhaps the economic benefits of such a requirement outweigh the inequity.

[326] CAL. WELF. & INST'NS CODE § 14200 *et seq.* (West Supp. 1976) (enacted 1972, and significantly amended, 1974).

[327] See note 315 *supra.* For discussion of California's experience with Medicaid-HMO contracting and the particular abuses that resulted in enactment of the Waxman-Duffy Prepaid Health Plan Act, *see* Schneider & Stern, *supra* note 54, at 124-38.

[328] CAL. WELF. & INST'NS CODE §§ 14256(d), 14304.5 (West Supp. 1976).

[329] *Id.* § 14450(i).

[330] *See* text after note 53 *supra.* Note that the Waxman-Duffy Act's expanded delegation requirement is consistent with a similar requirement for all HMOs in California, CAL. HEALTH & SAFETY CODE § 1367(f) (West Supp. 1976), and thereby avoids a claim of unfairness by Medicaid beneficiaries. *See* note 325 and accompanying text *supra.*

[331] CAL. WELF. & INST'NS CODE § 14404 (West Supp. 1976).

[332] *Id.* §§ 14405, 14406, 14408.

[333] The sanctions are as follows: revocation of one or more permitted methods of marketing, prohibition of new Medicaid enrollments for a specified period, forfeiture of the per capita payment for persons enrolled as a result of the misrepresentations, and termination of the contract. *Id.* § 14409(b).

the enrollee and from which an appeal may be taken to the state agency.[334] Last, the Act requires that the state agency hold public hearings prior to the execution of any contract or contract renewal in order to make a finding of fact "as to the ability of the prepaid health plan to comply with its previous and proposed contract obligations,"[335] with notice to be given to the HMO, its Medicaid enrollees, and "any interested party who requests notification."[336]

These requirements are, in the aggregate, more extensive than those imposed by any state HMO enabling act.[337] They may be appropriate safeguards against the risk of underservice by "poor people's" HMOs if most Medicaid HMOs in a state will serve primarily Medicaid and Medicare enrollees, which was the case in California at the time the Waxman-Duffy Act was passed.[338] On the other hand, federal law now limits HMO memberships to no more than 50 percent Medicare and Medicaid enrollees, although waivers may be obtained from HEW for good cause.[339] For states where relatively few HMOs are likely to exceed the 50 percent limit permanently, it might be preferable to rely more on non-legislative constraints to ensure HMO quality[340] and only impose this full panoply of requirements on HMOs that obtain substantially more than 50 percent of their membership from Medicare and Medicaid enrollees.

Last, the Waxman-Duffy Act's provisions for HMO payment rates may limit the possibility of HMOs retaining cost savings generated by their more efficient performance. Under the Act, HMO rates are fixed in advance and are not subject to retroactive adjustment.[341] The HMO thus is allowed to retain cost savings that it generates during the following year under its payment rate.[342] Yet, this payment rate is not pegged by statute at the amount (or some percentage thereof) which would be paid to other providers for equivalent services. Instead, the rate is to be determined by "actuarial methods" and may not exceed an estimated amount that would be paid to fee-for-service providers for the same services.[343] These provisions together appear to require that HMOs' rates, at least after some experience has been obtained in serving Medicaid enrollees, be based on HMOs' own cost experience. In fact, California's Health Department has implemented this provision by initially paying HMOs 100 percent of the estimated amount that would have been paid to other providers and gradually reducing the percentage, until now, on a statewide basis, it is approximately 86 percent of the estimated amount that would be paid other providers.[344]

---

[334] *Id.* § 14450(1).
[335] *Id.* § 14300.
[336] *Id.*
[337] *See* text at notes 189-202 *supra.* Michigan's HMO enabling act contains marketing disclosure and grievance procedure requirements, MICH. COMP. LAWS ANN. §§ 325.925-.927, .934, .939, .941 (1975), that most clearly approximate the Waxman-Duffy Act's requirements, but Michigan does not direct the regulatory agency to prepare basic disclosure information to be distributed to prospective enrollees, nor does it provide the same variety of sanctions.
[338] Schneider & Stern, *supra* note 54, at 134-35.
[339] 45 C.F.R. § 249.82(c)(5)(ii) (1975).
[340] These non-legislative constraints are described in text at note 37 *supra.*
[341] CAL. WELF. & INST'NS CODE § 14301 (West Supp. 1976).
[342] Initial contracts may not exceed one year and renewal contracts may not exceed two years in duration, but the HMO's payment rate must be determined annually. *Id.* § 14301, 14302.
[343] *Id.* § 14301.
[344] Telephone interview with Richard Ross, Legal Affairs Department, California Health Department, August 4, 1976.

The percentage apparently will continue to be reduced until it approximates HMOs' actual costs as determined by experience.[345] To obtain future cost savings under this scheme, HMOs must continually better themselves or continually increase economizing at the expense of Medicaid enrollees. Neither result seems particularly desirable. A better approach, as we have recommended, would be to pay HMOs either the premium they charge other enrollees or, in cases where this is not feasible, a negotiated amount between 95 percent and 100 percent of fee-for-service payments for equivalent services.[346]

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

State HMO enabling acts in general appear to be true to their name. They "enable" HMOs to operate free of several restrictions in traditional state insurance and medical practice laws without meeting the costly qualifying conditions of the Federal HMO Act. These statutes also appear to be relatively well-designed to guard against financial insolvency and potential marketing and service abuses by HMOs. The state acts do not, however, generally provide several important benefits that seem to be useful for promoting HMO development, nor do these acts employ the reformmongering technique to require HMOs to provide full coverage of drug services or to make maximum use of expanded medical delegation. Although we have not attempted to canvass the efforts of state Medicaid programs to contract with HMOs, from the scattered evidence we have introduced, there would appear to be substantial opportunities for states to promote effective HMO development in this area as well.

We have several major recommendations for improving the design of state HMO legislation. First, HMOs should be required to cover all related drug services in their basic policies. Second, HMOs should be encouraged to increase the use of expanded medical delegation by requirements of "maximum feasible use" of such delegation, annual progress reports, and appropriate professional and consumer education related to this goal. In addition, HMOs licensed under an enabling act should be exempt from any restrictions on expanded medical delegation under the state's medical practice and allied health professional acts, although such delegation would of course remain subject to control by the HMO regulatory agency.[347] Third, HMOs should be free to advertise about health care quality, subject to the usual limitations on health insurers that prohibit unfair or deceptive advertising. Fourth, all state and local public employers and private employers of a minimum size should be required to include an HMO option in any health benefits plan offered to their employees. Fifth, any imposition of rate regulation over HMOs should be considered carefully in light of the several theoretical objections to such regulation that we have outlined above.[348] Last, it may be desirable in any particular state for the legislature to establish a statutory framework to authorize and govern prepaid contracts with HMOs to serve Medicaid beneficiaries. This statute, importantly, should ensure that the financial arrangements of such contracts offer adequate incentives to both HMOs and Medicaid beneficiaries to participate in this program on an expanded basis.

---

[345] *Id.*

[346] *See* text at notes 321-24 *supra.*

[347] For recommendations on the form that such exemption and alternative regulation should take, *see* Kissam, *supra* note 24, at 59-65.

[348] *See* text at notes 266-82 *supra.*