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SENATE FINANCE COMMITTEE REPORT

DATE: 2/28/90

FURTHER:

DATE TURNED INTO OFFICE: 3/16/90

The Finance Committee considered SSSB 335

Health maintenance organizations; efd.

and recommended:

- replace with CS 33 SB 335 (Finance)
- or adopt CS _____
- attached amendment(s)
- _____ letter of intent adopted

- same title
- new title
- technical title change (HB only)

do pass

do not pass

no recommendation

individual recommendations

further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Dept/Date:

fiscal note(s) _____

zero fiscal note(s) _____

APPROVES PREVIOUS:

Dept/Date:

fiscal note(s) _____

zero fiscal note(s) DCEED 2/7/90

appropriation-no fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

James Duncan

Mark

Paul

Paul (Do Pass)

1. _____ -- 2. _____

Co-Chairs: Signatures and Recommendations

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to Health
Maintenance Organizations
Sponsor: Sen. Kerttula
Requestor: Senate Labor & Commerce

Agency Affected: Commerce & Econ. Dev.
BRU: Insurance
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary) No fiscal impact in FY 90.

No fiscal impact on the division.

Changes in CSSS SB 335 (Fin)
have no fiscal impact.
This fiscal note is
appropriate. 3/16/90 new

Prepared by: Joan Brown, Administrative Officer
Division: Insurance

Phone: 465-2597
Date: February 7, 1990

Approved by Commissioner: Larry Merculieff SM
Agency: Department of Commerce & Economic Development

Date: 2/7/90

Distribution (by preparer):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Changes in CSSS SB 335 (L+C)
have no fiscal impact. This
fiscal note is appropriate.
Projections of no fiscal impact
would continue through 1996.

6-16-90
Ford
3-13-90
Adopted
SFC
3-16-90
(No changes)

Original sponsor(s): SEN. KERTTULA, Sturgulewski

1 IN THE SENATE

BY THE FINANCE COMMITTEE

2 CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 335 (Finance)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to health maintenance organizations;
7 and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 21 is amended by adding a new chapter to read:

10 CHAPTER 86. HEALTH MAINTENANCE ORGANIZATIONS.

11 Sec. 21.86.010. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZA-
12 TIONS. (a) A person may apply to the director for and obtain a
13 certificate of authority to establish and operate a health maintenance
14 organization in compliance with this chapter. A person may not estab-
15 lish or operate a health maintenance organization in this state unless
16 the person obtains a certificate of authority under this chapter. A
17 foreign corporation may, subject to its registration, qualify under
18 this chapter to do business in this state as a foreign corporation.

19 (b) An application for a certificate of authority must be veri-
20 fied by an officer or authorized representative of the applicant, must
21 be in a form prescribed by the director, and must contain or be accom-
22 panied by the following:

23 (1) a copy of the organizational documents of the appli-
24 cant, including the articles of incorporation, articles of associa-
25 tion, partnership agreement, trust agreement, or other applicable
26 documents, and all amendments to the documents;

27 (2) a copy of the bylaws, regulations, or similar document,
28 if any, regulating the conduct of the internal affairs of the appli-
29 cant;

1 (3) a list of the names, addresses, and official positions
2 of the persons who are responsible for the conduct of the affairs of
3 the applicant, including all members of the board of directors, board
4 of trustees, executive committee, or other governing board or commit-
5 tee, the principal officers in the case of a corporation, and the
6 partners or members in the case of a partnership or association;

7 (4) a copy of contracts made or to be made between the
8 applicant and providers or between the applicant and persons listed in
9 (3) of this subsection;

10 (5) a copy of the form of evidence of coverage that is to
11 be issued to the enrollees;

12 (6) a copy of the form or group contract, if any, that is
13 to be issued to employers, unions, trustees, or other organizations;

14 (7) financial statements showing the applicant's assets,
15 liabilities, and sources of financial support; if the applicant's
16 financial affairs are audited by independent certified public accoun-
17 tants; a copy of the applicant's most recent certified financial
18 statement satisfies the requirement of this paragraph unless the
19 director finds that additional or more recent financial information is
20 required for the proper administration of this chapter;

21 (8) a description of the proposed method of marketing, a
22 financial plan that includes a projection of operating results antic-
23 ipated until the organization has had net income for at least one
24 year, and a statement as to the sources of working capital as well as
25 any other sources of funding;

26 (9) a power of attorney executed by the applicant, if not
27 domiciled in this state, appointing the director and the director's
28 successors in office, and authorized deputies, as the true and lawful
29 attorney of the applicant in and for this state, upon whom all lawful

process in any legal action or proceeding against the health maintenance organization, on a cause of action arising in this state, may be served;

(10) a statement reasonably describing the geographic area or areas to be served;

(11) a description of the complaint procedures to be used, as required under AS 21.86.100;

(12) as required by regulations adopted by the director, a description of the procedures and programs to be implemented to assure compliance with state and federal statutes and regulations regarding the quality of health care;

(13) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under AS 21.86.040;

(14) the deposit required under AS 21.86.140(b);

(15) other information that the director requires in order to make a determination under AS 21.86.020;

(16) the application fee prescribed under AS 21.06.250.

(c) An applicant, or a health maintenance organization holding a certificate of authority granted under this chapter, shall, unless otherwise provided for, file a notice describing any material modification of the organization's operation as described in the information submitted under (b) of this section. The notice shall be filed with the director before the modification. If the director does not disapprove the modification within 30 days after the filing of the notice, the modification is considered approved. The director may adopt regulations exempting from the filing requirements of this subsection those items that the director considers unnecessary to report.

1 (d) An applicant, or a health maintenance organization holding a
2 certificate of authority granted under this chapter, shall file with
3 the director all contracts of reinsurance. An agreement between the
4 organization and an insurer is subject to the laws of this state
5 regarding reinsurance. All reinsurance agreements, and modifications
6 to a reinsurance agreement, shall be filed with the director and must
7 be approved by the director. A reinsurance agreement remains in full
8 force and effect for at least 90 days following written notice to the
9 director, by registered mail, of cancellation by either party.

10 Sec. 21.86.020. ISSUANCE OF CERTIFICATE OF AUTHORITY; APPROVAL
11 OF CHANGES. (a) Within 10 days after receipt of an application for a
12 certificate of authority, the director shall forward a copy of the
13 application to the commissioner of health and social services. Within
14 60 days after the commissioner of health and social services receives
15 the copy of the application, the commissioner shall make a recommenda-
16 tion regarding the granting of the certificate of authority.

17 (b) The director shall either issue or deny a certificate of
18 authority within 30 days after receipt of the commissioner of health
19 and social services' recommendation. However, the director may extend
20 the time for issuance or denial of a certificate of authority if
21 additional information is needed in order to make a decision, and
22 notice of the extension is provided to the applicant by the 90th day
23 after the director received the application. A certificate of author-
24 ity shall be issued if the director determines that the following
25 conditions are met:

26 (1) the persons responsible for the conduct of the affairs
27 of the applicant are competent and trustworthy;

28 (2) the applicant will effectively provide or arrange for
29 the provision of basic health care services on a prepaid basis,

1 through insurance or otherwise, except to the extent of reasonable
2 requirements for copayments;

3 (3) the applicant is financially responsible and may rea-
4 sonably be expected to meet its obligations to enrollees and pro-
5 spective enrollees; in determining if this condition is met, the
6 director may consider

7 (A) the financial soundness of the arrangements for
8 health care services and the schedule of charges used in con-
9 nection with those services;

10 (B) the adequacy of working capital;

11 (C) an agreement with an insurer, a hospital or medi-
12 cal service corporation, a government, or other organization for
13 ensuring the payment of the cost of health care services or
14 providing for automatic applicability of an alternative coverage
15 if the health maintenance organization is discontinued;

16 (D) an agreement with providers for the provision of
17 health care services; and

18 (E) a deposit of cash or securities submitted under
19 AS 21.86.140;

20 (4) the enrollees will be afforded an opportunity to par-
21 ticipate in matters of policy and operation as provided in AS 21.86.-
22 040;

23 (5) nothing in the proposed method of operation, as shown
24 by the information submitted under AS 21.86.010 or by independent
25 investigation, is contrary to the public interest;

26 (6) the information submitted under AS 21.86.010(b)(12)
27 indicates that the applicant will be able to comply with state and
28 federal statutes and regulations regarding the quality of health care.

29 (c) If a certificate of authority is denied under this section,

1 the applicant may request a hearing under AS 21.86.200.

2 Sec. 21.86.030. POWERS OF A HEALTH MAINTENANCE ORGANIZATION.

3 (a) A health maintenance organization may

4 (1) purchase, lease, construct, renovate, operate, or
5 maintain hospitals, other health care facilities, their ancillary
6 equipment, and property reasonably required for its principal office
7 or for purposes necessary in the transaction of the business of the
8 organization;

9 (2) make loans to a medical group under contract with it in
10 furtherance of its program, or make loans to a corporation or corpora-
11 tions under its control for the purpose of acquiring or constructing
12 medical facilities and hospitals or in furtherance of a program
13 providing health care services to enrollees;

14 (3) furnish health care services through providers that are
15 under contract with or employed by the health maintenance organiza-
16 tion;

17 (4) contract with a person for the performance, on the
18 organization's behalf, of certain functions such as marketing, enroll-
19 ment, and administration;

20 (5) contract with an insurance company licensed in this
21 state, or with a hospital or medical service corporation authorized to
22 do business in this state, for the provision of insurance, indemnity,
23 or reimbursement against the cost of health care services provided by
24 the health maintenance organization;

25 (6) offer other health care services, in addition to basic
26 health care services.

27 (b) A health maintenance organization shall file a notice and
28 adequate supporting information with the director before the exercise
29 of a power granted in (a)(1), (2), or (4) of this section. The

1 director may disapprove the exercise of a power only if, in the direc-
2 tor's opinion, it would substantially and adversely affect the finan-
3 cial soundness of the health maintenance organization and endanger its
4 ability to meet its obligations. If the director does not disapprove
5 the exercise of power within 30 days after the filing of the notice,
6 it is considered approved. The director may adopt regulations ex-
7 emption from the filing requirement of this section those activities
8 having a minimal effect on the health maintenance organization.

9 (c) Nothing in this section relieves a health maintenance orga-
10 nization that wishes to exercise the power described in (a)(1) of this
11 section from the requirements of

- 12 (1) AS 18.07, regarding obtaining a certificate of need;
- 13 (2) AS 18.20, regarding regulation of hospitals; and
- 14 (3) other statutes applicable to hospitals or other health
15 care facilities.

16 Sec. 21.86.040. GOVERNING BODY; ENROLLEE PARTICIPATION. (a)
17 The governing body of a health maintenance organization may include
18 providers, or other individuals, or both. At least one-third of the
19 governing body must consist of consumers who are substantially repre-
20 sentative of enrollees.

21 (b) The governing body of a health maintenance organization
22 shall establish a mechanism to afford its enrollees an opportunity to
23 participate in matters of policy and operation through the establish-
24 ment of advisory panels, by the use of advisory referenda on major
25 policy decisions, or through the use of other mechanisms.

26 Sec. 21.86.050. FIDUCIARY RESPONSIBILITY. (a) A director,
27 officer, employee, or partner of a health maintenance organization who
28 receives, collects, disburses, or invests money in connection with the
29 activities of that organization is responsible for that money in a

fiduciary relationship to the organization.

(b) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000, or another amount prescribed by the director. The bond must be written with at least a one-year discovery period and, if written with less than a three-year discovery period, must contain a provision that cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, does not take effect sooner than 90 days after written notice of cancellation or termination has been filed with the director, unless an earlier cancellation or termination date is approved by the director.

Sec. 21.86.060. PROVISION OF SERVICES. (a) A health maintenance organization may provide physician services directly, through physician employees, or may provide the services under arrangements with individual physicians or one or more groups of physicians.

(b) In addition to basic health care services, a health maintenance organization may provide, or arrange for, other health care services on a prepayment or other financial basis.

(c) Health care services may be provided only by appropriately licensed health care providers.

Sec. 21.86.070. EVIDENCE OF COVERAGE; CHARGES FOR HEALTH CARE SERVICES. (a) An enrollee residing in this state is entitled to evidence of coverage. If an enrollee obtains coverage from an insurance policy or from a subscriber contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or hospital or medical service corporation shall issue the evidence of coverage, otherwise, the health maintenance organization shall issue the evidence of coverage. Each subsequent change in coverage must be evidenced in a separate document issued to the

enrollee.

