THE SOCIAL HMO FOR LOW-INCOME FAMILIES: CONSUMER PROTECTION AND COMMUNITY PARTICIPATION†

*Louise G. Trubek**

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* Clinical Professor of Law, University of Wisconsin Law School, Madison, Wisconsin. I wish to thank Claudia Egan for her outstanding research assistance.

I. INTRODUCTION

States will have substantial flexibility in designing their health plans under proposed Congressional Medicaid revisions: income limits are raised, benefits can be revised and mandated oversight is reduced. This flexibility creates an opportunity to redesign health care systems for low-income families.[1]

Understanding how the current Medicaid Health Maintainance Organization (HMO) system functions is essential to system redesign. The ability of Medicaid HMOs to provide quality health care to low-income families depends on an intricate and complex system of consumer protection and community participation institutions and mechanisms. These protection and participation elements developed in conjunction with the switch to managed care by state Medicaid programs.[2] State Medicaid managed care programs are moving towards similar systems for protection and participation as states share information and successes.[3]

Dubbed the "social HMO for low-income families," this model for protection and participation is based on observations of Wisconsin's HMO Medicaid program and examination of documents from other states.[4] The phrase also resonates with the "social

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1 Diane Duston, *Governors Grilled on Welfare Reform*, WIS. ST. J., Feb. 23, 1996, at 3A. Wisconsin, for example, enacted legislation expanding Medicaid to cover low-income families by placing them in a managed care pool financed with Medicaid dollars and administered by the existing Medicaid administrators. If their employers offer a health care plan and pay 50% of the cost, the families no longer would be eligible for the State plan. *See* 1995 Wis. Act 289 [hereinafter 1995 Act].

2 There is an Aid to Families with Dependent Children program (AFDC) aspect of the Medicaid program. A large percentage of women and children now receive health care coverage through Medicaid HMOs. A Federal waiver system allows state Medicaid programs to enroll recipients in HMOs. *See* Vernallia Randall, *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 SETON HALL L. REV. 1069 (1996). This Article only discusses the HMO risk contract programs, where the HMO is responsible for providing a comprehensive set of health care services. The state pays the HMO a monthly capitation or premium to provide health care. MILLIMAN & ROBERTSON, INC., UNDERSTANDING MEDICAID 12 (undated). This Article does not distinguish between HMO types that provide risk contract services. I have not observed significant variation on the points that I discuss.

3 The Wisconsin administrators circulated HMO contracts from other states to HMOs and community groups when they expanded to statewide HMO enrollment. California legislators are considering emulating the Wisconsin financial recoupment system to encourage preventive care. *See* Tom Philip, *New Way to Access Care Plan*, SACRAMENTO BEE, Dec. 4, 1995, at B8.

4 For a description of the historical development of the Milwaukee Medicaid Social HMO system, see generally Louise G. Trubek, *Making Managed Competition a Social Arena: Strategies For Action*, 60 BROOK. L. REV. 275 (1994). The author is a member of the Wisconsin Department of Health and Social Services statewide committee to advise on expansion to the entire state. The committee has examined state HMO con-

HMO for frail elderly," a decade-old model for integrated acute and long-term care.[5] The model contributes to evaluation of how consumer and community participation assist in overcoming barriers to HMO quality health care for low-income families. It is important, however, to understand the model as an ideal because no program effectively provides all elements. It takes time and energy to maintain the key aspects and imagination to implement the entire vision.[6]

Health care systems in the workplace are also demonstrating aspects of the social HMO model. Public and private organizations are incorporating consumer protections and community dimensions into proposed state regulations and private certification. Integrating these elements enables state agencies, legislators, HMOs, employers, and community and client groups to design effective health care systems for working families.

First, this Article examines the Medicaid social HMO model and analyzes its key elements. Next, the Article discusses the emergence in workplace health systems of proposed consumer protection and analyzes these proposals. The Article concludes with proposals for health care coverage for low-income families that include consumer protection and community participation.

II. THE SOCIAL MEDICAID HMO

A. *Barriers to Quality Managed Care for Low-Income Families*

Commentators expressed concerns about the ability of HMOs to serve low-income families.[7] Specifically, their concerns involved the general limitations of HMO service for all consumers and the special needs of low-income families. For all families, though, managed care consistently demonstrated two problems: under-utilization of services and unusable consumer information. In terms of service, prepaid plans deliver relatively comprehensive health care to an enrolled population.[8] Supplying a fixed set of services

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tracts from Massachusetts, Arizona, Missouri, Ohio, and Minnesota. *See* WISCONSIN BUREAU OF HEALTH CARE FINANCING, PROCUREMENT AND CONTRACT WORKGROUP, UPDATE FOR SWAG (May 25, 1995).

5 *Long-Term Care Lessons From the Social HMOs and PACE Models*, 3 DIVERSITY AND LONG-TERM CARE NEWS 1, 3 (Brandeis Univ., Institute for Health Policy/San Diego State Univ. Ctr. on Aging, 1996) [hereinafter *Long-Term Care Lessons*].

6 *See id.* at 3 (discussing the struggle to achieve the social HMO for the frail elderly).

7 *See generally* Rand E. Rosenblatt, *Health Care, Markets and Democratic Values*, 34 VAND. L. REV. 1067 (1981).

