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Insurance - Nonprofit Health Care Corporations Are Not Insurance Providers

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INSURANCE—NONPROFIT HEALTH CARE CORPORATIONS ARE NOT INSURANCE PROVIDERS. *New Mexico Life Insurance Guaranty Association v. Moore,* 93 N.M. 47, 596 P.2d 260 (1979).

INTRODUCTION

In *New Mexico Life Insurance Guaranty Association v. Moore,*[1] the New Mexico Supreme Court was presented with the issue of whether corporations formed under the New Mexico Nonprofit Health Care Plan Act[2] are insurance providers for purposes of the New Mexico Life Insurance Guaranty Act[3] (hereinafter referred to as the Guaranty Act). The court, finding the nonprofit health care corporations to be service benefit organizations and not insurance providers, held that they were not subject to the Guaranty Act.[4] Because of this decision, nonprofit health care corporations will not be required to be members of the New Mexico Life Insurance Guaranty Association (Guaranty Association) and therefore will not be liable for assessments which are levied against members of the Guaranty Association. This Note will discuss the New Mexico Supreme Court's decision and the substantial impact it will have upon health care in the state.

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1. 93 N.M. 47, 596 P.2d 260 (1979). Kenneth C. Moore is the Superintendent of Insurance of the State of New Mexico. This suit was brought against him in his official capacity solely to assure his presence as a party. Record at 1, New Mexico Life Ins. Guar. Ass'n v. Moore, 93 N.M. 47, 596 P.2d 260 (1979). Moore agreed that his interests were adequately represented by the parties and waived his right to participate in the suit. Record at 10.

2. N.M. Stat. Ann. §§ 59-19-1 to -48 (1978).

3. N.M. Stat. Ann. §§ 59-22-1 to -17 (1978).

4. The decision in *New Mexico Life* follows the majority of jurisdictions which have decided this issue. In the majority are: *District of Columbia:* Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939); *California:* California Physicians' Serv. v. Garrison, 28 Cal. 2d 790, 172 P.2d 4 (1946); *Michigan:* Michigan Hosp. Serv. v. Sharpe, 339 Mich. 357, 63 N.W.2d 638 (1954); *New Jersey:* New Jersey Ass'n of Independent Ins. Agents v. Hosp. Serv. Plan of N.J., 128 N.J. Super. 472, 320 A.2d 504 (Super. Ct. App. Div. 1974); and *Rhode Island:* Hospital Serv. Corp. of R.I. v. Pennsylvania Ins. Co., 101 R.I. 708, 227 A.2d 105 (1967). The State of New York has decided that a prepaid legal services plan is not insurance. Feinstein v. Att'y Gen., 36 N.Y.2d 199, 326 N.E.2d 288 (1975). Ohio is the only state that has clearly decided that a nonprofit hospital service corporation was engaged in the business of insurance. Cleveland Hosp. Serv. Ass'n v. Ebright, 142 Ohio St. 51, 49 N.E.2d 929 (1943). The state of the law in Washington, the other state which has considered this issue, is unclear. In Fishback v. Universal Serv. Agency, 87 Wash. 413, 151 P. 768 (1915), the court decided that a corporation similar to New Mexico's nonprofit health care corporations was not providing insurance. A later case distinguished *Fishback* and reached the opposite result. McCarty v. King County Medical Serv. Corp., 26 Wash. 2d 660, 175 P.2d 653 (1946).

STATEMENT OF THE CASE

Plaintiff Guaranty Association was organized in 1975[5] pursuant to the Guaranty Act.[6] The Guaranty Association protects policyholders of insurance companies which become insolvent by guaranteeing or reinsuring the policies and by providing money or other means of assuring payment of the insolvent insurer's contractual obligations.[7] The funds necessary to carry out the duties and administration[8] of the Guaranty Association are obtained through assessments.[9]

Lovelace-Bataan Health Program (LBHP) and New Mexico Health Care Corporation (Mastercare), defendants in the case,[10] were organized under the 1963 Nonprofit Health Care Plan Act[11] as

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5. Record at 98.

6. N.M. Stat. Ann. §§ 59-22-1 to -17 (1978). The purpose of the Guaranty Act is to provide a mechanism to facilitate the continuation of coverage, the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies and to provide an association to assess the cost of such protection among insurers.

N.M. Stat. Ann. § 59-22-2 (1978).

