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The Impact of Michigan's Health Maintenance Organization Act

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LEGISLATIVE NOTE:

THE IMPACT OF MICHIGAN'S HEALTH MAINTENANCE ORGANIZATION ACT

Growing dissatisfaction with the shortcomings of the traditional system of health care[1] has led to renewed interest in the Health Maintenance Organization (HMO)[2] concept in recent years.[3] Although some HMO's

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[1] Current literature is replete with commentary on the problems associated with the traditional system of health care. *See, e.g.*, Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644, 646 (1972), where the problems are addressed in these terms:

> First, medical care costs have escalated rapidly. . . . Second, . . . the overall quality of care dispensed by the present system appears . . . to be lower than expected. Moreover, there seems to be considerable variation in the quality of care provided by different institutions and . . . individual practitioners. Third, a disproportionately low number of health care resources are available to people living in rural areas or to the poor regardless of where they live. Fourth, the actual medical care production process is relatively inefficient for a number of reasons [including the facts that] the present health insurance system emphasizes acute, hospitalized, and high-cost care at the expense of ambulatory, preventive and chronic care; and no single entity is responsible for the continuous care of consumers, significantly reducing the coordination between different units which deliver care, with consequent inefficiencies in production. Fifth, the present diffusion of continuing responsibility for medical care and the fact that consumers must enter the system with relatively little knowledge has made it difficult for many consumers to gain access to the present system. Finally, the current specialty distribution of physicians with its steadily decreasing proportion of primary care physicians . . . further complicates the access problem by making it difficult for consumers both to find a point at which to enter the system and to locate treatment for common and/or chronic ailments.

See also Faltermayer, *Better Care at Less Cost Without Miracles*, FORTUNE, Jan., 1970, at 80; Feldstein, *The Medical Economy*, 229 SCI. AM., Sept., 1973, at 151; *Health Services for All*, 152 CURRENT 32 (1973).

[2] Basically, an HMO is an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of an agreed upon set of comprehensive health maintenance services to a voluntarily enrolled group of persons in a geographic area, and is reimbursed through a fixed or per capita prepaid sum made by or on behalf of each person or family unit enrolled in the plan. An HMO differs from a Blue Cross insurance plan in that it delivers health care services rather than merely reimbursing a subscriber if he can find them on his own. For an example, see MICH. COMP. LAWS ANN. §§ 325.904(2), (3) (1975).

[3] Experience has shown that prepaid plans such as HMO's can provide high-quality health care efficiently and at reduced costs. Greenberg & Rodburg, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 921-23, 933 (1971). The most successful plan, Kaiser-Permanente based in Oakland,

have been operating in the United States for over forty years,[4] conditions have been less than favorable to their growth and development. Major obstacles have been opposition from the medical profession,[5] lack of public understanding about the nature and function of HMO's,[6] and state laws restricting or prohibiting the establishment of HMO's.[7] In order to create a more favorable legal climate and encourage HMO development, a number of states, including Michigan, have recently enacted laws to provide for the establishment, regulation, and licensing of HMO's.[8] The effect of these new laws is not yet clear but an analysis of the statutory provisions enables one to predict what that effect might be. This article undertakes an analysis of the Michigan Health Maintenance Organization Act of 1974,[9] discussing the problems antedating enactment and evaluating the provisions of the Act which address those problems.

California, has supplied care at a substantial savings over the traditional delivery system. Medical expenses for enrollees of this plan went up only 19.1 percent between 1960 and 1965, while they rose 43.5 percent in the nation as a whole. A. SOMERS, HEALTH CARE IN TRANSITION: DIRECTIONS FOR THE FUTURE 114-15 (1971). *See also One Stop Health Care,* U.S. NEWS & WORLD REP., May 21, 1973, at 54.

Interest in HMO's has been nurtured by the expectation that the advantages of HMO's will, by increasing competition in the delivery of health care, improve the overall efficiency of health care in the United States. Havighurst, *HMO's and the Market for Health Services,* 35 LAW & CONTEMP. PROB. 716 (1970). For a more detailed statement of the advantages of HMO's, see Holley & Carlson, *supra* note 1, at 649-53.

[4] The first HMO in the United States was organized by a farmers' union in Elk City, Oklahoma, in 1929. Statement of Donald C. Smith, M.D., Governor's Principal Advisor on Health and Medical Affairs 1, in *Public Hearing on Health Maintenance Organizations Before the Senate Comm. on Health and Social Services and the House Comm. on Public Health,* 77th Mich. Leg., Reg. Sess. (1973) [hereinafter cited as *1973 Public Hearing*]. The best-known HMO, Kaiser-Permanante, was established in 1933. *HMO's: Are They the Answer to Your Medical Needs?,* 39 CONSUMER REP. 756 (1974).

[5] *HMO's: Are They the Answer to Your Medical Needs?,* 39 CONSUMER REP. 756 (1974).

[6] Rothfeld, *Sensible Surgery for Swelling Medical Costs,* FORTUNE, April, 1973, at 110, 111.

[7] *See generally* Holley & Carlson, *supra* note 1, at 653-62.

[8] Legislation evidencing an express design to authorize and regulate the formation and operation of HMO's has been enacted in seventeen states to date. Seven of these states enacted this legislation in 1974. IDAHO CODE § 41-3901 *et seq.* (Supp. 1975); ILL. REV. STAT. ch. 111 1/2, § 1401 *et seq.* (Smith-Hurd Cum. Supp. 1975-76); ch. 181, [1974] KAN. LAWS 605; KY. REV. STAT. ANN. § 304.38-010 (Cum. Supp. 1974); MICH. COMP. LAWS ANN. § 325.901 *et seq.* (1975); S.C. CODE ANN. § 37-1131 *et seq.* (Cum. Supp. 1974); S.D. COMPILED LAWS ANN. § 58-41-1 *et seq.* (Supp. 1974).

Likewise, seven states enacted such a law in 1973. ARIZ. REV. STAT. ANN. § 20-1051 *et seq.* (Supp. 1973-74); COLO. REV. STAT. ANN. § 10-17-101 *et seq.* (1974); IOWA CODE ANN. § 514B.1 *et seq.* (Cum. Pamphlet 1975-76); MINN. STAT. ANN. § 62D-01 *et seq.* (Cum. Supp. 1975-76); NEV. REV. STAT. § 695C.010 *et seq.* (1973); N.J. STAT. ANN. § 26:2J-1 *et seq.* (Supp. 1975-76); UTAH CODE ANN. § 31-42-1 *et seq.* (1974).

