St. Mary's Law Journal

Volume 11 | Number 4 Article 2

12-1-1980

Health Maintenance Organizations: An Overview of the History, Federal and Texas Legislation, and Current Problems.

John D. Jackson

HEALTH MAINTENANCE ORGANIZATIONS: AN OVERVIEW OF THE HISTORY, FEDERAL AND TEXAS LEGISLATION, AND CURRENT PROBLEMS

JOHN D. JACKSON*

		Page
I.	Introduction	813
	A. General Definition	814
	B. Kaiser Foundation Health Plan	815
II.	Federal HMO Legislation	816
	A. History	816
	B. Federal Definition	817
	C. Control Through Federal Funding	820
	D. Other Federal Encouragement	821
III.	Application in Texas	822
IV.	Problem Areas	826
V.	Conclusion	827

I. INTRODUCTION

The crisis in health care is well evidenced by the numerous proposed national health care plans submitted to Congress within the last several years.[1] The thrust of these proposals is to develop alternatives to the existing structure of health care services. These range from attempting to engraft solutions to existing health care models to seeking far-reaching structural changes.[2] Out of this legislative and administrative confusion has emerged the competitive

* B.B.A., M.P.A., Texas Christian University, J.D., Southern Methodist University, Officer & Stockholder, Malouf Lynch & Jackson Professional Corporation.

1. *See, e.g.*, Comprehensive Health Care Reform Act, S. 1590, 96th Cong., 1st Sess. (1979) (Schweiker bill); Health Care for All Americans Act, S. 1720 96th Cong., 1st Sess. (1979) (Kennedy bill); National Health Plan Act, S. 1812, 96th Cong., 1st Sess. (1979) (Carter-Cranston bill).

2. *See* Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644, 647-48 (1972).

health maintenance organization (HMO), the development of which is now encouraged by a federal funding program.[3] On October 20, 1979, United States Congressman Al Ullman introduced legislation to remove tax incentives that encourage employers to maintain expensive health care coverage for their employees.[4] Additionally, the legislation encourages employers to use HMOs and prepaid health care plans.[5] This article gives an overview of the nature and current status of the HMO without concluding on the concept's soundness or viability.

A. *General Definition*

An HMO is an organization that delivers comprehensive health care for a fixed prepaid price to a voluntarily enrolled group of people.[6] HMOs compete with each other and with traditional health care services.[7] The differences between the HMO and tradi-

---

3. *See* Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C.A. § 300e (West 1974, Pamph. Supp. 1974-1978 & Supp. 1979)).

4. *See* Health Cost Constraint Act of 1979, § 102, H.R. 5740, 96th Cong., 1st Sess. (proposed I.R.C. § 86); 125 CONG. REC. H9960 (daily ed. Oct. 30, 1979). Section 102 of H.R. 5740 would place a limit, $120 per month for family coverage, on the amount an employer could contribute tax free towards an employee health plan. *See* Health Cost Constraint Act of 1979, § 102, H.R. 5740, 96th Cong., 1st Sess. (proposed I.R.C. § 86). Employer contributions exceeding this limit would be included in the employee's gross income. *Id.* Excess contributions would be treated as wages and, therefore, would be subject to federal withholding and social security taxes. *See id.* § 103 (proposed I.R.C. § 3508). Legislation of a similar nature is pending in the United States Senate. *See* Health Incentive Reform Act, S. 1968, 96th Cong., 1st Sess. (1979). *But cf.* Weiner, *Governmental Regulation of Health Care: A Response to Some Criticisms Voiced by Proponents of a "Free Market,"* 4 AM. J. L. & MED. 15, 30-31 (1978) (arguing that extent of employers' tax incentives to maintain expensive employee health insurance has been overstated).

5. Under H.R. 5470 most employee health plans would be required to offer an HMO option or other low cost option providing certain minimum services; failure to comply would result in all employer contributions becoming part of the employee's gross income, subject to federal employers wage taxes. *See* Health Cost Constraint Act of 1979, §§ 102, 103, H.R. 5470, 96th Cong., 1st Sess. (proposed I.R.C. §§ 86, 3508).

6. *See* Havighurst, *Health Maintenance Organizations and the Health Planners*, 1978 UTAH L. REV. 123, 123; Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487, 488.

