SB

335

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

DATE: 2/6/90

FURTHER: Finance

Date of 5-Day Notice: 2/22/90
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 2/27/90

Labor and Commerce Committee considered SS SB 335

"An Act relating to health maintenance organizations; and providing for an effective date."

and recommended:

[✓] replace with CSSSSB 335 (L&C) [✓] same title
[ ] new title

[ ] attached amendment(s)

[ ] _____ letter of intent adopted

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

[ ] fiscal note(s) _____

Department(s)/Date:

[✓] zero fiscal note(s)
Dept of Commerce 2/7/90
(for SSSB 335 + CSSSSB 335(L+C))

[ ] appropriation-no fiscal note

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Chair: Signature and Recommendation

Alaska State Legislature

SENATE

Official Business

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

M E M O R A N D U M

TO: Senator Eliason, Chairman
Senate Labor and Commerce
Committee

FROM: Senator Kerttula

SUBJ: Analysis -- Sponsor Substitute for Senate Bill 335, An Enabling Act for Health Maintenance Organizations.

DATE: February 6, 1990

I would appreciate your scheduling Senate Bill 335, relating to Health Maintenance Organizations, at your earliest convenience.

The sponsor substitute for Senate Bill 335 incorporates an unintroduced bill by the Governor into the original SB 335. The sponsor substitute for SB 335 is based on a National Association of Insurance Commissioners's model act.

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 SB 335:

1. Requirements for Certificate of Authority: Sponsor substitute for SB 335 requires that a list of conditions, 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 the HMO's operation. Sponsor substitute for SB 335 requires that a copy of the 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 doe 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 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 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.

JK:kh

a:3sb335

The 1991 Budget: How $1.23 Trillion Would Be Distributed

SB 335

Proposals

How Domestic Efforts Would Fare Under Budget

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, a 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 $60 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 Elizabeth Dole obtained room for spending increases in areas that she has put high among her priorities. She would reduce spending for special summer training programs, from $715 million to $220 million, but she would raise spending from $44 million in the 1990 fiscal year to $1.4 billion for longer-term programs, especially one designed to ease young people's transition from school to work.

The Occupational Safety and Health Administration would get 34 more inspectors, bringing to more than 200 the number that she has added since taking office. Department fines against industrial violators of the safety laws reached a record last year.

Science and Space

A major theme of the proposed budget is investment in the future, and the Bush Administration sees the space program as a big part of that, and wants to increase the National Aeronautics and Space Administration's budget to $15.2 billion. That would be a 24 percent rise from the previous year, which would be the largest increase for any major agency.

The additional $2.9 billion includes a 36 percent increase for the space station, alloting $2.6 billion for the manned space platform, which is to be launched in 1995, so that construction could begin on those parts requiring long lead times. The space agency also asked for $237 million to start an orbiting Earth Observing System, a program that would use a series of satellites and a computer network to measure and monitor environmental changes.

Transportation

The Transportation Department requested $26.9 billion, a figure that is 4.2 percent below this year's spending level. Big increases for the Federal

The Book

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

Budget Proposals

Figures in billions.

WHAT GAINS

- Military
- International affairs
- Science, space and technology
- Natural resources and environme
- Agriculture
- Transportation
- Education
- Health
- Medicare
- Income security
- Social security
- Veterans benefits and services
- Administration of justice
- General government

WHAT LOSES

- Energy
- Commerce and housing credit
- Community, regional development

OTHER ITEMS

- Interest
- Allowances*
- Undistributed offsetting receipts

TOTAL

*Includes cuts to be proposed for Federa proposed legislation for reduced govern

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SSSB 335
PUBLISH DATE: _____

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
REVENUE	0	0	0	0	0	0

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.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: February 7, 1990

Approved by Commissioner: Larry Merculieff
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)

3712D-2/011990b

STATE OF ALASKA
OFFICE OF THE GOVENOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
Commerce & Econ. Dev.	Insurance	SSSB 335	Kerttula

