HEALTH MAINTENANCE ORGANIZATIONS STUDY COMMITTEE

Report to the Legislative Council
and the Members of the
First Session of the Sixty-fifth General Assembly

State of Iowa
1973

FINAL REPORT
OF THE
HEALTH MAINTENANCE ORGANIZATIONS STUDY COMMITTEE

Senate Concurrent Resolution 117, introduced during the Second Session of the Sixty-fourth General Assembly, requested that the Iowa Legislative Council establish a committee to study the feasibility of authorizing the establishment of health maintenance organizations (HMOs) to provide prepaid health care services to the citizens of Iowa.

The Legislative Council created a ten-member study committee and appointed the following members:

Senator James W. Griffin, Sr.
Senator William C. Palmer
Senator W. R. Rabedeaux
Senator James F. Schaben
Senator George L. Shawver
Representative Leonard C. Andersen
Representative Harold C. McCormick
Representative W. R. Monroe, Jr.
Representative Barton L. Schwieger
Representative Jewell O. Waugh

At its first meeting on July 13, 1972, the Committee elected Senator Rabedeaux and Representative Schwieger Co-chairmen of the Study Committee and received testimony from the regional program director of the Health Maintenance Organizations Service office of the Department of Health, Education, and Welfare (DHEW) and from the executive director of the Health Planning Council of Central Iowa (HPCCI) regarding current developments in the formation of HMOs in Iowa. At this meeting the Committee learned that there is a positive effort on the part of both physicians and hospitals in Iowa to obtain technical assistance from DHEW in the formation of HMOs, but that prohibitive restrictions in Iowa law discourage experimentation in the delivery of health care services. James Mebs of HPCCI told the Committee that fourteen Des Moines physicians are involved in planning for a potential HMO and are awaiting the enactment of permissive legislation.

THE HMO CONCEPT

The system of health care envisioned in the HMO concept is the provision of comprehensive health care services to persons who have paid the cost of the services in advance on a capitation (i.e., flat periodic rate per individual or family) basis, by health care practitioners who receive a fixed rate of compensation that is not directly tied to the services performed. Under traditional systems, providers of health care are remunerated on a fee-for-service basis; i.e., they are paid according to the number and type of services rendered. Advocates of the HMO system of health care contend that physicians paid on a fee-for-service basis have no economic incentive to concentrate on keeping people healthy and that a fixed-price contract for comprehensive health care reverses

this illogical incentive because the income remaining after the cost of providing services has been covered grows not with the number of days a person is sick, but with the number of days he is well. HMOs therefore have a strong financial interest in preventing illness and practice preventive medicine by providing routine examinations and immunizations to enrollees.

In order to accomplish its purpose of maintaining the health of its enrollees, an HMO must bring together a wide range of medical services in a single organization so that a defined population is assured of convenient access to all of them and so that the right combination of health care resources will be utilized. The concept moves beyond the prepayment technique developed by Blue Cross-Blue Shield associations in that the HMO does not ordinarily provide indemnification against the cost of health care services obtained by a subscriber if and when such services can be obtained, but undertakes direct responsibility for the provision, availability, and accessibility of those services for a single periodic payment by the subscriber. The HMO may offer indemnity or service benefits provided through insurers, medical or hospital service corporations, or otherwise, in order to cover services which are not available through the HMO, but these indemnity benefits are usually limited to cover services obtained by a subscriber in an emergency situation arising while the subscriber is outside the HMO's service area or in other unusual circumstances.

According to DHEW, the emerging trend toward HMOs is a result of the successes of a variety of medical foundations and prepaid group practice organizations in various parts of the United States in arranging for a more economically efficient delivery of health care. Subsequent testimony received by the Committee from DHEW indicates that the highly-organized HMO model, a prepaid group practice plan operating through facilities owned by it, and the more loosely-knit HMO model, a medical foundation plan controlled by physicians in solo practice, are actually two extremes in the type of organizational structures under which HMOs might operate. DHEW personnel testifying before the Committee provided Committee members with a comprehensive outline of widely varying HMO structures ranging from hospital-based prepaid group practice plans to cooperative organizations which contract with the various providers of health care services.

THE HMO AND IOWA LAW

The legal impediments to the development of HMOs stem in part from the so-called "Blue Cross-Blue Shield" laws which, in some eighteen states, have the effect of requiring any health service corporation to incorporate under them. The Health Law Center division of Aspen Systems Corporation has listed Iowa as one of the states having a restrictive Blue Cross-Blue Shield statute. Chapter 514 of the Code of Iowa mandates the use of the nonprofit corporate form of organization by hospital and medical service plans, requires that a majority of the directors of a medical service corporation must be physicians who have contracted with the

corporation to provide services, and requires that the corporation must have, at a minimum, 150 physicians under contract.