7. Havighurst, *Health Maintenance Organizations and the Health Planners*, 1978 UTAH L. REV. 123, 126. The total costs of health care for HMO subscribers is between ten and forty percent lower than costs for people with conventional health insurance coverage. U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE, OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS, NATIONAL HMO DEVELOPMENT STRATEGY THROUGH 1988, at 6 (1979) [hereinafter cited as HMO DEVELOPMENT STRATEGY]. The cost-effectiveness of HMOs can lead to reduced costs for all

tional health care insurance systems may be summarized as follows:

> In a health maintenance organization—
>
> an individual on behalf of himself (or as part of a group plan) contracts in advance with an organization . . . for substantially all of his and his family's health care needs. The organization in turn accepts legal responsibility for the direct provision of those needs through its own physicians and facilities which it either owns or controls.[8]
>
> Under traditional health care insurance systems—
>
> the patient chooses his own physician and other health care facilities. A health insurance carrier then reimburses him for all of or part of his costs either on an indemnity or service basis. The health insurance carrier may pay the doctor or hospital on the basis of an assignment or a service agreement but it does not employ the physician or own the hospital.[9]

B. *Kaiser Foundation Health Plan*

The HMO is the result of numerous trials and errors in the health care field where traditional systems did not or could not function effectively. Probably the most encouraging single impetus to the movement toward HMOs has been the success of the Kaiser Health Foundation Plan[10] which originated in California in the early 1930's.[11] The Kaiser plan was developed because of a lack of medical facilities for construction workers building an aqueduct between the Colorado River and the City of Los Angeles. A group of physicians, responding to the contractors' request, organized

---

health consumers through competitive response from traditional health care services. Kissam & Johnson, *Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering*, 29 VAND. L. REV. 1163, 1178-79 (1976); *cf.* HMO DEVELOPMENT STRATEGY, *supra*, at 7 (inverse relationship found between state HMO market share and Blue Cross hospital utilization rates in private sector). *See generally* Luft, *How Do Health-Maintenance Organizations Achieve Their 'Savings'?*, 298 NEW ENGLAND J. MED. 1336 (1978).

8. Ludlam, *Health Maintenance Organizations HMOs: Do They Really Work?* 10 FORUM 405, 406 (1974).

9. *Id.* at 406.

10. Also known as the Kaiser-Permanente Medical Care Program.

11. Scannell, *The Kaiser Foundation Health Plan*, in PROCEEDINGS REPORT OF REGIONAL CONFERENCE ON HEALTH MAINTENANCE ORGANIZATIONS 29 (1971) (Region VI Office of Dep't of Health, Education, and Welfare).

and staffed a small hospital in the desert for the benefit of the workers. The physicians offered economical services by combining talent and equipment. Initially they charged for their services on the traditional "fee-for-service" basis; however, the fees received did not equal the operating costs. Fear of losing the facility prompted contractors to encourage assistance from insurance carriers. An arrangement was developed in which the medical organization was prepaid $1.50 per month for each employee, and the fee-for-service was eliminated. After undergoing minor adjustments, the new plan proved successful. Kaiser continued to refine the prepaid health care concept, implementing similar plans during construction of the Grand Coulee Dam in 1938 and during World War II in Kaiser's shipyards. After the war the plan was continued, opened to the public, and has remained the largest single prepaid health plan operating. In addition to the successful Kaiser model, the number of other prepaid health care plans has increased significantly during the past decade.[12] As of January 7, 1980, there were eight state-certified HMOs in Texas.[13]

II. FEDERAL HMO LEGISLATION

A. *History*

The prepaid direct health care concept gained impetus when President Nixon made public reference to a "Health Maintenance Organization" in his 1971 special message to Congress, "Building a National Health Strategy."[14] When the Administration requested financial assistance for the development of HMOs in 1971,[15] Senator Kennedy and Congressman Roy responded by introducing more comprehensive legislation.[16] Congress then passed a $375 mil-

12. HMOs increased in number from 39 to 213 during the 1970's and now serve eight million Americans. HMO DEVELOPMENT STRATEGY, *supra* note 7, at 1. Ninety-nine HMOs are federally qualified, 74 of which received federal funding. HMO DEVELOPMENT STRATEGY, *supra* note 7, at 2.

