

HB

481



# Alaska State Legislature

## House

JUNEAU ALASKA

HOUSE HESS COMMITTEE MEETING

MARCH 15, 1976

Present: Sullivan            Hackney  
          Beirne                Ose            Osterback

Testifying: Dr. Pauls, Dept. H&SS, Public Health  
              Dick Block, Div. of Ins.  
              Sonya Johansen, Dept. H & SS HIS

### HB 481 - Health Maintenance Organizations - HESS

Dick Block - Explanation of bill, HMO similar and mandatory to various types of health insurance. Reasons why we need regulation on HMO 1. to keep high standard of medical care 2 Since subscribers pay in advance, organization must be financially sound.

Committee - How much money would be needed to assure solvency, Block had no definite answer. Teamsters example as an HMO. Can this bill be redone to eliminate alot of the unneeded regulations, Block thinks so.

Committee requests Dick to submit a draft of an alternative to this bill. Dr. Pauls said Dept. will work along with him on this.

Dr. Pauls - did not have an official position paper on this bill from the Dept. but feelings regarding it are that there are now other health bills which speak to the same issue., for instance the Indian Health Service. So he doesn't feel this bill is needed.

Committee decided not to take any action on this now.

### HB 395 - Registry of Impairments - HESS

Sonja Johnson - Dept. H&SS, feels that there is some problems with this bill, relating mainly to mandatory signing and also confidentiality. But she also feels that eventually everything will have to be on a registry.

Committee - If this is implemented what are the problems with it? Should this bill speak to the problems of data processing at the same time, yes. Dept. is now working to standardize procedures for data processing and will have done by the end of April.

Hackney - Is this bill really needed or does everything spoken to in here redo what is already in the regulations??

Dr. Pauls - If it is done by regulations instead of a bill, there must be a public hearing all over and then the regs. must be rewritten. This bill does not force the regulations to be rewritten.

Sullivan concerned with whether some of the confidentiality problems are unconstitutional??, nobody seems to know.



# Alaska State Legislature

## House

JUNEAU ALASKA

Page 2  
March 15

Beirne - thinks this bill is much needed, but doesn't want to take rights away from individuals to choose to be on a registry.

Committee decided to hold bill.



# Alaska State Legislature

## House

JUNEAU ALASKA

HOUSE HESS COMMITTEE MEETING

MARCH 15, 1976 7:00 P.M.

Present:

Ostrosky	Parr	Sullivan
Swanson	Beirne	Hackney

HB 733 - Commitment procedures for mentally ill - HESS

Louise Ma - Research Analyst, Legis. Affairs Office - explained basis and provisions for the bill

Parr - After 270 days what can be done with someone who cannot be helped but is dangerous??

Gruening - have to be new circumstance to begin commitment procedures.

Jerry Schrader, Director, Div. of Mental Health - Presented the dept. position regarding this bill. Basically in favor, but have a few problems with it. Can make amendments to correct. See position paper.

Beirne wanted to know if it might be possible to combine into one facility the function of crisis intake and mentally ill, alcoholics, drug addicts, etc.??

Pat Spartz - Kodiak Aleutian Mental Health Center - Supports bill, but would like to see some amendments. Hard to see how bill would actually work until it is tried.

no action on bill

Table 2. BASIC HEALTH CARE BENEFITS REQUIRED BY PROGRAM

	HMO Act	HB 481	DHSS Amend.	Model Legislation (NAIC)	Legislation (Federal)	AS 47.07. Medicaid	Medicaid Amend. (AS 47.07.030) SB 542	(AS 47.25.120) General Relief Medical
1. Physician Services	X	X		X	X	X		X
2. Inpatient hospital	X	X		X	X	X		X
3. Outpatient hospital	X	X		X	X	X		X
4. Emergency services	X	X		X	X	X		X
5. Psychiatric inpatient						X*		
6. Short term mental health	X						X	X
7. Drug & Alcohol services	X							
8. Skilled nursing						X		X
9. Intermediate nursing						X		X
10. Home health services	X					X		X
11. Laboratory & X-ray	X		X		X	X		X
12. Preventive Services	X**		X		X	X***		
13. Drugs							X	X
14. Dental care	X(children)							X(emergency, adult)
15. Wheelchairs, hearing aids, ect.								X

\* for persons over 65 and under 21 years.

\*\* minimum preventive services are family planning and fertility counseling, preventive dental care for children, and children's eye exams.

\*\*\* Early periodic screening, diagnosis and treatment for children is required under Medicaid.

STATE OF ALASKA  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
JUNEAU ALASKA 99811  
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 10, 1976

SUBJECT: HB 481, The Health Maintenance Organization Enabling Legislation (W.O.#2049)

TO: The Honorable Susan Sullivan

FROM: Brian L. Saylor *BLS*  
Research Analyst

The passage of House Bill 481 would make Alaska the 18th state to enact enabling health maintenance organization legislation. In most states, the HMO legislation was designed to counteract the inhibiting effects of statutes regulating health insurance companies, hospital and medical service corporations and professional licensure. HB 481 succeeds in accomplishing this.

Major issues within HB 481 and the pages in this memo that refer to them are:

1. Requirements for rate reviews for HMO's (18.18.030)..... p 5
2. Safeguards for consumers:
  - Surety bonds (18.18.030, 18.18.110)..... p 6, 9
  - Certificate of need (18.18.040)..... p 7
  - Governing Boards (18.18.040)..... p 7
  - Complaints system (18.18.100)..... p 9
3. Required benefit packages (18.18.250) ..... p 11,12  
Table 2
4. Open vs closed enrollment ..... p 12

In addition to the above basic considerations, with the organization of an HMO, there are problems with the administration of the program review, and regulation of HMO's are split between the Department of Health and Social Services and the Department of Commerce and Economic Development. Both departments are currently trying to find solutions to this problem. As more information reaches us, we'll pass it on.

BLS:jm  
Enclosures

## I. BACKGROUND

A "Health Maintenance Organization" provides an alternative to the present fragmented "non-system" of medical care. The term refers to the organization of health care services organized along the lines of either a group practice or a federation of individual medical practices. HMO's undertake the delivery of comprehensive medical services to a defined population on a prepaid basis with a fixed charge for each person enrolled. Thus, the term HMO can describe any alternative health care delivery system which welds together a series of services required by its enrolled population. 1/

The idea of prepaid health care is not new in the United States. The theoretical model for the HMO type of health care delivery was developed almost fifty years ago. A group of experts refined the idea and published their recommendations in 1932 in a paper entitled Medical Care for the American People. 2/ The basic concept stated:

- 1) Groups of physicians, rather than solo practitioners, should give necessary services, enforcing high standards through peer evaluation.
- 2) All costs should be prepaid.
- 3) Disease prevention should be emphasized.
- 4) Facilities should be planned on a community basis.
- 5) Consumer groups should sponsor such health care delivery systems and contract with provider groups.

These recommendations were developed by a large number of prepaid practice plans during the next 20 years. One of the first applications

of the idea of prepaid group practice was developed in Oklahoma in a small farming community about 1929. By 1950 there existed 24 similar plans in farm cooperatives throughout the country.

Prepaid health care gained momentum in the urban areas with the organization of Group Health Association of Washington, D. C. in 1937 and the New York Health Insurance Plan (HIP) in 1947. The idea continued to be refined by Kaiser-Permanente in California and the Group Health Cooperative of Puget Sound in Seattle and Tacoma. 3/

None of these programs had an easy time becoming self-sufficient or gaining acceptance in the community. Most of them suffered from discrimination by organized medicine, which declared that programs in which patients did not pay for services but rather were in the prepaid mold were unethical. Physicians serving in such programs were refused access to professional associations as well as to hospitals.

Law suits gradually eliminated the worst prohibitions against prepaid group practices. By 1973 the number of states which effectively prohibited HMO's had been reduced from thirty to less than ten. 4/

Federal commitment to the concept first appeared in Presidential White Paper in 1971. 5/ The Health Maintenance Organization Act of 1973 (P.L. 93-222) was signed into law at the end of that year, and provisions to override restrictive state laws were included in it. The legislation was considered a great advance toward bringing order, cost consciousness and entrepreneurial spirit to the disorderly system of health care delivery.

As of December, only four Health Maintenance Organizations in the United States have been certified as an HMO qualified under the Act. They are in Rhode Island, Connecticut, Illinois, and Pennsylvania. 6/

P.L. 93-222 has been considered by some to be too restrictive in a number of areas. Among these are:

- 1) The benefit package required by law is too expansive and, therefore, costly.
- 2) Because the package is set by law, the insurance carriers cannot vary the benefits in response to community need.
- 3) The law requires HMO's to community rate their health care risks. This means that while an HMO will have to accept anybody (open enrollment) other insurance carriers will be able to skim all the good risks off the top through experience rating mechanisms.

These provisions restrict the ability of HMO's to compete with other health insurance carriers in the open market. 7/

In response to these problems, the National Association of Insurance Commissioners developed model state legislation which would allow states much more latitude in developing HMO's which meet their unique needs. 8/ The federal government has proposed another approach which is slightly more flexible in its proposed regulatory provisions.

Alaska's enabling HMO legislation (HB 481) makes use of the NAIC model legislation. A comparison of the federal model legislation and Alaska's proposed legislation is presented section by section in narrative form for greater applicability. Both the NAIC and the federal proposals are attached. Table 1 shows how HB 481 compares with similar legislation in other states. Table 2 compares benefit packages under public programs within Alaska with those proposed under alternative HMO structures.

## II. SECTION BY SECTION ANALYSIS: HB 481

Section 18.18.010. A certificate of authority is required by any person who wants to establish or operate a HMO. Existing Alaskan HMO's (there aren't any now) are allowed 60 days to comply with the law.

This section is consistent with NAIC model legislation.

Section 18.18.020. The application form, approved by the commissioner of Commerce and Economic Development, will require:

- 1) a basic organizational document
- 2) bylaws for internal affairs
- 3) list of responsible persons
- 4) copies of all contracts between participating providers
- 5) description of health care plan including services offered, and facilities and manpower used.
- 6) evidence of coverage for enrolled persons (see 18.18.070)
- 7) contract forms with enrolled persons
- 8) statement of HMO finances
- 9) marketing methods
- 10) power of attorney
- 11) geographic area served
- 12) complaint procedure used (see 18.18.100)
- 13) quality control procedures
- 14) methods of involving enrollees in policy decisions
- 15) anything else the commissioner wants

Any modification of these statements must also be approved by the commissioner within 45 days.