Two states enacted their provisions in 1972. FLA. STAT. ANN. § 641.17 *et seq.* (1974); PA. STAT. ANN. tit. 40, § 1551 *et seq.* (Supp. 1975-76).

Tennessee has had this legislation since 1971. TENN. CODE ANN. § 56-4101 *et seq.* (Cum. Supp. 1974).

[9] MICH. COMP. LAWS ANN. § 325.901 *et seq.* (1975).

I. PURPOSE AND PROVISIONS OF THE MICHIGAN HEALTH MAINTENANCE ORGANIZATION ACT

Prior to the enactment of the Health Maintenance Organization Act of 1974, the legal status of HMO's in Michigan was uncertain. No state law specifically authorized the creation and operation of HMO's. In the absence of such legislation, HMO's were incorporated under the Michigan Blue Cross-Blue Shield Acts,[10] although these provisions were not drafted with the regulation of comprehensive health care delivery systems in mind.[11] A number of restrictive state statutes plagued HMO's,[12] and it was not clear which state agencies had authority over them.[13] As a result, the growth and development of HMO's were hampered,[14] and the public was inadequately protected from misrepresentation and improper care.[15] Recognizing the necessity for specific licensing and regulation provisions that would clarify the legal options and limitations of HMO's, Michigan lawmakers gave this Act their vote of approval.[16]

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[10] MICH. COMP. LAWS ANN. § 550.301 *et seq.*, § 550.501 *et seq.* (1967).

[11] *See* Statement of Daniel J. Demlow, Insurance Bureau 1, in *Public Hearing on Health Maintenance Organizations Before the Senate Comm. on Health and Social Services and the House Comm. on Public Health*, 77th Mich. Leg., Reg. Sess. (1974) [hereinafter cited as *1974 Public Hearing*].

[12] *See, e.g.*, Medical Care Corporations Act, MICH. COMP. LAWS ANN. § 550.301 *et seq.* (1967) (required each HMO to obtain approval of a majority of its directors by the officers of the organized medical profession, to allow any physician to participate, and to submit to insurance-type regulations; also prohibited was the nonprofit corporate practice of medicine except as provided in the Act); Hospital Service Corporation Act, MICH. COMP. LAWS ANN. § 550.501 *et seq.* (1967) (required HMO's to submit to insurance-type regulations and to include representatives of the general public in its governing body; also prohibited the corporate practice of medicine); Professional Service Corporation Act, MICH. COMP. LAWS ANN. § 450.221 *et seq.* (1973); Dental Care Corporation Act, MICH. COMP. LAWS ANN. § 550.351 *et seq.* (1967) (required HMO's to submit to insurance-type regulations and to include representatives of the general public in their governing boards).

[13] Letter from John T. Dempsey, Michigan Department of Management and Budget, to Governor Milliken, Dec. 26, 1973 (on file with the *University of Michigan Journal of Law Reform*) where, at 2, it is stated:

> At the state level, the Insurance Bureau and the Department of Social Services and Public Health are currently overseeing HMO operations. Their respective functions and limits of authority are unclear. The situation has become so serious that one HMO had considered litigation against the state for failure to grant a full operating certificate.

[14] MICH. S. JOUR. No. 100, at 1650 (Oct. 24, 1973), where, in a special message to the legislature, the Governor said, "[HMO] progress has been hindered by the lack of concrete State action."

[15] TECHNICAL WORK GROUP ON HMO'S, MICHIGAN OFFICE OF COMPREHENSIVE HEALTH PLANNING, PRELIMINARY REPORT ON HMO'S 2 (1972) (on file with the *University of Michigan Journal of Law Reform*).

[16] The seeds of the Michigan Health Maintenance Organization Act were sown in 1971 in a special message to the legislature submitted by Governor Milliken wherein he directed the Office of Health and Medical Affairs and the Director of the Department of Public Health to develop a state program for health care "including the design and encouragement of a health maintenance strategy and action plan." MICH. H.R. JOUR. No. 61, at 1238, 1240 (May 19, 1971). Under the Governor's direction a Technical Work Group was created, which developed a legislative pro-

The Act gives the Director of the Department of Public Health and the Commissioner of the Insurance Bureau the responsibility to develop a system of licensing and regulation which will promote the delivery of high quality health care by financially sound and efficient organizations.[17] The Act also establishes the State Health Maintenance Organization Commission, composed of consumers and providers of HMO services,[18] which has the authority to review and control rules and decisions made under the Act.[19]

Before any HMO may enter into a health maintenance contract, it must be licensed by the Director of the Department of Public Health.[20] The services which an HMO must provide in order to receive a license are defined in detail.[21] To qualify for an initial three-year license,[22] an HMO must provide, as a minimum, six services deemed to be "primary health maintenance services."[23] These services must be expanded to include

posal providing for the establishment and regulation of health care delivery organizations. TECHNICAL WORK GROUP ON HMO'S, MICHIGAN OFFICE OF COMPREHENSIVE HEALTH PLANNING, PRELIMINARY REPORT ON HMO'S 2 (1972). As a result of its recommendations, S. 1000, providing for the establishment, regulation, and licensing of HMO's, was introduced. MICH. S. JOUR. NO. 113, at 1882 (Nov. 15, 1973). On December 10, 1973, and January 30, 1974, public hearings on HMO's were held before the House and Senate health committees. *1973 Public Hearing, supra* note 4; *1974 Public Hearing, supra* note 9. After these hearings, the Senate Committee on Health and Social Services recommended to the Senate that a substitute bill be enacted. MICH. S. JOUR. No. 48, at 605 (April 3, 1974). After a number of amendments were made, the substitute bill was given unanimous support by the Senate. MICH. S. JOUR. NO. 60, at 823 (May 2, 1974). On July 2, 1974, the House committee unanimously passed a substitute bill of its own. MICH. H.R. JOUR. No. 100, at 2510 (July 10, 1974). This House committee substitute was then approved by the House, MICH. H.R. JOUR. No. 102, at 2604 (July 12, 1974), concurred in by the Senate, MICH. S. JOUR. No. 99, at 1568 (July 13, 1974), signed by the Governor on August 7, 1974, MICH. S. JOUR. No. 100, at 1626 (Sept. 17, 1974), and enacted as the Health Maintenance Organization Act on January 1, 1975. MICH. COMP. LAWS ANN. § 325.947 (1975).