All insurers are required to be members of the Guaranty Association as a condition of their authority to transact insurance business in New Mexico. N.M. Stat. Ann. § 59-22-5 (1978).

7. *Id.* § 59-22-7.

8. For purposes of administration and assessment, the Guaranty Association maintains three accounts: the health insurance account, the life insurance account, and the annuity account. *Id.* § 59-22-5. For example, if an insurance company provides health insurance, it will participate in the health insurance account.

9. Members are liable for two kinds of assessments. Assessments to generate administrative funds are made of all member insurers in an amount determined by the board of directors of the Guaranty Association. *Id.* § 59-22-8. At the time of this case, each company had been assessed two times, for a total of $40. Record at 13. The Guaranty Association fulfills its obligation to policyholders of an insolvent insurance company by assessing companies participating in the same account as the insolvent insurer. For example, if the insolvent insurer is a health insurance company, only members who provide health insurance will be assessed. This litigation arose because an assessment of health insurance companies was anticipated. Record at 13.

10. New Mexico Blue Cross-Blue Shield, Inc. (Blue Cross) was also a defendant in the case. Blue Cross was a member of the Guaranty Association from its inception. Their purpose in joining this litigation was to discontinue their membership in the Guaranty Association. Record at 12-13. For that reason, the issues relating to Blue Cross are different from those concerning LBHP and Mastercare. Therefore, this Note will consider only LBHP and Mastercare.

11. N.M. Stat. Ann. §§ 59-19-1 to -48 (1978). The Act defines a health care plan as "a nonprofit corporation which is authorized by the superintendent of insurance to enter into contracts with subscribers and to make health care expense payments . . . ." *Id.* § 59-19-3. The purpose of the Nonprofit Health Care Plan Act is to "provide for the reasonable regulation of membership corporations organized for the purpose of making health care expense payments on a service benefit basis or on an indemnity benefit basis, or both, for persons who become subscribers under contracts with such corporations." *Id.* § 59-19-2. All health care plans are subject to the provisions of the Nonprofit Health Care Plan Act. *Id.* § 59-19-4(C).

This Act is not the first in New Mexico to regulate nonprofit health care plans. The

health maintenance organizations (HMOs).[12] HMOs are health care delivery systems in which the organization contracts with health care providers to render services to members of the organization. Members make periodic advance payments to guarantee the provision of basic health care services. The HMOs use the pre-payments, after deducting administrative and marketing costs, to pay the health care service providers.[13] Physicians and hospitals participating in both plans agree to accept their pro rata share of available funds as full payment and to take no recourse against subscribers to the plans.[14] Because of this agreement, if the HMO becomes insolvent, hospitals and physicians take the risk of sustaining a loss.

The Guaranty Association sought a declaratory judgment that defendants Blue Cross, LBHP, and Mastercare were subject to the Guaranty Act. The district court held that defendants did not provide any kind of insurance to which the Guaranty Act applies and therefore were not liable for assessments levied by the Guaranty Association.[15] On appeal, the New Mexico Supreme Court affirmed.[16]

ANALYSIS OF THE OPINION

The question presented in this case was whether nonprofit health care organizations are engaged in the business of providing health insurance, thereby subjecting them to the Guaranty Act. Neither the Guaranty Act nor the Insurance Code (of which the Guaranty Act is a part) offers an explicit definition of insurance.[17] In the absence of

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legislature in 1939 passed the Nonprofit Hospital Service Plans, 1939 N.M. Laws, ch. 66, and in 1947 enacted the Physicians Service Plan Act, 1947 N.M. Laws, ch. 157. Unlike the 1963 Act, both of these earlier Acts contained a blanket exemption from insurance laws for plans organized pursuant to them. Health care plans formed under these Acts were subject only to the insurance laws mentioned in the legislation. For example, the health care plans were required to submit financial reports to the Superintendent of Insurance and allow the Superintendent to examine the corporate records. 1939 N.M. Laws, ch. 66, §§ 601, 604, 605 (repealed 1959); 1947 N.M. Laws, ch. 157, §§ 3, 8, 9 (repealed 1963).

12. New Mexico Life Ins. Guar. Ass'n v. Moore, 93 N.M. 47, 596 P.2d 260 (1979).

13. Answer Brief of Appellees LBHP and Mastercare at 3, New Mexico Life Ins. Guar. Ass'n v. Moore, 93 N.M. 47, 596 P.2d 260 (1979).