Comment: Public Law 93-641 requires the issuance of a certificate of need for HMO's. The type of information required for the HMO review should be coordinated with the information required by the certificate of need review. Alternative certificate of need proposals are now under consideration.

All provisions are consistent with recommended NICA model legislation.

Section 18.18.030 As soon as the application reaches the commissioner of Commerce and Economic Development, a copy is given to the commissioner of Health and Social Services. HSS is responsible for the first review. Time for review is 30 days. Criteria for review are:

- 1) Adequacy of personnel, facilities and continuity of service
- 2) Availability and accessibility
- 3) Quality assurance (see 18.18.140)
- 4) Adequacy of statistical reporting systems

After the commissioner of Health and Social Services approves the HMO application, the commissioner of Commerce and Economic Development begins a review of the HMO's plan of operation. Criteria for the second review are:

- 1) Approval of HSS
- 2) Appropriateness of HMO mechanism to provide services

Comment: The latitude in deciding what is "appropriate" seems to be very wide. This clause could have the effect of preventing innovative types of HMO's from developing.

- 3) Financial responsibility in terms of
  - A) charges for services

Comment: The federal model legislation deletes any reference to rate review. The drafters felt that it would be more appropriate to rely on the free market mechanisms. Rate review may stifle completion by promoting rate uniformity.

- B) working capital

- C) agreements with other insurance carriers
- D) agreements with health care providers
- E) surety bonds

Comment: Surety bonds are required. Specific dollar figures are given in Sec. 18.18.110. These figures may be insufficient to safeguard consumers. For example, it might cost as much as \$640,000 to provide necessary health care services to 2,500 enrollees for one year. The surety bond requires \$10,000.

- 4) Opportunity for consumer involvement
- 5) Assurances that the project is in the public good.
- 6) Consistency of policy awards and termination are consistent with other carriers
- 7) Problems in HSS review were corrected.

The entire review must be conducted within 60 days unless there is a modification of a previous application. In that case the review takes 45 days.

Comment: Time requirements for review are very long. The time allowed for a HMO review is 60 days. If a certificate of need is also required, the process could take 150 days. Concurrent DHSS reviews at the state level could reduce this figure by at least 30 days.

<u>Proposed Review Timeframe</u>	<u>Alternative Concurrent Review Timeframe</u>
30 days HSS review	90 days concurrent review:
90 days cert. of need	30 days HSS review
30 days Commerce review	60 days cert. of need
	30 days Commerce review
<hr/>	<hr/>
150 days	120 days

Section 18.18.040. An HMO can:

- 1) Build
- 2) Loan money
- 3) Contract for services
- 4) Contract for marketing health plan
- 5) Contract to other carriers to underwrite HMO
- 6) Offer basic services
- 7) Accept public or private money

The HMO has to inform the commissioner of any intent to build or loan money. There must be a response within 30 days.

Comment: A capital expenditure in excess of \$100,000 will probably require a certificate of need under new federal requirements. Processing a certificate of need application takes 90 days. Only 30 days are allowed under this section.

Section 18.18.050. establishes a governing body. There is no specification of the proportion of consumers and providers.

Comment: Arguments against the inclusion of consumers on the governing board include: (1) such participation is unnecessary and perhaps even harmful to the efficient and professional delivery of health care services, (2) a consumer role will impede the initiation of an HMO since more people must be involved and (3) consumers can always seek alternative health care. The arguments for a consumer role include (1) consumer participation results in a more responsive organization, and (2) consumer participation is not the same as lay control over the rendering of professional service.

Section 18.18.060 makes sure one person is responsible for financial matters.

Section 18.18.070 itemizes the kind of evidence that must be given to

each enrollee regarding benefits. There can be no changes in benefits without notice. Evidence of coverage should contain:

- 1) No misleading statements
- 2) A summary of
  - A) benefits
  - B) limitations of service
  - C) sources of information about how to get services
  - D) total payment for services
  - E) complaints system

Forms for evidence of coverage must be approved by the commissioner within 30 days of its submission.

Comment: The federal model legislation includes a provision that enrollees shall be told of service priorities in case of epidemic or other emergency affecting the demand for medical services. The inclusion of the provision would probably be an asset.

The Department of Health and Social Services has suggested that two additional sections be added:

1. Add to (2) another subsection (F) requiring the inclusion of criteria for disenrollment in the evidence of coverage form.
2. Another section prohibiting the HMO from cancelling the enrollment of a participant or refusing to transfer an enrolled participant from a group for reasons relating to age, sex, race or health status.

Section 18.18.080 requires an annual report submitted to the commissioner containing:

- 1) a financial statement of receipts and disbursements
- 2) any changes in the original certificate of authority
- 3) number of persons enrolled
- 4) anything else the commissioner requires

Comment: The model federal legislation requires that the annual report contain a statement disclosing the percent of enrolled participants assisted by public funds. This clause can provide an evaluation tool to see if public health care dollars are better spent on HMO programs vs traditional public assistance programs.

Section 18.18.090 requires a similar report to be submitted to all enrollees containing:

- 1) a financial statement
- 2) a description of services
- 3) the method of resolving complaints

Section 18.18.100 describes the complaint system. The only requirements are that it exist and maintain written records.

Comment: HB 481 requires that a system exist for handling written complaints only. The Department of Health and Social Services suggests that the language of the NAIC model legislation be included. The change would require the HMO to keep records of the underlying causes of such complaints, as well as the number and resolution of all malpractice cases filed against the HMO.

Section 18.18.110 addresses requirements for surety bonding which obligates the health plan to provide services. This provision is not in the federal model legislation. Required dollar amounts are specified (see "Comment", 18.18.030(3)(E)).

Section 18.18.120 allows joint operation with hospital service corporations (Blue Cross) and medical service corporations (Blue Shield).

Section 18.18.130 prohibits an HMO from issuing misleading statements, cancelling a policy or using certain words in advertising.

Section 18.18.140 requires a review of each HMO program every three years.

Comment: Federal law (P.L. 93-641) requires a review of institutional health services every five years.

Section 18.18.150 allows the commissioner to suspend a certificate of authority if:

- 1) The HMO is not in compliance with its basic organizational document (see Section 18.18.020).
- 2) Charges are not in line with those stated in the evidence of coverage.
- 3) There is no consumer involvement in policy development
- 4) There is no complaint system
- 5) Advertising is misleading, false or unfair
- 6) The commissioner determines that the HMO doesn't comply with the law.

The commissioner can go farther and revoke a certificate of authority if:

- 1) The commissioner of HSS agrees that the HMO is unable to continue providing services, or
- 2) The HMO is found to be financially unsound.

As soon as the decision to suspend or revoke a certificate of authority is made, the HMO must stop functioning.

Section 18.18.160 authorizes the commissioner to write necessary regulations.

Section 18.18.170 establishes administrative procedures for appeals.

These procedures are consistent with the Administrative Procedures Act.

Section 18.18.180 sets fees for application and review processing.

Comment: The fees charged for review contain no provisions for the equitable allocation of fees between the Department of Commerce and the Department of Health and Social Services.

Section 18.18.190 itemizes sanctions against an HMO for non-compliance.

The fee is \$100 to cover the administrative expenses of the department and can go as high as the commissioner estimates the damages suffered to be.

Section 18.18.200 requires all documents to be available for public scrutiny.

Section 18.18.210 assures that medical or hospital service corporations are still under separate laws. Advertising by an HMO does not violate the Medical Practices Act.

Section 18.18.220 establishes confidentiality of medical records.

Section 18.18.230 allows the commissioner of Health and Social Services to contract for review functions.

Section 18.18.240 requires all agents associated with the HMO to be controlled by regulation.

Section 18.18.250 sets out definitions (See Table 2).

Comment: There is a great deal of controversy regarding the required benefit package for an HMO. One side says that an overly rigid benefit package might inhibit competition among HMO's and between HMO's and other forms of health insurance. The federal legislation (P.L. 93-222) has been criticised for this. Those in favor of a structured and comprehensive benefit package argue that

the package should assure enrollees of a reasonable amount of services to meet their basic health care needs. A more rigid benefit structure could have the effect of either putting the HMO out of business or promoting necessary changes in the health care delivery system.

### III: ADDITIONAL CONSIDERATIONS

#### Open Enrollment

The NAIC proposes a period of at least one month when anyone could enroll in the HMO. The first open enrollment period begins after the HMO has been operational for 24 months. Open enrollment allows people access to the program who may not be eligible for other types of health insurance, thereby encouraging a community rating rather than an experience rating approach. Critics contend that open enrollment would make it difficult for an HMO to compete with other types of insurance.

#### Liquidation Procedures

The NAIC model HMO bill includes complex insurance type liquidation procedures. Critics oppose increasing government involvement in the internal workings of an HMO and prefer to rely on existing general bankruptcy laws.

## Footnotes

1. For a complete discussion of Health Maintenance Organizations, see:
  - Klarman, H., "Analysis of the HMO Proposal--Its Assumptions, Implications and Prospects, pp. 24-38, Health Maintenance Organizations, A Reconfiguration of the Health Services System, Chicago, 1971
  - Glasgow, J., "Prepaid Group Practice as a National Policy: Problems and Perspectives, Inquiry, March, 1972
  - Greenlick, M., "The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation," The Annals of the American Academy of Political and Social Science, January, 1972
2. Wilbur, R. L. et al, Medical Care for the American People, University of Chicago Press, 1932
3. Birnbaum, Hilde, "Competition Between Health Care Delivery Systems Under the 1973 HMO Legislation?", Ninth Annual Pacific Northwest Regional Economic Conference, Spokane, Washington, 1975
4. Clarke, G. C., "Health Maintenance Organizations," Health Programs in the States: A Survey, Center for State Legislative Research and Service, Eagleton Institute for Politics, Rutgers University, March, 1975
5. U. S. Department of Health, Education and Welfare. Towards a Comprehensive Health Policy for the 70's: White Paper. Washington, D. C.: Government Printing Office, 1970
6. HMO Update #2, DHEW Health Services Administration, December 15, 1975
7. Birnbaum, Hilde, op cit.
8. Suggested Health Maintenance Organization Act, Draft. National Association of Insurance Commissioners, Suggested State Legislation, 1975