13. *See* STATE BOARD OF INSURANCE, TEXAS HMO STATUS REPORT (rev. Jan. 7, 1980). The eight state-certified organizations, six of which are federally qualified, have a combined membership of over 76,000 persons. An additional seven HMOs are in various stages of planning and development in Texas. *See id.*

14. *See* 117 CONG. REC. 3015, 3016 (1971).

15. *See* S. 1182, 92d Cong., 1st Sess. (1971).

16. *See* S. 14, 93d Cong., 1st Sess. (1973) (Kennedy bill); H.R. 11728, 92d Cong., 1st Sess. (1971) (Roy bill).

lion funding act, and the bill was signed into law as the Health Maintenance Organization Act of 1973.[17] Because of initial restrictions placed on HMOs qualifying for federal funding,[18] very few were able to qualify. In response to the problem, Congress amended the Act in 1976[19] and again in 1978[20] to eliminate some of the idealistic concepts of the earlier draftsmen and to extend greater financial assistance to HMOs.[21]

B. *Federal Definition*

The present definition of the HMO qualified for federal funding purposes is a legal entity that:

1. Provides basic health services[22] to its members without limitations on time or cost (but allows inclusion of supple-

---

17. Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e (1976) (amended 1976, 1978, 1979)). For an in depth discussion of the legislative history of the Health Maintenance Organization Act of 1973, and of the problems in its implementation, see Rosoff, *Phase Two of the Federal HMO Development Program: New Directions After a Shaky Start*, 1 AM. J. L. & MED. 209, 210-36 (1975).

18. *See generally* Kissam & Johnson, *Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering*, 29 VAND. L. REV. 1163, 1203-09 (1976).

19. Health Maintenance Organization Amendments of 1976, Pub. L. No. 94-460, 90 Stat. 1945 (amending 42 U.S.C. § 300e (1976)).

20. Health Maintenance Organization Amendments of 1978, Pub. L. No. 95-559, 92 Stat. 2131 (amending 42 U.S.C. § 300e (1976)).

21. Continued support for HMOs was demonstrated by President Carter's remarks in the 1980 State of the Union Address. *See* Annual Message to the Congress, 16 WEEKLY COMP. OF PRES. DOC. 133 (Jan. 21, 1980).

22. *See* Health Maintenance Organization Act, 42 U.S.C.A. § 300e-1(1) (West Pamph. Supp. 1974-1978). For purposes of the Act, "basic health services" are defined as:

(A) physician services (including consultant and referral services by a physician);
(B) inpatient and outpatient hospital services;
(C) medically necessary emergency health services;
(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;
(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;
(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;
(G) home health services; and
(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

Id.

mental services);[23]

2. Receives a periodic payment for each member, which payment:

a. is paid on a periodic basis without regard to the dates on which basic health services are provided;[24]

b. is fixed without regard to the frequency, extent, or kind of basic health service actually furnished;[25]

c. is fixed under a community rating system unless the member is a full-time student at an accredited institution of higher learning;[26]

d. may be supplemented by additional nominal payments which may be required for the provision of specific basic health services;[27]

3. Provides the health services through any combination of the staff of the organization, individual practice associations, or one or more medical groups;[28]

4. Provides basic health services to each of its members promptly and in a manner that assures continuity, as well as emergency services twenty-four hours a day, seven days a week;[29]

5. Provides reimbursement to its members for outside services if those services were medically necessary and immediately required because of an unforeseen illness, injury, or

---

23. *Id.* § 300e(b). For purposes of the Act, "supplemental health services" are defined as:

(A) services of facilities for intermediate and long-term care;
(B) vision care not included as a basic health service;
(C) dental services not included as a basic health service;
(D) mental health services not included as a basic health service . . . ;
(E) long-term physical medicine and rehabilitative services (including physical therapy);
(F) the provision of prescription drugs prescribed in the course of the provision by the health maintenance organization of a basic health service or a service described in the preceding subparagraphs of this paragraph; and
(G) other health services which are not included as basic health services and which have been approved by the Secretary for delivery as supplemental health services.

Id. § 300e-1(2).