At a meeting of the Committee on September 20, David Neugent, president of Iowa Blue Cross and Blue Shield, expressed the view that if a group of less than 150 physicians were willing to make their services available to the public on a prepaid basis involving a fixed periodic rate of compensation to the physicians, a medical service corporation operating under Chapter 514 could legally enter into an agreement to sell contracts for such services to subscribers and collect payments from subscribers on behalf of the physicians offering their services in this manner. Mr. Neugent supported his statement by pointing out that a medical service corporation already contracts with more than 150 physicians in this state and therefore would merely be offering a new and alternative package of health care benefits to subscribers. At the request of Committee members, an opinion was sought from the Attorney General in regard to this interpretation of Chapter 514 of the Code. No opinion has been issued as of the date of preparation of this report.

The Study Committee investigated other legal barriers to the formation of HMOs in Iowa, including (1) applicable state insurance laws and regulations which might impose upon HMOs certain requirements for liquid reserves and (2) the common law restrictions of the corporate practice of medicine rule which, in the absence of specific legislation to control the commercialization of medicine, the courts have adopted in order to prevent profit-making schemes that might adversely affect the health of those who subscribe to them.

Many states apply insurance laws to HMOs, assuming such organizations are not otherwise prohibited by restrictive state legislation. These laws usually call for establishment of reserves, contingency funds, and other such requirements to make sure the dollars available exceed potential claims for those dollars. If a prepaid group practice plan were able to incorporate under Iowa's "Blue Cross-Blue Shield" statute, it also would be subject to insurance regulation including, but not limited to, approval by the Commissioner of Insurance of acquisition costs in connection with the solicitation of subscribers and the requirement that funds of the corporation be invested only in securities permitted by Iowa law for the investment of funds of life insurance companies.

The simplest argument that can be made to warrant exempting HMOs from the application of insurance regulations is that HMOs do not ordinarily deal in insurance. Fundamentally, an insurance company or a nonprofit prepayment program of the Blue Cross-Blue Shield type deals in claims and dollars and is considered fiscally sound only if its capital structure and cash flow assure that the organization will have the dollars available to pay claims. An HMO, on the other hand, is sound only to the extent that it encompasses in some effective manner, the facilities, physicians and other personnel required for the actual provision of health care services. For an HMO, economic soundness is hampered rather than

fostered by requiring capital to be tied up in investments readily converted to cash which are unrelated to providing health care services themselves. Enrollees of an HMO are protected not by a "legal reserve", but by the contractual obligation of physicians, hospitals, and other providers to render health care services to them.

The corporate practice rule is based upon two legal doctrines. First, that the corporation is a "person", and second that the acts of natural persons can be attributed to the legally recognized corporate entity which employs them. From this it follows that the corporation would be practicing a profession if it employed professional individuals. The corporate practice rule therefore prohibits a corporation from furnishing health care services for compensation through physicians engaged and paid by it.

Iowa law relating to the corporate practice of medicine rule is limited to prohibiting contracts between hospitals and pathologists or radiologists that in any way create the relationship of employer and employee between the hospital and the doctor. The law (see Chapter 135B of the Code) was enacted pursuant to a district court opinion stating that pathologists and radiologists are considered to be practicing medicine and therefore cannot be hired by the hospital which is providing their services.

ATTITUDES OF AFFECTED GROUPS

Representatives of several groups appeared before the Study Committee at its second and third meetings to express their group's attitude toward the concept of HMOs. Although the statements received by the Committee from these groups reveal differences of opinion in regard to the type of HMO legislation that should be enacted, all of the groups basically support the establishment of HMOs as one alternative to traditional systems of health care delivery. All groups dealt either directly or indirectly with Iowa laws restricting the development of HMOs:

1. Both the Iowa Medical Society and the Iowa Society of Osteopathic Physicians and Surgeons are strongly opposed to the employment of physicians by HMOs and believe that the inclusion of such a provision in HMO legislation would materially hinder the enactment of HMO legislation in Iowa. The Iowa Medical Society has not taken a definite stand on the possible organization of HMOs as profit-making corporations. However, it does see dangers to the public and to the profession in permitting profit-making corporations other than insurance companies licensed to do accident and health business in this state to become HMOs.

2. The Iowa Nurses' Association supports the HMO concept as expressed in Senate File 239 introduced during the First Session of the Sixty-fourth General Assembly and the president of the Association personally supports the provisions of Senate File 1212 of the Sixty-fourth General Assembly on the basis that it offers the greatest degree of flexibility in the formation and establishment of HMOs.