TABLE 1. HEALTH MAINTENANCE ORGANIZATION

As of May 1974	States With HMO Laws								States Without Specific HMO Laws (primarily Blue Cross/Blue Shield provisions)									
	Form Required		Mandatory Policy-Making Role for Enrollees	Prior Rate Approval Required	Mandatory Dual Choice	Mandatory Open Enrollment	Financial Require- ments		Form Required		Insurance Type Regulation	Specific Prohibition of Advertising	Mandatory Open Panel	Require Physicians to be % of Governing Body**	Medical Society Approval Required	Specific Restriction on Corporate Contract for, Practice of, Medicine	Specific Exemption from Corporate Practice of Medicine Restrictions	Legislative Activity in 1974
	For Profit	Non-Profit					Insolvency Protection	Investment Protection*	For Profit	Non-Profit								
(HB 481)	Alabama	X	X	X	X		X		X	X	X					X		
	Alaska	X	X	X	X		X		X	X	X					X	X	
	Arizona																	
	Arkansas								X	X	X							
	California		X	X	X	X	X	X										
	Colorado	X	X	X	X	X	X	X										
	Connecticut								X	X			25%					
	Delaware								X	X								
	Florida	X	X		X		X	X								X		
	Georgia								X	X		X	maj.	X	X		X	
	Hawaii								X	X						X	X	
	Idaho	X	X	X	X	X	X	X								X	X	
	Illinois								X	X		X	maj.			X	X	
	Indiana															X		
	Iowa	X	X	X	X	X	X	X								X		
	Kansas	X	X	X	X		X	X								X		
	Kentucky	X	X		X	X	X <sup>2</sup>	X								X		
	Louisiana								X		X		maj.	X		X		
	Maine								X	X			maj.			X	X	
	Maryland								X	X	X					X	X	
	Massachusetts								X	X		X	33%			X	X	
	Michigan	X	X	X	X	X		X										
	Minnesota		X	X		X												
	Mississippi								X	X						X		
	Missouri								X	X	X					X		
	Montana								X	X		X		X	X			
	Nebraska								X	X	X		67%			X	X	
	Nevada	X	X	X	X	X	X											
	New Hampshire								X	X				X		X	X	
	New Jersey	X	X	X		X	X	X								X	X	
	New Mexico								X	X	X					X		
	New York		X		X		X	X										
	North Carolina								X	X						X		
	North Dakota								X	X		X	maj.		X		X	
	Ohio								X	X								
	Oklahoma								X	X	X							
	Oregon								X	X						X		
	Pennsylvania		X <sup>1</sup>	X	X	X												
	Rhode Island								X	X	X		33%	X		X		
	South Carolina								X	X	X					X	X	
	South Dakota		X	X		X	X <sup>2</sup>											
	Tennessee	X	X			X												
	Texas								X	X			maj.		X		X	
	Utah	X	X	X	X	X												
	Vermont								X	X						X	X	
	Virginia								X	X	X	X				X	X	
	Washington								X	X	X					X	X	
	West Virginia								X	X	X					X	X	
	Wisconsin								X	X	X					X	X	
	Wyoming								X	X	X					X		

\* Investments restricted to those allowed insurance companies.  
 \*\* Physicians or hospital representatives.  
<sup>1</sup> And non profit hospital "corporation" only.  
<sup>2</sup> May be waived by director or commissioner.  
 Adapted from: Aspen Systems Corporation, H.M.O. Sourcebook - 1973 Edition and H.M.O. Sourcebook Supplement: Legislative Developments in 1973 (Rockville, Md.: Health Law Center, Aspen Systems Corporation, 1973 and 1974). Information also supplied by Interstudy, Minneapolis, Minnesota.

SECTION I - DEFINITIONS

(a) "Health Maintenance Organization" means a public or private organization, which is organized under the laws of this State or the laws of another State or the District of Columbia, which:

(1) provides or otherwise make available to enrolled participants health care services, including at a minimum those basic health care services which are [determined by the Administrator to be] generally available on an insured or prepaid basis in the locality served by the organization;

(2) is compensated [(except for copayments)] for the provision of basic health care services to enrolled participants solely on a predetermined periodic rate basis;

(3) provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) under arrangements with one or more groups of physicians [(organized on a group practice or individual practice basis) under which each such] group [(A)] is compensated for its services primarily on the basis of an aggregate fixed sum or on a per capita basis and (B) is provided with an effective incentive to avoid unnecessary inpatient utilization, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis; and

0

(4) assures the availability, accessibility and quality (including effective utilization) of comprehensive health care services through clearly identifiable focal points of legal and administrative responsibility.

(b) "Basic Health Care Services" means usual physician hospitalization, laboratory, X-ray, emergency and preventive service, and out-of-area coverage.

(c) "Health Care Services" means basic health care services and other services, medical equipment and supplies which may include, but are not limited to, medical, surgical and dental care; psychological, obstetrical, osteopathic, optometric, optic, podiatric, nursing, physical therapy services and pharmaceutical services; health education, preventive medical, rehabilitative and home health services; inpatient and outpatient hospital services, extended care, nursing home care, convalescent institutional care, laboratory and ambulance services, appliances, drugs, medicines and supplies; and any other care, service or treatment of disease, the correction of defects of the maintenance of the physical and mental well-being of human beings.

(d) "Enrolled Participant" means a person who has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(e) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations,

or corporations or other business entities.

(f) "Provider" means any physician, hospital, or ~~other~~  
institution, organization or person that furnished health care  
services and is licensed or otherwise authorized to practice  
in the State.

(g) "Administrator" means the head of (name of agency).  
The Administrator may call upon any other State agency in administering this Act.

## SECTION II - APPLICATION FOR CERTIFICATE OF AUTHORITY

(a) No person may operate a health maintenance organization without obtaining a certificate of authority from the Administrator.

(b) Applications for a certificate of authority shall be made in the form required by the Administrator and shall be verified by the individual who plans to operate a health maintenance organization or an officer or authorized representative of the applicant and shall set forth or be accompanied by:

(1) A copy of the basic organizational documents of the applicant, if any, such as articles of incorporation, partnership agreements, trust agreements, or other applicable documents.

(2) A copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant.

(3) A list of the names, addresses and official capacity with the organization of all the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation, and the partners or members in the case of a partnership or corporation.

(4) A statement generally describing the organization, its enrollment process, its operation, its quality assurance mechanism, its internal grievance procedures, the methods it proposes to use to offer its enrolled participants or public representatives an opportunity to participate in matters of policy and operation, the location of the facilities at which health care services will be regularly available to enrolled participants, the type and speciality of health care personnel engaged to provide health care services, the number of personnel in each category and the medical records system providing documentation of utilization rates for enrolled participants.

(5) Copies of all contract forms the organization proposes to offer enrolled participants and the basis for developing the proposed or actual rates to be charged.

(6) A statement of the financial condition of the organization, including income statement, balance sheet (assets and liabilities) and cash flow statement.

(7) A statement describing with reasonable certainty the geographic area or areas to be served, and the hours during which services will be provided.

(8) A description of the proposed marketing techniques and copies of any proposed advertising materials.

(9) A power of attorney duly executed by such applicant appointing the Administrator and his successors in office,

and duly authorized deputies as the true and lawful attorney of such applicant upon whom lawful process in any legal action against such organization on any cause of action arising in this State may be served.

(10) Such other information as may be required by the Administrator to make the determinations required in Section III of this Act.

### SECTION III - ISSUANCE OF CERTIFICATE OF AUTHORITY

(a) The Administrator shall issue a Certificate of Authority to any person filing an application within sixty (60) days of such filing unless he notifies the applicant within such time that such application is not complete and the reasons therefore or that payment of the fees required by Section XI has not been made or that he is not satisfied that:


(1) The basic organization document of the applicant when combined with the powers enumerated in Section IV, permits the applicant to conduct business as a health maintenance organization.

(2) The organization has demonstrated the intent and ability to assure that health care services will be provided in a manner to assure both their availability and accessibility.

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination the Administrator shall consider among other relevant factors:

(i) any agreements with an insurer, a medical or hospital service corporation, a government

- agency or any other organization paying or insuring payment of health care services;
- (ii) any agreements with providers for the provision of health care services;
  - (iii) any arrangements for insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care services.



(4) The procedures for offering health care services and offering and terminating contracts to enrolled participants will not discriminate on the basis of age, sex, race, health or economic status. This requirement shall not prohibit reasonable underwriting classifications for the purpose of establishing rates nor shall it prohibit experience rating.

(5) Procedures, subject to the regulations of the Administrator, are established to:

- (i) monitor the quality of care provided by such organization, including, at a minimum, internal peer review;
- (ii) resolve complaints and grievances initiated by enrolled participants; and
- (iii) offer enrolled participants or public representatives an opportunity to participate in matters of policy and operation.

(6) The organization will maintain a readily accessible medical records system which is adequate to provide an accurate documentation of utilization rates for every enrolled participant, such system to clearly identify, at a minimum, each patient by name, number, age and sex and to clearly indicate the services provided, when, where, and by whom, the diagnosis, treatment, and drug therapy and to document the patient's health status. The Administrator may in accordance with regulations permit an organization to contract potential enrolled participants prior to the granting of a Certificate of Authority, to discuss the health care services such organization proposes to offer if a certificate of Authority were granted.

The powers of a holder of a certificate of authority issued pursuant to Section III of this Act shall include, in addition to any powers conferred by the law under which the health maintenance organization is organized, the following:

(a) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

(b) The furnishing of health care services on a prepaid basis through providers which are under contract with, otherwise associated with, or employed by the health maintenance organization;

(c) Marketing, enrollment and administration or the contracting with any person for the performance on its behalf of such functions;

(d) The contracting with an insurance company licensed in this State, or with a hospital or medical service corporation authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(e) The offering, in addition to health care services, of indemnity benefits covering out-of-area or emergency services;

(f) Receiving and accepting from governmental or private agencies or any persons, payments or grants covering all or part of the cost of the services provided or arranged for by the organization.

#### SECTION V - CONTRACT FORM

(a) All forms of contracts issued by the organization to enrolled participants or other marketing documents purporting to describe the organization's health care services shall contain clear and complete information indicating:

(1) The health care services and other benefits to which the enrolled participant is entitled;

(2) Where and in what manner services may be obtained;

(3) The predetermined periodic rate of payment for health care services and other benefits, if any, which the enrolled participant is obliged to pay;

(4) Any exclusions or any limitations on services or any other benefits to be provided including any deductible or copayment feature or any restrictions relating to pre-existing conditions;

(5) All criteria relating to disenrollment or denials of re-enrollment;

(6) Service priorities in case of epidemic, or other emergency conditions affecting demand for medical services.