14. *Id.*

15. Record at 90.

16. New Mexico Life Ins. Guar. Ass'n v. Moore, 93 N.M. 47, 596 P.2d 260 (1979).

17. The general Insurance Code defines insurance as "any form of insurance, bond or indemnity contract, the issuance of which is legal in the state of New Mexico." N.M. Stat. Ann. § 59-1-1 (1978). Although the Guaranty Act does not define insurance, its scope includes life and health insurance and annuity contracts. *Id.* § 59-22-3. The most illuminating definition in the Guaranty Act is that of a member insurer. A member insurer is "any person who: (1) writes any kind of insurance to which the Life Insurance Guaranty Act applies; and (2) is licensed to transact insurance in this state . . . ." *Id.* § 59-22-4(G).

a clear statutory definition, the court tried to determine whether the health care plans were providing health insurance within the meaning of the Guaranty Act.

Initially, the court considered various definitions of insurance.[18] This approach was not, however, dispositive of the issue.

The court also analyzed case law from other jurisdictions to determine if the New Mexico health care plans were insurance providers. In two landmark cases, *Jordan v. Group Health Association*[19] and *California Physicians' Service v. Garrison*[20], health care plans similar to LBHP and Mastercare were held not to be insurance providers. The New Mexico Supreme Court relied heavily on the reasoning of these two opinions in reaching their decision.[21]

In *Jordan v. Group Health Association,* the defendant health care provider was a nonprofit corporation organized to provide medical

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18. 93 N.M. at ____, 596 P.2d at 263. The court quoted Webster's Third New International Dictionary of the English Language 1173 (unabr. ed. 1976) which defines insurance as "[a] contract whereby for a stipulated consideration one party undertakes to indemnify or guarantee another against loss by a specified contingency or peril . . . ." The court next cited a definition of insurance from case law. According to Barkin v. Board of Optometry, 269 Cal. App. 2d 714, 75 Cal. Rptr. 337 (1969), insurance usually involves a contract whereby the insurer, for an adequate consideration, undertakes to indemnify the insured against loss arising from specified perils, or to reimburse him for all or part of an obligation he has incurred.

The court also considered the elements of an insurance contract as stated by the United States Supreme Court. They are "the spreading and underwriting of a policy holder's risk." Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

19. 107 F.2d 239 (D.C. Cir. 1939).

20. 28 Cal. 2d 790, 172 P.2d 4 (1946).

21. The New Mexico Supreme Court apparently did not find the reasoning in two cases relied upon by the Guaranty Association persuasive as no mention in the opinion is made of them. New Mexico Life Ins. Guar. Ass'n v. Moore 93 N.M. 47, ____, 596 P.2d 260, 264 (1979). In McCarty v. King County Medical Serv. Corp., 26 Wash. 2d 660, 175 P.2d 653 (1946), the Washington court distinguished an earlier case, Fishback v. Universal Serv. Agency, 87 Wash. 413, 151 P. 768 (1915), which had held that contracts similar to those in *McCarty* were not insurance contracts within the meaning of the statutory definition of insurance. The *McCarty* court, unlike the New Mexico court, was unpersuaded by *Jordan v. Group Health Ass'n* because of distinctions between the contracts they were considering and those in *Jordan.* The distinctions were that King County Medical Service Corporation was a charitable organization, not a consumer cooperative like the organization in *Jordan,* and that the Washington corporation maintained a right to determine the eligibility of employees to receive medical services, unlike the association in *Jordan.*

In the other case relied upon by the Guraranty Association, Cleveland Hosp. Serv. Ass'n. v. Ebright, 142 Ohio St. 51, 49 N.E.2d 929 (1943), the issue was whether a nonprofit hospital service corporation was liable for a franchise tax levied on domestic insurance companies. The Ohio court decided that the corporation was an insurance company within the meaning of the taxation statute but was not liable for the franchise tax because the statute under which the nonprofit health care corporations were organized exempted them from all provisions of insurance laws unless they were specifically included. Brief-in-Chief of Appellant New Mexico Life Insurance Guaranty Ass'n, New Mexico Life Ins. Guar. Ass'n v. Moore, 93 N.M. 47, 596 P.2d 260 (1979).

services and supplies to its members in return for monthly dues. Group Health Association provided these services by contracting with physicians and hospitals. The Court of Appeals for the District of Columbia found that the Association's primary concern, extending low-cost service to its members, made it more like a consumer cooperative than an insurance company, whose goal is to reduce the policyholders' risk of medical costs.[22]