SHORT TITLE OF BILL
An Act Relating to Health Maintenance Organizations

DEPARTMENT POSITION
Favor

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
Don Koch, Acting Deputy Director	2/26/90		2-26-90

SUMMARY

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

FISCAL IMPACT: ☐ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND LEGISLATIVE INTENT 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 hybred 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

01-008 (Rev. 11/89)

SSSB 335

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. Th 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 render 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:

- a financial statement of the organization;
- any material changes in the information submitted pursuant to AS 21.86.010(b)(3);
- the number of persons enrolled at the beginning and end of the year; and
- 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 thephrase "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.

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."

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 335
PUBLISH DATE: 1-8-90

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-
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)

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: Mora McMenamin
Agency: Health and Social Services
Date: Jan 15, 1990

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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?

BY DONALD ROBINSON

PREPAID 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-buck 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., Moses 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 redtired

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 b's 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 pone its effective date until April 1

• Senate investigators found tha HMOs fraudulently enrolled sen izens without their knowledge an Medicare for treatment that was delivered. An employee of one C nia HMO detailed 10 cases in wl enrollment forms had been forg

"The real crisis today is with that treat Medicare patients," sa Ronald S. Bronow, a dermatolo Los Angeles who is executive vic ident of Physicians Who Care, a n grass-roots organization that su patients' rights. "The elderly use m services, costing prepaid plans mor ey than younger, healthier patier some HMOs are raising premiums elderly, cutting their benefits—or ing them. Twenty-nine plans d renew their Medicare contracts for resulting in the disruption of healt for 84,000 senior citizens."

Dr. Paul M. Ellwood, chairm InterStudy, a research group in M sior, Minn., and an expert on pr health plans, cautions against the w sale criticism of HMOs. "Fixing th tors' fees until the end of the yea example, is common among insu companies, including Blue Cros even Medicare," he notes. "The rea here is that more medicine is not a better medicine. If a doctor is goi allow money to heavily influence th he gives his patients—whether too care or too much—I'd say that's doctor and *not* that HMOs are nece ily a bad system."

How to guarantee the best care the facts. Start by asking these quest

1. What does your HMO membe include: Drugs? Dental care? Eyegla Hearing aids? What's the cost to y including extras?
2. How many of your HMO's do are board-certified? How are physi reimbursed? Are there incentive induce them to skimp on care?
3. Can you choose the doctor you fer? How long does it take to ge appointment? How difficult is it to sult a specialist?
4. Is your HMO affiliated with hospitals?
5. What's the reimbursement polic emergency treatments? Suppose you denly become very ill and must ca an outside doctor not affiliated with HMO. Or you are in a serious acci and are rushed to a hospital that ha contract with your HMO. Who pays bills—you or your HMO?
6. Is there an effective quality-assur program by a competent outside or ization?
7. Is your HMO financially stable c danger of closing its doors? Request ies of its financial statements to see facts and figures.
8. Can members influence HMO p cies? To find out, ask other members

HMO Dominance Seen In '90s

National Health Care Expected In Next Century

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 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. □

Medical Benefits

Volume 6, Number 15 August 15, 1989

HEALTH CARE COSTS

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.[1]

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.