(b) No health maintenance organization authorized under this Act shall cancel the enrollment of a participant or refuse to transfer an enrolled participant from a group to an individual basis for reasons relating to age, sex, race, or health status. However, nothing contained herein shall prevent cancellation of a contract with enrolled participants who violate any published policies of the organization which have been approved by the Administrator.

(c) No health maintenance organization authorized under this Act shall contract with any provider requiring enrolled participants to guarantee payment (other than copayments and deductibles) to such provider if the health maintenance organization shall fail or refuse to pay the provider for any costs related to benefits to which the enrolled participant is entitled.

(d) No contract form or amendment to an approved contract form shall be issued unless the same is filed with the Administrator. Such contract form or amendment shall become effective within thirty (30) days of such filing unless the Administrator finds that such contract form does not comply with the requirements of Section III(a) or Subsection(a) above.

#### SECTION VI - ANNUAL DISCLOSURE

(a) Every health maintenance organization shall provide annually to its enrolled participants and make available to the general public:

(1) A statement of financial condition including a balance sheet and summary of receipts and disbursements.

(2) A description of the benefit packages available and their rates.

(3) A description of the accessibility and availability of services including where and how to obtain them.

(4) A statement disclosing by category the percent of enrolled participants assisted by public funds.

(5) Such other information as the Administrator may by regulation prescribe.

(b) Such information shall be presented in clear, readable, and concise form and shall include, at a minimum, all of the material elements required of contracts with enrolled participants.

#### SECTION VII - REPORTS TO THE ADMINISTRATOR

(a) Every organization subject to this Act shall annually, on or before \_\_\_\_\_, file a report with the Administrator, verified by an appropriate official of the organization, showing its financial condition on the last day of the preceding calendar year.

(b) Such report shall be filed on forms prescribed by the Administrator and shall include:

(i) financial statement of the organization including its balance sheet and statement of income and expenditures for the preceding year, certified by an independent public accountant;

- (ii) any changes in the information submitted pursuant to Section II of this Act;
- (iii) such other information relating to the performance of the organization as the Administrator may require to enable him to carry out his duties under this Act.

#### SECTION VIII - EXAMINATIONS

(a) The Administrator shall make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as he deems it necessary but not less frequently than once every three (3) years.

(b) The Administrator shall make an examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as he deems it necessary but not less frequently than once every three (3) years.

(c) Every health maintenance organization and provider shall submit its books and records relating its operation to such examinations and in every way facilitate them. Medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall be subject to such examination, but the identity of patients shall not be disclosed by the Administrator. For the purpose of examination the Administrator may issue subpoenas, administer oaths to, and

examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

#### SECTION IX - SANCTIONS

(a) Upon satisfactory evidence that any health maintenance organization has:

(1) Operated significantly in contravention of its basic organizational documents and the authorities conferred by this Act;

(2) Has failed to fulfill its obligations to furnish the health care services specified in its contracts with enrolled participants;

(3) Violated any provision of this Act, or any regulations promulgated hereunder;

(4) Made any false statement with respect to any report or statement required by this Act or by the Administrator under this Act;

(5) Advertised or marketed, or attempted to market, its services in such a manner as to misrepresent its services or capacity for service, or has engaged in deceptive, misleading or unfair practices with respect to advertising or marketing;

(6) Prevented the Administrator from the performance of any duty imposed by this Act; or

(7) Fraudulently procured or fraudulently attempted to procure any benefit under this subtitle;

the Administrator may, in his discretion, pursue any one or more of the following courses of action:

(i) suspend or revoke the certificate of authority to operate as a health maintenance organization under this Act:

(A) when the certificate of authority is suspended, the organization shall not, during the period of such suspension, enroll any additional enrolled participants except newborn children or other newly acquired dependents of existing enrolled participants, and shall not engage in any advertising or solicitation whatever;

(B) when the certificate of authority is revoked, such organization shall proceed under the supervision of the Administrator, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such

organization. It shall engage in no further advertising or solicitation whatsoever. The Administrator may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrolled participants, to the end that enrolled participants will be afforded the greatest practical opportunity to obtain continuing health care coverage.

(ii) impose a penalty of not more than ten thousand dollars (\$10,000) for each and every unlawful act committed;

(iii) issue an administrative order requiring the health maintenance organization:

(A) to cease or modify inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(B) to fulfill its contractual obligations;

(C) to provide a service which has been improperly denied; or

(D) to take appropriate steps to restore its ability to provide a contracted - for service.

(iv) apply to any Court for such legal or equitable relief as the Administrator deems appropriate.

(b) Before the Administrator takes any action as set forth in (i), (ii), (iii) or (iv) above, he shall give written notice to the organization its agent or officer thereof, accused of a violation, stating specifically the nature of such alleged violation and fixing a time and place, at least ten days thereafter, when a hearing of the matter shall be held. After a hearing or upon failure of the accused to appear at the hearing, the Administrator may impose any of the above penalties as he deems advisable.

(c) (Insert here provisions regarding administrative hearings and review, including but not limited to the judiciary, consistent with State's existing law.)

#### SECTION X - FEES

Every organization subject to this chapter shall pay to the Administrator the following fees:

(1) For filing a copy of its application for a certificate of authority or amendment thereto \$\_\_\_\_\_.

(2) For filing each annual report pursuant to Section \_\_\_\_\_, \$\_\_\_\_\_.

(3) The expenses of any examinations conducted pursuant to Section VIII.

#### SECTION XI - STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS

(a) Provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be

applicable to any health maintenance organization granted a certificate of authority under this Act; provided that, no health maintenance organization shall include in its name the words "insurer," "casualty," "surety," "health and accident" or any words generally regarded as descriptive of the insurance industry; provided further, that this provision does not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State, except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

(b) The provision of factually accurate information regarding coverage, rates, locations and hours of service, names of affiliated institutions, and credentials of participating providers by a health maintenance organization or its personnel to potential enrolled participants shall not be construed to be violative of any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this Act shall be exempt from the provision of (insert proper State law citation) prohibiting the practice of medicine by corporations, associations, or other organizations.

(d) Any health maintenance organization authorized under this act which contracts with a health facility or enters into arrangements with one or more groups of physicians organized

on a group practice or individual practice basis shall not by virtue of such contracts or arrangements be deemed to have entered into a "conspiracy in restraint of trade" in violation of (insert proper State law citation) the State's antitrust laws.

(c) No law or regulation of this State shall be applied to prohibit or unreasonably interfere with the ability of any health maintenance organization or provider or group of providers, under arrangements with a health maintenance organization to provide any health care service to the enrolled participants of such health maintenance organization, from employing or otherwise associating with any provider of such health care service.

#### SECTION XII - MULTIPLE CHOICE

(a) Every public or private employer or employee benefit fund within this State having more than 25 employees or members must make available to every employee to which it offers a health benefit program of any kind the opportunity in accordance with regulations promulgated by the Administrator (1) to participate in a plan which does not restrict an employee's choice of physician or hospital and (2) to obtain health care services from health maintenance organizations which are representative of all significantly different health maintenance organization delivery systems available in the employment area; provided that no employer or fund may be required to select more than one health

...organization of any single type. No employer or fund shall be required to pay any health maintenance organization an amount in excess of payments required under the applicable collective-bargaining agreement or any other agreement providing health care benefits.

(b) The provision of this section may be enforced by the Administrator or by any aggrieved party in civil litigation.

#### SECTION XIII - IMPLEMENTING REGULATIONS

The Administrator may, after notice and hearing, promulgate reasonable rules and regulations as are necessary or proper to carry out the provisions of this Act. Nothing in this Act shall be construed to prohibit the Administrator from requiring changes in procedures previously approved by him.

#### SECTION XIV - SEVERABILITY

If any section, term or provision of this Act shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this Act, but the remaining section, terms, and provisions shall be and remain in full force and effect.

#### SECTION XV - FEDERAL LEGISLATION

Nothing in this Act shall prohibit any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or enroll beneficiaries assisted by federal funds.



OFFICE OF THE SECRETARY  
*file # 481*

TO : Assistant General Counsel, Legislation  
THROUGH: Assistant Secretary for Health \_\_\_\_\_  
FROM : Deputy Assistant Secretary for Health Policy Development  
SUBJECT: HMC Model State Legislation

We hereby request that the attached model State HMO Enabling Act be included as an addendum to the Department's model State law submissions to OMB and the Council of State Governments. The bill has been developed pursuant to the mandate contained in the President's 1971 Health Message and subsequent policy directives issued by former Secretary Richardson. It was drafted by the staff of the HMO Service with assistance from Interstudy, a private, non-profit policy development center on contract to the HMO Service, and the staff of the Office of the Deputy Assistant Secretary for Health Policy Development. Informal review sessions have been held with representatives of the Office of the General Counsel and the Assistant Secretary for Legislation (Health).

The bill represents non-restrictive HMO Enabling Legislation which would encourage a full range of HMO models to compete both with each other and with the fee-for-service sector. It provides basic authority for HMO organization and regulation, while at the same time invalidating a number of the traditional State legal barriers to HMO development and growth.

The bill does not address the issues of comprehensive health planning, personnel licensure or Medicaid contracting, which are more easily addressed in other legislation, or the issues of medical claims subrogation and coordination of benefits which can be handled in enrollee contracts, at least in most States. Nor does it address specifically the issues of special tax benefits for "charitable" non-profit HMOs or premium taxes for HMOs. In principle we oppose provisions

that discriminate against certain kinds of HMOs, or against HMOs as a class. (We have included provisions for licensure fees to help finance regulatory activities.)

2  
The regulatory style utilized in the bill focuses, wherever possible, on public disclosure and information as opposed to government control. In this regard, it differs from the model bill developed by the National Association of Insurance Commissioners which relies more heavily on government action rather than private competition, made effective through public disclosure, as a means of assuring product adequacy.

There are several significant specific differences between our bill and the NAIC bill which are as follows:

(1) Exclusivity.

The NAIC bill is designed to be the exclusive regulatory vehicle. No pre-paid health delivery system which does not meet the regulatory standards described in the bill, or implementing regulations, would be permitted to exist. In contrast, our bill would provide only that a organization which does not meet standards imposed by the bill could not be called an HMO. Whether the State would choose to permit such organizations to exist, or to regulate them through other means, would be left to State by State determination.

(2) Delegation of regulatory authority to the Insurance Commissioner.

The NAIC bill delegates regulatory responsibility to the Insurance Commissioner.