[17] MICH. COMP. LAWS ANN. § 325.910(1) (1975). The Director of the Department of Public Health is in charge of regulating the health care delivery aspects, while the Commissioner of Insurance regulates the business and financial aspects of HMO operations. MICH. COMP. LAWS ANN. §§ 325.910(2), (3) (1975).

[18] MICH. COMP. LAWS ANN. § 325.907 (1975).

[19] MICH. COMP. LAWS ANN. § 325.908 (1975). It is provided, *inter alia,* that this Commission *shall* review licenses suspended, denied, limited, or revoked under this Act. The Commission *may* also review licenses granted or renewed. The decisions of the Commission made, following such a review, are binding on the Director and the Commissioner.

[20] MICH. COMP. LAWS ANN. § 325.911 (1975).

[21] *See* MICH. COMP. LAWS ANN. § 325.912(d) (1975).

[22] MICH. COMP. LAWS ANN. § 325.914 (1975) declares that the initial license issued to an HMO shall continue in force for a period of three years after the date of issuance.

[23] MICH. COMP. LAWS ANN. § 325.912(d) (1975). Those services which must be provided to receive the initial license include (a) physician services including consultant and referral services, but not including psychiatric services; (b) ambulatory services; (c) inpatient and outpatient hospital services, other than those for the treatment of mental illness; (d) emergency health services; (e) diagnostic laboratory and diagnostic and therapeutic radiologic services; and (f) preventive health services. MICH. COMP. LAWS ANN. § 325.905(4) (1975).

certain "basic health services"[24] in order for an HMO to obtain a three-year renewal.[25] In addition, an HMO must offer the option of "supplemental health services"[26] to its subscribers within three years of issuance of the initial license, unless a waiver is granted by the Director.[27] Issuance or renewal of a license is also dependent upon an HMO's demonstration to the authorities that the HMO is financially sound,[28] that its proposed contracts and rates are reasonable and nondiscriminatory,[29] that solicitation of enrollment subscriptions will not work a fraud upon the persons solicited,[30] that the HMO has adequate arrangements for continuing evaluation of the quality of health care it provides,[31] that there is a reasonable procedure for resolving enrollee grievances,[32] and that there are satisfactory provisions for emergency and out-of-area health maintenance services for enrollees.[33]

The Act also provides for the continuing regulation of HMO's. Investment activities are monitored; an HMO is allowed to invest its assets only within the constraints presently applicable to insurance companies.[34] If during the period of its initial license or provisional renewal an HMO is not providing "basic health services,"[35] it must use any earned surplus solely to improve operations or increase benefits for enrollees.[36] HMO's are required to make an annual report to the Director of the Department of Public Health.[37] A summary of the report, excluding confidential records regarding malpractice claims, must be sent to all subscribers.[38]

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[24] MICH. COMP. LAWS ANN. § 325.912(d) (1975). In addition to the components of "primary" services listed in note 23 *supra*, "basic health services" include short-term (defined as twenty visits or fewer) outpatient mental health services and home health services. MICH. COMP. LAWS ANN. § 325.903(2) (1975).

[25] MICH. COMP. LAWS ANN. § 325.914 (1975). However, if an HMO is temporarily unable to supply the "basic health services" and its services are needed in the community, it may be issued a two-year provisional renewal. MICH. COMP. LAWS ANN. § 325.915 (1975).

[26] MICH. COMP. LAWS ANN. § 325.912(d) (1975). Supplemental health services include (a) services of licensed facilities for intermediate and long-term care; (b) vision care, including optometric services; (c) dental services; (d) mental health services not included in the basic health services; (e) long-term physical medicine and rehabilitative services including physical therapy; (f) clinical pharmacy services or prescription drugs prescribed in the course of the provision of a primary, basic, or supplemental health service; and (g) chiropractic services. MICH. COMP. LAWS ANN. § 325.906(2) (1975).

[27] MICH. COMP. LAWS ANN. § 325.912(d) (1975). *See* text accompanying note 66 *infra*.

[28] MICH. COMP. LAWS ANN. § 325.912(a) (1975).

[29] MICH. COMP. LAWS ANN. § 325.912(b) (1975).

[30] MICH. COMP. LAWS ANN. § 325.912(c) (1975). *See also* MICH. COMP. LAWS ANN. §§ 325.923, 325.924 (1975).

[31] MICH. COMP. LAWS ANN. § 325.912(h) (1975).

[32] MICH. COMP. LAWS ANN. § 325.912(j) (1975). *See also* MICH. COMP. LAWS ANN. § 325.927 (1975).

[33] MICH. COMP. LAWS ANN. § 325.912(i) (1975).

[34] MICH. COMP. LAWS ANN. § 325.921 (1975). *See also* MICH. COMP. LAWS ANN. §§ 500.901-500.947 (1967).

[35] *See* note 24 *supra*.

[36] MICH. COMP. LAWS ANN. § 325.922 (1975).

[37] MICH. COMP. LAWS ANN. § 325.938 (1975). This report must include a detailed financial statement, a summary of complaints handled, the number of subscribers enrolled and terminated, and such other information as the Director may require.

[38] MICH. COMP. LAWS ANN. § 325.939 (1975).

Another significant requirement imposed by the Act is mandatory open enrollment. After the initial twenty-four months of operation, and annually thereafter, an HMO must establish a thirty-day period during which it will accept, up to its capacity, any individuals in the order in which they apply.[39] However, if the HMO provides services to a group, any member of that group not presently covered may be accepted before nonmember applicants.[40]

The Act also mandates enrollee policymaking participation[41] and dual choice.[42] To satisfy the enrollee participation requirement, at least one-third of the governing board of an HMO must consist of subscribers of the HMO who are not compensated officers, employees, stockholders who own more than 5 percent of the shares of the HMO, or other persons responsible for the conduct of, or financially interested in, the HMO's affairs.[43] Dual choice is ensured by requiring any employer who is covered by a state or federal minimum wage law and who employs twenty-five or more employees to include in any health benefits plan offered to its employees the option of membership in a licensed HMO which provides "basic health services,"[44] if such an HMO is located in the employer's geographic area.[45]

The Michigan Act makes certain restrictive laws inapplicable[46] and expressly grants licensed HMO's the authority to contract with subscribers[47]

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[39] MICH. COMP. LAWS ANN. § 325.928(1) (1975). If this requirement will jeopardize an HMO's financial stability or its ability to comply with the requirements for license renewal enumerated in MICH. COMP. LAWS ANN. § 325.912 (1975), the Commissioner of Insurance may waive the requirement for up to three years. MICH. COMP. LAWS ANN. § 325.928(1) (1975).