(b) Except as provided in (d) of this section, evidence of coverage, or an amendment or endorsement to coverage, may not be issued or delivered to a person in this state until a copy of the form of the evidence of coverage, amendment, or endorsement has been filed with and approved by the director. A filing shall be made not less than 30 days before the intended date of delivery or issuance. The form of evidence of coverage, amendment, or endorsement is considered approved 30 days after it was filed, unless it is affirmatively approved or disapproved by an order of the director before the expiration of the 30-day period. If the form of evidence of coverage, amendment, or endorsement is disapproved, the director's order must specify the reasons for disapproval. A hearing shall be granted to a person aggrieved by either an approval or disapproval under this subsection if a written request is made by that person to the director. The hearing shall be granted within 30 days after the receipt of the written request.

(c) An evidence of coverage

(1) may not contain a provision or statement that is unjust, unfair, inequitable, misleading, deceptive, or encourages misrepresentation, or that is untrue, misleading, or prohibited under AS 21.86.150; and

(2) must contain a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of

(A) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(B) limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including a deductible or copayment feature;

(C) where, and in what manner, information is available as to how services may be obtained;

(D) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(E) the health maintenance organization's method for resolving enrollee complaints.

(d) If a form of the evidence of coverage, or an amendment or endorsement to it, is subject to the jurisdiction of the director under AS 21.42.120 and 21.42.130, or under AS 21.87.180, the filing requirements of (b) of this section do not apply. If a form of evidence of coverage, or an amendment or endorsement to it, is subject to AS 21.42.120 and 21.42.130, or to AS 21.87.180, those applicable provisions, as well as (c) of this section, apply to the content of the form of evidence of coverage, amendment, or endorsement.

(e) A schedule of charges for enrollee coverage for health care services, or an amendment or endorsement to it, may not be used until a copy of the schedule has been filed with and approved by the director. A filing shall be made not less than 30 days before its proposed use. The schedule of charges, amendment, or endorsement is considered approved 30 days after it was filed unless it was affirmatively approved or disapproved by an order of the director before the expiration of the 30-day period. If a schedule of charges, amendment, or endorsement is disapproved, the director's order must specify the reasons for disapproval. A hearing shall be granted to a person aggrieved by either an approval or disapproval under this subsection if a written request is made by that person to the director. The hearing shall be granted within 30 days after receipt of the written

request.

(f) A schedule of charges, or an amendment or endorsement to it, shall be established according to sound actuarial principles for various categories of enrollees, but charges applicable to an enrollee may not be individually determined based on that enrollee's health status. The charges may not be excessive, inadequate, nor unfairly discriminatory. Certification by an actuary who is a member in good standing of the American Academy of Actuaries or another person who is considered qualified by the director, as to the appropriateness of the application of the charges, based on reasonable assumptions, must accompany each filing under (e) of this section, along with adequate supporting information.

(g) The director may require that additional relevant material considered necessary by the director be submitted in order to determine the acceptability of a filing made under either (b) or (e) of this section.

Sec. 21.86.080. ANNUAL STATEMENT; ADDITIONAL REPORTS. A health maintenance organization shall file an annual statement with the director under AS 21.09.200 and shall provide a copy to the commissioner of health and social services. The annual statement shall be verified by at least two principal officers of the organization. The director may require additional reports that are reasonably necessary and appropriate in order for the director or the commissioner of health and social services to carry out the duties prescribed by this chapter.

Sec. 21.86.090. INFORMATION TO ENROLLEES. A health maintenance organization shall promptly notify its enrollees of a material change in its operation that would directly affect the enrollees.

Sec. 21.86.100. COMPLAINT SYSTEM; REPORT. (a) A health

1 maintenance organization shall establish and maintain a complaint
2 system to provide reasonable procedures for the resolution of written
3 complaints initiated by its enrollees. A complaint system must pro-
4 vide a procedure for forwarding to the commissioner of health and
5 social services a duplicate copy of a complaint relating to patient
6 care or facility operation.

7 (b) A health maintenance organization must annually, on or
8 before March 1, submit to the director, in a form prescribed by the
9 director, a report covering the preceding calendar year. The health
10 maintenance organization shall provide a copy of this report to the
11 commissioner of health and social services. The report submitted
12 under this subsection must include

13 (1) a description of the procedures used in its complaint
14 system;

15 (2) the total number of complaints handled through its
16 complaint system and a compilation of the causes underlying the com-
17 plaints filed; and

18 (3) the number, amount, and disposition of malpractice
19 claims made by an enrollee that were settled during the year by the
20 health maintenance organization; information concerning malpractice
21 claims shall be held confidential by the director and by the commis-
22 sioner of health and social services, and is not subject to public
23 disclosure.

24 (c) The director or the commissioner of health and social ser-
25 vices may, at any time during normal business hours, examine the
26 complaint system in any place of business of the health maintenance
27 organization in order to determine compliance with this section.

28 Sec. 21.86.110. RECOVERY OF HEALTH CARE COSTS. If a health
29 maintenance organization determines that an enrollee has received

health care services that the enrollee is not entitled to receive under the terms of the health maintenance agreement, the organization may not recover an amount above the actual cost of providing the health care service. This section does not apply if the enrollee gave or withheld information to the health maintenance organization with the intent to mislead or misinform the organization as to the enrollee's right to receive the health care services.

Sec. 21.86.120. RETURN OF AGREEMENT. A person who enters into a health maintenance agreement may return the agreement to the health maintenance organization or the agent from whom it was purchased within 10 days of the delivery of the agreement to the person if the person is not satisfied for any reason. Upon return of the agreement, the health maintenance organization shall promptly refund the fee paid for the agreement. Notice of the substance of this section must be printed on the face of the agreement.

Sec. 21.86.130. INVESTMENTS. With the exception of investments made under AS 21.86.030, a health maintenance organization's money may only be invested as allowed by AS 21.21 for the investment of legal reserves of a life insurer.

Sec. 21.86.140. PROTECTION AGAINST INSOLVENCY. (a) Except as otherwise provided in this section, a health maintenance organization shall deposit with the director, or with an organization or trustee acceptable to the director through which a custodial or controlled account is used, cash, securities, or a combination of these or other means acceptable to the director in the manner and amount required by this section.

(b) Except as provided in (d) and (e) of this section, the deposit amount for a health maintenance organization that begins operation after the effective date of this Act is the greater of 10

percent of its estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or \$250,000. Except as provided in (d) and (e) of this section, at the beginning of each succeeding year of operation, the organization shall deposit with the director, or organization or trustee, cash, securities, or a combination of these or other means acceptable to the director in an amount equal to four percent of its estimated annual uncovered expenditures for that year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(c) Except as provided in (d) and (e) of this section, a health maintenance organization that is in operation on the effective date of this Act shall, on the first day of its fiscal year beginning six months or more after the effective date of this Act, make a deposit equal to the greater of one percent of the preceding 12 months' uncovered expenditures or \$250,000. The organization shall, at the beginning of its second fiscal year after the effective date of this Act, deposit an amount equal to two percent of the organization's estimated annual uncovered expenditures for that year. At the beginning of its third fiscal year, the organization shall deposit an amount equal to three percent of its estimated annual uncovered expenditures for that year. At the beginning of the fourth fiscal year and subsequent years, the organization shall deposit an amount equal to four percent of its estimated annual uncovered expenditures for that year. Each year's estimate, after the first year of operation, must reasonably reflect the prior year's operating experience and delivery arrangements.

(d) The director may waive the deposit requirements in (b) and

(c) of this section if the director is satisfied that

(1) the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(2) the organization's performance and obligations are guaranteed by another organization that has sufficient net worth and an adequate history of generating net income; or

(3) the assets of the organization, or its contracts with insurers, hospital or medical service corporations, governments, or other organizations, are reasonably sufficient to assure the performance of its obligations.

(e) The annual deposit requirements of (b) and (c) of this section do not apply if

(1) a health maintenance organization has achieved a net worth, not including land, buildings, and equipment, of at least \$1,000,000 or has achieved a net worth, including land, buildings, and equipment, of at least \$5,000,000;

(2) the total amount of the health maintenance organization's accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or is equal to the capital and surplus requirements for the formation for admittance of a disability insurer in this state, whichever is less;

(3) a health maintenance organization has a guaranteeing organization that

(A) does not sponsor any other health maintenance organization; and

(B) has been in operation for at least

(i) five years and has a net worth, not including land, buildings, and equipment, of at least \$1,000,000; or

(ii) 10 years and has a net worth, including land, buildings, and equipment, of at least \$5,000,000; or

(4) a health maintenance organization has a guaranteeing organization that sponsors more than one health maintenance organization and that

(A) has been in operation for at least

(i) five years and has a net worth that is at least that required by (3)(B)(i) of this subsection multiplied by a number equal to the number of organizations sponsored; or

(ii) 10 years and has a net worth that is at least that required by (3)(B)(ii) of this subsection multiplied by a number equal to the number of organizations sponsored; or

(B) has, for each organization sponsored, a net worth at least equal to the capital and surplus requirement for a disability insurer.

(f) All deposit income belongs to the depositing health maintenance organization, and shall be paid to it as it becomes available. A health maintenance organization that has made a deposit of securities may withdraw that deposit, or any part of it, after making a substitute deposit of cash, securities, or a combination of these or other means of equal amount and value. Substitution of securities must have prior approval by the director.

(g) In a year in which an annual deposit is not required of a health maintenance organization under this section, at the organization's request the director shall reduce the required, previously accumulated deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of an organization's net worth is

reduced to less than the amount that allowed a reduction in accumulated deposit, the organization shall immediately redeposit \$100,000 for each \$250,000 of reduction in net worth, except that the total deposit need not exceed the maximum required under this section.

(h) A health maintenance organization that obtains a certificate of authority shall have and maintain a capital account of at least \$100,000 in addition to deposit requirements under this section. The capital account must equal at least \$100,000 after deducting accrued liabilities, and must be in the form of cash, securities, or a combination of these or other means acceptable to the director.

Sec. 21.86.150. PROHIBITED PRACTICES. (a) A health maintenance organization or a representative of a health maintenance organization may not cause or knowingly permit a person to provide, on behalf of the health maintenance organization, health care services that the person is not licensed to provide.

(b) A health maintenance organization, or a representative of a health maintenance organization, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or a form of evidence of coverage that is deceptive. For purposes of this chapter,

(1) a statement or item of information is considered to be untrue if it does not conform to fact in any respect that is or might be significant to an enrollee of, or person considering enrollment with, a health maintenance organization;

(2) a statement or item of information is considered to be misleading, whether or not it is untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information might be understood by a reasonable person, not possessing special knowledge regarding health

care coverage, as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not exist;

(3) an evidence of coverage is considered to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as to language, might cause a reasonable person, not possessing special knowledge regarding health maintenance organizations or an evidence of coverage, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health maintenance organization issuing the evidence of coverage does not regularly make available for an enrollee covered under the evidence of coverage.

(c) AS 21.36 applies to health maintenance organizations and to an evidence of coverage except to the extent that the director determines that the nature of health maintenance organizations and the evidence of coverage renders that chapter clearly inappropriate.

(d) A health maintenance organization may not cancel or refuse to review an enrollee, except for

(1) reasons stated in the organization's regulations applicable to all enrollees;

(2) failure to pay the charge for the enrollee's coverage; or

(3) other reasons adopted by the director by regulation.

(e) Unless it is licensed as an insurer, a health maintenance organization may not refer to itself as an insurer or use a name deceptively similar to the name or description of an insurance or surety corporation doing business in the state.

(f) A person may not use the phrase "health maintenance organization" or "HMO" in the course of the person's operations unless the person possesses a valid certificate of authority issued under this chapter.

Sec. 21.86.160. REGULATION OF AGENTS. (a) The director may adopt regulations necessary to provide for the licensing of health maintenance organization agents.

(b) The director may, by regulation, exempt certain classes of persons from the requirement of obtaining an agent license if

(1) the function the class performs does not require special competence or trustworthiness, or the regulatory surveillance made possible by licensing; or

(2) other existing safeguards make regulation through licensing unnecessary.

Sec. 21.86.170. POWERS OF INSURERS AND OF HOSPITAL OR MEDICAL SERVICE CORPORATIONS. (a) An insurer licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Two or more insurance companies, hospitals or medical service corporations, or subsidiaries or affiliates of them, may jointly organize and operate a health maintenance organization. The business of insurance is considered to include providing health care by a health maintenance organization owned or operated by an insurer or subsidiary of an insurer.

(b) An insurer or hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage in the event

of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under this title. Under a contract authorized by this subsection, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Sec. 21.86.180. EXAMINATIONS. (a) The director shall examine the affairs and transactions of a health maintenance organization in the same manner as prescribed for an insurer in AS 21.06.140 - 21.06.-180.

(b) As often as is reasonably necessary for the protection of the interests of the people of the state, but at least once every three years, the director shall require submission of an independent review of the quality of care provided by a health maintenance organization either directly or indirectly through contract, agreement, or other arrangement for provisions of health care services to enrollees of the health maintenance organization. The review required under this subsection shall be done by a review organization approved by the Department of Health and Social Services and shall be done under regulations adopted by that department. The health maintenance organization shall pay the cost of the review.