8 *Id.* at 1076.

for a predetermined amount, HMOs had an incentive to provide as little service as possible in order to retain a profitable amount of the capitation fee. By creating obstacles, such as elaborate referral systems for specialists, limits on chronic care services, and long waits for service, HMOs were able to limit provision of services.

The HMO model also depended on providing consumers usable information at the right time.[9] The "informed consumer" is necessary at two points. First, when consumers choose among competing HMOs, they must have good information on quality, access and cost. Second, when seeking health care within an HMO, they must know how to find the primary care doctor, how to request a referral to a specialist, and how to complain when they are dissatisfied.[10] At neither point had usable information been forthcoming. HMOs had no incentive to collect or disseminate the data, and consumers did not have the resources to gather the information.

For low-income families, there were additional barriers in the HMO system: lack of easy access to health care, cultural insensitivity of providers, and obstacles to the use of specialized providers. Low-income families are often concentrated in central city areas or other neighborhoods which may have few health care providers,[11] and some rural areas have a large percentage of low-income families and a limited number of providers. Inadequate transportation may also restrict the ability of low-income families to efficiently reach health services. HMOs may require the use of cost-efficient mass processing systems. Local access may be foregone, resulting in long trips for service and delays in receiving treatment.[12]

Low-income families' health care needs are complex; different languages and cultures may block the ability of HMOs to provide

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9 *Id.* at 1077; *see also* Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 29 (Supp. 1993) (borrowing concepts of competition from theories of microeconomics).

10 *See generally* Alan Hillman et al., *Safeguarding Quality in Managed Competition*, 12 HEALTH AFF. 116 (Supp. 1993); Rand E. Rosenblatt, *Medicaid Primary Care Case Management, The Doctor-Patient Relationship, and the Politics of Privatization*, 36 CASE W. RES. L. REV. 915, 919 (1986).

11 Louise G. Trubek & Elizabeth A. Hoffman, *Searching for a Balance in Universal Health Care Reform*, 43 DEPAUL L. REV. 1081, 1098-99 (1994); *see also* Note, *The Impact of Managed Care on Doctors Who Serve Poor and Minority Patients*, 108 HARV. L. REV. 1625, 1634-35 (1995).

12 MILLIMAN & ROBERTSON, INC., *supra* note 2, at 12; *see also generally* Roberta Riportella-Muller et al., *Barriers to the Use of Preventive Health Care in the EPSTD Program: A Survey of Users and Nonusers*, 3 PUB. HEALTH REP. 71-77 (1996) (identifying barriers to care resulting in only 1/3 of eligible children in the United States receiving Medicaid checkups and discussing improving access to care).

appropriate care.[13] To insure cost-efficient delivery, HMOs may refuse to hire translators, conduct outreach, or require sensitivity training for providers.

Specialized providers are now an integral aspect of health care delivery, providing quality care for pregnancy, childhood diseases, alcoholism, drug abuse and mental illness. Using nontraditional methods, these providers deliver successful treatment.[14] HMOs may seek, however, to maximize cost-efficiency by limiting their provider pool. HMOs are under revenue pressure and a small number of providers may be easier to control and monitor. Therefore, HMOs may not include specialized providers in their networks, preferring to use a small number of mass processing providers instead.

B. Overcoming the Barriers

Medicaid managed care programs have demonstrated the ability to overcome these barriers. Providers, government administrators, and community groups have developed an intricate system of institutions and mechanisms. These innovations have created a process that continually seeks to overcome the barriers to quality health care for low-income families.

Medicaid social HMOs are providing protections. Their ability to provide quality health care for low-income families is based on three elements: client voice, administrative oversight, and community participation. Each element contains a set of institutions and mechanisms. The intricacy and complexity of this framework is essential to success.

1. Client Voice[15]

a. *The Complaint: Individual and Group*

Complaint systems provide clients with a legitimate method to appeal denial of service, dispute unsatisfactory treatment, and question bureaucratic interpretations. These systems are also feed-

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13 Trubek & Hoffmann, *supra* note 11, at 1091-94.

14 These providers are described as "Essential Community Providers" in the Clinton Health Security Act. *Id.* at 1098-99; Note, *supra* note 11.

15 The importance of client voice is seen both in conceptualizing justice and in economic analysis. Voice is defined as the amount of access to or input into all stages of the decision making process as indicated in ethical decision making. *See* Mark R. Fondacaro, *Toward a Synthesis of Law and Social Science: Due Process and Procedural Justice in the Context of National Health Care Reform*, 72 DEN. U.L. REV. 303, n.174 (1995). For an economic analysis of the importance of client voice, see Mark A. Rodwin, *Protecting the Consumer in Managed Care: What Are The Issues*, 26 SETON HALL L. REV. 1007 (1996).

back mechanisms, providing HMOs and government regulators with information about client dissatisfaction and alerting them to systemic problems. For example, the information can alert HMOs to a lack of adequate referral procedures or identify a chronic lack of mental health treatment services.