[40] MICH. COMP. LAWS ANN. § 325.928(2) (1975).

[41] *See* MICH. COMP. LAWS ANN. § 325.933 (1975).

[42] *See* MICH. COMP. LAWS ANN. § 325.943 (1975). *See* part II *M infra*. If an employer subject to the Act provides health benefits for his employees, the dual choice requirement forces that employer to offer those employees access to available HMO services as well. *See* note 45 and accompanying text *infra*.

[43] MICH. COMP. LAWS ANN. § 325.933 (1975).

[44] *See* note 24 *supra*.

[45] MICH. COMP. LAWS ANN. § 325.943(1) (1975).

[46] *See* MICH. COMP. LAWS ANN. § 325.931 (1975). Laws made inapplicable to HMO's include Medical Care Corporations Act, MICH. COMP. LAWS ANN. § 550.301 *et seq.* (1967) (required each HMO to obtain the approval of a majority of its directors by the officers of the organized medical profession, to allow any physician to participate, and to submit to insurance-type regulations; also prohibited was the nonprofit corporate practice of medicine except as provided in the Act); Hospital Service Corporation Act, MICH. COMP. LAWS ANN. § 550.501 *et seq.* (1967) (required HMO's to submit to insurance-type regulations and to include representatives of the general public in its governing body; also prohibited the corporate practice of medicine); Professional Service Corporation Act, MICH. COMP. LAWS ANN. § 450.221 *et seq.* (1973); Dental Care Corporation Act, MICH. COMP. LAWS ANN. § 550.351 *et seq.* (1967) (required HMO's to submit to insurance-type regulations and to include representatives of the general public on its governing body). The Act also provides that solicitation of enrollees or advertising of the services, charges, or other nonprofessional aspects of an HMO is not a violation of laws relating to solicitation or advertising by health professionals. MICH. COMP. LAWS ANN. § 325.924 (1975).

[47] MICH. COMP. LAWS ANN. § 325.918(1) (1975). "Subscriber" means an individual who has entered into a health maintenance contract, or on whose behalf a health maintenance contract is entered into with a health maintenance organization licensed

and affiliated providers.[48] If the Director of the Department of Public Health determines that an HMO is not operating in compliance with the Act or rules promulgated pursuant to it, or is not providing the required health care, he may, after proper notice, suspend, deny, limit, or revoke the HMO's license.[49] He is further empowered to liquidate[50] or order a receivership[51] of an HMO that is financially unsound.

II. Implications of the Health Maintenance Organization Act

The provisions of the Act designed to facilitate the rational development of HMO's in Michigan having been outlined,[52] the remainder of this article examines these provisions in light of important policy considerations and evaluates the potential of the Act for solving the problems to which it is addressed.

A. Eligibility of Sponsors

One aspect of an HMO which distinguishes it from other methods of providing health care services is that it assumes contractual responsibility for delivering specified medical services to enrollees.[53] The Michigan Health Maintenance Organization Act permits an HMO to satisfy this obligation either directly or by means of contractual arrangements with third parties.[54] Accordingly, an HMO need not have the direct capability to deliver agreed-upon services, but can engage subcontractors to deliver those services. That being the case, HMO sponsorship is open to those who have had no experience in the delivery of health care. An important issue thus raised is whether it would be desirable to restrict sponsorship of HMO's to those who have proven to be responsible health care providers in the past.

The approach of the Michigan Act, not to restrict the sponsorship of HMO's to any particular group,[55] is to be commended. This "open-door"

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under this Act and to whom evidence of coverage is issued. MICH. COMP. LAWS ANN. § 325.907(1) (1975).

[48] MICH. COMP. LAWS ANN. § 325.918(3) (1975). "Affiliated provider" means a health professional licensed or certified to practice by the state, licensed hospital, licensed pharmacy, or any other institution, organization, or person who or which has contracted in writing with a health maintenance organization to look solely to the organization under the terms of the contract for payment for a health maintenance service rendered to an enrollee.

[49] MICH. COMP. LAWS ANN. § 325.936 (1975).

[50] MICH. COMP. LAWS ANN. § 325.917 (1975).

[51] MICH. COMP. LAWS ANN. § 325.937 (1975).

[52] *See* part I *supra*.

[53] *See* note 2 *supra*.

[54] MICH. COMP. LAWS ANN. § 325.904(3)(a) (1975), which defines an HMO as an entity which "delivers health maintenance services to enrollees . . . directly or through arrangements with affiliated providers."

[55] The Act provides that an HMO is a "legal entity." MICH. COMP. LAWS ANN. § 325.904(3) (1975). "Legal entity" means an individual, partnership, domestic or foreign corporation registered under the laws of Michigan, or a cooperative, association, government, or governmental subdivision or agency, or an operation or activity carried on by any of the above which: (1) is financially separate and independent of any other operation or activity carried on by that same entity; and (2) has a separate and independent policymaking body which is granted unrestricted authority to

policy engenders the development of HMO's of varied characteristics whose unique experiences may point the way to better health care delivery, a result consistent with the state policy of improving health-care services and practices.[56]

B. Minimum Benefits

"Ideally, the HMO concept calls for a comprehensive range of health services."[57] To constitute an improvement over the traditional system of health care, the HMO must provide enough benefits to increase the accessibility of medical services to consumers at lower out-of-pocket cost.[58] The services which could be provided by an HMO are numerous, but providing broad-ranging services requires extensive financing, a fact which in the past has prohibited delivery of the total range of services.[59] Consideration must be given, therefore, to the range of benefits that should be required.

Under the Act, the services an HMO is required to deliver depend upon how long it has been in existence.[60] Initially, an HMO is required to provide substantially more than the "irreducible minimum"[61] of services.[62] At a later date an HMO is required to expand the scope of services which it delivers,[63] and ultimately it must deliver "comprehensive"[64] services.[65] However, if an HMO satisfactorily demonstrates either that compliance with the requirements of the final phase of this process would tend to

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determine policies and procedures of that operation or activity. MICH. COMP. LAWS ANN. § 325.905(1) (1975). Such a policymaking body is deemed to be a governing body for the purposes of the Act. MICH. COMP. LAWS ANN. § 325.905(1) (1975).

[56] *See* MICH. H.R. JOUR. NO. 61, at 1238, 1239 (May 19, 1971), where, in a special message to the legislature on health care, the Governor said, "I call upon all Michigan residents . . . to join with the state government as we seek to improve our health-care services and practices."