Sec. 21.86.190. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY. (a) After compliance with AS 21.86.200, the director may suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter if

(1) the health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in other information submitted under AS 21.86.010 or 21.86.020(d);

(2) the health maintenance organization issues an evidence of coverage, or uses a schedule of charges for health care services, that does not comply with the requirements of AS 21.86.070;

(3) the health maintenance organization does not provide or arrange for the provision of basic health care services;

(4) the health maintenance organization is not in compliance with state and federal statutes and regulations as required under AS 21.86.010(b)(12), or is unable to fulfill its obligations to furnish health care services;

(5) the health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) the health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under AS 21.86.040;

(7) the health maintenance organization has failed to implement the complaint system required by AS 21.86.100 in a reasonable manner to resolve valid complaints;

(8) the health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) the continued operation of the health maintenance organization would be hazardous to its enrollees;

(10) the health maintenance organization has otherwise failed substantially to comply with this chapter.

(b) If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of the suspension, enroll additional enrollees except newborn children or other newly acquired dependents of existing

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enrollees, and may not engage in advertising or solicitation. The director may, by written order, specify limitations in the operation of the organization during the period of suspension as the director finds to be in the best interests of enrollees.

(c) If the certificate of authority of a health maintenance organization is revoked, the organization shall, immediately following the effective date of the order of revocation, proceed to wind up its affairs, and may not conduct further business except that essential to the orderly conclusion of the affairs of the organization. The organization may not engage in further advertising or solicitation. The director may, by written order, permit continued operation of the organization as the director finds to be in the best interest of enrollees, so that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Sec. 21.86.200. ADMINISTRATIVE PROCEDURES. (a) If the director has reason to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the director shall notify the applicant or the health maintenance organization in writing, specifically stating the grounds for denial, suspension, or revocation. A person aggrieved by a decision of the director regarding denial, suspension, or revocation of a certificate of authority may request a hearing under AS 21.06.180. If a hearing is requested, it shall be held under the procedures in AS 21.06.170 - 21.06.220, except that AS 21.06.190 does not apply in the case of a hearing regarding denial of a certificate.

(b) After a hearing under (a) of this section, or upon the failure of an applicant or health maintenance organization to appear at such a hearing, the director shall make written findings and issue an order, that shall be mailed to the applicant or health maintenance

organization and concurrently provided to the commissioner of health and social services. An appeal of the director's order may be made in the manner provided by AS 21.06.230.

Sec. 21.86.210. REHABILITATION, LIQUIDATION, OR CONSERVATION.

(a) A rehabilitation, liquidation, or conservation of a health maintenance organization is considered to be a rehabilitation, liquidation, or conservation of an insurer, and shall be conducted under AS 21.78. The director may apply to the superior court for an order directing the rehabilitation, liquidation, or conservation of a health maintenance organization upon one or more of the grounds contained in AS 21.78.040, 21.78.050, or 21.78.060, or if, in the director's opinion, the continued operation of the organization would be hazardous to either enrollees or to the people of the state.

(b) Enrollees of a health maintenance organization have the same priority in the event of liquidation or rehabilitation as AS 21.78 provides to policyholders of an insurer. A claim made by a health care provider in a liquidation or rehabilitation that pertains to services provided to an enrollee, has the same priority as an enrollee if the provider agrees not to assert the claim against an enrollee and if any payment fully discharges the obligation of the enrollee.

Sec. 21.86.220. REGULATIONS. The commissioner of health and social services may adopt regulations necessary to carry out the commissioner's duties under this chapter. The director may adopt regulations necessary to carry out the director's duties under this chapter.

Sec. 21.86.230. FEES. (a) A health maintenance organization shall pay fees to the director as provided under AS 21.06.250.

(b) A health maintenance organization shall pay to the commissioner of health and social services fees, as established in regu-

lations adopted by the commissioner of health and social services, that relate to the regulatory functions performed by that department under this chapter.

Sec. 21.86.240. TAXATION. A health maintenance organization is taxed as provided under AS 21.09.210(b)(1), and shall file the report required of an authorized insurer under AS 21.09.210(a).

Sec. 21.86.250. PENALTIES AND ENFORCEMENT. (a) Instead of, or in addition to, suspending or revoking a certificate of authority, the director may, in an order issued under AS 21.86.200, impose an administrative penalty in an amount not less than \$1,000 nor more than \$25,000 for each violation of an applicable provision of this chapter or a regulation adopted under this chapter.

(b) The director may issue an order directing a health maintenance organization or a person representing a health maintenance organization to stop engaging in an act or practice that is in violation of this chapter or a regulation adopted under this chapter. Within five days after service of a stop order under this subsection, the respondent may request, in writing, a hearing on the question of whether the act or practice has occurred in violation of this chapter or a regulation adopted by the director. The hearing shall commence within 10 days after the written request for the hearing has been received by the director unless the respondent requests that the hearing take place at a later date and the director agrees to the later hearing date.

Sec. 21.86.260. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAW. (a) Except as provided in this chapter, this title does not apply to a health maintenance organization that obtains a certificate of authority under this chapter. This subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service

corporation licensed under AS 21.87 except with respect to its health maintenance organization activities authorized by and regulated under this chapter.

(b) Solicitation of enrollees by a health maintenance organization that has obtained a certificate of authority or by its licensed agents or authorized employee representatives, may not be construed to violate a law of this state relating to solicitation or advertising by health care professionals.

(c) A health maintenance organization that obtains a certificate of authority under this chapter is not considered to be practicing medicine, and is exempt from a law of this state relating to the practice of medicine. However, this subsection does not exempt a health care provider from a licensing requirement, or from another law of this state regarding providers.

Sec. 21.86.270. FILINGS AND REPORTS AS PUBLIC DOCUMENTS. Except for information described in AS 21.86.100(b)(3) and except for trade secrets, privileged, confidential commercial, or financial information as determined by the director, all applications, filings, and reports required under this chapter, including annual financial statements that are required under AS 21.86.080, are public documents.

Sec. 21.86.280. CONFIDENTIALITY OF MEDICAL INFORMATION. Data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant that is obtained from that person, or from a provider, by a health maintenance organization shall be held in confidence and may not be disclosed except (1) to the extent necessary to carry out the purposes of this chapter; (2) upon the express consent of the enrollee or applicant; (3) under a statute or court order for the production of evidence or discovery; or (4) in the event of a claim or litigation between the person and the health maintenance

organization regarding which the data or information is relevant. A health maintenance organization may claim a statutory privilege against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

Sec. 21.86.290. CONTRACT AUTHORITY FOR COMMISSIONER OF HEALTH AND SOCIAL SERVICES. In carrying out duties under this chapter, the commissioner of health and social services may contract with qualified persons to make recommendations concerning the determinations required to be made by the commissioner. Recommendations made by a contractor may be accepted in full or in part by the commissioner of health and social services.

Sec. 21.86.300. ACQUISITION OF CONTROL OR MERGER OF A HEALTH MAINTENANCE ORGANIZATION. (a) A person may not acquire control of the voting securities of a domestic health maintenance organization, if, after the consummation of the transaction, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, or enter into an agreement to merge or consolidate with, or otherwise to acquire control of, a health maintenance organization.

(b) Subsection (a) of this section does not apply to a person who at the time the offer, request, or invitation is made or the agreement is entered into, or before the acquisition of the securities if no offer or agreement is involved, has filed with the director and has sent to the health maintenance organization, information required by AS 21.22 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director under this subsection is governed by AS 21.22.

(c) In this section

(1) "acquire control of" means to make a tender for, make a

request or invitation for tenders of, enter into an agreement to exchange securities for, or acquire in the open market or otherwise;

(2) "domestic" means formed under the laws of this state.

Sec. 21.86.310. DUAL CHOICE. (a) An employer in this state, whether public or private, that offers its employees a health benefit plan and employs 25 or more employees during any week of the calendar year, and an employee benefit fund in this state that offers its members any form of health benefit, shall make available to its employees or members the option to enroll in at least one health maintenance organization, holding a valid certificate of authority, that provides health care services in the geographic areas in which substantial numbers of the employees or members reside. If employees of the employer are members of a collective bargaining unit, the option of enrollment in a health maintenance organization shall first be submitted to the bargaining representative of the bargaining unit. If the option is approved by the bargaining representative, the option of enrollment shall then be made to each represented employee.

(b) An employer in this state is not required to pay more for employee health benefits as a result of the application of this section than would be required if this section did not apply to the employer. If an employee chooses enrollment in a health maintenance organization, the employer is required to pay, on behalf of that employee, only an amount equal to the lesser of

(1) the amount that would have to be paid to an insurer on behalf of its employees for substantially similar health benefits; or

(2) the health maintenance organization's charge for coverage that is approved by the director under AS 21.86.070.

(c) This section does not apply to an employer whose employees or members reside in an area where health care services are not

provided by a health maintenance organization.

Sec. 21.86.900. DEFINITIONS. In this chapter,

(1) "agent" means a person who is appointed by a health maintenance organization and who engages in solicitation of membership in the organization; "agent" does not include a person enrolling health maintenance organization members on behalf of an employer, a union, or other organization to whom a master subscriber contract has been issued, or an employee, who is not an independent contractor, of the health maintenance organization;

(2) "basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services, but does not include mental health services or services for alcohol or drug abuse;

(3) "enrollee" means an individual who is enrolled in a health maintenance organization;

(4) "evidence of coverage" means a certificate, agreement, or contract issued to an enrollee, setting out the coverage to which the enrollee is entitled;

(5) "health care services" means services for medical or dental care, or hospitalization, or services incident to the furnishing of that care or hospitalization, and includes services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

(6) "health maintenance organization" means a person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis;

(7) "person" has the meaning given in AS 01.10.060 and includes a joint venture;

(8) "provider" means a physician, hospital, or other person

licensed or otherwise authorized in this state to furnish health care services;

(9) "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization, but for which an enrollee would also be liable if the organization became insolvent.

* Sec. 2. AS 39.30.090(a)(4) is amended to read:

(4) The Department of Administration shall comply with the dual choice requirements of AS 21.86.310, and shall obtain the insurance policy from any insurer authorized to transact business in the state under AS 21.09 and AS 21.90, or from a health maintenance organization authorized to operate in this state under AS 21.86.

* Sec. 3. AS 39.30.090(b)(3) is amended to read:

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts, and health maintenance organizations.

* Sec. 4. TRANSITION. A health maintenance organization operating in the state on the effective date of this Act shall submit an application as required under AS 21.86.010(b), enacted in sec. 1 of this Act, for a certificate of authority within 60 days after the effective date of this Act. An applicant may continue to operate until the director acts upon the application. If the application is denied under AS 21.86.020, enacted in sec. 1 of this Act, the applicant shall be treated as a health maintenance organization whose certificate of authority has been revoked.

* Sec. 5. APPLICABILITY. AS 21.86.310(a), enacted in sec. 1 of this Act, applies to an employer or a collective bargaining agreement upon the expiration or renewal date of a contract or policy under the employer's health benefit plan, or of the collective bargaining agreement.

* Sec. 6. This Act takes effect immediately under AS 01.10.070(c).



Alaska State Legislature

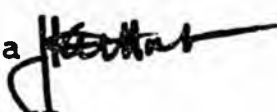
SENATE

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

TO: Senator Uehling, Co-Chairman
Senate Finance Committee

FROM: Senator Kerttula 

SUBJ: Senate Bill 335
An Enabling Act for
Health Maintenance Organizations

As I mentioned in an earlier memorandum, sponsor substitute for Senate Bill 335 incorporates an un-introduced bill by the Governor into the original SB 335. The sponsor substitute for SB 335 is based on a National Association of Insurance Commissioners' model act. Sponsor substitute for Senate Bill 335 has a "0" fiscal note.

HMOs provide for basic health care services on a prepaid basis. Under our existing statutes this form of organization -- an HMO -- is not possible because it combines the functions of health care provider and insurer. This form of organization allows health care providers to share in the financial risk and creates incentives for cost containment and preventive medicine. Following is a description of the major provisions of sponsor substitute for Senate Bill 335:

1. Requirements for Certificate of Authority: Sponsor substitute for SB 335 requires that a list of conditions be met -- including demonstration of financial solvency -- prior to issuance of a certificate of authority. The bill also lists specific items of information that must be included within an application, and allows the department to acquire any other information that may be found necessary in the future.