There are three different complaint systems in the HMO programs: grievance procedures, advocate positions, and ombudsman programs.[16] Grievance procedures within HMOs are required under the Medicaid regulations and the state contract for HMO services.[17] Some programs actively assist clients in using the grievance procedures.[18] In such programs, grievances must be reported to the regulator and are part of the quality assurance system.[19]

The advocate is an officer within each HMO required by the state HMO contract specifications. The advocate's role is to provide client outreach and education in order to reduce the number of grievances.[20] The advocate also maintains community connections and resolves issues through collaborative initiatives.[21]

Ombudsman programs provide a person to whom or site where clients can voice dissatisfaction. These programs can be located in a government office or in nonprofits. Funding can be provided by Medicaid dollars or by private or public agencies. Two models exist in Wisconsin. Several nonprofit organizations receive grants from Milwaukee County to serve as ombudsmen on behalf of Milwaukee HMO Medicaid clients. These nonprofits advocate with HMOs, supply recipient and provider education, and influence policy decisions.[22] The 1996 Wisconsin Medicaid program

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16 This is a short review of a complex issue. Many HMOs and state agencies use different names for the same function.

17 Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organization: Towards a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1702-04 (1994); *see also* DEP'T. OF HEALTH & SOC. SERVS., HEALTH MAINTENANCE ORGANIZATION (HMO) CERTIFICATION REVIEW SECTION 11 (Mar. 1, 1996 - Aug. 30, 1996) [hereinafter CERTIFICATION REVIEW SECTION].

18 Wisconsin has just required the enrollment contractor to assist clients in filing grievances with the HMOs. *See* STATE OF WISCONSIN, DEP'T OF HEALTH AND SOC. SERV., STATEWIDE ADVOCACY-MEDICAID MANAGED CARE PROGRAMS 75-76 (Feb. 8, 1996) [hereinafter MEDICAID MANAGED CARE].

19 CERTIFICATION REVIEW SECTION, *supra* note 17, at 11.

20 The HMO advocate position is a Wisconsin initiative. *Id.* at 12.

21 One example of an HMO advocate response to enrollee dissatisfaction is a program called "Dental Days." This project cooperated with the Head Start Program to deal with the underutilization of dental care by recipients. The HMOs and Head Start developed an improved dental appointment system which has been highly successful. Trubek, *supra* note 4, at 285.

22 *See* HEALTHWATCH, AN ADVOCACY COALITION FOR MEDICAID HMO ENROLLEES

creates an HMO ombudsman funded and housed within the Medicaid fiscal agent.[23] The functions of the statewide program will include assisting clients and facilitating working relations with the HMO advocates, community organizations, and state agency representatives.

b. *Consumer Information and Centralized Enrollment*

Consumers express their voices both when they select an HMO and when they seek services within an HMO; to do so, they must have adequate information. To select an appropriate HMO, consumers must know the type of provider and accessibility of the services. They need lists of providers who have contracts with the HMOs and they need to know the availability of transportation to services.[24] Once enrolled in an HMO, they must have certain knowledge to express needs and concerns: examples of crucial information are referral system procedures and preventive care availability.

A centralized enrollment system is a mechanism for providing consumers with essential information. Several states employ enrollment contractors who assist the client in choosing an HMO by providing useful and accessible information.[25] Special attention to language difficulties and appropriate outreach is required. An enrollment system can allow the client to effectively participate in choosing health care providers. The information is coordinated and provided during the enrollment period when the client chooses the HMO. The enrollment contractor can also provide assistance to the client within the HMO. Wisconsin, for example, requires the contractor to assist the client when filing a grievance. A well-run system should coordinate eligibility for Medicaid with HMO selection and enrollment to avoid delay in accessing care.[26]

(informing, in flyer form, of monthly HealthWatch meetings open to any member or interested party).

23 *See* MEDICAID MANAGED CARE PROGRAMS, *supra* note 18, at 75-76.

24 DIV. OF MEDICAL ASSISTANCE, HEALTH MAINTENANCE ORGANIZATION PROGRAM, EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVS., COMMONWEALTH OF MASSACHUSETTS, REQUEST FOR PROPOSALS 2 (August 5, 1994) [hereinafter MASSACHUSETTS REQUEST FOR PROPOSALS].

25 *See generally* DIV. OF HEALTH, BUREAU OF HEALTH CARE FINANCING, DEP'T OF HEALTH AND SOC. SERVS., STATE OF WISCONSIN, REQUEST FOR PROPOSALS FOR THE MANAGED CARE ENROLLMENT AND EDUCATION SPECIALIST (Dec. 15, 1995); MASSACHUSETTS REQUEST FOR PROPOSALS, *supra* note 24.

26 Massachusetts' system has streamlined the enrollment process so that the Medicaid recipient can participate immediately in the HMO. *See* MASSACHUSETTS REQUEST FOR PROPOSALS, *supra* note 24. Continued attention to this issue should be noted. A Wisconsin HMO administrator recently commented that first trimester prenatal care

The enrollment contractor is the crucial means of assembling and providing information and facilitating client voice. The specifications for the contractor should require cultural sensitivity, language capability, and knowledge of community agencies. Funding must also be sufficient. Insufficient assistance undermines client voice.