3. The Iowa Pharmaceutical Association supports HMO legislation that would include under the provision spelling out services to be offered by an HMO, the services of a clinical pharmacist independently contracting with the HMO to provide such services.

4. The Iowa Hospital Association agrees with the Iowa Medical Society that the organizational form of an HMO should be limited to nonprofit corporations, but would have certain restrictions placed on the role of insurance companies in the operation of HMOs. The Iowa Hospital Association also expressed the view that physicians should be allowed the option of entering into an employment contract with an HMO.

5. The Iowa Chiropractic Society suggests that the wording of HMO legislation specifically include chiropractors along with other health care practitioners providing services to the public through an HMO.

6. An officer of The Bankers Life Company appeared on behalf of the Health Insurance Association of America, whose member companies write approximately 80% of the health insurance written by private carriers in the United States and whose position basically corresponds to the amendments submitted to Senate File 239 which allow for the operation of HMOs by insurance companies licensed to do accident and health business in Iowa. The Association believes that the insurance industry is eminently equipped, in both skills and resources, to make a significant contribution to the development and operation of HMOs and also advocates that HMOs be allowed to contract for insurance to indemnify or reimburse the HMO against the cost of health care services not available through the HMO plan.

The Director of the Legal Aid Society of Polk County also appeared before the Study Committee on behalf of Medicaid recipients and medically needy persons who are often forced onto the welfare rolls because of the high cost of medical care. The Director suggested that if the state were permitted by law to contract with HMOs for the provision of services to such persons, not only would better health care be within reach of these persons, but the Medicaid program itself could be expanded to include the medically needy at a cost the state can afford. In its investigation of the possible savings to the State of Iowa through Medicaid-HMO-type contracts, the Committee ascertained that twelve states presently contract with eighteen HMOs to provide services to Medicaid recipients and that additional contracts are being negotiated. The Committee also examined recently enacted federal legislation (H.R. 1) which spells out the requirements to be met by HMOs serving Medicare recipients.

A RURAL HMO

In recognition of the fact that no person involved in the actual operation of an HMO had been consulted, the Committee requested, at the suggestion of President Neugent of Iowa Blue Cross-Blue Shield, that the director of the Marshfield Clinic in Marshfield, Wisconsin be invited to speak at the Committee's

November 9 meeting. The Greater Marshfield Community Health Plan is one of several prepaid group practice plans developed by the Wisconsin Blue Cross association and consists of a joint venture between the Marshfield Clinic, a multi-specialty physician group, a hosptial, and Blue Cross, with contracts emanating outward from Blue Cross, which is legally responsible for making services available to subscribers.

DHEW personnel suggested that the Marshfield Plan is one type of HMO structure most likely to serve rural populations. According to testimony presented by the director of the Marshfield Clinic, the Plan not only contracts with physicians providing primary care to enrollees living on the periphery of the area served by the plan, but also makes indemnity payments to providers of health care services outside the territorial boundaries of the Plan. The Director of the Clinic asserted that transportation problems are not an insurmountable barrier to the rural patients seeking specialized services from the Clinic in Marshfield.

CONCLUSION

The Committee has concluded that requiring HMOs to incorporate under existing statutes is discriminatory in nature because it prohibits some kinds of organizations from delivering health care services without determining whether the quality of care which would be provided by such organizations meets appropriate standards. The Committee is therefore recommending legislation based on the National Association of Insurance Commissioners' model HMO bill, which, the Committee feels, adequately removes existing legal barriers to the establishment and operation of HMOs, while providing for regulation of HMOs according to the various needs of individual HMO structures. The Committee reviewed the December 5 draft of the N.A.I.C. bill and received favorable comment on it from representatives of the Iowa Medical Society, The Bankers Life, DHEW, the Iowa Hospital Association, the Iowa Life Insurance Association, Blue Cross, and the Iowa Chiropractic Society.

The N.A.I.C. Subcommittee which was charged with drafting the bill states that the purpose of the bill is twofold. First, it attempts to provide a legal framework enabling the organization and functioning of a wide variety of HMOs including those based upon the medical care foundation concept. Second, the bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuses, but also to assist in the future improvement and development of this alternative form of health care delivery.

At its December 13 meeting, the Study Committee acted upon several issues that were raised during the course of its study of HMOs and directed the Legislative Service Bureau staff to draft a bill which would accomplish the following:

1. Retain the provisions of the N.A.I.C. bill allowing any person to apply for and obtain a certificate of authority to establish and operate an HMO in compliance with the requirements of the

N.A.I.C. bill, except that coinsurance and deductible charges may not be applied to health care services that are provided on a prepaid basis, except when required under federal programs.