Our bill says nothing on this issue. Again, we believe that the choice of a regulatory vehicle should be a determination of the State, not the Federal government. In some States, it may be best to select the Health Department, or an entirely new agency rather than delegate authority to the Insurance Commissioner.

(3) Approval of rates.

The NAIC bill includes insurance type rate approval. In contrast, we believe it would be more appropriate to rely on the free market. It is doubtful whether rate regulation would provide an effective control on costs. Indeed, it may be -- because of limited HMO experience -- that rate regulation would actually promote rate uniformity, and thus stifle price competition. (Of course, the financial responsibility requirements of our bill would insure that any rate chosen by an HMO would be adequate to pay incurred costs.)

(4) Definition.

The definition contained in the NAIC bill does not make clear that the HMO is responsible for the provision or arrangement for medical care services rather than simply payment for such services. Our bill does.

(5) Benefit package.

The benefit package contained in the

NAIC bill is overly rigid and comprehensive and, thus, may make HMOs uncompetitive with traditional insurance.

(6) Different standards for insurance run HMOs.

Under the NAIC bill, HMOs controlled by insurance companies are subject to different standards than other kinds of HMOs. Our bill makes no such distinction.

(7) Open enrollment.

The NAIC bill contains open enrollment provisions which could make it more difficult for HMOs to compete with traditional insurers which, typically, are not subject to such requirements.

(8) Restrictions on investments.

The NAIC bill contains insurance type restrictions on HMO investments. Our bill contains no such restrictions. We would prefer to rely solely on disclosure and general financial responsibility standards.

(9) Approval of contract changes.

The NAIC bill would require advance approval of any contract changes. In contrast, our bill requires only notification. Of course, the regulatory authority would remain free to subsequently

challenge any modification which adversely and materially alters a contract.

(10) Insurance liquidation provisions.

The NAIC bill includes complex insurance type liquidation and rehabilitation provisions which we believe may encourage unwarranted government incursions into the internal affairs of HMOs. Our bill includes no specific liquidation or rehabilitation provisions. We would rely more heavily on HMO management, and on the general bankruptcy law where HMOs do fail.

(11) Liquid reserve requirement.

The NAIC bill includes liquid reserve requirements which are inappropriate, ineffective, and inhibiting to certain kinds of HMOs. In contrast, our bill utilizes a variety of different criteria for determining financial responsibility.

(12) Multiple Choice.

While the NAIC bill includes no mandatory multiple choice provision, our bill currently does. It may be, however, that this provision is not consistent with present Administration policy. The arguments in favor of the provision are:

- (1) that mandatory multiple choice is essential to rapid HMO development and,
- (2) that in this case it is the State rather than the Federal government which is levying the requirement.

The arguments against the provision are:

- (1) that it is inappropriate until the results of Federal demonstration efforts are evaluated and,
- (2) that, as it applies only to companies presently offering health insurance coverage, it is discriminatory in its impact. Moreover, it could be argued that such discrimination will encourage employers, and particularly small employers, presently offering coverage to cease to do so because of the added administrative burdens, or alternatively, inhibit employers who would otherwise begin to offer coverage.

On balance, we would prefer to retain this provision.

We believe that the Department's posture toward the NAIC bill should be basically supportive as that bill also adopts a non-restrictive, competitive approach. However, for the foregoing reasons, we believe that our bill is substantially superior to the bill developed by the NAIC. Moreover, we do not believe that the

DRAFT

SUGGESTED HEALTH MAINTENANCE ORGANIZATION ACT

Assistant General Counsel, Legislation  
Page Seven

introduction of our bill will harm chances of passage of meaningful HMO legislation. Existing experience suggest that it would simply improve the quality of the bills which are finally enacted.

Scott Fleming

Attachment (1)

cc: Mr. Rubel  
Dr. Zapp  
DR. MACLEOD

THE HEALTH MAINTENANCE ORGANIZATION ACT

Sections:

I Definitions

II Application for Certificate of Authority

III Issuance of Certificate of Authority

IV Powers of Health Maintenance Organizations

V Contract Form

VI Annual Disclosure

VII Reports to the Administrator

VIII Examinations

IX Sanctions

X Fees

XI Statutory Construction and Relationship to other Laws

XII Multiple Choice

XIII Implementing Regulations

XIV Severability

XV Federal Legislation

STATEMENT OF FINDINGS AND DECLARATION OF PURPOSE

(a) The legislature finds that --

(1) The medical care system in this State is not organized in a manner which encourages the provision of medical care at reasonable costs.

(2) The medical care system in this State is oriented toward providing care once a health need has occurred rather than towards providing health maintenance and preventive health services.

(3) Experience of prepaid group health organizations operating in various areas across the Nation indicates that such organizations have great potential for reducing the inefficiencies in the present system.

(b) It is therefore the purpose of this Act to authorize and facilitate the establishment of Health Maintenance Organizations, and to regulate their operation to insure that high quality health services are provided to all enrolled participants of such organizations throughout the State.

THE HEALTH MAINTENANCE ORGANIZATION ACT

Sections:

- I Definitions
- II Application for Certificate of Authority
- III Issuance of Certificate of Authority
- IV Powers of Health Maintenance Organizations
- V Contract Form
- VI Annual Disclosure
- VII Reports to the Administrator
- VIII Examinations
- IX Sanctions
- X Fees
- XI Statutory Construction and Relationship to other Laws
- XII Multiple Choice
- XIII Implementing Regulations
- XIV Severability
- XV Federal Legislation

file HB 491



Public Law 93-222  
93rd Congress, S. 14  
December 29, 1973

An Act

87 STAT. 914

To amend the Public Health Service Act to provide assistance and encouragement for the establishment and expansion of health maintenance organizations, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Health Maintenance Organization Act of 1973.

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act, with the following table of contents, may be cited as the "Health Maintenance Organization Act of 1973".

TABLE OF CONTENTS

- Sec. 1. Short title and table of contents.
- Sec. 2. Health maintenance organizations.

"TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

- "Sec. 1301. Requirements for health maintenance organizations.
- "Sec. 1302. Definitions.
- "Sec. 1303. Grants and contracts for feasibility surveys.
- "Sec. 1304. Grants, contracts, and loan guarantees for planning and for initial development costs.
- "Sec. 1305. Loans and loan guarantees for initial operation costs.
- "Sec. 1306. Application requirements.
- "Sec. 1307. Administration of assistance programs.
- "Sec. 1308. General provisions relating to loan guarantees and loans.
- "Sec. 1309. Authorizations of appropriations.
- "Sec. 1310. Employees' health benefits plans.
- "Sec. 1311. Restrictive State laws and practices.
- "Sec. 1312. Continued regulation of health maintenance organizations.
- "Sec. 1313. Limitation on source of funding for health maintenance organizations.
- "Sec. 1314. Program evaluation.
- "Sec. 1315. Annual report."

- Sec. 3. Quality assurance.
- Sec. 4. Health care quality assurance programs study.
- Sec. 5. Reports respecting medically underserved areas and population groups and non-metropolitan areas.
- Sec. 6. Health services for Indians and domestic agricultural migratory and seasonal workers.
- Sec. 7. Conforming amendments.

HEALTH MAINTENANCE ORGANIZATIONS

Sec. 2. The Public Health Service Act is amended by adding after title XII the following new title:

1973, p. 536.

"TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

"REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

"Sec. 1301. (a) For purposes of this title, the term 'health maintenance organization' means a legal entity which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

Definitions.

Basic health services.

"(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

"(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary.

"(2) For such payment or payments (hereinafter in this title referred to as 'supplemental health services payments') as the health maintenance organization may require in addition to the basic health services payment, the organization shall provide to each of its members each health service (A) which is included in supplemental health services (as defined in section 1302(2)), (B) for which the required health manpower are available in the area served by the organization, and (C) for the provision of which the member has contracted with the organization. Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system.

"(3) The services of health professionals which are provided as basic health services shall be provided through health professionals who are members of the staff of the health maintenance organization or through a medical group (or groups) or individual practice association (or associations), except that this paragraph shall not apply in the case of (A) health professional services which the organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or (B) any basic health service provided a member of the health maintenance organization other than by such a health professional because it was medically necessary that the service be provided to the member before he could have it provided by such a health professional. For purposes of this paragraph, the term 'health professionals' means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

"(4) Basic health services (and supplemental health services in the case of the members who have contracted therefor) shall within the area served by the health maintenance organization be available and accessible to each of its members promptly as appropriate and in a manner which assures continuity, and which, medically necessary, be available and accessible twenty-four hours a day and seven days a week. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic or supplemental health services other than through the organization if it was medically necessary that the services be provided before he could secure them through the organization.

"Health professionals."

"(c) Each health maintenance organization shall—

"(1) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary;

"(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may obtain insurance or make other arrangements (A) for the cost of providing to any member basic health services the aggregate value of which exceeds \$5,000 in any year, (B) for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, and (C) for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year;

"(3) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary);

"(4) have an open enrollment period of not less than thirty days at least once during each consecutive twelve-month period during which enrollment period it accepts, up to its capacity, individuals in the order in which they apply for enrollment, except that if the organization demonstrates to the satisfaction of the Secretary that—

"(A) it has enrolled, or will be compelled to enroll, a disproportionate number of individuals who are likely to utilize its services more often than an actuarially determined average (as determined under regulations of the Secretary) and enrollment during an open enrollment period of an additional number of such individuals will jeopardize its economic viability, or

"(B) if it maintained an open enrollment period it would not be able to comply with the requirements of paragraph (3), the Secretary may waive compliance by the organization with the open enrollment requirement of this paragraph for not more than three consecutive twelve-month periods and may provide additional waivers to that organization if it makes the demonstration required by subparagraph (A) or (B);

"(5) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

"(6) be organized in such a manner that assures that (A) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (B) there will be equitable representation on such body of members from medically underserved populations served by the organization;

"(7) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

"(8) have organizational arrangements established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians

and other health professionals of the process followed in the provision of health services;

"(9) provide medical social services for its members and encourage and actively provide for its members health education services, education in the appropriate use of health services and education in the contribution each member can make to the maintenance of his own health;

"(10) provide, or make arrangements for, continuing education for its health professional staff; and

"(11) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

#### "DEFINITIONS

"Sec. 1302. For purposes of this title:

"(1) The term 'basic health services' means—

"(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 voluntary family planning services, infertility services, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, or podiatrist, a health maintenance organization may provide such service through a dentist, optometrist, or podiatrist (as the case may be) licensed to provide such service. For purposes of this paragraph, the term 'home health services' means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization. A health maintenance organization is authorized, in connection with the prescription of drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such service, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

"(2) The term 'supplemental health services' means—

"(A) services of facilities for intermediate and long-term care;

"(B) vision care not included as a basic health service under paragraph (1)(A) or (1)(H);

"(C) dental services not included as a basic health service under paragraph (1)(A) or (1)(H);

"(D) mental health services not included as a basic health service under paragraph (1)(D);

"(E) long-term physical medicine and rehabilitative services (including physical therapy); and

"(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.