2. Administrative Oversight

a. *Quality Assurance*

Quality assurance refers to techniques to monitor the quality of care that HMOs provide.[27] The state Medicaid agencies use three mechanisms: internal quality assurance systems, client-based indicators, and the HEDIS national standards. Medicaid HMOs must include internal quality assurance systems, such as data collection systems, in order to bid for Medicaid clients. The state agency uses the HMO data to document problems. In Wisconsin, for example, the state analyzed data and compared HMOs and fee-for-service in use of primary and specialty physicians, childhood immunization, adverse reactions to drug therapy, and Caesarian section deliveries. Wisconsin has used the data to defend managed care and to improve service to clients.[28]

Data collection can also incorporate client voice. Studies of client disenrollment rates and satisfaction surveys can be implemented by the Medicaid agency to obtain information on HMO performance. Client groups have used the quality assurance system as an advocacy technique, proposing HMO data collection and analysis in areas where they suspect poor client service.[29]

The HEDIS Medicaid national standard is a complex and lengthy document which state Medicaid directors are developing in conjunction with the National Committee for Quality Assurance (NCQA). This document may provide uniform standards for

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for women lags in Medicaid HMOs, possibly because women must first qualify for assistance before joining an HMO. The delay may mean that women are in the second trimester before they are enrolled. *See Federal Medicaid Cuts "No Problem" for Wisconsin Recipients*, 2 WISCONSIN HEALTH POLICY REPORT, Nov. 13, 1995, at 1.

27 *See* Michele Melden & Lorna Hennington, *Quality Assurance in Medicaid Managed Care*, CLEARINGHOUSE REV. 1450, 1451 (Mar. 1993).

28 *See* Kevin B. Piper & Peggy Bartels, *Medicaid Primary Care: HMOs or Fee-for-Service*, PUB. WELFARE 18 (Spring 1995) (finding that HMOs are more effective than fee-for-service in primary and preventative health care).

29 *See generally* WISCONSIN DEP'T OF HEALTH AND SOC. SERVS., WISCONSIN MEDICAID MANAGED CARE EXPANSION, SUMMARY OF CONTRACT/CERTIFICATION RECOMMENDATIONS (1996) [hereinafter WISCONSIN SUMMARY]; *see also generally* Trubek, *supra* note 4.

HMO internal systems requirements throughout the nation.[30] The NCQA specifies that the "set of measures includes new quality and access measures to respond more directly to the needs of women and children, who make up the majority of Medicaid managed care enrollees, and to address historical concerns related to access to care."[31]

Incorporated into an active process, quality assurance systems are crucial. Client and community groups use the data to document their complaints.[32] Medicaid agencies use the data to trigger enforcement mechanisms such as contract requirements and financial incentives.

b. *The Contracting Process*

Administrative control over Medicaid HMO providers is exercised through a contract model.[33] Most aspects of the program are addressed through a bidding process and subsequent individual contracts with HMOs. The request for bids is regulated by federal and state requirements, as well as specifications on organizational, financial, access, and quality issues. Regular review of problems in the system is facilitated by yearly rewriting of the bids and contract negotiations. Health care activists and providers can submit proposed changes in the bid requirements to the administrators, documenting, for example, inadequate alcohol and drug abuse treatment or lack of primary care providers. Administrators can impose requirements to address concerns about access, quality, and cultural sensitivity.[34]

Wisconsin, for example, is expanding the Medicaid HMO program to the entire state. During the request period for contract

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30 *See, e.g.*, NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA), DRAFT, MEDICAID HEDIS viii (July 1995) (offering an adaptation of the Health Plan Employer Data and Information Set (HEDIS) to promote standardizaton and to provide state Medicaid agencies with performance information, assistance in quality improvement, and information for beneficiaries).

31 Letter from Patricia MacTaggert, Chairperson, Medicaid HEDIS Work Group, and Ann Page, Director, Medicaid HEDIS Project, NCQA, to the general readership audience for review and comment 1 (July 6, 1995) (on file with the author).

32 *See supra* notes 15-26 and accompanying text (discussing client voice).

33 In the fee-for-service system, control over the Medicaid program is carried out through administrative agency rulemaking which can require legislative review and mandatory input from the public.

34 For example, Wisconsin administrators solicited suggestions for changes in the system from community groups, HMOs, and providers. The administrators sought to implement suggested changes through contract requirements and responded in writing to each of the recommendations submitted. *See generally* WISCONSIN SUMMARY, *supra* note 29.

revisions, extensive suggestions were submitted in the area of rural access. As a result, the present contract now includes a specific section on rural health clinics, and the State is issuing an access standard to be used for rural HMOs.[35]

The contract is the basic document regulating the HMO-state relationship and forms the basis for certification and the ability to enroll clients and receive the capitation payment. The contract requirement allows a state to hold HMOs to a certain level of quality. If the capitation rate is sufficient, HMOs are willing to abide by the standards.

c. *Financial Incentives*

Financial incentives such as reinsurance, risk-sharing, and recoupment can encourage Medicaid contract participation by HMOs. The state may offer reinsurance coverage to encourage HMOs to submit bids without fear of insolvency. Specific risk-sharing for certain types of diseases and procedures that are costly can also encourage hesitant HMOs to bid. Wisconsin, for example, provides special reimbursement for neo-natal intensive care, AIDS patients, and ventilator-dependent patients.[36]

Recoupment is another means of insuring quality care. States can reduce capitation payments if the requirements of the contract are not met. In Wisconsin, failure to provide sufficient preventive care will result in recoupment. HMOs have been very responsive to this incentive. HMO outreach programs have increased, enabling many children to obtain preventive care.[37]

3. Community Participation

a. *Resource Integration*

An unexpected result of the shift to managed care is the development of a positive connection between HMOs and community institutions. Integration of social services, educational institutions,

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[35] *See id.* at 41-45.