2. Permit HMOs to furnish health care services to the public through providers which are under contract with or employed by the HMO.

3. Exempt from premium taxation all payments received from contracts with enrollees for health care services provided through an HMO.

4. Authorize the Commissioner of Social Services to contract with HMOs for the purpose of providing benefits to Medicaid recipients.

At its January 4, 1973 meeting, the Study Committee approved the bill draft attached to this report and recommended that it be introduced during the First Session of the Sixty-fifth General Assembly.

Prepared for the Health Maintenance Organizations Study Committee for introduction during the First Session of the Sixty-fifth General Assembly.

Passed Senate, Date_____ Passed House, Date_____

Vote: Ayes_____ Nays_____ Vote: Ayes_____ Nays_____

Approved_____

A BILL FOR

An Act to authorize the establishment and continuing regulation of health maintenance organizations and to provide penalties.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. PURPOSE. The general assembly determines that health maintenance organizations, when properly regulated, encourage methods of treatment and controls over the quality of care which effectively contain costs and provide for continuous health care by undertaking responsibility for the provision, availability, and accessibility of services. It is the intent of this Act that legal barriers be removed to allow a variety of organizational structures to establish and operate health maintenance organizations in order to provide for experimentation with and improvement in this alternative system of health care delivery. For this reason, and because the primary responsibility of a health maintenance organization lies in providing health care services on a prepaid basis without regard to the type and number of services actually rendered, rather than providing indemnification against the cost of such services, the general assembly finds it necessary to provide a statutory framework for the establishment and continuing regulation of health maintenance organizations which is separate from the insurance laws of this state, except as otherwise provided in this Act.

Sec. 2. NEW SECTION. DEFINITIONS. As provided in this Act, unless the context otherwise requires:

1. "Commissioner" means the commissioner of insurance.

2. "Health care services" means services included in the furnishing to any individual of medical or dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of all other services for the purposes of preventing, alleviating, curing, or healing human illness or injury.

3. "Health maintenance organization" means any arrangement by which a person undertakes to provide, arrange for, pay for or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of

such services, on a prepaid basis through insurance or otherwise.

4. "Enrollee" means an individual who is enrolled in a health maintenance organization.

5. "Provider" means any physician, hospital, or person as defined in chapter four (4) of the Code which is licensed or otherwise authorized in this state to furnish health care services.

6. "Basic health care services" means services which an enrollee might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient and other medical services.

7. "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

Sec. 3. NEW SECTION. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS. Any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. A person shall not establish or operate a health maintenance organization in this state, nor sell, offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate under this Act.

Every person operating a health maintenance organization on January 1, 1974 shall submit an application for a certificate of authority under section four (4) of this Act not later than January 31, 1974. The health maintenance organization may continue to operate until the commissioner acts upon the application, but if the application is denied the applicant shall be treated as a health maintenance organization whose certificate of authority has been revoked.

Sec. 4. NEW SECTION. APPLICATION FOR A CERTIFICATE OF

AUTHORITY. An application for a certificate of authority shall be verified by an officer or authorized representative of the health maintenance organization, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

1. A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all of its amendments.

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

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

4. A copy of any contract made or to be made between any providers or persons listed in subsection three (3) of this section and the applicant.

5. A statement generally describing the health maintenance organization including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the commissioner directs that

additional financial information is required for the proper administration of this Act.

9. A description of the proposed method of marketing the plan and a three-year projection of operating expenses and sources of funding.

10. A power of attorney executed by any applicant who is not domiciled in this state appointing the commissioner, his successors in office and deputies as the true and lawful attorney of the applicant for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served.

12. A description of the complaint procedures to be utilized as required under section fifteen (15) of this Act.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care review as determined by the commissioner of public health under this Act.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by section eight (8) of this Act.

15. Other information the commissioner finds necessary to make the determinations required in section six (6) of this Act.

A health maintenance organization shall, unless otherwise provided for in this Act, file notice with the commissioner and receive approval from him before modifying the operations described in the information required by this section.

Upon receipt of an application for a certificate of authority, the commissioner shall immediately transmit copies of the application and accompanying documents to the commissioner of public health.

Sec. 5. NEW SECTION. DUTIES OF THE COMMISSIONER OF PUBLIC

HEALTH. The commissioner of public health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

1. Has demonstrated the willingness and potential ability to assure the availability, accessibility and continuity of service through adequate personnel and facilities.