2. Coordination with the Department of Health and Social Services: The nature of an HMO is that it is both an insurer and a health care provider. Therefore, both the Department of Commerce and the Department of Health and Social Services has an interest in the quality of an HMO's operation. Sponsor substitute for SB 335 requires that a copy of the

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application be forwarded by the Director of Insurance to the Department of Health and Social Services within 10 days after its receipt. Within 60 days after the Commissioner of Health and Social Services receives a copy of the application, he or she makes a recommendation; and within 30 days after that recommendation, the Department of Commerce either "issues or denies" a certificate of authority.

3. Solvency and Limits on Investments: Sponsor substitute for SB 335 requires each HMO to make a custodial deposit of \$100,000 or an amount equal to five percent of the estimated expenditures for health care during the first year or "twice its estimated average monthly uncovered expenditures for its first year of operation." Each year, an HMO shall deposit in a custodial account an amount equal to "four percent of its estimated annual uncovered expenditures for that year." The deposit requirements do not apply if the HMO has a net worth of \$1 million without buildings, or \$5 million with buildings, or some alternative formulas are met which demonstrate similar financial stability. Finally, the HMO must have and maintain a "capital account of at least \$100,000" in addition to any of the deposit requirements.

4. Governing Body: The sponsor substitute requires that the governing body of an HMO be made up of at least one-third "consumers who are substantially representative of the participants." The sponsor substitute also requires that the HMO establish advisory panels so that enrollees would have an opportunity to participate in matters of policy and operation.

5. Dual Choice: Sponsor substitute for SB 335 requires that each employer in the state, whether public or private, having 25 employees or more "shall make available to its employees or members the option to enroll" in an HMO. Mandatory dual choice is viewed as necessary to make an HMO viable in Alaska. Under the sponsor substitute, an employer is not required to pay more for employee health benefits than they would have been required to pay if they were not covered by the bill.

6. Form Filing and Rate Approval: Sponsor substitute for SB 335 includes a mechanism for the approval of "an evidence of coverage." The bill provides that the HMO file the form with the Division of Insurance 30 days before it is to be used. The form is considered approved unless the

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director has affirmatively approved or disapproved the form within the 30 day period.

7. Complaint System: Sponsor substitute for SB 335 contains a detailed section requiring that the HMO establish and maintain a complaint system.

8. Powers of an HMO: Sponsor substitute for SB 335 has a section listing the powers of an HMO, and lists prohibited practices. The bill also limits the amount of money that can be recovered from an HMO from a participant who was not entitled to receive certain services to the actual cost of providing the health care service. Sponsor substitute for SB 335 also provides a window of 10 days in which a participant who has just signed up with an HMO can return the agreement and demand a refund.

9. Taxation: Sponsor substitute for SB 335 provides that an HMO is to be taxed and shall file reports as an authorized insurer.

10. Other Provisions: Sponsor substitute for SB 335 contains a section imposing fiduciary obligations in the handling of money by an HMO. The bill also provides that health care services must be provided by appropriately licensed health care providers.

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CSSSSB 335 (L&C): "An Act relating to health maintenance organizations; and providing for an effective date."

The department is in favor of this legislation. HMO's provide or arrange for basic health care services to persons on a prepaid basis. This form of organization combines some of the functions of an insurer with those of traditional health care providers. In this way, the providers of medical care share in the financial risk of health care and, therefore, have an incentive to reduce health care costs and to promote preventative medicine. This kind of organization is not possible under our present statutes. This proposal will provide a framework for the establishment of these hybrid organizations. It is based on a National Association of Insurance Commissioners model statute.

The attached commentary will provide an analysis of CSSSSB 335 (L&C).



Larry Mercurieff, Commissioner

Date: 3/6/90

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CSSSSB 335 (L&C)

Introductory Comment:

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which will provide improved health care at a lower cost. The health maintenance organization is a concept which has received such attention as one means through which an improvement in delivery might be achieved.

Shortcomings of Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas:

1. In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate.
2. Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc.
3. Even if health care is available and accessible, it may not be continuous: that is, a single patient may not be treated as a person with a continuing or a variety of problems but rather as a single isolated health care problem incident. The problems of viability, accessibility, and continuity, at least in part, have been attributed to the lack of responsibility vested in one person, group, or organization to assure the delivery of health care.

A second problem is the escalating cost of health care services. This stems from the limited supply of health care service facilities which is confronted by an expanded and fragmented financing mechanism and the consequent tremendous increase of demand for such services. This is the classic model for inflation. Traditional reimbursement of providers by the federal government, insurance plans, and hospital and medical service corporations, because of the inherent difficulties involved, has been accompanied by uneven efforts toward ineffective cost review or control. Furthermore, services or facilities are often duplicated or used inefficiently. A basic cause of inflation and inefficiency rests with the improper structuring of incentives. Where no individual group, or organization is responsible for the use of more economical services and facilities, including those relating to preventive care, greater income is generated for providers by the more frequent use of services and facilities and by the use of the more expensive facilities and services available.

A third problem is the quality of health care delivered. Throughout various parts of the country, the quality of health care can range from the very best to the very poor. Generally speaking, there is no locus for quality assessments either as to health care processes or health care results. In the absence of a means to measure quality, it is virtually impossible to design and implement effective programs to rectify defects.

This brief discussion in no way attempts to provide a comprehensive discussion of the problems of the health care delivery system in the United States nor does it give adequate recognition to the strenuous efforts of many to improve the existing system. However, it does highlight some of the major problems prevailing today. Development of the health maintenance organization (HMO) concept offers one alternative means to help alleviate some of these problems.

Nature of the Health Maintenance Organizations:

A health maintenance organization may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by or on behalf of the enrollees. An HMO can be organized, operated and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, insurance companies, etc. Generally speaking, an HMO delivery system is predicated on three principles:

1. It is an organized system for the delivery of health care which brings together health care providers.
2. Such an arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability.
3. The payments will be made on a prepayment basis, whether by the individual enrollees, medicare, medicaid, or through employer-employee arrangements.

An HMO can directly address itself to the problems of availability, accessibility, and continuity since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus, the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentives toward lessening costs in delivering health care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment, and, in general, provide a monitoring mechanism.

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to and are accepted by the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept often contract with an insurer or other prepayment plan (e.g., hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundation establishes some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients' viewpoint, from the physicians' viewpoint, the fee-for-service practice is maintained. Under the federal HMO Act, this type of organization is called an Individual Practice Association Type HMO.

The Need for State Authorizing and Regulatory Legislation

From 1970 to 1973, the administration and committees in both houses of Congress spent much time analyzing the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO's. This analysis resulted in the enactment of the federal HMO Act in 1973. Since then, the number of health maintenance organizations and the number of HMO enrollees has grown rapidly. Prior to 1972, however, few states had a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation and other supervision was being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. Because the HMO is a unique type of organization, many provisions of such state laws were inapplicable, highly restrictive or prohibitive to the formation and operation of an HMO. Therefore, in 1972, the National Association of Insurance Commissioners (NAIC) adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMO's. CSSSSB 335 (L&C) substantially tracks that model act.

Purpose of CSSSSB 335 (L&C)

CSSSSB 335 (L&C) clearly authorizes the establishment and operation of HMO's. Restrictive provisions in other laws which are inappropriate to HMO's are rendered inapplicable. Appropriate grants of authority are established to enable the HMO's to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient, and ethical operation of HMO's. As is the case with insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Thus, the purpose of this bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety, including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

Since the model bill on which CSSSSB 335 (L&C) was approved, the federal HMO Act has been enacted and amended four times. The model, or substantial portions of it, has been enacted in 27 states and substantial experience has been gained in implementing and regulating HMO's under its terms. In addition, a few HMO's have become insolvent and commissioner have had to deal with the results of those insolvencies. Therefore, the model act has been revised to reflect changes which have occurred in the federal law, to reflect experience gained in administering the law and to clarify and strengthen the provisions relating to HMO agency.

AS 21.86.010

This section requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity, in which the responsibilities imposed by this Act are vested, serves as a focus of regulatory attention to assure that the consuming public is well served.

AS 21.86.020

A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. This section provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the Insurance Division and the Department of Health and Social Services. It is felt that the expertise of the Alaska Insurance Division on fiscal and other regulatory matters and the familiarity of the Alaska Department of Health and Social Services with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency - the Insurance Division. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the Insurance Division obligated to rely on the Department of Health and Social Services with respect to the latter's sphere of expertise.

Subsection (b)(2) makes explicit the requirement that an HMO must provide a minimum package of services on a prepaid basis. Reasonable co-payments, however, are permitted and do not violate the requirement for prepayment. Such co-payments may be used to (a) reduce the amount of prepayments; and (b) minimize frivolous utilization of services. In addition, an HMO may have more than one benefit package involving different levels of co-payments.

Under subsection (b)(3), to grant a certificate of authority, the director should be satisfied that the health maintenance organization will have the financial resources to provide the health care services for which it is obligated to its enrollees. However, it is recognized that requiring an HMO to have more than a minimum capitalization as set forth in AS 21.86.140(h) might prevent the organization or implementation of an otherwise viable HMO. Furthermore, with various possible insurance and surety arrangements available to back up the HMO's promise of performance, reserve requirements such as those found in the insurance laws are not deemed necessary.

AS 21.86.030

The exercise of authority granted in this section is subject to disapproval by the director within 30 days of a filing by a health maintenance organization. The director may promulgate rules and regulations exempting certain contracts from the filing requirement where exercise of the authority granted in the section would have little or no effect on the financial condition and ability to meet obligations of the organization.

AS 21.86.040

This section makes explicit the permissible membership of such a group. CSSSSB 335 (L&C) does not, however, require that a health maintenance organization be consumer controlled. It is expected that HMO's controlled in a variety of ways will be organized. Where organizations are not consumer controlled, it is believed that some means for enrollee participation should be provided. For example, such matters as availability, accessibility and continuity of health care services are factors which directly confront the consumers and in which they have a particular interest. The disclosure of information under other sections is also designed to assist the consumers.

Arguments against a role for the consumer 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 seem more persuasive. These 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.

AS 21.86.050

This section provides a level of fidelity protection for the consumer by requiring a bond.

AS 21.86.060

This section requires that services be provided through appropriately licensed persons. It allows the HMO to provide services directly or through other arrangements.

AS 21.86.070

Subsection (a) requires that every enrollee be provided with evidence of coverage and allocates the responsibility for providing that evidence.

Subsection (b) and (e) requires that evidences of coverage and forms are subject to filing with and approval by the director.

Subsection (c) establishes requirements which evidence of coverage must meet.

Subsection (d) provides that filing is required under subsection (b) unless the form is already subject to filing requirements under existing filing statutes.

Subsection (f) provides for the filing of charges for health care services, i.e., that part of the benefit package which is provided in the form of service vis-a-vis indemnity or service benefits. Those parts of the package providing benefits under agreement with an insurance company or hospital or medical service corporation will be subject to regulation in accordance with existing laws.

Paragraph (f) neither requires nor prohibits community rating. Reasonable underwriting classifications are permitted for the purpose of establishing the charges. Different charges may be imposed on different groups of enrollees. Such a rigid requirement as community rating would appear to be inappropriate when the competing financing mechanisms are not subject to such a constraint. The competitive disadvantage which such requirement might impose could impeded the development of HMO's.

Because of its somewhat different nature, an HMO is not required by this Act to meet reserve requirements similar to those imposed on insurance companies. Thus, it is important that the charges be set at an adequate level. The requirement for certification by an actuary or other qualified person, along with supporting information, is intended to assist the director in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the director may consider the amount necessary to assure a reasonable return on the initial and subsequent capital invested and an amount needed to accumulate adequate funds to stabilize the level of charges against fluctuation due to inflation, changes in medical technology and related causes.

AS 21.86.080

This section provides the director with the authority to require reports considered necessary to carry out his duties. The reports could include:

- o a financial statement of the organization;
- o any material changes in the information submitted pursuant to AS 21.86.010(b)(3);
- o the number of persons enrolled at the beginning and end of the year; and
- o the amount of uncovered and covered expenditures that are payable and more than 90 days past due.,

In establishing filing requirements, the director will be cognizant of the fact that HMO's that are qualified under the federal HMO Act must submit detailed reports to the Department of Health and Human Services. The director will make use of such reports when they are relevant and avoid the imposition of duplicate reporting requirements.

AS 21.86.090

This section requires the HMO to provide notice to enrollees of changes in operation affecting them.

AS 21.86.100

Every health maintenance organization is required to establish a complaint system to provide reasonable procedures for the disposition of complaints. The organizations may be expected to receive two types of complaints. One type is related to the basic health care services or additional services furnished by it. The other type is related to that portion of the coverage in addition to basic health care services which is provided by insurance, hospital or medical service corporations, or some means other than being furnished by the organization. For complaints arising from health care services, the administrative procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard, including the use of binding arbitration as a means of resolving claims concerning coverage. For complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the benefit package which are covered by insurance, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

AS 21.86.110

This section avoids duplication of benefits.