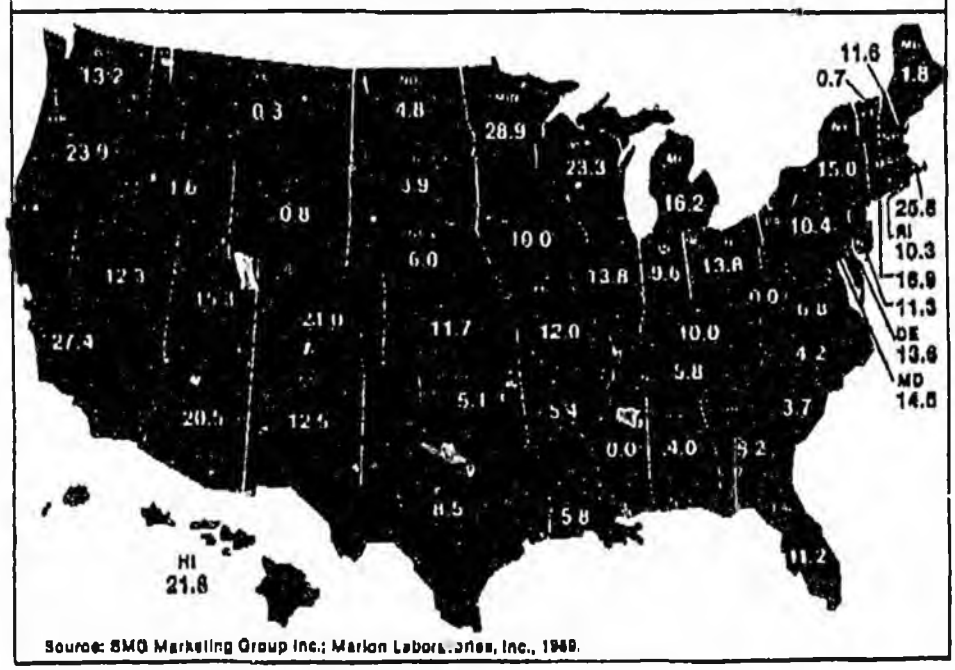
The number of operating HMOs fell 6.8% in 1988, compared with a 12% increase in 1987. An industry shakeout had been predicted for several years. The industry is likely to continue its consolidation through 1993 as the number of HMOs falls gradually each year.

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: SMG Marketing Group Inc.; Marion Laboratories, Inc., 1989.

Marion Managed Care Digest
(continued from page 1)

1,000 non-Medicare members dropped to 264 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)." MB

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	202.0	3.7	3.9	250.44	84.52
Arkansas	461.4	4.9	1.5	228.55	82.50
California	318.4	3.3	8.5	251.78	95.35
Colorado	275.6	3.5	2.0	228.90	84.93
Connecticut	402.8	3.9	3.1	282.40	112.98
Delaware	360.0	0.2	0.4	229.88	89.99
D.C.	362.7	2.9	3.3	236.32	89.80
Florida	385.9	3.3	2.6	220.67	83.42
Georgia	385.0	4.6	3.5	237.86	90.29
Hawaii	308.7	4.3	4.6	221.01	77.00
Idaho	212.0	—	—	227.50	93.50
Illinois	369.2	4.2	2.8	227.20	86.47
Indiana	383.9	4.5	2.9	237.21	81.68
Iowa	310.0	3.6	—	215.25	80.42
Kansas	441.0	3.3	2.1	248.80	94.79
Kentucky	370.0	—	—	236.99	85.44
Louisiana	406.0	3.7	0.2	235.46	85.66
Maine	343.3	—	—	248.33	96.67
Maryland	328.4	3.7	3.4	255.38	88.78
Massachusetts	389.1	3.5	4.2	292.27	109.89
Michigan	366.6	3.7	5.1	243.91	95.82
Minnesota	362.4	4.0	4.6	229.82	86.53
Missouri	394.3	2.8	1.4	250.50	90.45
Montana	375.0	4.4	3.1	205.00	80.00
Nebraska	329.9	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	416.2	3.0	3.7	222.79	88.52
New Mexico	365.0	3.5	—	272.27	104.88
New York	374.8	3.7	2.3	216.21	86.12
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	3.6	3.2	251.35	93.45
Oklahoma	300.0	3.9	9.9	253.17	87.00
Oregon	298.1	2.6	2.3	213.18	79.93
Pennsylvania	376.5	3.5	2.4	221.64	83.59
Rhode Island	366.5	4.5	—	242.50	101.50
South Carolina	385.7	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	98.76
Texas	356.9	4.0	3.0	254.40	90.48
Utah	288.7	2.7	4.2	278.40	80.25
Vermont	—	—	—	206.00	82.00
Virginia	392.1	3.6	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	93.57
Wyoming	560.0	4.0	1.7	220.00	90.00
Total U.S.	364.0	3.7	3.7	242.49	90.90

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

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

'Editor's note: The source for data used in this report was SMG Marketing Group Inc. See *MB*, 7/30/89, p. 8, for a report based on the same data base.