24. *Id.* § 300e(b)(1)(A).
25. *Id.* § 300e(b)(1)(B).
26. *Id.* § 300e(b)(1)(C).
27. *Id.* § 300e(b)(1)(D).
28. *Id.* § 300e(b)(3)(A)(i)-(v).
29. *Id.* § 300e(b)(4).

condition;[30]

6. Has a fiscally sound operation with provisions against risk of insolvency;[31]

7. Enrolls persons who are broadly representative of the age, social, and income groups within the geographical area, as well as persons entitled to medical assistance under a state plan approved under Title XIX of the Social Security Act;[32]

8. Provides an open enrollment period under the following conditions:[33]

a. if the HMO has provided comprehensive health services on a prepaid basis for at least five years or has an enrollment of at least 50,000 members;[34]

b. for the lesser of 30 days or the number of days in which the HMO enrolls a number of persons at least equal to three percent of its total net increase in enrollment during the previous fiscal year;[35]

c. during which the HMO shall accept persons in the order they apply, without regard to preexisting medical condition, except that the HMO shall not be required to enroll persons who are confined to an institution because of chronic illness or any other infirmity which would cause economic impairment to the HMO;[36]

d. unless this requirement is waived by the Secretary of Health, Education, and Welfare because it jeopardizes the economic viability of the HMO in its service area;[37]

9. Cannot expel or refuse to re-enroll any member because of

---

30. *Id.* § 300e(b)(4).

31. *Id.* § 300e(c)(1)(A). The organization may insure against or make other arrangements for costs in excess of $5,000 per year per member, for services rendered outside the organization when medically necessary, and for 90 percent of the costs which exceed 115 percent of its income. *Id.* § 300e(c)(2) (West 1974).

32. *Id.* § 300e(c)(3) (West Pamph. Supp. 1974-1978).

33. *Id.* § 300e(c)(4), (d).

34. *Id.* § 300e(d)(1)(A). As of August 30, 1978, 68 percent of all HMO enrollees belonged to plans with 100,000 or more members; 71 percent belonged to plans in existence for ten or more years. OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS, 4TH ANNUAL REPORT TO THE CONGRESS 95 (1978) [hereinafter cited as 1978 HMO REPORT TO THE CONGRESS].

35. Health Maintenance Organization Act, 42 U.S.C.A. § 300e(d)(1)(B) (West Pamph. Supp. 1974-1978).

36. *Id.* § 300e(d)(1)(A)(ii), (d)(2).

37. *Id.* § 300e(d)(4).

health status;[38]

10. Has as members of the organization at least one-third of the governing board and has representatives from medically underserved areas on the governing board;[39]

11. Provides meaningful procedures for hearing and resolving grievances between the organization and the members;[40]

12. Provides an ongoing quality assurance program for its health services;[41]

13. Provides and encourages health education services and the use of health services;[42]

14. Provides for continuing education of its staff;[43] and,

15. Provides an effective procedure for submitting statistical reports to the Department of Health, Education and Welfare.[44]

C. *Control Through Federal Funding*

To qualify for federal funding, HMOs must comply with a significant amount of regulation and control. Because the HMO concept is extremely expensive to implement, the Act is generous to those who do comply.[45] The Act provides (1) grants and contracts for feasibility surveys;[46] (2) grants, contracts, and loan guarantees for planning and initial development costs;[47] (3) loans and loan guarantees for initial operation costs;[48] and (4) forgiveness of loans "for

---

38. *Id.* § 300e(c)(5) (West 1974).

39. *Id.* § 300e(c)(6)(A) (West Pamph. Supp. 1974-1978).

40. *Id.* § 300e(c)(7) (West 1974).

41. *Id.* § 300e(c)(8).

42. *Id.* § 300e(c)(9).

43. *Id.* § 300e(c)(10).

44. *Id.* § 300e(c)(11).

45. For a delineation of the grant and loan program under the Federal HMO Act, see 1978 HMO REPORT TO THE CONGRESS, *supra* note 34, at 21-37.

46. Health Maintenance Organization Act, 42 U.S.C.A. § 300e-2 (West 1974 & Pamph. Supp. 1974-1978). Grants or contracts under this section are limited to a maximum of $75,000. *See id.* § 300e-2(e) (West Pamph. Supp. 1974-1978). This amount cannot amount to more than 90 percent of the total cost of the study unless the proposed HMO would serve a "medically underserved population," in which case the grant or contract may provide for the entire cost of the study. *Id.* § 300e-2(e). Medically underserved population is a designation the Secretary of HEW may make upon consideration of the comments of local authorities. *See id.* § 300e-1(7).

