Annals of Health Law

Volume 8
Issue 1 *1999*

Article 5

1999

Federalism and Managed Care: Introductory Comments to the American Association of Law Schools' Section on Law, Medicine and Health Care on the Role of the States in Managed Care Regulation

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Introduction

Federalism and Managed Care: Introductory Comments to the American Association of Law Schools' Section on Law, Medicine and Health Care on the Role of the States in Managed Care Regulation

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In this century health regulation has passed through three stages, the first of which was characterized by federal and state governmental efforts to promote public health and safety. The second stage of health policy entailed a dramatic expansion of health care services and research, promoted by both the states and the federal government. In the third stage, the focus of national and regional government has been on controlling health care expenditures, and balancing those controls against large public obligations. Within this history of health policy, there has never been a comfortable division between the respective roles of federal and state government. Federalism in the health care context, like other areas of domestic policy, is characterized by a history of tensions and ongoing disputes over policies and turf. But even with the history of acrimonious relationships, a sense of equilibrium did develop in the various periods of health policy, so that a certain de facto recognition of the boundaries of regulatory authority developed between the federal and state governments.

With the dramatic growth of managed care in the 1990s, we have entered into a new stage of health care regulation, one in which the boundaries of the federal/state regulatory enterprise are unclear. Both the states and the federal government are promoting managed care programs as vehicles to contain health care costs. While managed care is rapidly evolving, its various models can be characterized as hybrid insurance products, and

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as such these offshoots of health insurance fall under the ambit of state regulators.[1] Though states have acquired certain expertise in regulating managed care plans, particularly HMOs, their records have been spotty in effectively dealing with structural hybrids and fundamental questions of risk sharing. Thus, the federal government, given its considerable investment in managed care, has been ambivalent and distrustful about allowing states to be the primary regulators of managed care. Added to the mix of managed care insurance type regulation is the growing trend to utilize consumer protection law as a vehicle to stem the tide of abuses in the MCO area. Consumer law has also been traditionally dominated by the states, but here too, the federal regulators are moving to implement national controls to protect managed care consumers through patient's rights legislation, buttressing what often is perceived as shortfalls in state-based safeguards.

The era of managed care has moved federal and state governments into a period of parallel regulation, where there is considerable overlap of efforts, and no hesitation by the respective parties to create new MCO regulatory controls. Not only do we see federal regulators jumping into the fray to fill a void in state regulation, but often the states are moving aggressively to create new MCO regulations, impatient with the all too frequent legislative impasses in Washington. Though consensus may develop over how managed care should be regulated, the challenges in the area are compounded by the idiocrasies of a marketplace that is often far ahead of governments' abilities to regulate, and further affected by realizations that regulatory controls need to be tempered so that the efficiencies of the market may be realized.

This section of the *Annals of Health Law* concerns the respective roles of states in the regulation of managed care. The papers appearing in the section were first presented at the annual meeting of the American Association of Law Schools ("AALS"), Section on Law, Medicine and Health Care in January of 1999. The AALS session and the resultant papers were motivated by a belief that more focus needs to be placed on the study of state regulation of managed care, with the broader goal

1. Under the 1973 HMO Act, the federal government became fairly active in HMO regulation at an early stage in the development of these plans, and in fact the federal involvement resulted in the proliferation of these plans (42 U.S.C § 300e to 300e-17). In balance, however, state licensure has been and continues to be the dominant regulatory process in the HMO area.

of attempting to address the appropriate role of the state regulators in this area. Each of the four papers provides perspectives on different roles state regulators have assumed in dealing with managed care. Professor Louise Trubek from the University of Wisconsin School of Law focuses on MCO patient protection provisions in Wisconsin, a very active jurisdiction in the area. The Trubek paper covers consumer information requirements, dispute resolution mechanisms and the regulation of the physician - MCO contract. Professor Barbara Colombo from William Mitchell School of Law addresses the very difficult challenge state regulators face in controlling the various forms of managed care and the regulation of risk. The Colombo paper highlights the tensions between consumer protection and market competition, and focuses on the experiences of Minnesota regulators in this area. Professor Joan Krause from Loyola University Chicago School of Law writes about how states are dealing with managed care fraud issues, an area in which the federal government has clearly assumed a dominant role. Professor Krause discusses three approaches to medical fraud that have been followed by the states, parallel fraud and abuse regulations, regulation of the insurance industry and the use of state consumer protection law. The fourth paper in this grouping on managed care federalism, by Professor Ed Richards of the University of Missouri, Kansas City School of Law, returns to a very traditional role of state government, flowing from police power: licensure and related regulation of physicians. The Richards piece pushes the envelope of analysis in the medical licensure area by suggesting that this process be adjusted to act as a regulatory lever to promote positive physician behaviors in the managed care practice environment. Together the four papers present varied and interesting perspectives on the actual, and potential, roles of state governments in the managed care era, and each in its own right touches the broader questions of federalism in the current health policy environment.