[36] *See* MILLIMAN & ROBERTSON, INC., *supra* note 2; *see also* 1995 Contract for Medicaid HMO Services Between HMO and Wisconsin Department of Health and Social Services 30-33.

[37] *Id.* at 97 (providing a HealthCheck Recoupment Worksheet which tracks the number of eligible enrollees with the expected number of services by age group and then compares the actual number of services provided to determine the recoupment amount). California is struggling with administrative oversight of its newly implemented Medicaid HMO program. A recent article discussed the preferability of financial recoupment systems for guaranteeing HMO patients receipt of preventative care. *See* Philip, *supra* note 3, at B8.

and public health agencies into the HMO health care network is notable. Providing broad services for low-income families as part of the HMO package is a crucial aspect. This integration parallels the social HMO for the frail elderly in which integration of long-term care service into acute care is the goal.[38]

Two mechanisms encourage this interaction: HMO prepaid capitation and regulatory provisions. HMOs provide a comprehensive package of services in exchange for a prepaid capitation fee. Local social service groups, specialized health care providers, and public health agencies can be cost-effective, accessible, and culturally diverse sources for services. Community organizations and public agencies assist low-income families in health care through outreach, social services, and specialized health care services.[39] Planned Parenthood provides reproductive health services, public schools provide acute nursing care, and Head Start programs facilitate preventive care.

State Medicaid agency actions can also encourage HMOs to negotiate arrangements with nontraditional agencies. Certification requirements provide one mechanism for negotiating arrangements. Contracts may require HMOs to list community agencies that have been considered for subcontracts. If necessary, the requirements may be more stringent, requiring, in certain cases, that memoranda of understanding for service provision have been negotiated.[40]

b. *Economic Development*

HMO enrollment has an effect on the viability of communities. Medicaid managed care administrators have instituted methods to ensure that the economic well-being of rural and central city communities is maintained when managed care systems are initiated. Culturally relevant provider requirements, anti-discrimination and affirmative action language in bid specifications, and protection for community providers assist the maintenance of central city health care providers.[41] Rural communities worry about the loss of accessible health care, the loss of local health care jobs,

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38 *See Long-Term Care Lessons*, *supra* note 5, at 3.

39 MASSACHUSETTS REQUEST FOR PROPOSALS, *supra* note 24, at 1-2 (discussing the changes in the existing HMO program to include "greater emphasis on the coordination and continuity of all services to Medicaid recipients" including services provided by the community).

40 *See* CERTIFICATION REVIEW SECTION, *supra* note 17, at 9; MASSACHUSETTS REQUEST FOR PROPOSALS, *supra* note 24, at 2.

41 *See* Contract, *supra* note 36, at 13.

and the economic viability of the region when managed care is instituted. Differential capitation rates by region, bid specifications for provider accessibility, and requirements for a ratio of primary providers to clients are techniques that may be implemented to maintain health care in rural communities.[42]

c. *Coalitions and Forums*

A community coalition of local groups and concerned individuals can amplify the individual complaint, serve as an independent information source for clients and community groups, and provide a base for criticism. A community coalition can organize regular local meetings with state officials and alternative providers.[43] Community-based forums can monitor managed care by providing places for advocacy groups, clients, community-based organizations, HMOs, and government agencies to coordinate and communicate with each other. HMO contract requirements for outcome data, access, and cultural sensitivity can encourage HMOs to attend forums and use them for information gathering and networking. Community agencies such as Head Start programs, often ignored by the traditional health care organizations, may find the forums useful for networking. Advocacy groups can use the forums to present concerns and gather information. The meetings can also serve as an opportunity for oversight and review of the health conditions in the community.

III. EMERGING APPROACH: THE SOCIAL WORKPLACE HMO

A. *The Actors*

Many consumers receive health care coverage through HMO workplace plans regulated by a hodgepodge of state and federal agencies.[44] Protection systems for consumers enrolled in these

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[42] In Wisconsin's statewide expansion, there is significant concern about the maintenance of rural providers. *See* WISCONSIN SUMMARY, *supra* note 29, at 83, Attachment 4 (listing recommendations made regarding rural health clinics and offering responses and rationales).

[43] *See* THE HEALTHWATCH MODEL—A COMMUNITY-BASED APPROACH TO MONITORING MANAGED HEALTH CARE (May 1995) (on file with the author) (examining the Milwaukee County HealthWatch coalition as a model of how communities may best respond to ongoing concerns regarding the availability, accessibility, and quality of health care, and proposing to develop statewide and regional conferences to expand HealthWatch activities and assist other communities in establishing similar coalitions); *see also* Trubek, *supra* note 4, at 293 (discussing the development of the Milwaukee HMO forum).