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, or podiatrist, a health maintenance organization may provide such service through an optometrist, dentist, or podiatrist (as the case may be) licensed to provide such service. A health maintenance organization is authorized, in connection with the prescription or provision of prescription drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such services, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

"(3) The term 'member' when used in connection with a health maintenance organization means an individual who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

"(4) The term 'medical group' means a partnership, association, or other group--

"(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

"(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

"(C) the members of which (i) as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the members of the group; and (v) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group.

"(5) The term 'individual practice association' means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optome-

try, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

“(A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

“(B) to the extent feasible (i) that such persons shall utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the persons who are parties to the arrangement, (ii) for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff, and (iii) for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas.

“(6) The term ‘section 314(a) State health planning agency’ means the agency of a State which administers or supervises the administration of a State’s health planning functions under a State plan approved under section 314(a) (hereinafter in this title referred to as a ‘section 314(a) plan’); and the term ‘section 314(b) areawide health planning agency’ means a public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b) (hereinafter in this title referred to as a ‘section 314(b) plan’).

“(7) The term ‘medically underserved population’ means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each section 314(a) State health planning agency whose section 314(a) plan covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each section 314(b) areawide health planning agency whose section 314(b) plan covers (in whole or in part) such urban or rural area or the area in which such population group resides.

“(8) The term ‘community rating system’ means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. The following differentials in rates of payments may be established under such system:

“(A) Nominal differentials in such rates may be established to reflect the different administrative costs of collecting payments from the following categories of members:

“(i) Individual members (including their families),

“(ii) Small groups of members (as determined under regulations of the Secretary),

“(iii) Large groups of members (as determined under regulations of the Secretary).

“(B) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health

50 Stat. 1261.  
42 USC 246.

50 Stat. 447.

5 USC 8501.

benefits program for employees of States, political subdivisions of States, and other public entities.

"(9) The term 'non-metropolitan area' means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

"GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

"Sec. 1303. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations.

"(b) An application for a grant or contract under this section shall contain—

"(1) assurances satisfactory to the Secretary that, in conducting surveys or other activities with assistance under a grant or contract under this section, the applicant will (A) cooperate with the section 314(b) area-wide health planning agency (if any) whose section 314(b) plan covers (in whole or in part) the area for which the survey or other activity will be conducted, and (B) notify the medical society serving such area of such surveys or other activities; and

"(2) such other information as the Secretary may by regulation prescribe.

"(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

"(d)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:

"(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.

"(B) Any project for which a grant is made or contract entered into must be completed within twelve months from the date the grant is made or contract entered into.

"(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

"(e) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed \$50,000, and (2) the aggregate of the amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of (A) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved

80 Stat. 1191;  
84 Stat. 1304.  
42 USC 245.

Limitations.

population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants and contracts for such project should be determined by such greater percentage.

"(f) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(g) Contracts may be entered into under this section without regard to Sections 3645 and 3769 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

Post, p. 930.

"(h) Payments under grants and contracts under this section shall be made from appropriations made under section 1309(a).

"(i) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (1) to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations which the Secretary determines may reasonably be expected to have after their development or expansion not less than 65 per centum of their membership drawn from residents of non-metropolitan areas, and (2) the applications for which meet the requirements of this title for approval. Sums set aside in the fiscal year ending June 30, 1974, or June 30, 1975, for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under this section in the succeeding fiscal year for projects other than those described in clause (1) of such sentence.

**"GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR INITIAL DEVELOPMENT COSTS**

"Sec. 1301. (a) The Secretary may—

"(1) make grants to and enter into contracts with public or nonprofit private entities for planning projects for the establishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by, health maintenance organizations; and

"(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to private entities (other than nonprofit private entities) for planning projects for the establishment or expansion of health maintenance organizations to serve medically underserved populations.

Planning projects assisted under this subsection shall include development of plans for the marketing of the services of the health maintenance organization.

"(b) (1) The Secretary may—

"(A) make grants to and enter into contracts with public or nonprofit private entities for projects for the initial development of health maintenance organizations; and

"(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to any private entity (other than a nonprofit private entity) for a project for the initial development of a health maintenance organization which will serve a medically underserved population.

"Initial development."

"(2) For purposes of this section, the term 'initial development' when used to describe a project for which assistance is authorized by this subsection includes significant expansion of the membership of, or the area served by, a health maintenance organization. Funds under

grants and contracts under this subsection and under loans guaranteed under this subsection may only be utilized for such purposes as the Secretary may prescribe in regulations. Such purposes may include (A) the implementation of an enrollment campaign for such an organization, (B) the detailed design of and arrangements for the health services to be provided by such an organization, (C) the development of administrative and internal organizational arrangements, including fiscal control and fund accounting procedures, and the development of a capital financing program, (D) the recruitment of personnel for such an organization and the conduct of training activities for such personnel, and (E) the payment of architects' and engineers' fees.

"(3) A grant or contract under this subsection may only be made or entered into for initial development costs in the one-year period beginning on the first day of the first month in which such grant or contract is made or entered into. The number of grants made for any initial development project under this subsection when added to the number of contracts entered into for such project under this subsection may not exceed three. A loan guarantee under this subsection may only be made for a loan (or loans) for such costs incurred in a period not to exceed three years.

"(c)(1) An application for a grant, contract, or loan guarantee under subsection (a) for a planning project shall contain assurances satisfactory to the Secretary that in carrying out the planning project for which the grant, contract, or loan guarantee is sought, the applicant will (A) cooperate with the section 311(b) areawide health planning agency (if any) whose section 311(b) plan covers (in whole or in part) the area proposed to be served by the health maintenance organization for which the planning project will be conducted, and (B) notify the medical society serving such area of the planning project.

80 Stat. 1181;  
84 Stat. 1304.  
42 USC 246.

"(2) If the Secretary makes a grant or loan guarantee or enters into a contract under subsection (a) for a planning project for a health maintenance organization, he may, within the period in which the planning project must be completed, make a grant or loan guarantee or enter into a contract under subsection (b) for the initial development of that health maintenance organization; but no grant or loan guarantee may be made or contract entered into under subsection (b) for initial development of a health maintenance organization unless the Secretary determines that (A) sufficient planning for its establishment or expansion (as the case may be) has been conducted by the applicant for the grant, contract, or loan guarantee, and (B) the feasibility of establishing and operating, or of expanding, the health maintenance organization has been established by the applicant.

"(d) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

"(e)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants, loan guarantees, and contracts made under subsection (a) of this section:

itations.

"(A) If a planning project has been assisted with grant, loan guarantee, or contract under subsection (a), the Secretary may not make any other planning grant or loan guarantee or enter into any other planning contract for such project under this section.

"(B) Any project for which a grant or loan guarantee is made or contract entered into must be completed within twelve months

from the date the grant or loan guarantee is made or contract entered into.

"(2) The Secretary may not make more than one additional grant or loan guarantee or enter into not more than one additional contract for a planning project for which a grant or loan guarantee has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant, loan guarantee, or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

"(f)(1) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) for a planning project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for a planning project which may be guaranteed under such subsection, shall be determined by the Secretary, except that (A) the amount to be paid by the United States under any single grant or contract, and the amount of principal of any single loan guaranteed under such subsection, may not exceed \$125,000, and (B) the aggregate of the amounts to be paid for any project by the United States under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the greater of (i) 50 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

"(2) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (b) for an initial development project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for an initial development project which may be guaranteed under such subsection, shall be determined by the Secretary, except that the amounts to be paid by the United States for any initial development project under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the lesser of--

"(A) \$1,000,000, or

"(B) an amount equal to the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

"(3) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.

"(g) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(h) Contracts may be entered into under this section without regard to sections 3618 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(i) Payments under grants and contracts under this section shall be made from appropriations under section 1309(a). Post, p. 930.

"(j) Loan guarantees under subsection (a) (2) for planning projects may be made through the fiscal year ending June 30, 1976; and loan guarantees under subsection (b) (1) (B) for initial development projects may be made through the fiscal year ending June 30, 1977.

"(k) (1) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (a) of this section, not less than 25 per centum shall be set aside and obligated in such fiscal year for projects (A) to plan the establishment or expansion of health maintenance organizations which the Secretary determines may reasonably be expected to have after their establishment or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in the fiscal year ending June 30, 1974, or June 30, 1975, for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (a) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for projects other than those described in clause (A) of such sentence.

"(2) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (b) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) for the initial development of health maintenance organizations which the Secretary determines may reasonably be expected to have after their initial development not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in the fiscal year ending June 30, 1974, or in either of the next two fiscal years for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (b) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for projects other than those described in clause (A) of such sentence.

#### "LOANS AND LOAN GUARANTEES FOR INITIAL OPERATION COSTS

"Sec. 1305. (a) The Secretary may—

"(1) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their operating costs in the period of the first thirty-six months of their operation exceed their revenues in that period;

"(2) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their operating costs, which the Secretary determines are attributable to significant expansion in their membership or area served and which are incurred in the period of the first thirty-six months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

"(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to any private health maintenance organization (other than a private nonprofit health maintenance organization) for the amounts referred to in paragraph (1) or (2), but only if such health maintenance organization will serve a medically underserved population.

Non-Federal  
lenders,  
guaranteed  
payment,  
condition.

No loan or loan guarantee may be made under this subsection for the operating costs of a health maintenance organization unless the Secretary determines that the organization has made all reasonable attempts to meet such costs.

**Limitations.**

"(b) (1) Except as provided in paragraph (2), the principal amount of any loan made or guaranteed under subsection (a) in any fiscal year for a health maintenance organization may not exceed \$1,000,000 and the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed \$2,500,000.

"(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made, or with respect to which guarantees have been issued, under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

**Part, p. 930.**

"(c) Loans under this section shall be made from the fund established under section 1303(e).

"(d) A loan or loan guarantee may be made under this section through the fiscal year ending June 30, 1978.