2. Has arrangements established in accordance with regulations promulgated by the commissioner of public health for a continuous review of health care processes and outcomes.

3. Has a procedure established in accordance with regulations of the commissioner of public health to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and other matters as may be reasonably required by the commissioner of public health.

The commissioner of public health, in carrying out his obligations under this section and sections twenty-six (26) and twenty-seven (27) of this Act, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the commissioner of public health.

Within a reasonable period of time from the receipt of the application for a certificate of authority, the commissioner of public health shall certify to the commissioner whether the proposed health maintenance organization meets the requirements of this section. If the commissioner of public health certifies that the health maintenance organization does not meet these requirements, he shall specify in what respects it is deficient.

Sec. 6. NEW SECTION. ISSUANCE AND DENIAL OF A CERTIFICATE OF AUTHORITY. The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section four (4) of this Act within a rea-

sonable period of time after receiving certification from the commissioner of public health. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section twenty-three (23) of this Act if the commissioner is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent and trustworthy.

2. The commissioner of public health certifies that the health maintenance organization's proposed plan of operation meets the requirements of section five (5) of this Act.

3. The health maintenance organization provides or arranges for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except that the health maintenance organization may impose deductible and coinsurance charges which might be required to be paid by persons on whose behalf the federal government contracts with the health maintenance organization for health care services.

4. The health maintenance organization is fiscally sound and may reasonably be expected to meet its obligations to enrollees. In making this determination, the commissioner may consider:

a. The financial soundness of the health maintenance organization's arrangements for health care services in relation to its schedule of charges.

b. The adequacy of the health maintenance organization's working capital.

c. Any agreement made by the health maintenance organization with an insurer, a corporation authorized under chapter five hundred fourteen (514) of the Code or any other organization for insuring the payment of the cost of health care services or for providing immediate alternative coverage in the event of discontinuance of the health maintenance organization.

d. Any agreement made with providers for the provision

of health care services.

e. Any surety bond or deposit of cash or securities submitted in accordance with section seventeen (17) of this Act.

5. The enrollees may participate in matters of policy and operation pursuant to section eight (8) of this Act.

6. Nothing in the proposed method of operation as shown by the information submitted pursuant to section four (4) of this Act or by independent investigation is contrary to the public interest.

7. Any deficiencies certified by the commissioner of public health have been corrected.

A certificate of authority shall be denied only after compliance with the requirements of section twenty-seven (27) of this Act.

Sec. 7. NEW SECTION. POWERS OF HEALTH MAINTENANCE ORGANIZATIONS. The powers of a health maintenance organization include, but are not limited to, the following:

1. The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for transacting the business of the organization.

2. The making of loans to a medical group under contract with it or to a corporation under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees.

3. The furnishing of health care services to the public through providers which are under contract with or employed by the health maintenance organization.

4. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration.

5. The contracting with an insurance company authorized

to insure groups or individuals in this state for the cost of health care or with a corporation authorized under chapter five hundred fourteen (514) of the Code for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

6. The offering, in addition to basic health care services, of health care services and indemnity benefits to enrollees or groups of enrollees.

7. The acceptance from any person of payments covering all or part of the charges made to enrollees of the health maintenance organization.

A health maintenance organization shall file notice with the commissioner before the exercise of any power granted in subsections one (1) and two (2) of this section. The notice shall be accompanied by adequate supporting information obtained from the commissioner of public health relating to the health maintenance organization's need for physical facilities. The commissioner shall disapprove the exercise of power 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. The commissioner may promulgate rules exempting from the filing requirement of this section those activities having a minimum effect.

Sec. 8. NEW SECTION. GOVERNING BODY. The governing body of any health maintenance organization may include providers, other individuals, or both, but it shall establish a mechanism to allow enrollees to participate in matters of policy and operation.

Sec. 9. NEW SECTION. FIDUCIARY RESPONSIBILITIES. Any director, officer or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of a health maintenance organization shall be responsible for these funds in a

fiduciary relationship to the enrollees.

Sec. 10. NEW SECTION. EVIDENCE OF COVERAGE. Every enrollee shall receive an evidence of coverage and any amendments. If the enrollee obtains coverage through an insurance policy or a contract issued by a corporation authorized under chapter five hundred fourteen (514) of the Code, the insurer or the corporation shall issue the evidence of coverage. No evidence of coverage or amendment shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

An evidence of coverage shall contain a clear and complete statement of:

1. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled in the total context of the organizational structure of the health maintenance organization.