[57] Statement of Donald C. Smith, M.D., in *1973 Public Hearing, supra* note 4, at 2.

[58] S. CRANE & T. DWYER, ISSUES IN HMO STATE LEGISLATION: AN OVERVIEW 5 (Health Manpower Policy Discussion Paper Series No. B.4, 1974) (on file with the *University of Michigan Journal of Law Reform).*

[59] Statement of Donald C. Smith, M.D., in *1973 Public Hearing, supra* note 4, at 2.

[60] *See* text accompanying notes 21-27 *supra.*

[61] This phrase was coined by S. CRANE & T. DWYER, *supra* note 58, at 5.

> Experience and practice have taught . . . that to achieve benefits from reduction in hospital utilizations and to provide for the majority of usual health care and health maintenance needs of an individual, the following three categories of care represent an irreducible minimum for inclusion if the organization is to meet the basic criteria of an HMO: 1. Inpatient hospital and physician care[,] 2. Outpatient physician care[, and] 3. Emergency care[.]

Id.

[62] *See* text accompanying notes 22-23 *supra.*

[63] *See* text accompanying notes 24-25 *supra.*

[64] Statement of Donald C. Smith, M.D., in *1973 Public Hearing, supra* note 4, at 2.

> The term 'comprehensive' is often characterized by the following types of services: preventive care; inpatient hospital care; inpatient and ambulatory physician care; emergency care; dental care; psychiatric care; provision of pharmaceutical drugs; vision and hearing care; home health care; education; nursing home and extended care; and other rehabilitative services.

Id.

[65] *See* text accompanying notes 24-27 *supra.*

jeopardize the financial stability of the HMO, or that manpower or other resources necessary to provide comprehensive services are not available in the area served by the HMO, or that the additional services would not be used by enough subscribers to justify their provision, the requirements of this final phase will be waived.[66]

These provisions appear satisfactory but closer analysis reveals several deficiencies. First, substantially more services than the "irreducible minimum" are required in the start-up phase.[67] Second, the waiver provisions apply only to the final stage in the development of an HMO.[68] These two aspects of the Act combine to impose initial costs significant enough to threaten the very existence of a fledgling HMO.[69] This economic hurdle may discourage attempts to establish HMO's.[70] A more satisfactory balance might be achieved in one of two ways. The requirements of the first stage of HMO development could have been limited to the "irreducible minimum," with increases in required deliveries indexed to the capability of an HMO to supply, and the desire of its enrollees to receive, those services. Alternatively, the waiver provision could have been made available to an HMO during all phases of its development. The adoption of either of these alternatives would have better fostered the development of alternative systems of health care delivery.

C. Profit and Nonprofit Operation

The Michigan Act authorizes both for-profit and not-for-profit HMO's.[71] This was one of the most thoroughly debated issues during the drafting of HMO-enabling legislation.[72] On one side of the debate are those who favor the exclusion of for-profit HMO's.

> Those who favor exclusion of for-profit HMO[']s argue that: for-profit HMO[']s may sacrifice quality of care by overeconomizing and providing only "money-making" services; for-profit HMO[']s may skim off low-risk patients and locate in more affluent communities; because of their capital assets, profit-making HMO[']s would have an unfair advantage over not-for-profit HMO[']s in competing for manpower and facilities.[73]

On the other side of the debate, those who advocate the simultaneous existence of both for-profit and not-for-profit HMO's argue that:

> [P]roperly regulated, for-profit HMO[']s would stimulate competition, resulting in controlled costs and improved quality of care; for-profit organizations are usually in a better position to provide needed capital, as well as organization and management skills;

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[66] MICH. COMP. LAWS ANN. § 325.912(d) (1975). Such waiver may be granted for a period which the Director and Commissioner prescribe.

[67] *See* notes 22-23 and accompanying text *supra*.

[68] *See* note 66 and accompanying text *supra*.

[69] *See* S. CRANE & T. DWYER, *supra* note 58, at 5.

[70] *Id.*

[71] MICH. COMP. LAWS ANN. § 325.904(3) (1975).

[72] *See* R. HOLLEY & S. GROSSMAN, A BOOM YEAR FOR STATE HMO ENABLING LEGISLATION 5 (1973).

[73] Statement of Donald C. Smith, M.D., in *1973 Public Hearing*, *supra* note 4, at 7.

> for-profit organizations generally operate more efficiently than not-for-profit organizations, which is important to cost control; the threat of overeconomization—often attributed to for-profit organizations—applies to all HMO[']s, regardless of form; there is no real difference between "profits" and "operating surpluses."[74]

No data which would substantiate the claims of either the opponents or proponents of profit-oriented HMO's exists. Michigan's approach will be useful at least as an opportunity for experimentation with both types of organizations.

D. Consumer Participation

While there is general agreement that consumers should be involved in HMO decisionmaking, suggestions regarding the degree of that involvement range from mandating complete consumer control of boards of directors to allowing minimal consumer participation in HMO management.[75] A state has the option to merely permit consumer participation or to adopt affirmative measures which assure participation.[76] Michigan has exercised the latter option by requiring that one-third of the governing board of an HMO be composed of enrollees.[77] This approach could be very costly, especially for fledgling HMO's, because as more people become involved in management decisions the efficiency and professional effectiveness of the delivery of medical services could be hindered.[78] The Michigan approach seems unduly restrictive and may not be flexible enough to encourage HMO development as an alternative method of health care delivery. A more promising approach would be to limit consumer participation at first and increase such participation as the HMO develops. In this way, HMO's will have a better chance to become firmly established and enrollees will have an opportunity to become more familiar with the functioning of HMO's before being thrust into positions of responsibility. Both of these factors could contribute to more effective consumer input as the HMO develops.

E. Regulation of HMO's

Most states with HMO laws have allocated regulatory responsibilities among two or more authorities.[79] The two agencies most often considered

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[74] *Id.* at 6, 7.

[75] *Id.* at 4.

[76] *Id.*

[77] *See* text accompanying notes 41 and 43 *supra.*

[78] Statement of Donald C. Smith, M.D., in *1973 Public Hearing, supra* note 4, at 5.