"(e) Of the sums used for loans under this section in any fiscal year from the loan fund established under section 1303(e), not less than 20 per centum shall be used for loans for projects (1) for the initial operation of health maintenance organizations which the Secretary determines have not less than 66 per centum of their membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval.

**"APPLICATION REQUIREMENTS**

"Sec. 1306. (a) No grant, contract, loan, or loan guarantee may be made under this title unless an application therefor has been submitted to, and approved by, the Secretary.

"(b) The Secretary may not approve an application for a grant, contract, loan, or loan guarantee under this title unless--

**Auto, pp. 930, 931.**

"(1) in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee, such application meets the requirements of section 1305;

"(2) he determines that the applicant making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for;

"(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment of members of such organization, (D) estimated costs per member of the health and educational services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health and educational services, (F) organizational arrangements of such organization for an ongoing quality assurance program in conformity with the requirements of section 1301(c), (G) sources of prepayment and other forms of payment for the services to be provided by such organization, (H) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (I) administrative, managerial, and financial arrangements and capabilities

**Auto, p. 934.**

of such organization, (J) role for members in the planning and policymaking for such organization, (K) grievance procedures for members of such organization, and (L) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;

"(4) contains or is supported by assurances satisfactory to the Secretary that the applicant making the application will, in accordance with such criteria as the Secretary shall by regulation prescribe, enroll, and maintain an enrollment of the maximum number of members that its available and potential resources (as determined under regulations of the Secretary) will enable it to effectively serve;

"(5) the section 314(b) areawide health planning agency whose section 314(b) plan covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted, or if there is no such agency, the section 314(a) State health planning agency whose section 314(a) plan covers (in whole or in part) such area, has, in accordance with regulations of the Secretary under subsection (c) of this section, been provided an opportunity to review the application and to submit to the Secretary for his consideration its recommendations respecting approval of the application or if under applicable State law such an application may not be submitted without the approval of the section 314(b) areawide health planning agency or the section 314(a) State health planning agency, the required approval has been obtained;

80 Stat. 1101;  
84 Stat. 1304.  
42 USC 246.

"(6) in the case of an application made for a project which previously received a grant, contract, loan, or loan guarantee under this title, such application contains or is supported by assurances satisfactory to the Secretary that the applicant making the application has the financial capability to adequately carry out the purposes of such project and has developed and operated such project in accordance with the requirements of this title and with the plans contained in previous applications for such assistance; and

"(7) the application is submitted in such form and manner, and contains such additional information, as the Secretary shall prescribe in regulations.

An organization making multiple applications for more than one grant, contract, loan, or loan guarantee under this title, simultaneously or over the course of time, shall not be required to submit duplicate or redundant information but shall be required to update the specifications (required by paragraph (3)) respecting the existing or proposed health maintenance organization in such manner and with such frequency as the Secretary may by regulation prescribe.

Multiple applications.

"(c) The Secretary shall by regulation establish standards and procedures for section 314(b) areawide health planning agencies and section 314(a) State health planning agencies to follow in reviewing and commenting on applications for grants, contracts, loans, and loan guarantees under this title.

"ADMINISTRATION OF ASSISTANCE PROGRAMS

"Sec. 4307. (a) (1) Each recipient of a grant, contract, loan, or loan guarantee under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of the grant, contract, or

Record-keeping.

loan (directly made or guaranteed), the total cost of the undertaking in connection with which such assistance was given or used, the amount of that portion of the cost of the undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(2) The Secretary, or any of his duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of a grant, contract, loan, or loan guarantee under this title which relate to such assistance.

Report to  
Secretary of  
H.E.W.

"(b) Upon expiration of the period for which a grant, contract, loan, or loan guarantee was provided an entity under this title, such entity shall make a full and complete report to the Secretary in such manner as he may by regulation prescribe. Each such report shall contain, among such other matters as the Secretary may by regulation require, descriptions of plans, developments, and operations relating to the matters referred to in section 1305(b)(3).

Arts, p. 925.

Part, p. 930.

"(c) If in any fiscal year the funds appropriated under section 1309 are insufficient to fund all applications approved under this title for that fiscal year, the Secretary shall, after applying the applicable priorities under sections 1303 and 1304, give priority to the funding of applications for projects which the Secretary determines are the most likely to be economically viable.

79 Stat. 292;  
86 Stat. 1370.  
42 USC 1395.  
42 USC 1396.

"(d) An entity which provides health services to a defined population on a prepaid basis and which has members who are entitled to insurance benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act may be considered as a health maintenance organization for purposes of receiving assistance under this title if—

"(1) with respect to its members who are entitled to such insurance benefits or to such medical assistance it (A) provides health services in accordance with section 1301(b), except that (i) it does not furnish to those members the health services (with in the basic health services) for which it may not be compensated under such title XVIII or such State plan, and (ii) it does not fix the basic or supplemental health services payment for such members under a community rating system, and (B) is organized and operated in the manner prescribed by section 1301(c), except that it does not assume full financial risk on a prospective basis for the provision to such members of basic or supplemental health services with respect to which it is not required under such title XVIII or such State plan to assume such financial risk; and

"(2) with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).

"(e) In any fiscal year no loan guarantee may be made under this title if the making of such guarantee would cause the cumulative total of the principal of the loans guaranteed under this title in such fiscal year to exceed the amount of grant and contract funds obligated under this title in such fiscal year; except that this subsection shall not apply if the amount of grant and contract funds obligated under this title in such fiscal year equals the sums appropriated under section 1309 for grants and contracts for such fiscal year.

#### "GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

"Sec. 1308. (a) (1) The Secretary may not approve an application for a loan guarantee under this title unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the finan-

cial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this title.

"(2)(A) The United States shall be entitled to recover from the applicant for a loan guarantee under this title the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this title (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

"(C) Any loan guarantee made by the Secretary under this title shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

"(D) Guarantees of loans under this title shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

"(b)(1) The Secretary may not approve an application for a loan under this title unless—

Application requirements.

"(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

"(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

"(2) Any loan made under this title shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this title, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

"(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reason of the failure of a borrower to make payments of principal and interest on a loan made under this title, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

Right of recovery, waiver.

"(c)(1) The Secretary may from time to time, but with due regard to the financial interests of the United States, sell loans made by him under this title.

Sale of loans.

"(2) The Secretary may agree, prior to his sale of any such loan, to guarantee to the purchaser (and any successor in interest of the purchaser) compliance by the borrower with the terms and conditions of such loan. Any such agreement shall contain such terms and conditions as the Secretary considers necessary to protect the financial interests of the United States or as otherwise appropriate. Any such agreement may (A) provide that the Secretary shall act as agent of any such purchaser for the purpose of collecting from the borrower to which such loan was made and paying over to such purchaser, any payments of principal and interest payable by such organization under such loan; and (B) provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement. The full faith and credit of the United States is pledged to the payment of all amounts which may be required to be paid under any guarantee under this paragraph.

"(3) After any loan under this title to a public health maintenance organization has been sold and guaranteed under this subsection, interest paid on such loan which is received by the purchaser thereof (or his successor in interest) shall be included in the gross income of the purchaser of the loan (or his successor in interest) for the purpose of chapter 1 of the Internal Revenue Code of 1954.

"(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the loan fund established under subsection (e).

"(d) (1) There is established in the Treasury a loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loan guarantees issued by him under this title. There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts received by the Secretary in connection with loan guarantees under this title and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

"(2) If at any time the sums in the funds are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this title, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the 2<sup>d</sup> and Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations required by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund

63A Stat. 3.  
26 USC 1  
et seq.

Loan guarantee  
fund.  
Establishment.

40 Stat. 288.  
31 USC 174.

and redemption of such notes and obligations shall be made by the Secretary from the fund.

"(c) There is established in the Treasury a loan fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to make loans under this title. There shall also be deposited in the fund amounts received by the Secretary as interest payments and repayment of principal on loans made under this title and other property or assets derived by him from his operations respecting such loans, from the sale of loans under subsection (c) of this section, or from the sale of assets.

Loan fund.  
Establishment.

#### "AUTHORIZATIONS OF APPROPRIATIONS

"Sec. 1303. (a) For the purpose of making payments under grants and contracts under sections 1303, 1304(a), and 1304(b), there are authorized to be appropriated \$25,000,000 for the fiscal year ending June 30, 1974, \$55,000,000 for the fiscal year ending June 30, 1975, and \$85,000,000 for the fiscal year ending June 30, 1976; and for the purpose of making payments under grants and contracts under section 1304(b) for the fiscal year ending June 30, 1977, there is authorized to be appropriated \$85,000,000.

"(b) There is authorized to be appropriated to the loan fund established under section 1308(c) \$75,000,000 in the aggregate for the fiscal years ending June 30, 1974, and June 30, 1975.

#### "EMPLOYEES' HEALTH BENEFITS PLANS

"Sec. 1310. (a) Each employer which is required during any calendar quarter to pay its employees the minimum wage specified by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay his employees such wage but for section 13(a) of such Act), and which during such calendar quarter employed an average number of employees of not less than twenty five, shall, in accordance with regulations which the Secretary shall prescribe, include in any health benefits plan offered to its employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic and supplemental health services in the areas in which such employees reside.

52 Stat. 1062;  
77 Stat. 56;  
80 Stat. 838.  
29 USC 201.  
75 Stat. 71;  
80 Stat. 833;  
86 Stat. 375.  
29 USC 213.

"(b) If there is more than one qualified health maintenance organization which is engaged in the provision of basic and supplemental health services in the area in which the employees of an employer subject to subsection (a) reside and if—

"(1) one or more of such organizations provides basic health services through professionals who are members of the staff of the organization or a medical group (or groups), and

"(2) one or more of such organizations provides such services through an individual practice association (or associations), then of the qualified health maintenance organizations included in a health benefits plan of such employer pursuant to subsection (a) at least one shall be an organization which provides basic health services as described in clause (1) and at least one shall be an organization which provides basic health services as described in clause (2).

"(c) No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees. Failure of any employer to

52 Stat. 1029;  
63 Stat. 919.  
29 USC 215.  
"Qualified  
health  
maintenance  
organization."

comply with the requirements of subsection (a) shall be considered a willful violation of section 15 of the Fair Labor Standards Act of 1938.

"(d) For purposes of this section, the term 'qualified health maintenance organization' means (1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 1301(b) and that it is organized and operated in the manner prescribed by section 1301(c), and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 1301(b) and will be organized and operated in the manner prescribed by section 1301(c).