47. *Id.* § 300e-3 (West Supp. 1974 & Pamph. Supp. 1974-1978).

48. *Id.* § 300e-4.

good cause but with due regard to the financial interests of the United States."[49] The 1978 amendments to the Act increase the amount of money appropriated for these areas and extend availability through 1981.[50]

D. *Other Federal Encouragement*

The Act encourages and facilitates HMO development through means other than funding and financial assistance. Certain restrictive state laws and health care regulations are preempted.[51] Furthermore, the HMO concept has already been incorporated into existing Medicare[52] and Medicaid[53] programs.

Perhaps the most important aspect of the Act to attorneys, however, is a mandate requiring many employers with an average of twenty-five or more employees to offer the HMO as an alternative to existing health care benefits.[54] This "dual choice" provision is applicable only if at least twenty-five employees reside within the HMO service area and employers are already offering health care benefits.[55] The employer is required neither to spend more than

---

49. *Id.* § 300e-7(b)(3) (West 1974).

50. Health Maintenance Organization Amendments of 1978, Pub. L. No. 95-559, §§ 2, 3, 92 Stat. 2131-32 (amending 42 U.S.C. §§ 300e-3(j), 300e-4(b), (d) (1976)).

51. Health Maintenance Organization Act, 42 U.S.C.A. § 300e-10 (West 1974 & Pamph. Supp. 1974-1978). Section 300e-10 provides that federally qualified HMOs are not subject to state laws or regulations otherwise requiring the HMO to: obtain a medical society approval as a condition to doing business; maintain a percentage of physicians on its governing body; permit a percentage of local physicians to provide services for the HMO; or, meet state health care insurance financing requirements. *Id.* § 300e-10(a)(1) (West 1974). The states are further enjoined from establishing or enforcing laws that prevent federally qualified HMOs from advertising their basic services and rates. *See id.* § 300e-10(a)(2). *See generally* Kissam & Johnson, *State HMO Laws and the Theory of Limited Reformmongering*, 25 KAN. L. REV. 21, 28-35 (1976).

52. 42 U.S.C.A. § 1395mm (West 1974 & Supp. 1979).

53. *Id.* § 1396b.

54. Health Maintenance Organization Act, 42 U.S.C.A. § 300e-9 (West 1974, Pamph. Supp. 1974-1978, & Supp. 1979). *See generally* PRUDENTIAL INSURANCE COMPANY OF AMERICA, THE FEDERAL HMO ACT AS AMENDED AND ITS IMPACT ON EMPLOYERS 3-10 (rev. June 1979). This option, referred to as "Dual Choice," is monitored by the Department of Labor under the Fair Labor Standards Act of 1938, 29 U.S.C. §§ 201-216, 217-219, 557 (1976) (amended). The option must be offered by each employer covered by section 6 of the Fair Labor Standards Act of 1938 or who would be covered except for section 13(a). Public entities are also subject to the mandate.

55. *See* Health Maintenance Organization Act, 42 U.S.C.A. § 300e-9 (West 1974, Pamph. Supp. 1974-1978, & Supp. 1979).

the cost of the currently available plan[56] nor to promote the HMO concept to his employees; rather, the employer must offer a dual choice only if an HMO has petitioned the employer for an opportunity to serve the employees.[57] The administrative problems arising under this provision are not difficult to imagine. The employer already providing health care benefits cost-free to his employees may be unprepared to seek their opinions regarding alternative plans. Further consideration of this obligation placed on employers by the Act, however, is beyond the scope of this article.

HMOs do not necessarily need to be chartered, qualified, or otherwise sanctioned under federal law to perform services or to do business.[58] The federal statute only grants certain benefits to those HMOs qualifying under its provisions. The existence and ultimate regulation of the entities generally known as HMOs is a matter of state law.[59]

III. Application in Texas

As previously discussed, the encouragement given HMO development is bulwarked by a preemption of certain state laws.[60] The effect of this preemption was confusing in practical application until the Texas Legislature passed an enabling act during the 1975 session. Prior to passage of the Texas Health Maintenance Organization Act (Texas HMO Act),[61] the potential organizer of an HMO faced numerous difficulties despite the availability of the federal preemption. The Texas Medical Practice Act,[62] for example, imposes prohibitions against unlicensed persons who practice or aid and abet the practice of medicine.[63] This Act also restricts solicita-

56. *Id.* § 300e-9(c) (West Pamph. Supp. 1974-1978).