AS 21.86.120

This section provides a ten-day free look.

AS 21.86.130

Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this section excepts this type of investment when approved by the director in accordance with the standards set out in AS 21.86.030(b).

AS 21.86.140

Even though very serious problems can arise if a health maintenance organization defaults on its contracts, fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. The best protection for enrollees is a financially sound organization that generates net income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organization from starting or may unreasonably tie up the capital of those that do. Therefore, this section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account, a deposit of cash or securities in a minimum account, and the organization's generation of additional amounts annually as a source of funds to meet its contractual obligations to the enrollees in the event of insolvency. The director may waive all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization's performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of the health maintenance organization's uncovered expenditures. This amount will vary depending upon the type of organization and the nature of its arrangements with providers. For example, the physicians of the staff of the organization or a contracting medical group of individual practice association may agree to look only to the organization for payment of services provided to the organization's enrollees and agree not to bill them in the event of insolvency. An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met.

In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the director if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time. This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization.

AS 21.86.150

Subsection (a) requires licensing.

Subsection (b) addresses false or defective advertising and solicitation.

Subsection (c) applies the insurance Unfair Trade Practices Act to the degree applicable.

Subsection (d) is designed to foster continuance of coverage to the extent possible.

Subsection (e) addresses potential deception through name utilized.

Subsection (f) requires a certificate of authority to use the phrase "Health Maintenance Organization" or "HMO."

AS 21.86.160

Provides for regulation of assets.

AS 21.86.170

This section overrides the group laws to permit an insurer or a hospital or medical service corporation to provide coverage protecting enrollees of an HMO. This authority is intended to permit insurers and the service corporations to write coverage (1) to fill the gaps which the providers of health care services do not provide, (2) to provide coverage in excess of the services provided, (3) to cover catastrophe situations, (4) to provide protection to the enrollees in the event the HMO becomes insolvent, and (5) to provide coverage against the cost of health care services as the health maintenance organization deems necessary.

AS 21.86.180

The director is provided authority to examine health maintenance organizations as is reasonably necessary. However, any determination related to the quality of health care services is the exclusive responsibility of the commissioner of health and social services.

AS 21.86.190 - .200

These sections list the reasons for suspension or revocation of the HMO's certificate of authority. They also set forth a process for such action.

AS 21.86.210

This section provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the director under the statute applicable to insurance companies.

AS 21.86.220

This section provides authority to adopt regulations.

AS 21.86.230

Proper administration of the HMO program by the Division of Insurance and the Department of Health and Social Services will impose additional financial burdens on the respective agencies. For this reason, it is appropriate to establish a fee system through which HMOs are required to bear the expenses associated with their regulation by the state.

AS 21.86.240

This section provides for taxation of the HMO.

AS 21.86.250

This section authorizes the director to issue a cease and desist order and to apply for injunctive relief. It also provides penalties for violations.

AS 21.86.260

This section clarifies the relationship of HMOs to other insurance statutes.

AS 21.86.270

This section provides that filings and reports are public documents.

AS 21.86.280

This section provides that medical information on an enrollee is confidential.

AS 21.86.290

This section authorizes the Department of Health and Social Services to draw upon outside expertise where appropriate. One alternative would be to contract with Professional Standards Review Organizations established pursuant to Public Law 92-604.

AS 21.86.300

This section provides protection for HMOs from acquisitions which would run counter to this chapter.

AS 21.86.310

This section is similar to section 1310 of the federal HMO Act, but extends the dual choice requirement to state licensed HMOs. The licensing requirements of this act are less stringent than the federal requirements, so this provision will assist in the development and growth of state licensed HMOs.

AS 21.86.900

Definition section.

Paragraph (6) defines an HMO to be any person that undertakes to provide or arrange for at least basic health care services on a prepaid basis. This can achieve either (a) by providing the services directly through physician or other providers actually employed by the HMO and through hospitals or facilities

owned or directly operated by the HMO, or (b) by contracting or arranging with physicians, hospitals or other facilities to provide such services. The term "arrange" does not contemplate those traditional arrangements which hospital or medical service corporations make in conjunction with their prepayment service plans pursuant to hospital or medical service corporation laws. If it were otherwise, the traditional hospital and medical service corporation prepayment service plan, by itself, would be an HMO.

Paragraph (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in AS 21.86.020(b)(2) and AS 21.86.190(a)(3) establishes a minimum package of health care services which an HMO must provide or arrange for. This is intended to assure that the enrollees obtain at least a sufficiently broad range of services to meet a reasonable amount of their health care needs. At the same time, however, the definition should not be so broad as to be financially prohibitive to a substantial number of enrollees.

Since no HMO may function without either a certificate of authority and since an HMO must furnish basic health care services, no health care services may be provided or arranged for on a prepaid basis without the minimum package of basic health care benefits. This serves two purposes: (a) it requires the provision of adequate protection and (b) it prevents the avoidance of the applicability of the Act by the mere expediency of failing to meet the minimum package requirements.

In addition, the HMO may furnish additional services, certain limited indemnity benefits and more comprehensive indemnity benefits. These additional services and benefits can be put together in any one of a variety of ways. The indemnity or service benefits might cover such situations as out-of-area emergency services, out-of-area benefits for dependents away at college, or services which the affiliate providers lack the capacity to make available. This flexibility in piecing together the package of coverage through direct and indirect services and indemnity benefits enables an HMO type operation to meet health care needs in a wide variety of circumstances.

The definition of an HMO affords wide latitude for different arrangements. This highly flexible approach seems best suited to our diverse and pluralistic society with problems varying from locality to locality. Flexibility will allow continued innovation and experimentation with different organizational structures. It may be easier to recruit health personnel if a number of alternative approaches are available. Consistent with this philosophy is the absence of any requirement of a minimum number of employees or of a mandate as to whether or not the HMO should be a profit or nonprofit organization. Permitting both profit and nonprofit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Paragraph (9) defines uncovered expenditures. These are expenditures for health care services for which the HMO is at risk. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

Section 2 and Section 3

Includes reference to HMOs in related statutes.

Section 4

This is a temporary grandfather clause for existing HMOs.

Section 5

This section provides for applying AS 21.86.310(a) to new or renewal contracts or agreements but not those existing.

Section 6

Provides for an immediate effective date.

More and more, cost-conscious Americans are choosing health maintenance organizations for their medical care. But beware: Not all are the same.

HOW WELL DO YOU KNOW YOUR HMO?

PREPARED HEALTH PLANS—which offer comprehensive medical care for a fixed fee—have been revolutionizing our health-care delivery system. Most common are health maintenance organizations, or HMOs: You pay a single premium and are covered for all your medical needs, including surgery, hospitalization and access to a complete range of specialists, maternity and emergency care, sometimes even physical therapy, dental and vision care.

More than 31 million Americans are enrolled in HMOs. But, after 15 years of spectacular growth, membership has leveled off. Dozens of the nation's approximately 650 HMOs are losing money. This translates into cutbacks in services or, worse, the sick and elderly being left without crucial medical care.

No one yet knows the prognosis for these health plans—which, ideally, combat high costs without compromising the quality of care. A key question: Do big business and good medicine mix? That is, can we realistically expect HMO executives to care more about the medical well-being of their members than about showing profits to their stockholders?

I spent months investigating HMOs throughout the country. I talked with scores of HMO members and physicians, government officials and executives of the health organizations. I was highly impressed by most of the HMOs I visited. I was appalled by some of the others, most particularly by testimonies and other evidence that fast-track artists, political fixers and unethical physicians have moved into some HMOs in many sections of the country. From what I saw and heard, here's how to tell if you're

getting the best care from your HMO:

The ABCs of HMOs. There are two major types. *Group practice* plans provide medical services at centers staffed by salaried physicians. Laboratories, X-ray facilities and pharmacies are on the premises, so members can obtain outpatient care at one central location. *Individual practice* plans (IPAs) offer medical care in the private offices of doctors under contract to them: The advantage is a wider choice of physicians. These doctors sometimes receive a monthly payment for every IPA member who has signed up with them.

In general, if you enroll in an HMO, you are "locked in" to its doctors. If you consult another physician without the HMO's approval, you must pay him out of your own pocket. The average monthly cost of membership in an HMO is \$209 for a family, \$77 for an individual.

Today, HMOs are part of the health-benefits package that many companies offer their employees. Such was the case with Sharon Jordan of North Canton, Ohio. She enrolled in the Health Maintenance Plan of Community Mutual Blue Cross and Blue Shield of Ohio in March 1986, when she started working for Buckeye Color Labs. That July, her 15-year-old daughter, Kristin, was in a serious auto crash in Canada. She suffered a shattered pelvis, a hairline skull fracture and a head injury that caused her brain to swell. For a month, Kristin lay in a coma. Twice she developed pneumonia and almost died. She was flown by air ambulance to the Cleveland Clinic for treatment. Then she had to be transferred to a rehabilitation hospital in Warren, Ohio, for physical therapy. The HMO's doctors monitored Kristin's care, and the plan paid 70 percent of her \$100,000 medical bill.

"It was a miracle that my daughter



pulled through so beautifully," Mrs. Jordan says about Kristin, who is back in school full time. "And it was another miracle that we were covered by Health Maintenance Plan. Otherwise, I don't know what we would have done."

In Brooklyn, N.Y., Monas Seidman, 77, tells how grateful he is to Elderplan for covering the high costs incurred by Susan, his wife of 54 years.

Elderplan is one of the four pilot programs of the Health Care Finance Administration. Membership is limited to those 65 and older who are covered by Medi-

continued

Here's what you can do to guarantee that your entire family's health care is regulated—not reduced.

BY DONALD ROBINSON

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HMO/continued

care Parts A and B. In addition to standard services, it provides homemakers and nursing-home care. When Seidman applied, he candidly reported that Susan, 72, had advanced Alzheimer's disease and would need to spend the rest of her life in a nursing home. Elderplan accepted the couple anyway.

But not all HMOs are as reliable as these. Among the questionable policies: Many HMOs designate their primary-care physicians as "gatekeepers," with complete power over referrals to specialists, lab tests and other services. The HMOs then "ration" care by financially rewarding physicians who do not send patients to expensive specialists.

"The conflict of interest is obvious," notes Dr. Coleman R. Seskind, a Chicago internist. "The doctor often has to choose between his financial well-being and the patient's welfare. The physician has to persuade a patient against his own medical judgment—against his code of ethics—not to have lab work done because it hurts his own pocketbook."

One tragic example of the consequences of rationing medical care is the case of a young mother of two in the Midwest. She has filed a damage suit against her HMO and two of its physicians, charging that their laxness in ordering appropriate diagnostic tests resulted in a failure to detect her cervical cancer prior to its spread.

In August 1985, the woman went to her primary-care physician at the HMO because of vaginal bleeding. She maintains that the physician failed to order a Pap test or refer her to a gynecologist. Six months later, the woman charges, she was allowed to see the HMO's gynecologist, but he didn't order a Pap test either. By May 1986, she says, she was desperate and went to the emergency room of a nearby hospital. There, doctors made the appropriate tests, which showed that she was riddled with cancer. The woman underwent a hysterectomy, followed by radiation and chemotherapy, and finally a colostomy. Her suit charges that, to save money, the HMO discouraged lab tests and referrals to specialists. The case is still in litigation.

Many HMOs hold back a percentage of the money due their doctors until the end of the year. It's a compelling reminder to pinch pennies on patient care.

Some HMOs pay their doctors bonuses to limit treatment. One HMO in Texas reportedly paid its obstetricians only \$600 for a vaginal delivery if the mother stayed in the hospital for three days—but \$1025 when the doctors released the mother the day after she gave birth.

These questionable policies have not gone unnoticed by lawmakers. In late 1986, Congress passed a law that would ban HMOs from using financial incentives of any type to induce doctors to limit patient care. Both the HMOs and physicians would be subject to fines for

violating this law. But lobbyists HMOs have persuaded Congress to postpone its effective date until April. Senate investigators found HMOs fraudulently enrolled seniors without their knowledge in Medicare for treatment that was delivered. An employee of one HMO detailed 10 cases in enrollment forms had been for

"The real crisis today is with that treat Medicare patients," Ronald S. Bronow, a dermatologist in Los Angeles who is executive vice president of Physicians Who Care, a grass-roots organization that advocates patients' rights. "The elderly use services, costing prepaid plans more than younger, healthier patients. Some HMOs are raising premiums for the elderly, cutting their benefits—forcing them. Twenty-nine plans renew their Medicare contracts resulting in the disruption of care for 84,000 senior citizens."

Dr. Paul M. Ellwood, chairman of InterStudy, a research group in senior Miami, and an expert on health plans, cautions against the sale criticism of HMOs. "Fixing torts' fees until the end of the year, for example, is common among insurance companies, including Blue Cross of Michigan," he notes. "The real issue is that more medicine is not better medicine. If a doctor is allowed to heavily influence his care or too much—I'd say that doctor and not that HMOs are really a bad system."