2. Any limitations on the services or benefits to be provided, including any deductible or copayment feature permitted under section six (6), subsection three (3) of this Act.

3. The manner in which information is available on the method of obtaining health care services.

4. The total amount of payment for health care services and indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan offered through the health maintenance organization is contributory or noncontributory with respect to group contracts.

5. The health maintenance organization's method for resolving enrollee complaints.

A copy of the form of the evidence of coverage to be used in this state and any amendment shall be subject to the filing and approval requirements of this section unless it is subject to the jurisdiction of the commissioner under the laws

governing health insurance or corporations authorized under chapter five hundred fourteen (514) of the Code in which event the filing and approval provisions of such laws apply. To the extent, however, that those provisions are less strict than those provided under this section, then the requirements of this section shall apply.

Enrollees shall be entitled to receive the most recent statement of the financial condition of the health maintenance organization in which they are enrolled.

Sec. 11. NEW SECTION. CHARGES--APPROVAL REQUIRED. No schedule of charges for enrollee coverage for health care services or amendment to the schedule may be used by a health maintenance organization until a copy of the schedule or amendment to the schedule has been filed with and approved by the commissioner. Charges to enrollees may be established in accordance with actuarial principles for various categories of enrollees, but the charges shall not be determined according to the status of an individual enrollee's health and shall not be excessive, inadequate or unfairly discriminatory.

Sec. 12. NEW SECTION. DISAPPROVAL OF FILINGS. If the commissioner disapproves a filing made pursuant to sections ten (10) and eleven (11) of this Act, he shall notify the filer and in the notice specify the reasons for his disapproval. A hearing shall be granted by the commissioner within thirty days after receipt by the filer of the notice of disapproval. The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to disapprove a filing.

Sec. 13 NEW SECTION. ANNUAL REPORT. A health maintenance organization shall annually before the first day of March file with the commissioner, with a copy to the commissioner of public health, a report verified by at least two of its principal officers and covering the preceding calendar year. The report shall be on forms prescribed by the commissioner and shall include:

1. A financial statement of the organization, including its balance sheet, receipts and disbursements for the preceding year certified by an independent public accountant.

2. Any material changes in the information submitted pursuant to section four (4) of this Act.

3. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year.

4. A summary of information compiled pursuant to section five (5), subsection three (3) of this Act in the form required by the commissioner of public health.

5. Other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out his duties under this Act.

Sec. 14. NEW SECTION. OPEN ENROLLMENT. After a health maintenance organization has been in operation twenty-four months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner shall approve or deny the application made pursuant to this section within a reasonable period of time from the receipt of the application.

Health maintenance organizations providing services exclusively on a group contract basis may limit the open enrollment provided for in this section to all members of the group covered by the contract.

Sec. 15. NEW SECTION. COMPLAINT SYSTEM. A health

maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner in consultation with the commissioner of public health and which shall provide for the resolution of written complaints initiated by enrollees concerning health care services. A health maintenance organization shall submit to the commissioner and to the commissioner of public health an annual report in a form prescribed by the commissioner in consultation with the commissioner of public health, which shall include:

1. A description of the procedures of the complaint system.

2. The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed.

3. The number, amount and disposition of malpractice claims settled during the year by the health maintenance organization and any of its providers.

The health maintenance organization shall maintain statistical information of written complaints filed with it concerning benefits over which the health maintenance organization does not have control and shall submit to the commissioner a summary report at the time and in the format that the commissioner may require. Complaints involving other persons shall be referred to those persons and a copy of the complaint sent to the commissioner.

Sec. 16. NEW SECTION. INVESTMENTS. With the exception of investments made in accordance with section seven (7) of this Act, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by section five hundred eleven point eight (511.8) of the Code for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit. For purposes of this section, investable funds of a health maintenance organization are all moneys held in trust for

the purpose of fulfilling the obligations incurred by a health maintenance organization in providing health care services to enrollees.

Sec. 17. NEW SECTION. PROTECTION AGAINST INSOLVENCY. A health maintenance organization shall furnish a surety bond in an amount satisfactory to the commissioner, or deposit with the commissioner cash or securities acceptable to him in at least the same amount, as a guarantee that its obligations to enrollees will be performed. The commissioner may waive this requirement when satisfied that the assets of the organization or its contracts with other organizations are sufficient to reasonably assure the performance of its obligations.