#### "RESTRICTIVE STATE LAWS AND PRACTICES

"Sec. 1311. (a) In the case of any entity—

"(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise—

"(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

"(B) requires that physicians constitute all or a percentage of its governing body,

"(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or

"(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, and

"(2) for which a grant, contract, loan, or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section 1310 (relating to employees' health benefits plans);

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 1301.

"(b) No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section 1310 (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

#### "CONTINUED REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

"Sec. 1312. (a) If the Secretary determines that an entity which received a grant, contract, loan, or loan guarantee under this title as a health maintenance organization or which was included in a health benefits plan offered to employees pursuant to section 1310—

"(1) fails to provide basic and supplemental services to its members,

Study.

"(b) The Comptroller General shall also conduct a study of the economic effects on employers resulting from their compliance with the requirements of section 1310. The Comptroller General shall report to the Congress the results of such study not later than thirty-six months after the date of the enactment of this title.

Report to Congress.

"(c) The Comptroller General shall evaluate (1) the operations of distinct categories of health maintenance organizations in comparison with each other, (2) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and (3) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public. The Comptroller General shall report to the Congress the results of such evaluation not later than thirty-six months after the date of the enactment of this title.

## "ANNUAL REPORT

Review, report to Congress.

"Sec. 1315. (a) The Secretary shall periodically review the programs of assistance authorized by this title and make an annual report to the Congress of a summary of the activities under each program. The Secretary shall include in such summary—

"(1) a summary of each grant, contract, loan, or loan guarantee made under this title in the period covered by the report and a list of the health maintenance organizations which during such period became qualified health maintenance organizations for purposes of section 1310;

"(2) the statistics and other information reported in such period to the Secretary in accordance with section 1301(c)(11);

"(3) findings with respect to the ability of the health maintenance organizations assisted under this title—

"(A) to operate on a fiscally sound basis without continued Federal financial assistance,

"(B) to meet the requirements of section 1301(c) respecting their organization and operation,

"(C) to provide basic and supplemental health services in the manner prescribed by section 1301(b);

"(D) to include indigent and high-risk individuals in their membership, and

"(E) to provide services to medically underserved populations; and

"(4) findings with respect to—

"(A) the operation of distinct categories of health maintenance organizations in comparison with each other,

"(B) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and

"(C) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public.

Review.

"(b) The Office of Management and Budget may review the Secretary's report under subsection (a) before its submission to the Congress, but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report."

Comments, submission to Congress.

## QUALITY ASSURANCE

58 Stat. 691;  
65 Stat. 63.  
42 USC 241.

Sec. 3, Title III of the Public Health Service Act is amended by adding at the end thereof the following new part:

## "PART K—QUALITY ASSURANCE

## "QUALITY ASSURANCE

"Sec. 395c. (a) (1) The Secretary, through the Assistant Secretary for Health, shall conduct research and evaluation programs respecting the effectiveness, administration, and enforcement of quality assurance programs. Such research and evaluation programs shall be carried out in cooperation with the entity within the Department which administers the programs of assistance under section 304.

Research and  
evaluation  
programs.

"(2) For the purpose of carrying out paragraph (1), there are authorized to be appropriated \$1,000,000 for the fiscal year ending June 30, 1974, \$8,000,000 for the fiscal year ending June 30, 1975, \$9,000,000 for the fiscal year ending June 30, 1976, \$9,000,000 for the fiscal year ending June 30, 1977, and \$10,000,000 for the fiscal year ending June 30, 1978.

81 Stat. 534.  
42 USC 242b.  
Appropriation.

"(b) The Secretary shall make an annual report to the Congress and the President on (1) the quality of health care in the United States, (2) the operation of quality assurance programs, and (3) advances made through research and evaluation of the effectiveness, administration, and enforcement of quality assurance programs. The first annual report under this subsection shall be made with respect to calendar year 1974 and shall be submitted not later than March 1, 1975. The Office of Management and Budget may review the Secretary's report under this subsection before its submission to the Congress, but the Office may not revise the report or delay its submission to the Congress, and it may submit to the Secretary and the Congress its comments (and those of other departments and agencies of the Government) with respect to such report."

Annual report  
to President  
and Congress.

## HEALTH CARE QUALITY ASSURANCE PROGRAMS STUDY

Sec. 4. (a) The Secretary of Health, Education, and Welfare shall contract, in accordance with subsection (b), for the conduct of a study to—

- (1) analyze past and present mechanisms (both required by law and voluntary) to assure the quality of health care, identify the strengths and weaknesses of current major prototypes of health care quality assurance systems, and identify on a comparable basis the costs of such prototypes;
- (2) provide a set of basic principles to be followed by any effective health care quality assurance system, including principles affecting the scope of the system, methods for assessing care, data requirements, specifications for the development of criteria and standards which relate to desired outcomes of care, and means for assessing the responsiveness of such care to the needs and perceptions of the consumers of such care;
- (3) provide an assessment of programs for improving the performance of health practitioners and institutions in providing high-quality health care, including a study of the effectiveness of sanctions and educational programs;
- (4) define the specific needs for a program of research and evaluation in health care quality assurance methods, including the design of prospective evaluations protocols for health care quality assurance systems; and
- (5) provide methods for assessing the quality of health care from the point of view of consumers of such care.

(b) The Secretary shall contract for the conduct of the study required by subsection (a) with a nonprofit private organization which—

Contract with  
private organi-  
zation.

(1) has a national reputation for objectivity in the conduct of studies for the Federal Government;

(2) has the capacity to readily marshal the widest possible range of expertise and advice relevant to the conduct of such study;

(3) has a membership and competent staff which have backgrounds in government, the health sciences, and the social sciences;

(4) has a history of interest and activity in health policy issues related to such study; and

(5) has extensive existing contracts with interested public and private agencies and organizations.

The Secretary shall enter into such contract within 90 days of the date of the enactment of the first Act making an appropriation under subsection (d).

Reports to congressional committees.

(c) An interim report providing a plan for the study required by subsection (a) shall be submitted by the organization conducting the study to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate by June 30, 1974; and a final report giving the results of the study and providing specifications for an effective quality assurance system shall be submitted by such organization to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate by January 31, 1976.

Appropriation.

(d) There is authorized to be appropriated \$10,000,000, which shall be available without fiscal year limitation, for the conduct of the study required by subsection (a).

REPORTS RESPECTING MEDICALLY UNDERSERVED AREAS AND POPULATION GROUPS AND NON-METROPOLITAN AREAS

Reports to Congress.

Sec. 5. Within three months of the date of the enactment of this Act, the Secretary of Health, Education, and Welfare shall report to the Congress the criteria used by him in the designation of medically underserved areas and population groups for the purposes of section 1302(7) of the Public Health Service Act. Within one year of such date, the Secretary shall report to the Congress (1) the areas and population groups designated by him under such section 1302(7) as having a shortage of personal health services, (2) the comments (if any) submitted by State and areawide comprehensive health planning agencies under such section with respect to any such designation, and (3) the areas which meet the definitional standards under section 1302(9) of such Act for non-metropolitan areas. The Office of Management and Budget may review the Secretary's report under this section before its submission to the Congress, but the Office may not revise the report or delay its submission beyond the date prescribed for its submission, and it may submit to Congress its comments (and those of other departments and agencies of the Government) respecting such report.

Ante, p. 917.

Review.

Comments, submitted to Congress.

HEALTH SERVICES FOR INDIANS AND DOMESTIC AGRICULTURAL MIGRATORY AND SEASONAL WORKERS

68 Stat. 674.

Sec. 6. (a) The first section of the Act of August 5, 1954 (42 U.S.C. 2601), is amended by inserting "(a)" after "That" and by adding at the end thereof the following new subsection:

"(b) In carrying out his functions, responsibilities, authorities, and duties under this Act, the Secretary is authorized, with the consent of the Indian people served, to contract with private or other non-

Federal health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other similar basis."

(b) The Secretary of Health, Education, and Welfare, in connection with existing authority (except section 310 of the Public Health Service Act) for the provision of health services to domestic agricultural migratory workers, to persons who perform seasonal agricultural services similar to the services performed by such workers, and to the families of such workers and persons, is authorized to arrange for the provision of health services to such workers and persons and their families through health maintenance organizations. In carrying out this subsection the Secretary may only use sums appropriated after the date of the enactment of this Act.

76 Stat. 545.  
42 USC 247h.

#### CONFORMING AMENDMENTS

SEC. 7. (a) Section 1 of the Public Health Service Act is amended to read as follows:

58 Stat. 692;  
86 Stat. 137.  
42 USC 201 note.

#### "SHORT TITLE

"SECTION 1. This Act may be cited as the 'Public Health Service Act.'"

(b) Title XIII of the Act of July 1, 1914 (58 Stat. 682) (as so designated by section 2(b) of the Emergency Medical Services Systems Act of 1973 (Public Law 93-151)) is repealed.

Repeal.

Ante, p. 604.

(c) Section 306(g) of the Federal National Mortgage Association Act (12 U.S.C. 1721(g)) is amended by inserting "or which are guaranteed under title XIII of the Public Health Service Act" after "chapter 37 of title 38, United States Code".

82 Stat. 542.

38 USC 1801.

Approved December 29, 1973.

#### LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 93-451 accompanying H. R. 7974 (Comm. on Interstate and Foreign Commerce) and No. 93-714 (Comm. of Conference).

SENATE REPORTS: No. 93-129 (Comm. on Labor and Public Welfare) and No. 93-621 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 119 (1973):

May 14, 15, considered and passed Senate,

Sept. 12, considered and passed House, amended, in lieu of H. R. 7974.

Dec. 10, House agreed to conference report.

Dec. 19, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 10, No. 1 (1974):

Dec. 29, 1973, Presidential statement.

## Health Maintenance Organizations

Calif Health & Safety Code 11-75 et seq  
 Colorado Rev Code 1963 72-37-1  
 Florida Statutes 1971 641.17  
 Kentucky Revised Statutes 1971 304.38-010  
 Minnesota Statutes 1971 62D.01  
 Nevada Rev Statutes 1973 reprint 695a 010  
 New Jersey Rev. Statute 1937 26:211  
 Tennessee Code Annotated 1955 56-4101  
 South Dakota Laws 1974 Chap 321  
 Utah Code Annotated 1953 31-42-1

state

Place in Title 21

Age/Health considerations shouldn't be prohibited

Inadequate capitalization

HMO's should be regulated like other similar programs.

Do we really need it?

Who is testifying Wed night? (St. Pat's day!)