57. 44 Fed. Reg. 42,086 (July 18, 1979) (to be codified in 42 C.F.R. § 110.802(b)(2)).

58. As of November 30, 1978, about 40 percent of the prepaid health plans in the United States were federally qualified HMOs; these represented two-thirds of all prepaid health plan members. *See* 1978 HMO Report to the Congress, *supra* note 34, at 99 (Table 13).

59. *Cf.* Health Maintenance Organization Act, 42 U.S.C.A. § 300e-10(c) (West Pamph. Supp. 1974-1978) (requiring Secretary of HEW to develop and periodically update digest of state HMO laws, regulations, and practices).

60. *See id.* § 300e-10 (West 1974 & Pamph. Supp. 1974-1978).

61. Tex. Ins. Code Ann. art. 20A (Vernon Supp. 1963-1979).

62. Tex. Rev. Civ. Stat. Ann. arts. 4495-4512 (Vernon 1976).

63. *Id.* art. 4505, §§ 12, 15.

tion and advertisement of medical services.[64] Another obstacle was the common law rule prohibiting corporate practice of medicine.[65] A practical problem for the physician was the possible violation of ethical standards maintained by various medical associations of which he was a member.[66]

A great impediment the Texas HMO faced during this period was the subject of litigation in *Garcia v. Texas State Board of Medical Examiners*.[67] The case involved the denial of a charter to a proposed HMO by the State Board of Medical Examiners.[68] The Board had determined the HMO failed to comply with article 4509a of the Texas Revised Civil Statutes requiring directors of certain non-profit organizations providing medical services to be licensed physicians.[69] The case, after appeals and new hearings, upheld the constitutionality of the statute.[70]

The 1973 legislature failed to pass a bill designed to reduce the obstacles to creating and operating an HMO in Texas and to facilitate the availability of federal funds.[71] While many state insurance commissions hindered HMO development by requiring compliance with conventional insurance capital levels and requirements, the Texas State Board of Insurance took an active, positive role in assisting the organization of HMOs. After the Texas Legislature failed to pass an HMO act in 1973, the Board issued "Guidelines for the Formation and Operation of Prepaid Comprehensive Health Care Plans," which acknowledged that "an unrestricted prepaid health care plan could not be authorized at that time."[72]

---

64. *Id.* arts. 4505a, 4505b.

65. *See generally* Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 24 STAN. L. REV. 644, 657-58 (1972).

66. *See* Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 307.

67. 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975).

68. *See id.* at 436.

69. *See id.* at 436. *See generally* TEX. REV. CIV. STAT. ANN. art. 4509a (Vernon 1976).

70. *See* Garcia v. Texas State Board of Medical Examiners, 384 F. Supp. 434, 439 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975). The court found article 4509a a reasonable exercise of the state's police power to regulate basic societal services and agreed with the medical examiners that the proper forum for relief was the legislature. *See id.* at 437, 439.

71. Three bills pertaining to HMOs were introduced in the Sixty-third Texas Legislature: H.B. 1488, S.B. 136, S.B. 647. Telephone interview with Mary Ann Nethaway, State Board of Insurance, Office of Health Maintenance Organizations (March 14, 1980).

72. STATE BOARD OF INSURANCE, GUIDELINES FOR THE FORMATION AND OPERATION OF PREPAID COMPREHENSIVE HEALTH CARE PLANS 2 (1973).