How to guarantee the best care: Start by asking these questions:

1. What does your HMO membership include: Drugs? Dental care? Eye? Hearing aids? What's the cost to including extras?

2. How many of your HMO's are board-certified? How are physicians reimbursed? Are there incentives to induce them to skimp on care?

3. Can you choose the doctor you prefer? How long does it take to appointment? How difficult is it to see a specialist?

4. Is your HMO affiliated with hospitals?

5. What's the reimbursement policy for emergency treatments? Suppose you suddenly become very ill and must go to an outside doctor not affiliated with HMO. Or you are in a serious accident and are rushed to a hospital that contract with your HMO. Who pays the bills—you or your HMO?

6. Is there an effective quality-assurance program by a competent outside organization?

7. Is your HMO financially stable? danger of closing its doors? Request copies of its financial statements to facts and figures.

8. Can members influence HMO policies? To find out, ask other members.

HMO Dominance Seen In '90s

BY RICHARD DONAHUE

CHICAGO—Health maintenance organizations will become the dominant financier of private health care in the U.S. before year 2000, a business-forecasting consultant predicts.

Sometime after that, the nation will adopt a Canadian-like national health insurance system, according to Roy Amara, president of the Institute of the Future, Menlo Park, Calif.

Mr. Amara sees an increased use of HMOs in the 1990s as a way to check rapidly increasing health costs. "I mean use of the real HMOs," he said, "the kind that puts the health-care providers at financial risk, the kind that employs salaried physicians and the kind that puts emphasis on wellness and preventive care."

Preferred provider organizations and managed fee-for-service plans are not substitutes for HMOs, he told attendees at a health-care symposium sponsored by Society of Actuaries of Schaumburg, Ill. and the American Hospital Association, Chicago.

Rather, he said, they represent "palatable steps" to HMOs, which were at first a "bridge too far" for many people.

The HMO population in the U.S. will grow from the approximately 30 million persons which now use them to 60 million by 1995, and then up to 60 percent or 70 percent of all privately insured persons by the year 2000, according to Mr. Amara. (Currently, the entire

National Health Care Expected In Next Century

privately-insured population is 170 million, according to the Health Insurance Association of America, headquartered in Washington, D.C.)

"In HMOs, patients will lose their freedom to pick their own

physicians, and physicians will lose much of their clinical and economic autonomy as they watch their incomes shrink," Mr. Amara said.

He said the percentage of physicians who are salaried will increase from about eight percent in 1985 to about 35 percent in 2000.

Mr. Amara said Americans are not prepared for the dramatic changes coming in health care.

"The American public is not ready to accept rationing or restrictions in health care because health-care costs still don't bite deeply into the average household income," he said. "Only 5 percent of income goes for health expenditure now."

This will change, he said, as employers are forced to shift more of the burden of health-care cost to employees. Employers, who now pay more than 40 percent of the nation's health-care bill, will demand a bigger say in how the money is spent, he said.

Health-care costs, now at more than 11 percent of GNP, will, according to government predictions, be between 15 and 18 percent of GNP by the end of the century, he said.

Cont'd on Page 22

Dominance Of HMOs Seen By The 1990s

Cont'd from Page 21

But employers and the government—which pays about half of health-care costs—cannot tolerate such a level, he said, predicting that health costs will level off at 13.5 percent of GNP by the end of the century.

He said a national health-care system, when it comes, will be similar but not identical to the system in Canada "where government is the insurer and taxes finance the cost."

State governments and private health insurers undoubtedly will play a more significant role in a U.S. system than do the provinces and insurers under the Canadian system, he said.

A U.S. national health system will mean there will be fewer, but larger, health insurers, he said, some of which may be employed to administer the national plan. □

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HEALTH CARE COSTS

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Marion Managed Care Digest HMO Edition 1989

Marion Laboratories, Inc., July 1989

"For the year ended Dec. 31, 1988, 659 HMOs were in operation. Another seven were under development."

Operating HMOs reported total enrollments up 8.7% to 33 million in 1988, compared with 1987 when 707 operating HMOs reported more than 31 million enrollees.

The number of operating HMOs fell 6.8% in 1988, compared with a 12% increase in 1987. An industry shakeout had been predicted for

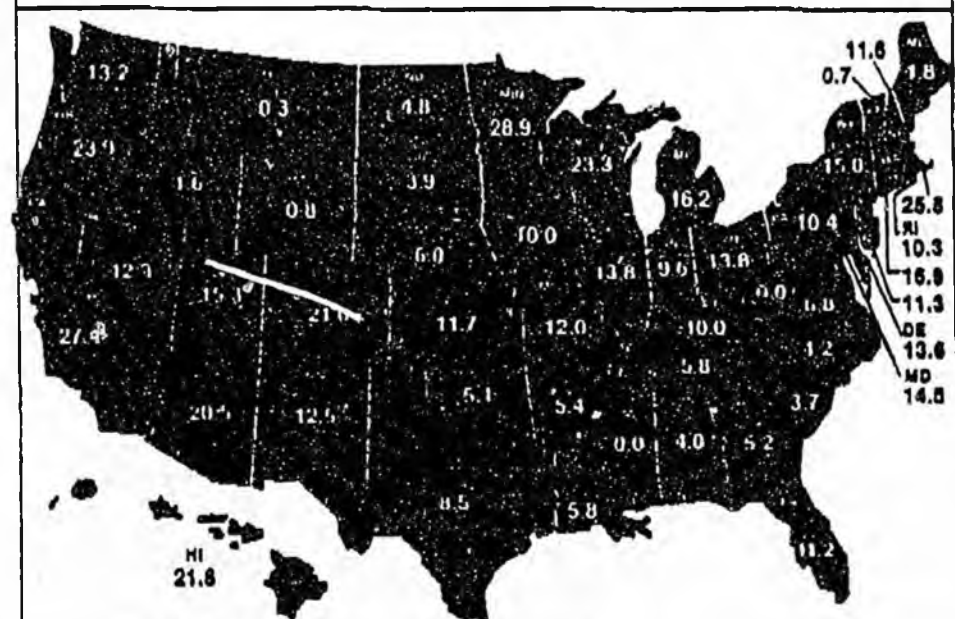
several years. The industry is likely to continue its consolidation through 1993 as the number of HMOs falls gradually each year.

HMOs are increasing their market penetration nationwide. Plans in 28 states reported enrolling 10% or more of their state's residents in 1988 (Figure 1), up from 24 states in 1987 and 20 a year earlier.

HMOs also successfully reduced the number of days that their enrollees spent in hospitals in 1988. Average annual hospital days per

Continued page 2

Figure 1. HMO market penetration (percent) by state, 1988.



Source: BMG Marketing Group Inc.; Marion Laboratories, Inc., 1988.

Medical Benefits

Marion Managed Care Digest
(continued from page 1)

1,000 non-Medicare members dropped to 364 from 377.2 a year earlier (Table 1).

Nearly 16% of HMOs operating at year-end 1988 offered an open-ended option, the newest and fastest growing HMO product. An open-ended plan offers enrollees the right to choose at point of service whether they want to seek care within the HMO or to go outside to the physician or hospital of their choice.

HMOs with open-ended options expected to have nearly 2 million enrollees in these plans by year-end 1989, an increase of 17.3% from year-end 1988. Enrollment in open-ended plans rose 53% to 1.6 million in 1988 from a year earlier. Enrollees in open-ended plans accounted for 4.8% of all HMO enrollees.

Non-Medicare enrollees averaged 3.7 ambulatory visits each to their HMOs in 1988, according to 167 reporting plans. HMOs averaged 3.7 physician encounters and visits per non-Medicare enrollee in 1988, according to 233 reporting plans.

The average family premium charge for all HMOs rose 11.8% in 1988 to \$242.50 per month from \$216.82 in 1987 (Table 1). **MM**

Editor's note: The source for data used in this report was SMC Marketing Group Inc. See MB, 7/30/89, p. 5, for a report based on the same data base.

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Table 1. Selected HMO utilization and premium averages by state, 1988.

State	Hospital days per 1,000 non-Medicare members	Physician encounters per member	Amb. visits per member	Premiums	
				Family	Individual
Alabama	380.7	3.0	4.8	\$228.81	\$87.14
Arizona	292.0	3.7	3.9	250.44	84.52
Arkansas	481.4	4.9	1.5	228.55	82.50
California	318.4	3.3	8.5	251.78	95.35
Colorado	275.8	3.5	2.0	228.90	84.93
Connecticut	402.8	3.9	3.1	282.40	112.98
Dalaware	350.5	0.2	0.4	228.88	89.99
D.C.	362.7	2.9	3.3	238.32	89.80
Florida	385.9	3.3	2.8	220.87	83.42
Georgia	385.0	4.8	3.5	237.88	90.29
Hawaii	308.7	4.3	4.8	221.01	77.00
Idaho	212.0	—	—	227.50	93.50
Illinois	369.2	4.2	2.8	227.20	86.47
Indiana	363.9	4.3	2.9	237.21	81.68
Iowa	310.0	3.8	—	215.25	80.42
Kansas	441.0	3.3	2.1	248.80	94.79
Kentucky	370.0	—	—	238.98	85.44
Louisiana	408.0	3.7	0.2	235.46	85.86
Maine	343.3	—	—	248.33	98.87
Maryland	328.4	3.7	3.4	255.38	88.78
Massachusetts	389.1	3.5	4.2	292.27	109.89
Michigan	366.8	3.7	5.1	243.91	95.82
Minnesota	362.4	4.0	4.6	229.82	88.53
Missouri	394.3	2.8	1.4	250.50	90.45
Montana	375.0	4.4	3.1	205.00	80.00
Nebraska	328.9	2.6	—	253.75	94.50
Nevada	—	—	—	300.00	115.00
New Hampshire	384.0	4.9	3.5	281.50	100.50
New Jersey	418.2	3.0	3.7	222.79	88.52
New Mexico	385.0	3.5	—	272.27	104.88
New York	374.8	3.7	2.3	218.21	88.12
North Carolina	332.8	3.8	2.0	235.63	86.34
North Dakota	359.0	6.9	2.7	250.24	105.29
Ohio	404.2	3.8	3.2	251.35	93.45
Oklahoma	300.0	3.9	9.9	253.17	87.00
Oregon	298.1	2.8	2.3	213.18	79.93
Pennsylvania	376.5	3.5	2.4	221.84	83.59
Rhode Island	368.5	4.5	—	242.50	101.50
South Carolina	386.7	3.1	0.7	186.67	72.33
South Dakota	578.8	4.4	4.4	280.54	91.30
Tennessee	432.8	4.0	2.1	245.38	98.78
Texas	358.9	4.0	3.0	254.40	90.48
Utah	288.7	2.7	4.2	278.40	89.25
Vermont	—	—	—	206.00	82.00
Virginia	392.1	3.8	3.0	282.89	108.44
Washington	320.1	4.2	3.3	242.99	84.54
Wisconsin	383.2	4.7	3.7	253.51	96.57
Wyoming	560.0	4.0	1.7	220.00	90.00
Total U.S.	384.0	3.7	3.7	242.49	90.90

Alaska, Mississippi and West Virginia had no operating HMOs in 1988.

Source: SMC Marketing Group Inc., Marion Laboratories, Inc., 1989

How Cost-Effective Is Your Health Plan?

Benefits, July 1989

"To determine your plan's rating, add up the points indicated for each answer, then compare your total with those illustrated on the plan evaluation chart at the end. If your plan's cost-effectiveness rating is less than 'excellent,' you should consider incorporating some cost-effective features your score shows are missing from your plan."