The nonprofit health care corporation involved in *California Physicians' Service v. Garrison* was formed by physicians and surgeons to render low-cost medical care to low-income individuals. Each professional member agreed to accept as full compensation his pro rata share of the funds available for distribution. The California Supreme Court examined the plan as a whole to determine whether the principal object was to provide service or indemnity. The court found that the health care corporation was a service benefit organization and not an insurance provider.[23]

Although the New Mexico Supreme Court did not find these cases to be factually on point, the court was nevertheless persuaded by their reasoning because the plans in *Jordan* and in *California Physicians' Service* have several elements in common with LBHP and Mastercare.[24] First, the primary concern of all the plans is the procurement of medical services for members at costs lower than the traditional fee-for-service scheme.[25]

A second common characteristic is the periodic prepayments for services that members make under both plans. Periodic payments are not unique to nonprofit health care plans. Individuals who are insured by traditional insurers also make periodic payments. Those payments, however, constitute the consideration for which the insurance company agrees to indemnify the insured against medically related losses.[26] Payments made to a nonprofit health care corporation are for a substantially different purpose. After the costs of administration are deducted, the payments are used to compensate physicians and hospitals for services rendered to the plans'

22. 107 F.2d 239 (D.C. Cir. 1939).

23. 28 Cal. 2d 790, 172 P.2d 4 (1946).

24. 93 N.M. 47, 596 P.2d 260 (1979). The elements common to all the plans are their concern with obtaining low-cost medical care for their members, receiving from their members prepayments for services, and not assuming the members' risk of loss.

25. 107 F.2d 239, 247 (D.C. Cir. 1939); 28 Cal. 2d 790, ____, 172 P.2d 4, 16 (1946). A traditional fee-for-service scheme is one in which individuals pay physicians and hospitals directly for services.

26. *See* Barkin v. Board of Optometry, 269 Cal. App. 2d 714, ____, 75 Cal. Rptr. 337, 345 (1969).

subscribers.[27] If the amount available is insufficient to pay the total charges, the providers bear the loss.[28]

A third feature present in all the plans is that the risk of loss is not transferred to the health care organization, but instead is assumed by the individual health care provider.[29] In *California Physicians' Service,* the California Supreme Court considered an assumption of the members' risk to be an essential element in an insurance contract, an element it found lacking in the agreement between the California Physicians' Service and its members.[30] The New Mexico Supreme Court adopted the California Supreme Court's reasoning and decided that a similar absence of assumption of risk removed LBHP and Mastercare subscriber agreements from the realm of insurance.[31]

The New Mexico Supreme Court rejected the Guaranty Association's argument that because the health care plans are subject to some insurance laws, they are necessarily subject to the Guaranty Act. The court found that health care plans are not subject to insurance legislation unless they are specifically mentioned.[32] Because

27. Answer Brief of Appellees LBHP and Mastercare at 3.

28. Record at 21, 23.

29. *Id.*

30. 28 Cal. 2d 790, 172 P.2d 4 (1946).

31. 93 N.M. 47, 596 P.2d 260 (1979).

32. *Id.* Health care plans are specifically mentioned in the Insurance Company Insolvency Act, N.M. Stat. Ann. §§ 59-6-31 to -35 (1978), the Unfair Insurance Practices Act, *Id.* §§ 59-11-9 to -22, and the statute which taxes insurance premiums, *Id.* § 59-5-1(E). The Insolvency Act defines insurance companies as "all corporations, . . . [including] *nonprofit medical service corporations* . . . writing contracts of insurance . . ." in New Mexico. *Id.* § 59-6-32 (emphasis added). For purposes of the Unfair Insurance Practices Act, health care plans are deemed to be engaged in the business of insurance. *Id.* § 59-11-11. The statute which governs the payment of taxes on insurance premiums, provides that "notwithstanding the provisions of the Nonprofit Health Care Plan Act, [this statute] is applicable to nonprofit hospital service and indemnity plans and physicians service plans." *Id.* § 59-5-1(E).