[44] *See* Geraldine Dallek et al., *Consumer Protection in State HMO Laws*, CENTER FOR HEALTH CARE RIGHTS, Nov. 1995, at ix, xi.

plans are necessary. Inadequate regulation and unavailable information contribute to poor quality care and dissatisfaction with HMOs.[45] Three groups are undertaking the project of including social protection in HMO systems. The first group, the National Association of Insurance Commissioners (NAIC), a voluntary organization of state regulators, is proposing model rules and legislation. These uniform HMO regulations require that health care networks be regulated as insurance and comply with complex model rules and legislation.[46] The NAIC program has no independent authority; proposals must be enacted state by state.

The State of New Jersey, a second entity working toward social protection, is crafting its own regulations. Len Fishman, New Jersey Health Commissioner, in conjunction with the Commissioner of Insurance, is developing a comprehensive set of regulations to create an overall framework that includes consumer protection. These regulations, unlike the NAIC model rules, provide for joint regulation by the Department of Health and the insurance regulatory agency.[47]

A third group working toward social protection in HMO systems is the NCQA, an independent, not-for-profit agency.[48] NCQA provides information to purchasers and consumers of managed health care as part of its mission to improve workplace health insurance by enabling purchasers and consumers to distinguish among plans based on quality. The NCQA efforts are organized around HMO accreditation and performance measurement (report cards) used by HMOs for marketing. Regulators are considering incorporating the NCQA products within their mandatory

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45 *Id.*

46 The determination that all states regulate HMOs in a uniform manner is important. In California, for example, the HMOs are regulated by the Department of Corporations, a notoriously weak agency. *See generally Treat Providers Like Insurers*, MOD. HEALTHCARE, Aug. 21, 1995. The proposed NAIC rules are currently in committee and are going through the approval process. *See generally* National Association of Insurance Commissioners, Draft, Managed Care Provider Network Adequacy and Contracting Model Act (Dec. 4, 1995) (providing a model version of a health care act drafted to assure the availability, accessibility, and quality of services under a managed health care plan, and soliciting comments thereon) [hereinafter NAIC Draft Model Act].

47 HMO Advisory Committee, State of New Jersey, Draft, Proposed HMO Regulations, N.J. ADMIN. CODE tit. 8, § 38 (Nov. 17, 1995) (proposing rules developed by the New Jersey Commissioner of Health in conjunction with the Commissioner of Insurance to govern the establishment and operation of New Jersey HMOs) [hereinafter New Jersey Proposed Regulations].

48 NCQA, 2000 L Street, N.W. Suite 500, Washington, D.C. 20036. For more information on the NCQA, NCQA News, accreditation, HEDIS, conferences, and publications, call (202) 955-3500 or fax (202) 955-3599.

system.[49]

The NAIC, New Jersey, and NCQA initiatives demonstrate serious efforts to incorporate social protection into workplace health policies.[50] Each program demonstrates an understanding of the barriers to adequate health care for low-income families using HMOs by proposing provisions for enabling and protecting consumers. These ambitious projects stem from two factors: competition among HMOs for workplace customers and proposed changes in Medicaid and welfare programs.

The competition for customers among HMOs has been based on price shopping. Few mechanisms provide for quality comparisons to be effectively communicated to customers. Adequate regulation and consumer voice have been absent in the workplace health insurance system. The employer and employee, therefore, have few options when dissatisfied by the performance of the servicing HMO except for the option to move to another HMO that claims to offer a better deal. HMOs offering quality service are also at a disadvantage: they are undercut by low-cost, low-quality HMOs. Inadequate information prevents the employer and employee from distinguishing between the good and poor HMO.

Federal initiatives in Medicaid and welfare programs are the second factor underlying these projects. Proposed welfare reforms and Medicaid revisions allow us to rethink health care financing and delivery to low-income families. The welfare reform proposals place virtually all low-income women in jobs. The availability of adequate and affordable health care coverage for workers is essential for the success of this new system. If families go without coverage, the charity system will be overburdened, health care indicators will decline, and workers will be unable to perform.

Medicaid block grant proposals allow funds to be used for people with income up to 300% of the federal poverty level.[51] The intent of the expanded eligibility is to create an opportunity to provide health care plans for working people. Legislation in Wisconsin, for example, expands health care coverage to people not currently eligible for Medicaid benefits by changing income limits and allowing client contribution.[52]

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[49] *See infra* note 70 and accompanying text (discussing the use of NCQA material in NAIC regulations).

[50] *See* Dallek et al., *supra* note 44, at xi (noting that there are other projects underway as well).

[51] *See generally* Jane Horvath et al., NATIONAL ACADEMY FOR STATE HEALTH POLICY, RESTRUCTURING MEDICAID: OPTIONS AND STRATEGIES FOR STATES (Feb. 1996).

[52] *See* 1995 Act 289.

Support for enrolling current Medicaid recipients in the workplace system is improved if workplace protections are credible. HMOs and advocates are reluctant to propose systems that will result in poor quality care and dissatisfied customers. These public and private initiatives are based on the assumption that credible workplace HMO health policies are necessary for both an equitable competitive market and an expansion of workplace coverage. Further, these proposals recognize that credible policies must include consumer protection and community participation.