To obtain a free copy of this 32-page report, contact: Communications Department, Marion Laboratories, Inc., P.O. Box 8480, Kansas City, MO 64114-0480, (816) 966-4000, ext. 4544.

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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 hospitalisation?
   - ___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 conditions 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% +

Model Health Maintenance Organization Act

Table of Contents.

Section 1. Short Title.

This Act may be cited as the Health Maintenance Organization Act of (insert year).

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 much 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: (a) In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate; (b) 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; and (c) 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 availability, 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.

Medical Care Foundations

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 statues, 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 NAIC adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMO's.

Purpose of a State Model Bill

The model bill 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." Regulatory safeguards dovetailed to the unique nature of HMO's are essential. Thus, the purpose of this model 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 model 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.

Of course, it is also possible that the statutes of a given State are presently broad enough to allow operation of at least certain types of HMO's and provide the commissioners with appropriate authority to regulate them. In those states, a bill such as this may be desirable in order to consolidate and define more clearly the authority for and manner of regulation of an HMO. However, it may be possible to form HMO's under existing laws in some states before passage of this model legislation and it is anticipated that such programs can develop concurrently with any legislative activity.

Comment. Subsection (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 achieved 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.

Subsection (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in Sections 4(2)(c) and 18(1)(c), 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. Services for mental illness and alcohol and drug abuse are not included because they are often not covered by insurance or hospital or medical service plans and their inclusion would create a competitive disadvantage of HMO's. If a state believes that such services, or others, should be included as basic health care services, all carriers in the state should be required to offer or cover them.

Since no HMO may function without either a certificate of authority (see Section 3(1)) and since an HMO must furnish basic health care services (see Section 4(2)(c)), 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. (See Section 5(1)(f).) 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 affiliated 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 non-profit organization. Permitting both profit and non-profit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Subsection (9) defines uncovered expenditures for use in Section 13. 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.

(k) A description of the complaint procedures to be utilized as required under Section 11;

(l) A description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4(1)(b);

(m) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under Section 6(2);

(n) Such other information as the commissioner (director, superintendent) may require to make the determinations required in Section 4.

(4) (a) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall, unless otherwise provided for in this Act, file a notice describing any material modification of the operation set out in the information required by Subsection (3). Such notice shall be filed with the commissioner (director, superintendent) prior to the modification. If the commissioner (director, superintendent) does not disapprove within (insert number) days of filing, such modification shall be deemed approved.

(b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirements of Paragraph (a) those items he deems unnecessary;

(5) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be filed and approved. Reinsurance agreements shall remain in full force and effect for at least ninety (90) days following written notice by registered mail of cancellation by either party to the commissioner (director, superintendent).

Comment. Section 3 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 the focus of regulatory attention to assure that the consuming public is well served.

Subsection (1) is intended to provide a general override to existing state laws which restrict or prevent the formation or operation of health maintenance organizations. Among other restrictions, existing state laws may:

(1) require approval of a health maintenance organization by a medical society;

(2) require that physicians constitute all or a majority of the governing body of a health maintenance organization;

(3) require that all physicians or a percentage of physicians in the local medical society be permitted to participate in rendering the services of the organization;

(4) require that such organization submit to regulation as an insurer of health care services;

(5) require that only unincorporated individuals or associations or partnerships may provide health care services;

(6) prohibit advertising by a professional group for recruitment of enrollees.

In addition to the general override provided in Subsection (1), Section 25 specifically provides that the insurance law, the hospital and medical service corporation law and certain other provisions do not apply to HMO's. Furthermore, Section 6 specifically provides that any persons, whether or not providers of health care services, may serve on the governing body. There is no statutory requirement as to the appropriate composition of the membership of the governing body.