Prior legislation governing physicians service plans and hospital service plans exempted such plans from Insurance Code regulations unless they were specificaly included. 1939 N.M. Laws, ch. 66, § 601 (repealed 1959); 1947 N.M. Laws, ch. 157, § 3 (repealed 1963). *See also* note 11 *supra.* In *New Mexico Life,* the Guaranty Association argued that the legislature intended that health care plans be subject to general insurance laws because of the absence of a blanket exemption for the plans in the Nonprofit Health Care Plan Act. The fact that the legislature chose to specifically include health care plans in the Insolvency Act, the Unfair Insurance Practices Act, and the insurance premium taxation statute mentioned above does not appear to support the Guaranty Association's argument.

A fact that further weakened the Guaranty Association's argument is that Chapter 59, Article 18, regulating accident and health insurance, and Article 19, the Nonprofit Health Care Plan Act, have been amended simultaneously and in substantially the same ways since 1969. *See* N.M. Stat. Ann. § 59-18-20 (1978) and § 59-19-49 (1978) (identical provisions) and § 59-18-23 (1978) and § 59-19-52 (1978) (substantially the same).

health care plans are not mentioned in the Guaranty Act,[33] they are not subject to it.

DISCUSSION

Henceforth in New Mexico, health care organizations which conform to the Nonprofit Health Care Plan Act will not be subject to insurance laws as a matter of course. This means that plans such as LBHP and Mastercare are not required to be members of, and hence are not subject to assessments made by, the Guaranty Association. The health care plans will thus be free to continue operating without having to raise subscriber rates to cover potential assessments.[34] The immediate consequence to the members of the Guaranty Association, however, will be a heavier finanical burden because the assessments will be spread over a smaller number of companies.[35]

The application of state insurance laws to HMOs could have presented obstacles to their development. Although such application might not prevent development of HMOs, the insurance law requirements may have prevented HMOs from operating economically and efficiently.[36] For example, the requirement that health care corporations maintain large reserves or become members of the Guaranty Association might have limited the financial flexibility of HMOs.[37]

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33. N.M. Stat. Ann. §§ 59-22-1 to -17 (1978). *See also* note 17 *supra.*

34. HMOs review the costs charged them by the health care providers with whom they have contracts at the end of each year. If a deficiency of available funds exists, the rates which subscribers must pay are adjusted upward for the coming year. Record at 20, 21, 23.

Even if health care plans had been required to be members of the Guaranty Association, it is doubtful that they would have benefitted from membership in the event of their insolvency. According to the Guaranty Association, "the Guaranty Act is not concerned with a health insurer's dealings with health care providers . . . . [A]n insolvent health plan might have outstanding liabilities to hospitals, physicians, or pharmacies, but the Guaranty Act would not require the Guaranty Association to satisfy those liabilities." Supplemental Brief of New Mexico Life Insurance Guaranty Association at 5, New Mexico Guar. Ass'n v. Moore, 93 N.M. 47, 596 P.2d 260 (1979). Therefore the main advantage in membership in the Guaranty Association, financial assistance in the event of insolvency, would not be enjoyed by health care plans.

35. The impact upon the Guaranty Association of the loss of these three health care organizations will be great. In New Mexico in 1976, Blue Cross ranked first (22.9%) in fees paid and premiums received by accident and health insurers and nonprofit health care organizations. Mastercare ranked sixth (3.0%) and LBHP ranked twenty-eighth (.5%). The company whose potential insolvency triggered this suit (Old Security Life Ins. Co.) ranked thirteenth (less than 2% of the total). Record at 107. *See* note 9 *supra.*

36. Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations,* 24 Stan. L. Rev. 644 (1972).

37. In New Mexico, in fact, maintenance of reserves is already regulated. As a condition of being authorized to transact business, health care plans are required to indemnify themselves.

Freeing HMOs from general insurance laws might have a positive affect on health care by reducing costs and raising quality. Rising medical costs are a national concern;[38] entities which strive to contain the cost of medical care should therefore be encouraged. Recent studies have suggested that enrollees of health maintenance organizations pay a lower total cost for premiums and out-of-pocket expenses than do people covered by conventional health insurance.[39] Although most of the cost differences are attributable to lower hospitalization costs,[40] HMOs can also reduce costs by competing with each other[41] and with fee-for-service practitioners. Competition between HMOs and the fee-for-service sector may in fact benefit not only HMO subscribers, but also policyholders of conventional insurers.[42]

Reducing the cost of medical care would not be desirable if the quality of care were diminished as well. The quality of HMO services seems uniformly high. Because services are extended to the patient for a fixed cost, physicians can practice preventive medicine.[43] HMOs, especially those which provide a clinic with physicians prac-

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They must make a trust deposit of securities having a market value of not less than $100,000. N.M. Stat. Ann. § 59-19-4(G) (1978). They are also required to maintain reserves in an amount which the superintendent of insurance deems adequate to cover liabilities. N.M. Stat. Ann. § 59-19-19 (1978).