Although the State Board of Insurance took the initiative for promoting HMOs, a conflict arose regarding administrative supervision of entities developing under the concept. The State Board of Medical Examiners, vested with supervisory powers for article 4509a organizations, appeared the victor in this conflict when the Attorney General concluded in 1974 that "the State Board of Insurance had no regulatory power over prepaid health care delivery systems," thereby implying that the State Board of Medical Examiners might have been the proper regulatory authority because of article 4509a.[73]

By passing the Texas Health Maintenance Organization Act,[74] the 1975 Texas Legislature eliminated much of the confusion resulting from the conflicts between state and federal law and between concerned state administrative agencies. The Act clarifies the powers and responsibilities of the Boards of Insurance, Medical Examiners, and Health. Strict control over the establishment and maintenance of the HMO entity is mandated. Most of the certificating and regulatory powers concerning financial and organizational matters were vested in the Commissioner of Insurance. Amendments in 1979, however, transferred certain rulemaking and regulatory authority from the Commissioner to the State Board of Insurance.[75] The State Board of Health also has authority over preliminary evaluation of HMOs for certification and supervision of the quality of health care provided.[76]

The certification process is a two-fold procedure. First, the Board of Health is required to determine whether the applicant has (1) demonstrated the willingness and ability "to assure . . . both availability and accessibility of adequate personnel and facilities," (2) has arrangements "for an ongoing quality of health care assurance program," and (3) has a procedure for compiling, evaluating, and reporting its services.[77] Second, if the Board certifies an organization, the Commissioner of Insurance must also be satisfied of (1) the competency and reputation of the "person responsible

---

73. *See* TEX. ATT'Y GEN. OP. NO. H-344 (1974).

74. 1975 Tex. Gen. Laws, ch. 214, at 514-30 (current version at TEX. INS. CODE ANN. art. 20A (Vernon Supp. 1963-1979)).

75. 1979 Tex. Gen. Laws, ch. 214, at 1449 (amending TEX. INS. CODE ANN. art. 20A.22 (Vernon Supp. 1963-1979)).

76. *See* TEX. INS. CODE ANN. art. 20A.05, .20 (Vernon Supp. 1963-1979).

77. *Id.* art. 20A.05(a)(2)(A)-(C).

for the conduct of the affairs of the applicant," (2) the appropriateness of the proposed plan to arrange effectively for "health care services on a prepaid basis," and (3) the financial responsibility of the organization.[78] The Act sets forth the authorized powers of the organization, including the power to insure for certain services not provided by the organization.[79]

Texas HMOs are expressly forbidden from engaging in certain activities such as deceptive advertising.[80] Only certified HMOs may use the term "health maintenance organization,"[81] and HMOs may not use terms descriptive of the insurance business unless separately licensed as an insurer.[82] Another significant prohibition disallows cancellation of a participant's rights except for failure to pay the charges for coverage or for such other reasons as the Commissioner may dictate.[83] Continuing supervisory authority of the respective administrative agencies is more than an information-gathering function. Whenever the financial condition of any HMO indicates continued operation might be hazardous to enrollees, creditors, or the public, the Commissioner is authorized to order the HMO "to take such action as may be reasonably necessary to rectify the existing condition."[84] The Commissioner is further authorized to suspend or revoke the HMO's certificate of authority if he makes any of ten statutory findings.[85]

The 1979 amendments to the Texas HMO Act altered the method of state taxation of HMOs by repealing the tax of one percent on all annual revenues.[86] Each HMO will continue to be taxed on gross receipts as an "insurance organization," within the terms of article 7064a.[87]

---

78. *Id.* art. 20A.05(b)(2)(A)-(C).

79. *Id.* art. 20A.06(a)(6)(B)-(C).

80. *Id.* art. 20A.14; *cf. id.* art. 20A.20(8) (subjecting HMO engaging in deceptive advertising to suspension or revocation of certificate of authority).

81. *Id.* art. 20A.14(f).

82. *Id.* art. 20A.14(d).

83. *Id.* art. 20A.14(c).

84. *Id.* art. 20A.19(a).

85. *Id.* art. 20A.20.

86. *See id.* art. 20A.33.

87. *See id.* art. 20A.33. *See generally* TEX. REV. CIV. STAT. ANN. 7064a (Vernon Supp. 1980).

IV. PROBLEM AREAS

The structural legal problems may prove among the least pressing of the obstacles facing the HMO. And more importantly for a variety of reasons, the business and financial aspects of HMOs represent a substantial risk.