[79] Thirteen of the seventeen states having HMO-enabling legislation divide regulatory functions among two or more authorities. COLO. REV. STAT. ANN. § 10-17-101 *et seq.* (1974); FLA. STAT. ANN. § 641.17 *et seq.* (1974); ILL. REV. STAT. ch. 111 1/2, § 1401 *et seq.* (Smith-Hurd Cum. Supp. 1975-76); IOWA CODE ANN. § 514B.1 *et seq.* (Cum. Pamphlet 1975-76); MICH. COMP. LAWS ANN. § 325.901 *et seq.* (1975); MINN. STAT. ANN. § 62D-01 *et seq.* (Cum. Supp. 1975-76); NEV. REV. STAT. § 695C.010 *et seq.* (1973); N.J. STAT. ANN. § 26:2J-1 *et seq.* (Supp. 1975-76); PA. STAT. ANN. tit. 40, § 1551 *et seq.* (Supp. 1975-76); S.C. CODE ANN. § 37-1131 *et seq.* (Cum. Supp. 1974); S.D. COMPILED LAWS ANN. § 58-41-1 *et seq.* (Supp. 1974); TENN. CODE ANN. § 56-4101 *et seq.* (Cum. Supp. 1974); UTAH CODE ANN. § 31-42-1 *et seq.* (1974).

appropriate for the job are state departments of public health and insurance commissions.[80] Those who advocate placing the responsibility on departments of public health suggest that the most crucial aspect of HMO regulation is health care delivery,[81] while those who prefer the insurance commission approach emphasize the need for effective regulation of financial affairs.[82] The fact that public health departments usually represent traditional medical interests, however, may lead to undue restraints on HMO's.[83] On the other hand, the fact that insurance commissions typically impose strict financial standards could prove to be detrimental to the early stages of HMO development.[84] The Michigan Act delegates regulatory functions to two administrators.[85] Although the HMO Commission has certain powers,[86] the Insurance Commissioner and the Director of the Department of Public Health are responsible for the licensing and regulation of HMO's.[87] Such an arrangement could lead to administrative rivalry, duplication, and waste. The establishment of an autonomous agency which would have sole responsibility for the regulation of HMO's has been suggested.[88] While such an agency might duplicate functions of both the health department and the insurance commission, the benefits of single-agency responsibility outweigh its cost.[89] The states which have most recently enacted HMO-enabling legislation have usually rejected the option of splitting regulatory authority.[90]

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[80] All thirteen of the states which provide for multiple regulatory authorities delegate regulatory duties to each entity. COLO. REV. STAT. ANN. § 10-17-101 *et seq.* (1974); FLA. STAT. ANN. § 641.17 *et seq.* (1974); ILL. REV. STAT. ch. 111 1/2, § 1401 *et seq.* (Smith-Hurd Cum. Supp. 1975-76); IOWA CODE ANN. § 514B.1 *et seq.* (Cum. Pamphlet 1975-76); MICH. COMP. LAWS ANN. § 325.901 *et seq.* (1975); MINN. STAT. ANN. §62D.01 *et seq.* (Cum. Supp. 1975-76); NEV. REV. STAT. § 695C.010 *et seq.* (1973); N.J. STAT. ANN. § 26:2J-1 *et seq.* (Supp. 1975-76); PA. STAT. ANN. tit. 40, § 1551 *et seq.* (Supp. 1975-76); S.C. CODE ANN. § 37-1131 *et seq.* (Cum. Supp. 1974); S.D. COMPILED LAWS ANN. § 58-41-1 *et seq.* (Supp. 1974); TENN. CODE ANN. § 56-4101 *et seq.* (Cum. Supp. 1974); UTAH CODE ANN. § 31-42-1 *et seq.* (1974).

Four states which have HMO-enabling statutes delegate regulatory authority solely to insurance commissions. ARIZ. REV. STAT. ANN. § 20-1051 *et seq.* (1975); IDAHO CODE § 41-3901 *et seq.* (Supp. 1974); ch. 181, [1974] KAN. LAWS 605; KY. REV. STAT. ANN. § 304.38-010 (Cum. Supp. 1974).

[81] Statement of the Northeast Community Health Council, in *1974 Public Hearings, supra* note 11, at 3.

[82] Letter from the Michigan Department of Commerce to Governor Milliken, Jan. 17, 1974 (on file with the *University of Michigan Journal of Law Reform*).

[83] S. CRANE & T. DWYER, *supra* note 58, at 43.

[84] *Id.*

[85] *See* text accompanying note 17 *supra.*

[86] *See* text accompanying notes 18-19 *supra.*

[87] *See* text accompanying note 17 *supra.*

[88] Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis,* 84 HARV. L. REV. 887, 980-82 (1971).

[89] The added expense incurred by a new agency could be substantially reduced by drawing on the expertise of the other departments in the administration of the program. This consideration makes the argument for the creation of a new regulatory agency all the more compelling. *Id.* at 921-27.

[90] Of the seven states which enacted HMO-enabling legislation in 1974, three delegated the entire responsibility for regulation to one authority. *See generally* IDAHO CODE § 41-3901 *et seq.* (Supp. 1974); ch. 181, [1974] KAN. LAWS 605; KY.

F. Disclosure Requirements

"Consumer knowledge is vitally important to the success of a health maintenance organization from the standpoint of the enrollee, the organization itself, and the public."[91] Disclosure reveals the quality and efficiency of the HMO and enables enrollees to make informed decisions.[92]

The Act mandates rather extensive disclosure. Each HMO must include in every subscriber's contract a complete description of services to be provided, information about where and how those services can be obtained, exclusions of or limitations on the services or benefits, the total payment or rate of payment for services provided, and a description of procedures for resolving enrollee complaints.[93] This information, which provides a consumer with facts upon which he or she can make a reasoned decision, is essential to the success of the HMO strategy.[94] The Act also requires an HMO to provide each subscriber with an annual summary of the organization's finances and operations.[95] Such disclosure is justified because it keeps the consumer informed as to the availability and cost of services and the ability of the HMO to meet its commitments.[96]

An HMO is also required to provide each subscriber with an annual summary of complaints handled through its grievance system.[97] Requiring such disclosure assures accountability, enables the consumer to evaluate an organization, and perhaps encourages the expeditious correction of problems.[98]

The Act does not mandate disclosure relating to the quality of care provided. Disclosure of such information on the quality of care provided by an HMO should not be required because quality assessment techniques are inadequately refined and may lead to the production of unreliable data, because an HMO could, absent sufficient controls, easily distort the information which it dispenses, and because HMO's would be handicapped unless such disclosure were required of other health care providers as well.[99]

G. Financial Security Requirements

The Michigan Act attempts to assure the financial stability of HMO's by mandating initial and periodic financial review[100] and by imposing

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REV. STAT. ANN. § 304.38-010 (Cum. Supp. 1974). This is true for only one of the ten states which enacted HMO-enabling legislation prior to 1974. *See generally* ARIZ. REV. STAT. ANN. § 20-1051 *et seq.* (1975).