B. The Proposals for Consumer Protection and Community Participation in Workplace HMO Policies

An examination of the documents drafted by the organizations reveals a substantial package of protection, an impressive improvement over current laws and regulations.[53] Requirements on quality assurance, consumer information, and access standards are the most progressive. Although essential elements of varied complaint mechanisms, effective enforcement, and community involvement require additional implementation, the proposals demonstrate a willingness to create systems that could enable low-income families to receive quality care in HMOs.

1. Complaint Mechanisms

Grievance procedures within the HMO are the preferred mechanism for expressing client dissatisfaction in the New Jersey and NAIC regulations. Both sytems create several elaborate levels of review.[54] Although the rules do not provide encouragement for interactive or informal complaint systems, the NAIC rules indicate that alternative dispute resolution systems are not prohibited.[55] Additional complaint systems would create more opportunities for consumer feedback. Provisions for group advocacy would create organizations and mechanisms for systemic analysis.[56]

Independent ombudsman programs provide advice to clients on redress, assemble information on systemic problems, and present data and information to decision makers. Funding for such groups to participate in complaint handling, rulemaking, or policy

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53 *See generally* Dallek et al., *supra* note 44.

54 *See* NAIC Draft Model Act, *supra* note 46 (including a "Grievance Procedure Model Regulation" rule creating an elaborate grievance procedure).

55 *See id.*

56 *See* Sylvia Law, *A Right to Health Care That Cannot Be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771, 779, 791 (1994).

development would be a dramatic step forward. The NAIC and New Jersey rules could create such ombudsman programs. The NAIC, in fact, has a funding program for consumer groups who wish to participate in the NAIC processes. These groups attend NAIC meetings, testify at hearings, and develop a consumer agenda.[57]

2. Consumer Information

NCQA and New Jersey propose different systems to provide consumer information. NCQA uses a system of accreditation combined with report cards. NCQA relies on a private mechanism where HMOs apply for certification based on compliance with a set of indicators. HMOs publicize this information when marketing their plans. The NCQA provides information on how to choose an HMO based on these quality indicators and encourages report cards comparing performance measures.[58] NAIC appears to be relying on the NCQA system for a consumer information system;[59] however, the rules do provide that HMOs must annually provide clients with information on the results of their data collection and quality assessment programs.[60]

The New Jersey system more closely parallels the Medicaid model. NAIC rules require a specified benefit package which allows consumers to compare plans, proposes controls on agent marketing, prevents misinformation, and insures an open enrollment period for consumers to compare plans.[61] The New Jersey approach, however, does not encourage institutions or mechanisms to assist consumers. For example, outreach to consumers who might not be able to read or understand the informational materials is not required.

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57 *See* Letter from Ellen Wilcox, Associate Counsel, NAIC, to Applicants for NAIC 1994 Consumer Participation Program 1 (Feb. 2, 1994) (on file with the author); Letter from Mary Griffin, Insurance Counsel, Consumers Union, to Susan Martin, NAIC 1 (Jan. 11, 1995) (on file with the author); NAIC, 1994 Guidelines for Reimbursement of Expenses for NAIC Funded Consumer Representatives (1994) (on file with the author); *see also* Trubek, *supra* note 4, at 297 (discussing funded consumer representation models).

58 For more information on NCQA and means of obtaining NCQA materials, see *supra* note 48 and accompanying text.

59 *See* NAIC Draft Model Act, *supra* note 46, at 4 (suggesting a "Quality Assessment and Improvement Model Regulation").

60 *See id.* at 7.

61 *See generally* New Jersey Proposed Regulations, *supra* note 47.

3. Access Standards

The access requirements in the New Jersey regulations and the NAIC proposed legislation are impressive.[62] Geographic access in the HMO networks is regulated, including a time in transit standard. Twenty-four hour hotlines are required, appointment waiting times are regulated, and the ratio of primary care physicians to clients is standardized.[63] Moreover, HMOs must maintain plans in a manner that does not discriminate against certain groups of clients. NAIC proposals also discuss diverse language requirements. One notable gap is the absence of an outreach requirement for families that do not utilize services. This requirement is essential to ensure adequate health care for low-income families. Without the requirement, an HMO may receive capitation payments with no obligation to insure that the client is aware of the potential services.[64]

4. Governance and Enforcement

The process by which HMOs are held accountable for their actions includes governance and enforcement systems. In workplace health policies, the employer, client, and regulator can be involved in both governance and enforcement. In developing model rules and legislation, the NAIC permitted substantial consumer and HMO comments.[65] The rulemaking process at the state level also requires opportunities for participation, and the legislative process allows for public input.

The New Jersey rules require that the HMO provide a "mechanism by which members and providers will be afforded an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referendum on major policy decisions, or through the use of other mechanisms."[66] People who wish to participate in this elaborate process of governance require training and information. The NAIC has initiated such a system; however, most states and HMOs do not provide those opportunities. Employer and client groups may require

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62 *See id.* (listing New Jersey access requirements); NAIC Draft Model Act, *supra* note 46 (proposing access requirements).

63 *See* NAIC Draft Model Act, *supra* note 46, at 4 (concerning geographic access regulations).

64 *See* Philip, *supra* note 3, at B8.

65 Telephone Interview with Elizabeth Hadley, Associate Counsel, National Association of Insurance Commissioners (NAIC) (Feb. 23, 1996).

66 New Jersey Proposed Regulations, *supra* note 47.

such assistance if they are to effectively communicate their concerns.