Sec. 18. NEW SECTION. CANCELLATION OF ENROLLEES. An enrollee shall not be cancelled except for the failure to pay the charges permitted under section eleven (11) of this Act or for other reasons stated in the rules promulgated by the commissioner and subject to review in accordance with chapter seventeen A (17A) of the Code. No notice of cancellation to an enrollee shall be effective unless delivered to the enrollee by the health maintenance organization in a manner prescribed by the commissioner and at least thirty days before the effective date of cancellation and unless accompanied by a statement of reason for cancellation. At any time before cancellation of the policy for nonpayment, the enrollee may pay to the health maintenance organization the full amount due, including court costs if any, and from the date of payment by the enrollee or the collection of the judgment, coverage shall revive and be in full force and effect.

Sec. 19. NEW SECTION. FALSE REPRESENTATION. A health maintenance organization, unless licensed as an insurer, shall not use in its name, contracts, or literature any words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

No health maintenance organization or any person on its behalf shall advertise or merchandise its services in a manner to misrepresent its services or capacity for service, nor shall it engage in misleading, deceptive or unfair practices with respect to advertising or merchandising. This section does not exempt health maintenance organizations which are engaged in the business of insurance from regulation under the provisions of chapter five hundred seven B (507B) of the Code.

Sec. 20. NEW SECTION. REGULATION OF AGENTS. The commissioner may, after notice and hearing, promulgate such reasonable rules under the provisions of chapter five hundred twenty-two (522) of the Code that are necessary to provide for the licensing of agents who engage in solicitation or enrollment for a health maintenance organization.

Sec. 21. NEW SECTION. POWERS OF INSURERS AND HOSPITAL AND MEDICAL SERVICE CORPORATIONS. An insurance company authorized to engage in insuring individuals or groups for the cost of health care in this state or a corporation authorized under chapter five hundred fourteen (514) of the Code may either directly or through a subsidiary or affiliate do one or more of the following:

1. Organize and operate a health maintenance organization under the provisions of this Act.

2. Contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through the health maintenance organization.

3. Contract with a health maintenance organization to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

Any two or more insurance companies, corporations, or their subsidiaries or affiliates may jointly organize and operate a health maintenance organization.

Sec. 22. NEW SECTION. PUBLIC EMPLOYEES INCLUDED. Any employee of the state, political subdivision of the state, or of any institution supported in whole or in part by public

funds may authorize the deduction from his salary or wages of the amount charged to him for any health care services provided through health maintenance organizations under this Act in the manner provided in section five hundred fourteen point sixteen (514.16) of the Code.

Sec. 23. NEW SECTION. FEES. Every health maintenance organization subject to this Act shall pay to the commissioner the following fees:

1. For filing an application for a certificate of authority or an amendment to the certificate, one hundred dollars.

2. For filing each annual report, twenty-five dollars.

Fees charged under this section shall be remitted to the treasurer of state and credited by him to the general fund.

Sec. 24. NEW SECTION. RULES. The commissioner and the commissioner of public health may promulgate rules as are necessary to carry out the provisions of this Act, subject to review in accordance with chapter seventeen A (17A) of the Code.

Sec. 25. NEW SECTION. EXAMINATIONS PERMITTED. The commissioner shall make an examination of the affairs of any health maintenance organization and its providers as often as he deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years.

The commissioner of public health shall make an examination concerning the quality of health care services provided through any health maintenance organization as often as he deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years.

Every health maintenance organization and provider shall submit its books and records to the commissioner and the commissioner of public health and in every way facilitate the examination. For the purpose of examinations, the commissioners may administer oaths to and examine the officers

and agents of the health maintenance organization and the principals of its providers concerning their business. The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner or commissioner of public health as the case may be.

In lieu of the examination required by this section, either commissioner may accept the report of an examination made by the appropriate departments in other states.

Sec. 26. NEW SECTION. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY. The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this Act if he finds that the health maintenance organization is operating in contravention of its proposed plan of operation on the basis of which a certificate of authority was issued to it or has failed to comply with the provisions of and rules promulgated under this Act. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of suspension, enroll any additional enrollees except newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation or merchandising for the health maintenance organization. When the certificate of authority of a health maintenance organization is revoked, the health maintenance organization shall, immediately following the effective date of the order of revocation, conduct no further business except as may be essential to the orderly conclusion of its affairs and shall engage in no further advertising or solicitation or merchandising. The commissioner may in writing permit continued operation of the organization as he finds 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.

The commissioner may, in lieu of suspension or revocation

of a certificate of authority, levy an administrative penalty in an amount not more than five thousand 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 may increase 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.