[91] Statement of Donald C. Smith, M.D., in *1974 Public Hearing, supra* note 11, at 1.

[92] S. CRANE & T. DWYER, *supra* note 58, at 13.

[93] MICH. COMP. LAWS ANN. § 325.926(1) (1975).

[94] S. CRANE & T. DWYER, *supra* note 58, at 13. *See also* Statement of Donald C. Smith, M.D., in *1974 Public Hearing,* supra note 11, at 1.

[95] MICH. COMP. LAWS ANN. §§ 325.939, 325.938 (1975).

[96] S. CRANE & T. DWYER, *supra* note 58, at 14, 15.

[97] MICH. COMP. LAWS ANN. §§ 325.939, 325.938(2)(b) (1975).

[98] S. CRANE & T. DWYER, *supra* note 58, at 14.

[99] *Id.*

[100] MICH. COMP. LAWS ANN. § 325.912(a) (1975) states that issuance and renewal of licenses are dependent upon the HMO satisfying the authorities that it "is actuarially sound and possesses adequate working capital and reserves . . . ." MICH COMP.

insurance-type restrictions on HMO investments.[101] Review of an HMO's financial position before licensing assures that only those operations which are financially sound at the outset are approved.[102] Periodic review will monitor the ongoing financial stability of such operations.[103] The investment restrictions guard against improvident investments which could weaken an HMO's financial foundation.[104] This provides a check against insolvency but could unduly limit the financial options available to an HMO. Insurance-type regulations will probably impose greater capital requirements than is desirable for HMO's whose operations depend on the availability of capital for establishment and growth.[105] Furthermore, such restrictions will impair the flexibility of financial arrangements HMO's would be able to employ in obtaining capital for their operational needs.[106]

H. Rate and Contract Approval Requirements

The Act provides a mechanism for the regulation of HMO contracts and rates.[107] It is contended, but not in any way proved, that such regulation protects the consumer.[108] Other providers of health care are not subject to contract regulation; therefore the imposition of such regulations on HMO's may restrict their growth and development by placing them at a competitive disadvantage.

I. Quality Assurance Requirements

The assurance of high quality health care services[109] is an issue of growing concern.[110] One way to ensure HMO delivery of high quality health

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LAWS ANN. §§ 325.938(1), (2)(a) (1975) declare that an HMO must file a detailed financial statement with the Director of the Department of Public Health each year.

[101] The earned surplus which an HMO is allowed to invest must be invested within the constraints applicable to insurance companies as provided in MICH. COMP. LAWS ANN. § 500.901 *et seq.* (Supp. 1975-76). MICH. COMP. LAWS ANN. § 352.921 (1975).

[102] S. CRANE & T. DWYER, *supra* note 58, at 40-41.

[103] *Id.*

[104] *Id.* at 42.

[105] *Id.*

[106] *Id.* at 40.

[107] MICH. COMP. LAWS ANN. §§ 325.912(b), 325.925 (1975) authorize the regulating authorities to review and approve health maintenance contracts and rates.

[108] S. CRANE & T. DWYER, supra note 58, at 36.

[109] *Id* at 16.

> The concept of quality health care encompasses such varied concerns as continuity, availability, accessibility of care and appropriate utilization of services, not to mention the skill and performance of health care providers and the safety and sophistication of health care equipment.

Id.

[110] One example of this increased concern is the establishment of mandatory peer review of all services provided to Medicare and Medicaid patients. 42 U.S.C. § 1320c to c-19 (Supp. III, 1973). Another is the increasing volume of malpractice suits currently being litigated in the courts. *See generally* U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973).

care services is public regulation and control.[111] It has been suggested that strict standards of quality should be formulated and applied to HMO's.[112] This approach, however, overlooks the consideration that information about what constitutes quality is sparse; reliance on detailed standards may not assure quality but may instead merely increase the cost of care by establishing goals that few HMO's can obtain.[113] The Act adopts the more suitable approach of focusing on the adequacy of the processes employed to monitor the quality of care. Under the Act, an HMO is required, as a condition of licensing or renewal, to satisfy the Director of the Department of Public Health of the adequacy of its arrangements for the continuing evaluation of the quality of health care it provides.[114]

J. Solicitation

The Michigan Act adopts an exemplary approach to the issue of solicitation and advertising by HMO's. While it preempts laws which would prevent an HMO from soliciting or advertising,[115] it incorporates many provisions designed to guard against abuses in such activity.[116] The state policy of encouraging the establishment of HMO's[117] appears to be harmonious with preemption of state laws which expressly prohibit solicitation and ad-

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111 S. CRANE & T. DWYER, *supra* note 58, at 17.

112 *Id.*

113 *Id.*

114 MICH. COMP. LAWS ANN. § 325.912(h) (1975).

115 MICH. COMP. LAWS ANN. § 325.924 (1975), declares *inter alia:*

> Solicitation of enrollees or advertising of the services, charges, or other nonprofessional aspects of the operation of a health maintenance organization . . . shall not be construed to be in violation of laws relating to solicitation or advertising by health professionals. . . .

116 MICH. COMP. LAWS ANN. §§ 325.923-325.924 (1975). These sections restrict permission to solicit enrollees to legal entities organized solely for HMO purposes and to labor unions, corporations, and organizations approved by the Commissioner; they prohibit advertising which identifies, refers to, or makes qualitative judgments concerning a health professional who provides services for an HMO; they prohibit solicitation or advertising which reflect qualitative or quantitative judgment upon health professionals or other systems of health care which do not provide services for an HMO; and they prohibit solicitation or advertising which offer material benefits or other things of value, other than the services of the HMO, as an inducement to prospective subscribers.

See also MICH. COMP. LAWS ANN. §§ 325.911(g), 325.912(c) (1975). These provisions require an applicant for an HMO license to include with his application copies of solicitation materials and a general description of the marketing and enrollment techniques to be employed. The Director of the Department of Public Health must, before issuing or renewing a license, be satisfied that the HMO's solicitation of enrollment subscriptions will not defraud the persons solicited.