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments;

(d) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner (director, superintendent) may consider:

(i) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) The adequacy of working capital;

(iii) Any agreement with an insurer, a (hospital or medical service corporation), a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) Any agreement with providers for the provision of health care services; and

(v) Any deposit of cash or securities submitted in accordance with Section 13.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Section 6;

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 3 or by independent investigation, is contrary to the public interest; and

(g) Any deficiencies identified by the (commissioner of public health) have been corrected.

(3) A certificate of authority shall be denied only after compliance with the requirements of Section 21.

Comment. 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. Section 4 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 state insurance and health departments. It is felt that the expertise of the state insurance department on fiscal and other regulatory matters and the familiarity of the state health department 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 department. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the insurance commissioner obligated to rely on the health department with respect to the latter's sphere of expertise.

Subsection (1)(b) empowers the commissioner of public health to establish and apply standards of quality concerning health care. Among the arguments raised against quality control are: (1) they may limit the number of HMO's which will get started, (2) quality assurance procedures will prove to be expensive and (3) such controls will engender opposition from certain providers. On the other hand, existing methods for quality control are said to be fragmented and inadequate. If the states are to authorize and encourage HMO's by this legislation, they have an obligation to assure that the health care services provided are of reasonable quality. This is particularly true because of the built-in incentive for an HMO to restrict the utilization of services due to the incentives to stay within a fixed budget.

(2) (a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner (director, superintendent) prior to the exercise of any power granted in Subsections (1)(a), (b) or (d). The commissioner (director, superintendent) shall disapprove such exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner (director, superintendent) does not disapprove within (insert number) days of the filing, it shall be deemed approved.

(b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirement of Paragraph (a) those activities having a de minimis effect.

Comment: The exercise of authority granted in Subsections (1)(a), (1)(b) and (1)(d) shall be subject to disapproval by the commissioner within (insert number) days of a filing by a health maintenance organization. The commissioner 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.

Section 6. Governing Body.

(1) The governing body of any health maintenance organization may include providers, or other individuals, or both.

(2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

Comment: While Section 3(1) should adequately override restrictive laws related to membership of a governing body, Section 6(1) makes explicit the permissible membership of such a group. The model bill 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.

Section 7. Fiduciary Responsibilities.

(1) Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner (director, superintendent). All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination has been filed with the commissioner (director, superintendent) unless an earlier date of such cancellation or termination is approved by the commissioner (director, superintendent).

(b) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary or other qualified person acceptable to the commissioner (director, superintendent), to the appropriateness of the use of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(3) The commissioner (director, superintendent) shall within a reasonable period, approve any form if the requirements of Subsection (1) are met and any schedule of charges if the requirements of Subsection (2) are met. It shall be unlawful to issue such form or to use such schedule or charges until approved. If the commissioner (director, superintendent) disapproves such filing, he shall notify the filer. In the notice, the commissioner (director, superintendent) shall specify the reasons for his disapproval. A hearing will be granted within (insert number) days after a request in writing by the person filing. If the commissioner (director, superintendent) does not approve any form or schedule of charges within (insert number) days of the filing of such forms or charges, they shall be deemed approved.

(4) The commissioner (director, superintendent) may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Section.

Comment: Subsection (1)(a) requires that every enrollee be provided with evidence of coverage and allocates the responsibility for providing that evidence. Paragraph (c) establishes requirements which such evidence of coverage must meet. The group contracts to be filed pursuant to Section 3(3)(f) are not subject to the standards and filing requirements of Section 8, since such group contracts are not issued to enrollees. Paragraph (d) clarifies the relationship between filing requirements under this Section and under the state insurance or hospital or medical service corporation law. Filing is required under Paragraph (b) unless the form is already subject to filing requirements under existing state law. However, where existing state law does not apply standards as strict as those contained in Paragraph (c), such standards are, in effect, read into the existing law. Where the filing under state insurance or medical or hospital service corporation law is required to meet standards as strict as those in Paragraph (c), the former would be applicable. A state may want Paragraph (d) to be revised to make specific reference to existing state laws.