1. Does your plan have first-dollar coverage for hospitalization?
 - A) (+ 20) No/Do have hospital pre-certification
 - B) (- 5) No/No hospital pre-certification
 - C) (- 15) Yes/Do have hospital pre-certification
 - D) (- 30) Yes/No hospital pre-certification
2. Does your plan have first-dollar coverage for medical/surgical services?
 - A) (+ 10) No/Do have pre-certification
 - B) (- 0) No/No pre-certification
 - C) (- 5) Yes/Do have pre-certification
 - D) (- 15) Yes/No pre-certification
3. Your group plan's major medical deductible is:
 - A) (+ 10) \$300 per calendar year or more
 - B) (- 0) More than \$100/less than \$300 per calendar year
 - C) (- 20) \$100 per calendar year or less
4. Is your major medical deductible indexed to your company's employees' earnings?
 - A) (+ 10) Yes/Also indexed to trend increases
 - B) (+ 5) Yes
 - C) (- 0) No
5. Your major medical co-insurance out-of-pocket limit is:
 - A) (+ 10) More than \$1,000 per employee per year
 - B) (- 0) More than \$500/up to \$1,000 per employee per year
 - C) (- 10) \$500 or less per employee per year
6. Is your major medical co-insurance limit indexed to the employees' earnings?
 - A) (+ 10) Yes/Also indexed to trend increases
 - B) (+ 5) Yes
 - C) (- 0) No
7. Does your plan include a large claims management review/assistance service?
 - A) (+ 15) Yes/Also includes psychiatric claim review
 - B) (+ 10) Yes
 - C) (- 10) No
8. Does your plan include a limit, or a review service, for chiropractic and/or podiatric care?
 - A) (+ 5) Yes/Chiropractic and podiatric care review
 - B) (- 0) Yes/Chiropractic or podiatric care review
 - C) (- 5) No
9. Does your plan include a hospital bill audit service?
 - A) (+ 5) Yes
 - B) (- 5) No
10. Does your plan have a pre-existing condition limitation for new hires?
 - A) (+ 10) Yes
 - B) (- 10) No
11. Do you require employee contributions for dependent coverage?
 - A) (+ 10) Yes/Dependents only
 - B) (- 0) No
12. Do you have an employee assistance program (EAP)?
 - A) (+ 5) Yes
 - B) (- 0) No
13. Do you provide a wellness program or incentives for a healthier lifestyle?
 - A) (+ 5) Yes
 - B) (- 0) No
14. Does your plan include a mail-order or prescription drug program?
 - A) (+ 5) Yes
 - B) (- 0) No
15. Does your plan include a preferred provider organization (PPO)?
 - A) (+ 15) Yes/PPO pays less than 100% of charges
 - B) (+ 5) Yes/PPO pays 100% of eligible charges
 - C) (- 10) No
16. Do you provide employees with an HMO option?
 - A) (+ 15) Yes/HMO experience is integrated with primary plan's experience
 - B) (+ 5) Yes/HMO is a stand-alone service—less than 20% of employees participate
 - C) (- 5) Yes/HMO is a stand-alone service—more than 20% of employees participate
 - D) (- 0) No
17. Do you actively police the coordination of benefits provision of your program?
 - A) (+ 10) Yes
 - B) (- 10) No
18. Is your waiting period for new entrants long enough to avoid providing coverage during the initial 'heavy turnover' period?
 - A) (+ 5) Yes
 - B) (- 5) No
19. Do you have an in-house COBRA compliance system or use an outside service?
 - A) (+ 10) Yes/Includes notification of new hires, qualifying event notification, monitoring of eligibility period, monthly bill processing and management
 - B) (- 0) Yes/But doesn't include all of the above
 - C) (- 10) No
20. Do you provide retiree health coverage?
 - A) (+ 10) No
 - B) (- 10) Yes/Contributory
 - C) (- 15) Yes/Non-contributory

Plan evaluation		
Total points	Plan rating	Anticipated rate increase
170 - 195	Excellent	0% - 10%
130 - 170	Good	10% - 20%
100 - 130	Fair	30% - 40%
60 - 100	Poor	40% - 50%
under 60	Disastrous	50% +

New York Times
January 30, 1990

THE NEW YORK TIMES NATIONAL TUESDAY, J.

The 1991 Budget: How \$1.23 Trillion Would Be Distributed

Proposals

How Domestic Efforts Would Fare Under Bu

Here are President Bush's budget proposals for major domestic programs for the 1991 fiscal year:

Drugs and Crime

The President's spending proposal would increase the Justice Department's budget by 19 percent from last year to nearly \$9 billion, excluding funds set aside for a multi-year Federal prison construction program. The most significant increases, earmarked for anti-drug activities, were announced last week as part of President Bush's new plan to combat drug trafficking.

Some agencies in the Justice Department would suffer reductions. The Federal Bureau of Investigation, for instance, would receive a slight spending increase, but would lose nearly 400 positions under the President's budget. The decrease would probably result in a reduction of the number of agents assigned to areas like organized crime and white-collar crime.

Education

The Administration proposed \$41 billion for education, training, and employment programs and ancillary social services, \$400 million more than would be spent under current law and \$3 billion more than is expected to be spent in the current fiscal year.

The budget proposed an \$880 million increase in spending for elementary and secondary school education for the disadvantaged, to a total of \$10 billion.

The budget would also increase by \$500 million the funds for Head Start,

program intended to prepare young children to succeed in school, for a total of \$1.9 billion. The program would also increase by \$1.2 billion, to a total of \$19.7 billion, discretionary funds for education.

The budget also proposed \$239 million for adult literacy programs, a 25 percent increase over the current budget.

Environment

Continuing to reverse the pattern of budgets under President Reagan, Mr. Bush is proposing substantial new spending on environmental programs. Among the significant additions are \$269 million for an "America the Beautiful" program which is to provide money for acquiring parkland and for a major reforestation effort across the country. He is also calling for increased spending for protecting wetlands, a hefty increase for research into global climate change and nearly \$780 million for cleaning up nuclear contamination and other pollution at Federal installations.

The Environmental Protection Agency's total proposed budget would rise by a modest \$48 million dollars to \$5.6 billion. But its all-important operating budget, with which it administers the anti-pollution laws, would rise by 12 percent to \$2.17 billion.

Health

The Administration proposed reducing Medicare premiums by \$50 a year for beneficiaries who join a Health Maintenance Organization. To further

encourage membership in such programs, the Administration is developing a new program, "Medicare Plus," that would combine membership in a Preferred Provider Organization with some form of Medicare supplemental (Medigap) insurance.

The proposal would also offer the states incentives to enroll their patients in such programs. An H.M.O. is a highly structured organization of doctors and others that offers a full range of medical services. A P.P.O. is a less structured group of doctors who have agreed to take lower fees than they would otherwise charge in exchange for a higher volume of patients.

The Administration also proposed reducing the projected growth of Medicare by \$5.6 billion, and obtaining \$1.9 billion more in revenues. But Medicare expenditures are still expected to increase by \$10 billion, to \$116 billion.

The budget would also provide a \$109 million increase in AIDS research, prevention and other activities, for a total of \$1.7 billion. Total spending on AIDS would be \$3.1 billion.

Labor

For the Labor Department, the President proposes a small increase in spending, from \$24.9 billion in the 1990 fiscal year to \$26.3 billion. Most of the budget, \$19.4 billion, represents benefits the Government pays to unemployed workers. If the unemployment rate is higher than the 5.3 percent the Government predicts for the year — a rate that some economists say is optimistic — that spending would rise.

Still, Labor Secretary E. obtained room for spending in areas that she has put higher priorities. She would be asking for special summer programs, from \$715 million in 1990 to \$744 million in the 1990 fiscal year, but she would raise \$44 million for longer-term projects, one designed to ease the people's transition from school to work.

The Occupational Safety and Health Administration would get more inspectors, bringing to more than 10,000 the number that she has added in her office. Department fines for industrial violators of the law reached a record last year.

Science and S

A major theme of the budget is investment in the Bush Administration program as a big part of the program to increase the Department of the Navy and Space Agency budget to \$15.2 billion. That is a 24 percent rise from the \$12.2 billion which would be the large any major agency.

The additional \$2.9 billion is a 36 percent increase for the program, allotting \$2.6 billion for a space platform, which is to be launched in 1995, so that construction on those parts requires more time. The space agency would use \$237 million to start an Observing System, a program that would use a series of satellites to monitor environmental

Transporta

The Transportation Department requested \$26.9 billion, a 1 percent increase over the 1990 level. But increases for

The Book

The U.S. Budget Made Easy. More or Less

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Department of Administration
 Title: SB 335: Relating to health BRU: Labor Relations
maintenance organizations
 Sponsor: Kerttula Components: _____
 Requestor: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

This bill provides for the certification and operation of health maintenance organizations in the State of Alaska. Alternative methods of health care delivery are standard topics in collective bargaining. Consequently, the legislation would provide additional materials for discussion, but will not have any foreseeable financial impact with FY 90, or thereafter except in the event that cost savings in health insurance are achieved. Such impact is incalculable at this time.

Prepared by: Dianne M. Corso Phone: 465-4404
 Division: Labor Relations Date: _____
 Approved by Commissioner: Frank S. Baxter Date: 1/23/90
 Agency: Department of Administration

Distribution (by preparer):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget
 Impacted Agency(ies)

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to Health Maintenance Organizations.
Sponsor: Senator Kerttula
Requestor: _____

Agency Affected: Health & Soc. Svcs.
BRU: _____
Components: _____

1990

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
CONTRACTUAL	-0-	-0-	-0-	-0-	-0-	-0-
SUPPLIES	-0-	-0-	-0-	-0-	-0-	-0-
EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
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REVENUE	-0-	-0-	-0-	-0-	-0-	-0-
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FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS : (Attach a separate page if necessary)

SB 335 would not directly affect the Department of Health & Social Services. Facility certification and licensure activities would continue to be handled as in the past regardless of whether the facility was owned by an HMO or had a financial arrangement with an HMO.

Prepared by: Dave W. Williams
Division: Admin. Svcs., DHSS

Phone: 465-3015
Date: 1-11-90

Approved by Commissioner: *Moya M. Mueser*
Agency: Health and Social Services

Date: Jan 15, 1990

Distribution (by preparer):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)



**STATE OF ALASKA
OFFICE OF THE GOVERNOR
BILL ANALYSIS**

DEPARTMENT Commerce & Economic Development Insurance	BILL NUMBER SSSB 335	SPONSOR Kerttula
SHORT TITLE OF BILL An Act Relating to Health Maintenance Organizations		
DEPARTMENT POSITION Favor		
PREPARED BY Don Koch, Acting Deputy Director	DATE 2/26/90	COMMISSIONER'S SIGNATURE <i>[Signature]</i>
		DATE 2-26-90

SUMMARY

OTHER AGENCIES AFFECTED BY BILL Department of Health and Social Services Department of Administration	CONSTITUENT GROUP(S) AFFECTED BY BILL All
ORGANIZATIONAL SUPPORT FOR BILL Not known	ORGANIZATIONAL OPPOSITION TO BILL Not known

FISCAL IMPACT: NONE FISCAL NOTE ATTACHED

BACKGROUND LEGISLATIVE INTENT HMO's provide or arrange for basic health care services of persons on a prepaid basis. This form of organization combines some of the functions of an insurer with those of traditional health care providers. In this way, the providers of medical care share in the financial risk of health care and, therefore, have an incentive to reduce health care costs and to promote preventative medicine. This kind of organization is not possible under our present statutes. This proposal will provide a framework for the establishment of these hybrid organizations. It is based on a National Association of Insurance Commissioners model statute.

ANALYSIS OF BILL PROGRAM EFFECTS

See Attached

AMENDMENTS PROPOSED

See Attached

6381D-1/22390a

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

ANALYSIS OF BILL/PROGRAM EFFECTS

Introductory Comment:

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which will provide improved health care at a lower cost. The health maintenance organization is a concept which has received such attention as one means through which an improvement in delivery might be achieved.

Shortcomings of Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas:

1. In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate.
2. Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc.
3. Even if health care is available and accessible, it may not be continuous: that is, a single patient may not be treated as a person with a continuing or a variety of problems but rather as a single isolated health care problem incident. The problems of viability, accessibility, and continuity, at least in part, have been attributed to the lack of responsibility vested in one person, group, or organization to assure the delivery of health care.

A second problem is the escalating cost of health care services. This stems from the limited supply of health care service facilities which is confronted by an expanded and fragmented financing mechanism and the consequent tremendous increase of demand for such services. This is the classic model for inflation. Traditional reimbursement of providers by the federal government, insurance plans, and hospital and medical service corporations, because of the inherent difficulties involved, has been accompanied by uneven efforts toward ineffective cost review or control. Furthermore, services or facilities are often duplicated or used inefficiently. A basic cause of inflation and inefficiency rests with the improper structuring of incentives. Where no individual group, or organization is responsible for the use of more economical services and facilities, including those relating to preventive care, greater income is generated for providers by the more frequent use of services and facilities and by the use of the more expensive facilities and services available.

A third problem is the quality of health care delivered. Throughout various parts of the country, the quality of health care can range from the very best to the very poor. Generally speaking, there is no locus for quality assessments either as to health care processes or health care results. In the absence of a means to measure quality, it is virtually impossible to design and implement effective programs to rectify defects.

This brief discussion in no way attempts to provide a comprehensive discussion of the problems of the health care delivery system in the United States nor does it give adequate recognition to the strenuous efforts of many to improve the existing system. However, it does highlight some of the major problems prevailing today. Development of the health maintenance organization (HMO) concept offers one alternative means to help alleviate some of these problems.