The HMO system is based on contracts between the provider and the payor. The administrative rules are interpreted through contract negotiations and the enforcement system. The NAIC and New Jersey rules envision an enforcement system based on a triannual certification review, site visits, and financial penalties for regulatory noncompliance.[67] Employers who pay for health care and consumers who enrolled in the HMOs appear to have no role.[68] Financial incentives for compliance could be provided. The rules could provide for the remedy of recoupment of employer payments if the regulatory provisions are violated by the HMO. If the HMO fails to deliver the required service, such as the required ratio of primary care providers to consumers, the employer could obtain a refund for the inadequate service. Consumer-based remedies such as consumer class actions and reimbursement for low-quality care could be incorporated in the rules and statutes. A wide variety of enforcement tools are essential for compliance.

5. Quality Assurance

All three initiatives use quality assurance systems. The NCQA procedures are "works in progress" overseen by a diverse group that includes employers, consumer and labor representatives, health providers, quality experts, regulators, and representatives from organized medicine. The NCQA system serves as the basis for the NAIC and New Jersey rules. The elaborate data requirements for the HMOs, including the use of filed grievances and the continuous quality measures, are useful mechanisms for quality health care.[69] The NAIC proposed regulations for specific data collection for specific groups is commendable. Low-income families benefit from indicators, for example, that reveal perinatal service provision and immunization rates.[70]

6. Community Participation

There is scarcely any indication of the importance of health care facilities and personnel to the well-being of communities.

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67 *Id.*; NAIC Draft Model Act, *supra* note 46.

68 In many health plans, the consumers also contribute to the payment for health care.

69 See NAIC Utilization Review Model Act, Draft of April 3, 1996 and Proposed New Jersey Regulations subchapter 7.

70 *See* NAIC Draft Model Act, *supra* note 46 (including a "Quality Assessment and Improvement Model Regulation").

There are few regulations or incentives for use of minority providers, maintenance of rural facilities, or community organizations. The exception is the NAIC requirement of integrating public health into the HMO system. The legislative proposal requires that HMOs must provide a "description of the . . . strategy for integration of public health goals with the health services offered."[71] Schools, social service agencies, and community-based providers can also be effective providers. The only assistance for these organizations is the NAIC provision that health carriers are required to make available to anyone their general requirements for selection and retention.[72]

The three initiatives do not discuss the community forums that have been so significant in the Medicaid HMO system. The forums allow HMOs, regulators, payers, consumer and community groups and government administrators to gather and discuss specific problems in HMO delivery as well as plan for the overall health of their community, creating a nonadversarial, exploratory site for information sharing, networking, and planning.[73] States could encourage the development of forums by requiring HMOs to participate, funding groups that wish to organize or attend the meetings, or hosting the forums themselves.

IV. CONCLUSION

The convergence of social aspects in workplace and Medicaid systems allows one to be optimistic about improved health care coverage for low-income families. The Medicaid model demonstrates unexpected responsiveness by regulators, HMO administrators, and consumer and community groups. Workplace regulators and private certifiers are initiating systems that recognize the importance of consumer and community participation in the provision of quality HMO health care to working families. Finally, the Medicaid experience indicates that HMOs will enroll low-income persons when a supportive, reasonable system is offered.

The presence of the social HMO in both the workplace and Medicaid systems encourages consideration of a single system. Medicaid managed care has a history that can be studied, evaluated and improved. The newly-issued NAIC and New Jersey regulations demonstrate that workplace policies can include social protection to provide adequate health care coverage for low-income families.

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[71] NAIC Draft Model Act, *supra* note 46, at 6.

[72] *See id.* at 12.

[73] *See* Trubek, *supra* note 4, at 293 (discussing community forums).

Proposals for a single health care system for low-income families should be considered. A seamless system would permit employed and unemployed people to maintain coverage in an HMO.[74]

There are two approaches to blending the workplace and Medicaid systems: merging Medicaid into workplace policies (the workplace approach) and allowing low-income working families into the Medicaid system (the Medicaid approach). Under the workplace approach, all policies would be monitored by a single agency. Low-income employees would be subsidized with Medicaid dollars.[75] Under the Medicaid approach, low-income families would be offered a well-developed social framework for health care delivery. The Medicaid system offers a comprehensive health care package to all consumers with experienced oversight, redress, and enforcement.[76] Eligibility would be expanded to more low-income workers using Medicaid HMO dollars and regulation.

Both the workplace and Medicaid approaches are on the table, and a period of experimentation is likely and acceptable.[77] Providing quality care, community health, and a profit for providers is a major task for an HMO system that serves low-income families. Success in either system can be achieved only when regulation and oversight are combined with client voice, community participation, and sufficient funding.

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74 *See* Law, *supra* note 56, at 772 (arguing that a single health care system for all people is crucial for low-income people).

75 An early version of the Wisconsin welfare reform proposal suggested using Medicaid dollars to finance up to 80% of the private health care policy for low-income workers.

76 Barbara L. Wolfe, *Reform of Health Care for the Nonelderly Poor, in* CONFRONTING POVERTY (Sheldon Danziger et al. eds., 1994) (preferring a Medicaid-based model).

77 *See generally* RESTRUCTURING MEDICAID, *supra* note 51.