Subsection (2)(a) 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 (b) 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 impede 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 commissioner in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the commissioner 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.

Comment: 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.

In establishing the format for records and reports pursuant to this Section, the commissioner may want to require disclosure similar to that provided for under the NAIC Model Unfair Trade Practices Act. Section 4(10) of that Act requires, among other data, a record of total number of complaints since the last examination, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint. (See 1972 NAIC Proceedings I 443).

Section 12. Investments.

With the exception of investments made in accordance with Section 5(1)(a) and (b) and Section 5(2), the funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner (director, superintendent) may permit.

Comment: 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 commissioner in accordance with the standards set out in Section 5(2).

Section 13. Protection Against Insolvency.

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner (director, superintendent) or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to him in the amount set forth in this section.

(2) The amount for an organization that is beginning operation shall be the greater of: (a) five percent (5%) of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation or (c) $100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the commissioner (director, superintendent) or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the commissioner (director, superintendent), in an amount equal to four percent (4%) of its estimated annual uncovered expenditures for that year.

(3) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent (1%) of the preceding 12 months uncovered expenditures, or (b) $100,000 on the first day of the fiscal year beginning six (6) months or more after the effective date of this section.

Comment. 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 commissioner 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 or 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 commissioner 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. (Section 3(5) requires prior notification of cancellation of any reinsurance.) 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.

The requirement in Subsection (8) for a capital account only applies to organizations licensed after the effective date of the subsection. Thus, the capital account requirement would have to be taken into consideration by persons starting a new HMO. If a state wishes to apply the requirement to existing HMO's, it should allow for an appropriate phase-in period.

It is believed that these provisions and the related provisions of Section 4(2)(d), including possible insurance backup arrangements, provide adequate assurances. The failure to provide assurances as required would subject the health maintenance organization to suspension or revocation of its certificate of authority under Section 18.

Section 14. Prohibited Practices.

(1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment with a health maintenance organization;

*A Provision to accomplish this might read:

(2) The commissioner (director, superintendent) may by rule exempt certain classes of persons from the requirement of obtaining a license:

(a) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(b) If other existing safeguards make regulation unnecessary.

Section 16. Powers of Insurers and (Hospital and Medical Service Corporations).

(1) An insurance company 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 act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, (hospitals or medical service corporations), or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any provision of insurance and (hospital or medical service corporation) laws (citations), an insurer or a (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 health maintenance organizations 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 such laws. Among other things, under such contracts, the insurer or (hospital or medical service corporation) may make benefit payments to health maintenance organizations for health care services rendered by providers.

Comment: Subsection (2) 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. This section might also be redrafted to make specific reference to the relevant Section of existing law.

Section 17. Examination.

(1) The commissioner (director, superintendent) may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

(2) The (commissioner of public health) may make an examination concerning the quality of health care service of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

(3) Every health maintenance organization and provider shall submit its relevant books and records for such examinations and in every way facilitate them. For the purpose of examinations, the commissioner (director, superintendent) and the (commissioner of public health) may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

(2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Section 21.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner (director, superintendent) may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section 19. Rehabilitation, Liquidation, or Conservation of a Health Maintenance Organization.

(1) Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner (director, superintendent) pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner (director, superintendent) may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in (cite sections of state rehabilitation law), or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as an enrollee, provided such provider of services agrees not to assert such claim against any enrollee of the health maintenance organization.

Comment. Section 19 provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the Commissioner under state laws applicable to insurance companies. Inasmuch as all states have existing authority, it is felt that the use of such statutes would be appropriate and would avoid the necessity of developing new administrative procedures applicable only to health maintenance organizations. Subsection (2) is designed to provide the maximum protection for enrollees by paying those providers that can bill the enrollee before those that have agreed not to. However, in order to obtain this priority, the provider must agree that the payment fully discharges the obligation of the enrollee. Incidentally, the NAIC has recommended the adoption of a model liquidation and rehabilitation act (See 1968 NAIC Proceedings I 214).