38. Kennedy, *Preface: Public Concern and Federal Intervention in the Health Care Industry,* 70 Nw. U.L. Rev. 1 (1975).

39. Luft, *How Do Health Maintenance Organizations Achieve Their "Savings"? Rhetoric and Evidence,* 298 New Eng. J. Med. 1336 (1978).

40. *Id.* HMOs in a metropolitan area responded to competition by containing costs with reduced hospital usage and tighter regulation of physician behavior. It has been suggested that hospitals can reduce the prices which they charge HMOs because payments are not delayed and there are fewer unpaid bills. HMOs may also have a positive side effect on hospitals. By making contracts with HMOs, a hospital's occupancy may stabilize or even increase. Christianson & McClure, *Competition in the Delivery of Medical Care,* 301 New Eng. J. Med. 812 (1979).

41. Christianson & McClure, *supra* note 40, at 815.

42. Dorsey, *HMOs and the Cost of Medical Care,* 298 New Eng. J. Med. 1360 (1978). These benefits may be achieved in two ways—decreased hospitalization and organization of health care foundations by private physicians. A 1977 study found that hospitalization, and consequently health care cost, was substantially lower for Blue Cross subscribers in areas with well established HMOs. L. Goldberg & W. Greenberg, The Health Maintenance Organization and its Effects on Competition (1977). A health care foundation is a prepayment plan resembling health insurance sponsored by a medical society. Enrollees' prepayments entitle them to receive medical care from participating physicians, who bill the society on a fee-for-service basis. Sasuly & Hopkins, *A Medical Society-sponsored Comprehensive Medical Care Plan,* 5 Med. Care 234 (1967). An example of a private health care foundation is the San Joaquin Foundation for Medical Care which was created in anticipation of Kaiser Foundation Health Plan's expansion into San Joaquin County. Havighurst, *Health Maintenance Organizations and the Health Planners,* 1978 Utah L. Rev. 123, 133.

43. Kissam & Johnson, *HMOs and Federal Law: Toward a Theory of Limited Reformmongering,* 29 Vand. L. Rev. 1163, 1168 & n. 19 (1976). Practicing preventive medicine may be more costly, however, unless the savings achieved by preventing major medical expenses are greater than the cost of increased physician visits.

ticing a variety of specialties, have the opportunity to provide an integrated approach to health care.[44]

Offering low-cost, high-quality medical care may not be enough to insure the success of an HMO. HMO subscribers surveyed indicated that they particularly liked the following features of their plan: moderate cost, accessibility to care at times of acute need, and the physician-patient relationship.[45] These three factors would seem to be among the most important ones comprising a satisfactory health care delivery system.

CONCLUSION

In *New Mexico Life,* the New Mexico Supreme Court decided that if legislation is intended to regulate nonprofit health care plans, it must specifically refer to those plans. Because no mention of nonprofit health care plans is made in the Guaranty Act, the court held that the plans are not subject to that legislation. Therefore the nonprofit health care plans will not be required to contribute funds to the Guaranty Association to be used to pay contractual obligations of insolvent insurance companies.

The decision in *New Mexico Life* supports the continued development of alternative means of dealing with rising health care costs. The supreme court's refusal to subject nonprofit health care plans to the constraints of insurance legislation from which the plans will receive no benefit has the potential to encourage the development of HMOs in New Mexico. Development of these organizations may benefit consumers by increasing the availability of low-cost, high-quality health care.

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44. This can overcome the lack of coordination in treatment which can result when an individual visits a different physician for each ailment.

45. Pope, *Consumer Satisfaction in a Health Maintenance Organization,* 19 J. Health & Soc. Behav. 291 (1978). Satisfaction levels were highest for current subscribers who had a regular doctor in the program, were older, and lived in a family which rated its health as excellent. Those who had discontinued their memberships because of dissatisfaction were those who had lived in the area longer, did not have a regular doctor in the program, and lived in families who rated their health as less than excellent. Of those surveyed who had recently terminated their memberships, approximately two-thirds did so because the plan was no longer offered through their employer or they had moved out of the area. Only 7.7% terminated for dissatisfaction.