Nature of the Health Maintenance Organizations:

A health maintenance organization may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by or on behalf of the enrollees. An HMO can be organized, operated and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, insurance companies, etc. Generally speaking, an HMO delivery system is predicated on three principles:

1. It is an organized system for the delivery of health care which brings together health care providers.
2. Such an arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability.
3. The payments will be made on a prepayment basis, whether by the individual enrollees, medicare, medicaid, or through employer-employee arrangements.

An HMO can directly address itself to the problems of availability, accessibility, and continuity since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus, the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentives toward lessening costs in delivering health care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment, and, in general, provide a monitoring mechanism.

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to and are accepted by the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept often contract with an insurer or other prepayment plan (e.g., hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundation establishes some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients' viewpoint, from the physicians' viewpoint, the fee-for-service practice is maintained. Under the federal HMO Act, this type of organization is called an Individual Practice Association Type HMO.

The Need for State Authorizing and Regulatory Legislation

From 1970 to 1973, the administration and committees in both houses of Congress spent much time analyzing the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO's. This analysis resulted in the enactment of the federal HMO Act in 1973. Since then, the number of health maintenance organizations and the number of HMO enrollees has grown rapidly. Prior to 1972, however, few states had a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation and other supervision was being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. Because the HMO is a unique type of organization, many provisions of such state laws were inapplicable, highly restrictive or prohibitive to the formation and operation of an HMO. Therefore, in 1972, the National Association of Insurance Commissioners (NAIC) adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMO's. SSSB 335 substantially tracks that model act.

Purpose of SSSB 335

SSSB 335 clearly authorizes the establishment and operation of HMO's. Restrictive provisions in other laws which are inappropriate to HMO's are rendered inapplicable. Appropriate grants of authority are established to enable the HMO's to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient, and ethical operation of HMO's. As is the case with insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Thus, the purpose of this bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety, including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

Since the model bill on which SSSB 335 was approved, the federal HMO Act has been enacted and amended four times. The model, or substantial portions of it, has been enacted in 27 states and substantial experience has been gained in implementing and regulating HMO's under its terms. In addition, a few HMO's have become insolvent and commissioner have had to deal with the results of those insolvencies. Therefore, the model act has been revised to reflect changes which have occurred in the federal law, to reflect experience gained in administering the law and to clarify and strengthen the provisions relating to HMO agency.

AS 21.86.010

This section requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity, in which the responsibilities imposed by this Act are vested, serves as a focus of regulatory attention to assure that the consuming public is well served.

AS 21.86.020

A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. This section provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the Insurance Division and the Department of Health and Social Services. It is felt that the expertise of the Alaska Insurance Division on fiscal and other regulatory matters and the familiarity of the Alaska Department of Health and Social Services with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency - the Insurance Division. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the Insurance Division obligated to rely on the Department of Health and Social Services with respect to the latter's sphere of expertise.

Subsection (b)(2) makes explicit the requirement that an HMO must provide a minimum package of services on a prepaid basis. Reasonable co-payments, however, are permitted and do not violate the requirement for prepayment. Such co-payments may be used to (a) reduce the amount of prepayments; and (b) minimize frivolous utilization of services. In addition, an HMO may have more than one benefit package involving different levels of co-payments.

Under subsection (b)(3), to grant a certificate of authority, the director should be satisfied that the health maintenance organization will have the financial resources to provide the health care services for which it is obligated to its enrollees. However, it is recognized that requiring an HMO to have more than a minimum capitalization as set forth in AS 21.86.140(h) might prevent the organization or implementation of an otherwise viable HMO. Furthermore, with various possible insurance and surety arrangements available to back up the HMO's promise of performance, reserve requirements such as those found in the insurance laws are not deemed necessary.

AS 21.86.030

The exercise of authority granted in this section is subject to disapproval by the director within 30 days of a filing by a health maintenance organization. The director may promulgate rules and regulations exempting certain contracts from the filing requirement where exercise of the authority granted in the section would have little or no effect on the financial condition and ability to meet obligations of the organization.

AS 21.86.040

This section makes explicit the permissible membership of such a group. SSSB 335 does not, however, require that a health maintenance organization be consumer controlled. It is expected that HMO's controlled in a variety of ways will be organized. Where organizations are not consumer controlled, it is believed that some means for enrollee participation should be provided. For example, such matters as availability, accessibility and continuity of health care services are factors which directly confront the consumers and in which they have a particular interest. The disclosure of information under other sections is also designed to assist the consumers.

Arguments against a role for the consumer 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 seem more persuasive. These 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.

AS 21.86.050

This section provides a level of fidelity protection for the consumer by requiring a bond.

AS 21.86.060

This section requires that services be provided through appropriately licensed persons. It allows the HMO to provide services directly or through other arrangements.

AS 21.86.070

Subsection (a) requires that every enrollee be provided with evidence of coverage and allocates the responsibility for providing that evidence.

Subsection (b) and (e) requires that evidences of coverage and forms are subject to filing with and approval by the director.

Subsection (c) establishes requirements which evidence of coverage must meet.

Subsection (d) provides that filing is required under subsection (b) unless the form is already subject to filing requirements under existing filing statutes.

Subsection (f) provides for the filing of charges for health care services, i.e., that part of the benefit package which is provided in the form of service vis-a-vis indemnity or service benefits. Those parts of the package providing benefits under agreement with an insurance company or hospital or medical service corporation will be subject to regulation in accordance with existing laws.

Paragraph (f) neither requires nor prohibits community rating. Reasonable underwriting classifications are permitted for the purpose of establishing the charges. Different charges may be imposed on different groups of enrollees. Such a rigid requirement as community rating would appear to be inappropriate when the competing financing mechanisms are not subject to such a constraint. The competitive disadvantage which such requirement might impose could impeded the development of HMO's.

Because of its somewhat different nature, an HMO is not required by this Act to meet reserve requirements similar to those imposed on insurance companies. Thus, it is important that the charges be set at an adequate level. The requirement for certification by an actuary or other qualified person, along with supporting information, is intended to assist the director in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the director may consider the amount necessary to assure a reasonable return on the initial and subsequent capital invested and an amount needed to accumulate adequate funds to stabilize the level of charges against fluctuation due to inflation, changes in medical technology and related causes.

AS 21.86.080

This section provides the director with the authority to require reports considered necessary to carry out his duties. The reports could include:

- o a financial statement of the organization;
- o any material changes in the information submitted pursuant to AS 21.86.010(b)(3);
- o the number of persons enrolled at the beginning and end of the year; and
- o the amount of uncovered and covered expenditures that are payable and more than 90 days past due.,

In establishing filing requirements, the director will be cognizant of the fact that HMO's that are qualified under the federal HMO Act must submit detailed reports to the Department of Health and Human Services. The director will make use of such reports when they are relevant and avoid the imposition of duplicate reporting requirements.

AS 21.86.090

This section requires the HMO to provide notice to enrollees of changes in operation affecting them.

AS 21.86.100

Every health maintenance organization is required to establish a complaint system to provide reasonable procedures for the disposition of complaints. The organizations may be expected to receive two types of complaints. One type is related to the basic health care services or additional services furnished by it. The other type is related to that portion of the coverage in addition to basic health care services which is provided by insurance, hospital or medical service corporations, or some means other than being furnished by the organization. For complaints arising from health care services, the administrative procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard, including the use of binding arbitration as a means of resolving claims concerning coverage. For complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the benefit package which are covered by insurance, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

AS 21.86.110

This section avoids duplication of benefits.

AS 21.86.120

This section provides a ten-day free look.

AS 21.86.130

Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this section excepts this type of investment when approved by the director in accordance with the standards set out in AS 21.86.030(b).

AS 21.86.140

Even though very serious problems can arise if a health maintenance organization defaults on its contracts, fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. The best protection for enrollees is a financially sound organization that generates net income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organization from starting or may unreasonably tie up the capital of those that do. Therefore, this section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account, a deposit of cash or securities in a minimum account, and the organization's generation of additional amounts annually as a source of funds to meet its contractual obligations to the enrollees in the event of insolvency. The director may waive all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization's performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of the health maintenance organization's uncovered expenditures. This amount will vary depending upon the type of organization and the nature of its arrangements with providers. For example, the physicians of the staff of the organization or a contracting medical group of individual practice association may agree to look only to the organization for payment of services provided to the organization's enrollees and agree not to bill them in the event of insolvency. An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met.

In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the director if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time. This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization.

AS 21.86.150

Subsection (a) requires licensing.

Subsection (b) addresses false or defective advertising and solicitation.

Subsection (c) applies the insurance Unfair Trade Practices Act to the degree applicable.

Subsection (d) is designed to foster continuance of coverage to the extent possible.

Subsection (e) addresses potential deception through name utilized.

Subsection (f) requires a certificate of authority to use the phrase "Health Maintenance Organization" or "HMO."

AS 21.86.160

Provides for regulation of assets.

AS 21.86.170

This section overrides the group laws to permit an insurer or a hospital or medical service corporation to provide coverage protecting enrollees of an HMO. This authority is intended to permit insurers and the service corporations to write coverage (1) to fill the gaps which the providers of health care services do not provide, (2) to provide coverage in excess of the services provided, (3) to cover catastrophe situations, (4) to provide protection to the enrollees in the event the HMO becomes insolvent, and (5) to provide coverage against the cost of health care services as the health maintenance organization deems necessary.

AS 21.86.180

The director is provided authority to examine health maintenance organizations as is reasonably necessary. However, any determination related to the quality of health care services is the exclusive responsibility of the commissioner of health and social services.

AS 21.86.190 - .200

These sections list the reasons for suspension or revocation of the HMO's certificate of authority. They also set forth a process for such action.

AS 21.86.210

This section provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the director under the statute applicable to insurance companies.

AS 21.86.220

This section provides authority to adopt regulations.

AS 21.86.230

Proper administration of the HMO program by the Division of Insurance and the Department of Health and Social Services will impose additional financial burdens on the respective agencies. For this reason, it is appropriate to establish a fee system through which HMOs are required to bear the expenses associated with their regulation by the state.

owned or directly operated by the HMO, or (b) by contracting or arranging with physicians, hospitals or other facilities to provide such services. The term "arrange" does not contemplate those traditional arrangements which hospital or medical service corporations make in conjunction with their prepayment service plans pursuant to hospital or medical service corporation laws. If it were otherwise, the traditional hospital and medical service corporation prepayment service plan, by itself, would be an HMO.

Paragraph (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in AS 21.86.020(b)(2) and AS 21.86.190(a)(3) establishes a minimum package of health care services which an HMO must provide or arrange for. This is intended to assure that the enrollees obtain at least a sufficiently broad range of services to meet a reasonable amount of their health care needs. At the same time, however, the definition should not be so broad as to be financially prohibitive to a substantial number of enrollees.

Since no HMO may function without either a certificate of authority and since an HMO must furnish basic health care services, no health care services may be provided or arranged for on a prepaid basis without the minimum package of basic health care benefits. This serves two purposes: (a) it requires the provision of adequate protection and (b) it prevents the avoidance of the applicability of the Act by the mere expediency of failing to meet the minimum package requirements.

In addition, the HMO may furnish additional services, certain limited indemnity benefits and more comprehensive indemnity benefits. These additional services and benefits can be put together in any one of a variety of ways. The indemnity or service benefits might cover such situations as out-of-area emergency services, out-of-area benefits for dependents away at college, or services which the affiliate providers lack the capacity to make available. This flexibility in piecing together the package of coverage through direct and indirect services and indemnity benefits enables an HMO type operation to meet health care needs in a wide variety of circumstances.

The definition of an HMO affords wide latitude for different arrangements. This highly flexible approach seems best suited to our diverse and pluralistic society with problems varying from locality to locality. Flexibility will allow continued innovation and experimentation with different organizational structures. It may be easier to recruit health personnel if a number of alternative approaches are available. Consistent with this philosophy is the absence of any requirement of a minimum number of employees or of a mandate as to whether or not the HMO should be a profit or nonprofit organization. Permitting both profit and nonprofit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Paragraph (9) defines uncovered expenditures. These are expenditures for health care services for which the HMO is at risk. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

Section 2 and Section 3

Includes reference to HMOs in related statutes.

Section 4

This is a temporary grandfather clause for existing HMOs.

Section 5

This section provides for applying AS 21.86.310(a) to new or renewal contracts or agreements but not those existing.

Section 6

Provides for an immediate effective date.

Technical Amendments Necessary

Page 10, line 11, "AS 21.42.140 and 21.42.150" should read "AS 21.42.120 and 21.42.130"

Page 10, line 11, "AS 21.86.210" should read "AS 21.87.180"

Page 10, line 14, "AS 21.42.140 and 21.42.150" should read "AS 21.42.120 and 21.42.130"

Page 10, line 14, "AS 21.86.210" should read "AS 21.87.180"

Page 23, line 24, add "The director of insurance may adopt regulations necessary to carry out the director's duties under this chapter."