Section 20. Regulations.

The commissioner (director, superintendent) may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this Act. Such rules and regulations shall be subject to review in accordance with (insert section number providing for review of administrative orders).

Section 21. Administrative Procedures.

(1) When the commissioner (director, superintendent) has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the (commissioner of public health) in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least (insert number) days thereafter for a hearing on the matter.

Section 23. Penalties and Enforcement.

(1) The commissioner (director, superintendent) may, in lieu of suspension or revocation of a certificate of authority under Section 18, levy an administrative penalty in an amount not less than (insert amount) dollars nor more than (insert amount) dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner (director, superintendent) may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2) (a) If the commissioner (director, superintendent) or the (commissioner of public health) shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner (director, superintendent) or (commissioner of public health) may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner (director, superintendent) or the (commissioner of public health) may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section or Section 21 of this act are satisfied.

(3) (a) The commissioner (director, superintendent) may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(b) Within (insert number) of days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred. Such hearings shall be conducted pursuant to (cite Sections of State Administrative Procedure Act), and judicial review shall be available as provided by (cite sections of State Administrative Procedure Act).

(4) In the case of any violation of the provisions of this act, if the commissioner (director, superintendent) elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to Subsection (3), the commissioner (director, superintendent) may institute a proceeding to obtain injunctive or other appropriate relief in the (name of court of primary jurisdiction for actions of this nature).

Comment: Sections 23(3) and 23(4) authorize the commissioner to issue a cease and desist order and to apply for injunctive relief. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 24. Statutory Construction and Relationship to Other Laws.

(1) Except as otherwise provided in this act, provisions of the insurance law and provisions of (hospital or medical service corporation) laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or (hospital or medical service corporation) licensed and regulated pursuant to the insurance law or the (hospital or medical service corporation) laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

Section 29. Dual Choice.

Each employer, public or private, in this state which offers its employees a health benefit plan and employs not less than twenty-five employees, and each employee benefit fund in this state which offers its members any form of health benefit, shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which a substantial number of such employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organization(s) to be made available to the employees shall be made under the agreement.

No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, provided that the employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount equal to the lesser of (a) the amount paid on behalf of its other employees or members for health benefits or (b) the health maintenance organization's charge for coverage approved by the commissioner (director, superintendent) pursuant to Section 8 of this act.

Comment: This Section is similar to Section 1310 of the federal HMO Act, but extends the dual choice requirement to state licensed HMO's. 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 HMO's.

Section 30. Severability.

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

Legislative History (all references are to the Proceedings of the NAIC).