One of the most severe problems for the HMO is the uncertainty of the tax burdens on its revenue. While the Administration and Congress obviously intended to encourage rapid development of this alternative to traditional health care systems, the Internal Revenue Service has not taken a position consistent with other agencies involved in the supervision and execution of the federal statute. Specifically, while the IRS has not issued any rulings on the tax status of HMOs,[88] its position has long been that the revenue generated by the business activities of HMOs does not qualify for tax-exempt status under the Internal Revenue Code.[89] This uncertain status should be especially worrisome to organizers of HMOs that are presently 501(c)(3) type organizations, such as hospitals, since they might lose their favorable income tax status. However, the Tax Court recently held a member-owned HMO organized in the State of Washington qualified for the 501(c)(3) exemption. In *Sound Health Association v. Commissioner,*[90] the Tax Court applied the "community benefit" test[91] and found the HMO qualified as a 501(c)(3) charity because the class of people served was not so small that their relief could not be viewed as a benefit to the community.[92] The court found the HMO also passed the two-pronged test for charitable purposes provided in the income tax regulations.[93] In assessing the significance of the Tax Court holding in this case, one must note the organizers of the HMO apparently structured its programs and articles of incorporation to obtain favorable tax status.[94]

---

88. As of March 1, 1980.

89. *See* I.R.C. §§ 170, 501(c)(3); Bromberg, *Obtaining a 501(c)(3) Exemption for an HMO Should Be Easier Now Despite IRS Objections,* 51 J. TAX. 302, 302 (1979).

90. 71 T.C. 158 (1978).

91. *See id.* at 181; Rev. Rul. 69-5-45, 1969-2 C.B. 117; *cf.* Treas. Reg. § 1.501(c)(3)-1(b)(ii) (1959) ("An organization is not organized or operated exclusively for charitable purposes . . . unless it serves a public rather than a private interest").

92. *See* Sound Health Ass'n v. Commissioner, 71 T.C. 158, 181 (1978).

93. *Id.* at 183-84, *citing* Treas. Reg. § 1.501(c)(3)-1(b) (1959).

94. *See* Sound Health Ass'n v. Commissioner, 71 T.C. 158, 160-66 (1978). The Associa-

Most of the other non-taxation problems facing the HMO center on the following areas:

(1) Initial organizational, promotional, and sales costs are exceptionally high because the entity must compete with well-entrenched traditional health care insurers;[95]

(2) High front-end costs generally force organizers to seek federal financial assistance which imposes restrictions that may be too idealistic to be commercially feasible;[96]

(3) Motivating the public to accept a new health care system that would prescribe the person to perform the medical services is a difficult burden when many participants have long, close relationships with their existing health service providers;[97] and,

(4) The medical profession may be expected to hesitate in accepting or promoting a system that could alter their income, prestige, lifestyle, or professional independence.[98]

V. CONCLUSION

The immediate future of the HMO movement depends in large part on federal assistance becoming available to the struggling new plans, the realistic offering of the new alternative by certain employers with more than twenty-five employees as required by statute, and the guidance and cooperation of state regulatory authori-

---

tion's articles contained a purpose clause with language authorizing the association:

> to promote the general health of the community by making available its services, resources and facilities to those persons who may not be able to pay for services rendered and not exclusively to those who were members of Sound Health Association and/or otherwise able and expected to pay, to the extent of the financial ability of the Corporation to do so.

Id. at 160. The Association also planned a program for subsidizing the dues of persons wanting to join who could not afford full membership costs. *Id.* at *166.* The HMO, therefore, offered its services to the entire community. *See generally* Bromberg, *Obtaining a 501(c)(3) Exemption For an HMO Should Be Easier Now Despite IRS Objections,* 51 J. TAX. 302, 302-03 (1979).

95. *See* Havighurst, *Health Maintenance Organizations and the Health Planners,* 1978 UTAH L. REV. 123, 126-27.

96. *See id.* at 134-35.

97. *Cf.* HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, HEALTH MAINTENANCE AMENDMENTS OF 1978, H.R. REP. No. 1479, 95th Cong., 2d Sess. 15 (1978) (HMOs frequently criticized for providing "impersonal" medical care).

98. *Cf. id.* at 8-9 (noting continuing, although diminishing, resistance to HMOs by medical profession).

ties. While statutory authorization has been completed, perhaps the greatest problems to the organizers, employers, and participants will only appear after months or years of working with the concept as a realistic alternative to traditional health care systems.