117 MICH. H.R. JOUR. No. 61, at 1238, 1239 (May 9, 1971). Since early 1971, the policy in Michigan has been to encourage the establishment of HMO's as an alternative to the traditional system of health care delivery. *See* Address by Governor Milliken, Michigan State Medical Society House of Delegates, Oct. 9, 1973, at 5, where the Governor declared, "I am now prepared to act in support of health maintenance organization developments." *See also* MICH. S. JOUR. No. 100, at 1646, 1650 (Oct. 24, 1973), where in a special message to the legislature, Governor Milliken again indicated support for actions that would encourage the establishment of HMO's.

vertising by health professionals since the establishing of HMO's will be discouraged unless potential founders are guaranteed the kind of access to a market that advertising can provide.[118] Moreover, advertising is necessary to sway people who are unfamiliar with HMO's[119] and who are reluctant to shift to a radically different form of health care delivery; otherwise, HMO's might be forced to settle for an unusually large number of "high risk" subscribers.[120]

If HMO's are to be allowed the privileges of advertising and soliciting, protections against abuse must be provided. False advertising would be a tempting tool if growth and development were the only considerations guiding HMO's.[121] Controls are necessary to insure consumers of the opportunity to make rational choices unaffected by advertising gimmicks.[122] They are also necessary to protect the interests of other health professionals who are barred from soliciting and advertising.[123]

K. Grievance Systems

An important issue in HMO legislation is how best to deal with enrollee complaints. The Act provides consumer protection without mandating specific machinery for handling complaints. As a condition of issuance or renewal of a license, an HMO must satisfy the Director of the Department of Public Health that it has established or maintained reasonable procedures for receiving, processing, and resolving enrollee grievances relating to the operations of the organization.[124] This approach is commendable in that it is conducive to the establishment of systems uniquely tailored to the peculiar problems of particular HMO's.

L. Mandatory Open Enrollment

There is debate about whether HMO's should be able to limit enrollment to particular groups or should instead be required to enroll anyone who desires coverage.[125] Open enrollment would provide access to a health care delivery system for many who have no alternatives.[126] On the other hand, an open enrollment requirement would put HMO's at a competitive disadvantage with respect to other health care providers which are not subject to such a requirement.[127] Moreover, open enrollment would be likely to lead to a financially disastrous influx of high-risk individuals.[128] But that danger could be mitigated by exempting a fledgling HMO from the open

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118 S. CRANE & T. DWYER, *supra* note 58, at 19.
119 *See* note 6 and accompanying text *supra*.
120 S. CRANE & T. DWYER, *supra* note 58, at 19.
121 *Id.* at 20.
122 *Id.*
123 *Id.*
124 MICH. COMP. LAWS ANN. §§ 325.912(j), 325.927 (1975).
125 S. CRANE & T. DWYER, *supra* note 58, at 22-23.
126 *Id.*
127 *Id.*
128 *Id.*

enrollment requirement long enough to enable it to become firmly established. The Act takes a similar approach, exempting HMO's from mandatory open enrollment for the first two years of their existence.[129]

It has been suggested that open enrollment in HMO's be implemented on a first come-first served basis in order to eliminate the possibility of discrimination against certain groups.[130] On the other hand, it has been maintained that some preference should be given to unenrolled members of supporting groups.[131] The Michigan Act meets both considerations by providing that an HMO may give preference to unenrolled members of groups affiliated with the HMO but must otherwise accept applicants on a first come-first served basis during a thirty-day period each year.[132]

It is argued that since only the managers of an HMO know its capacity, they should have the sole discretion to determine the extent of its open enrollment.[133] If HMO management were allowed such discretion, however, it would be able to thwart the state's goal of providing more health care services to more of its citizens by holding the line on growth.[134] The Act, which provides that the determination of capacity is to be made by the HMO subject to the scrutiny of the Director of Public Health,[135] seems to strike a satisfactory balance.

M. Mandatory Dual Choice

"Mandatory dual choice is the requirement by law or regulation that an employer make available to his employees a minimum of two alternative health care programs where options exist."[136] There are two models for the implementation of mandatory dual choice. The Pennsylvania HMO Act makes dual choice applicable to state employees.[137] The Federal HMO Act makes dual choice mandatory for employers of twenty-five or more persons in geographical areas where one or more "qualified" HMO's exist.[138] The dual choice provision of the Michigan Act is based on the federal model.[139] This is potentially the most significant provision of the Michigan statute, for it enables HMO's to compete effectively with the traditional system of health care delivery. The prospects of obtaining quality health care services at a reasonable price are thus enhanced, not only for enrollees of HMO's but also for consumers of health care services in general.

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129 MICH. COMP. LAWS ANN. § 325.928(1) (1975).
130 S. CRANE & T. DWYER, *supra* note 58, at 23.
131 *Id.*
132 MICH. COMP. LAWS ANN. §§ 325.928(1), (2) (1975). *See* notes 39, 40 and accompanying text *supra.*
133 S. CRANE & T. DWYER, *supra* note 58, at 23.
134 *Id.* at 24.
135 MICH. COMP. LAWS ANN. § 325.928(1) (1975).
136 S. CRANE & T. DWYER, *supra* note 58, at 25.
137 PA. STAT. ANN. tit. 40, § 1568 (Supp. 1975-76).
138 42 U.S.C. § 300e-9 (Supp. III, 1974).
139 *See* text accompanying notes 42, 44-45 *supra.*

III. CONCLUSION

The Michigan Health Maintenance Organization Act incorporates a significant number of features which are likely to foster the growth and development of HMO's. The law preempts several restrictive state statutes; imposes no eligibility requirements for the sponsorship of HMO's; applies mandatory dual choice on a wide scale; and adopts a reasonable approach to quality assurance, open enrollment, solicitation, and enrollee grievance system requirements.

The effectiveness of the law is hampered, however, by the inclusion of a number of unduly restrictive requirements which may have the dual effect of discouraging HMO formation and raising the cost of health care. Specifically, the Act mandates the delivery of an unnecessarily large and potentially burdensome package of health care benefits, imposes unnecessary rate and contract approval requirements, and establishes consumer participation and financial security requirements that are too inflexible. Further drawbacks include the Act's provision for dual regulatory authorities, its failure to clearly mandate programs designed to evaluate the progress of HMO's and to enhance public knowledge about the HMO system of health care delivery, and its insufficient coordination of the HMO system with health resource planning. It is certainly too early to evaluate the effect of the Michigan Health Maintenance Organization Act, but its language suggests that it will have a mixed impact on the growth and development of HMO's.

—Roger Alan Petzke