1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).
1973 Proc. II 139 (synopsis of model).
1974 Proc. I 12, 14, 405, 413 (amended).
1982 Proc. I 19, 28, 431, 498-499, 530-554 (revised and reprinted).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA. CODE §§ 27-21A-1 TO 27-21A-32 (1986).	
Alaska	NO ACTION TO DATE	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1069 (1973/1985) "Health Care Service Organizations".
Arkansas	ARK. STAT. ANN. §§ 66-5201 to 66-5228 (1975/1987).	
California		CAL. HEALTH & SAFETY CODE §§ 1340 to 1399.64 (1979/1986) ("Knox-Keene Health Care Services Plan").
Colorado	COLO. REV. STAT. §§ 10-17-101 to 10-17-115 (1963/1986).	
Connecticut		CONN. GEN. STAT. §§ 33-179a to 33-179t (1971/1987) "Health Care Centers".
Delaware	HB 99 Model pending (1987).	DEL. CODE ANN. tit. 16 §§ 9101 to 9118 (1982). See also tit. 18 §§ 6401 to 6406 (1987).
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 641.17 to 641.33 (1985/1987).
Georgia	GA. CODE ANN. §§ 33-21-1 to 33-22-28 (1979/1986).	
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO CODE §§ 41-3901 to 41-3934 (1974/1985).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Illinois	ILL. REV. STAT. ch. 111 1/2 §§ 1401 to 1417 (1974/1987).	
Indiana		IND. CODE §§ 27-8-7-1 to 27-8-7-18 (1979/1987) ("Proposed Health Care Delivery Plans").
Iowa	IOWA CODE §§ 514B.1 to 514B.32 (1973).	
Kansas	KAN. STAT. ANN. §§ 40-3201 to 40-3227 (1974/1987).	
Kentucky		KY. REV. STAT. §§ 304.38-010 to 304.38-210 (1982/1986);
Louisiana	LA. REV. STAT. ANN §§ 22:2001 to 22:2025 (1986).	
Maine	ME. REV. STAT. ANN. tit. 24-A §§ 4201 to 4226 (1975/1986).	
Maryland		MD. ANN. CODE art 19 §§ 701 to 734 (1982/1987).
Massachusetts		MASS. GEN LAWS ch. 176G §§ 1 to 17 (1976/1986).
Michigan		MICH. COMP. LAWS. §§ 333.21001 to 333.21098 (1982/1986).
Minnesota	MINN. STAT. §§ 62D.01 to 62D.30 (1973/1986).	
Mississippi	MISS. CODE ANN. § 41-7-401 et seq. (1986).	
Missouri	MO. REV. STAT. §§ 354.400 to 354.550 (1983).	
Montana	MONT. CODE ANN. §§ 33-31-101 to 33-31-405 (1987).	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Nebraska	NEB. REV. STAT §§ 44-3201 to 44-3291 (1978/1985).	
Nevada		NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973/1987).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:22 (1977/1985).
New Jersey	N.J. REV. STAT. §§ 26:2J-1 to 26:2J-30 (1973).	
New Mexico	N.M. STAT. ANN. §§ 59A-46-1 to 59A-46-31 (1985/1986).	
New York		N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976).
North Carolina	N.C. GEN. STAT. §§ 57B-1 to 57B-25 (1979).	
North Dakota	N.D. CENT. CODE §§ 26.1-18-01 to 26.1-18-35 (1983).	
Ohio	OHIO REV. CODE ANN. §§ 1742.01 to 1742.36 (1976).	
Oklahoma		OKLA. STAT. tit. 63 §§ 2501 to 2510 (1975).
Oregon		OR. REV. STAT. §§ 750.003 to 750.075 (1985).
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 83-101 to 83-119 (1981).
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 1901 to 1927.
Rhode Island	R.I. GEN. LAWS §§ 27-41-1 to 27-41-29 (1983 1987).	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
South Carolina	S.C. CODE ANN. §§ 38-25-10 et seq. (1987).	
South Dakota		S.D CODIFIED LAWS ANN. §§58-41-1 to 58-41-97 (1974).
Tennessee	TENN. CODE ANN. §§ 56-32-201 to 56-32-225 (1986/1987).	
Texas	TEX. INS. CODE ANN. art. 20A.01 to 20A.35 (1975/1987).	
Utah		UTAH CODE ANN. §§ 31A-8-101 to 31A-8-406 (1986/1987).
Vermont	VT. STAT. ANN. tit. 8 §§ 5101 to 5113 (1979) (Most of model.)	
Virgin Islands	NO ACTION TO DATE	
Virginia	VA. CODE §§ 38.2-4300 to 38.2-4321 (1986).	
Washington		WASH. REV. CODE ANN. §§ 48.46.010 to 48.46.920 (1975/1986) (Parts of model).
West Virginia	W.VA. CODE §§ 33-25A-1 to 33-25A-28 (1977).	
Wisconsin		See WIS. STAT. § 628-36 (2m) providing that Commissioner may make rules for HMOs. See also ch. 609 (1985) on joint ventures.
Wyoming	WYO. STAT. §§ 26-34-101 to 26-34-128 (1986).	