Sec. 27. NEW SECTION. ADMINISTRATIVE PROCEDURES. When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, he shall notify the health maintenance organization in writing of the particular grounds for denial, suspension, or revocation and shall issue a notice of a time fixed for a hearing, which shall be held not less than ten days after the receipt by the health maintenance organization of the notice. The commissioner of public health or his designee shall participate in the proceedings of the hearing and his recommendation and findings with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority, or in connection with an order to the health maintenance organization by the commissioner to cease from methods or practices in violation of this Act, shall be conclusive and binding upon the commissioner.

At the time and place fixed for a hearing, the person charged shall have an opportunity to be heard and to show cause why the order should not be made by the commissioner. Upon good cause shown, the commissioner may permit any person to intervene, appear and be heard at the hearing by counsel or in person. Nothing contained in this Act shall require the observance at any hearing of formal rules of pleading or evidence. The provisions of section five hundred seven B point six (507B.6), subsections four (4) and five (5) of

the Code relating to the powers and duties of the commissioner in relation to the hearing and relating to the rights and obligations of persons upon whom the commissioner has served notice shall apply to this Act.

After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as he deems advisable and which is permitted by him under the provisions of this Act and shall reduce his findings to writing. Copies of the written findings shall be mailed to the health maintenance organization charged with violation of this Act and to the commissioner of public health.

Sec. 28. NEW SECTION. JUDICIAL REVIEW. The action of the commissioner and the recommendation and findings of the commissioner of public health under section twenty-seven (27) of this Act shall be subject to review by the district court of Polk county according to the proceedings set out under the provisions of section five hundred seven B point eight (507B.8) of the Code. Until the expiration of the ten days allowed for filing a petition for review, if no petition has been filed, or if a petition for review has been filed within that time, then until the transcript of the record in the proceeding has been filed in the district court as provided in section five hundred seven B point eight (507B.8) of the Code, the commissioner may at any time, upon notice, modify or set aside in whole or in part any order issued by him under section twenty-seven (27) of this Act. After the expiration of the ten days allowed for filing a petition for review and if no petition has been filed, the commissioner may at any time, after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under section twenty-seven (27) of this Act, when in his opinion conditions of fact or of law require the action, or if the public interest shall so require.

Sec. 29. NEW SECTION. INJUNCTION. The commissioner

may, in the manner provided by law, maintain an action in the name of the state for injunction or other process against the person violating any provision of this Act.

Sec. 30. NEW SECTION. PENALTIES. Where no other penalty is provided for in this Act, any person who violates any of the provisions of this Act shall be guilty of a misdemeanor and upon conviction shall be punished by a fine not to exceed one hundred dollars or by imprisonment for a period not to exceed thirty days or be punished by both such fine and imprisonment.

Sec. 31. NEW SECTION. CONFIDENTIALITY OF MEDICAL INFORMATION. Any data or information pertaining to the diagnosis, treatment, or health of an individual enrollee or applicant obtained by a health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purpose of this Act, or upon the express consent of the enrollee or applicant, or pursuant to statute or court order for the production or discovery of evidence, or in the event of a claim or litigation between the enrollee or applicant and the health maintenance organization, when the information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure of medical information which the provider who furnished the information to the health maintenance organization is entitled to claim.

Sec. 32. NEW SECTION. TAXATION. Payments received by a health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this Act and payments by a health maintenance organization to providers for health care services, to insurers, or corporations authorized under chapter five hundred fourteen (514) of the Code for insurance, indemnity, or other service benefits authorized under this Act are not

premiums received and taxable under the provisions of section four hundred thirty-two point one (432.1) of the Code.

Sec. 33. NEW SECTION. CONSTRUCTION.

1. Except as otherwise provided in this Act, laws regulating the insurance business in this state and the operations of corporations authorized under chapter five hundred fourteen (514) of the Code shall not be applicable to any health maintenance organization granted a certificate of authority under this Act with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives shall not be construed to violate any provision of law prohibiting solicitation or advertising by health professionals.

3. Any health maintenance organization authorized under this Act is not practicing medicine and shall not be subject to the limitations provided in section one hundred thirty-five B point twenty-six (135B.26) of the Code on types of contracts entered into between doctors and hospitals.

Sec. 34. Section two hundred forty-nine A point four (249A.4), subsection four (4), Code 1973, is amended to read as follows:

4. Have authority to contract with any corporation ~~or corporations,~~ authorized to engage in this state in insuring groups or individuals for all or part of the cost of medical, hospital, or other health care or with any corporation ~~or corporations~~ maintaining and operating a medical, hospital, or health service prepayment plan ~~or plans~~ under the provisions of chapter 514 or with any health maintenance organization authorized to operate in this state, for any or all of the benefits to which any recipients are entitled under this chapter to be provided by such corporation ~~or corporations~~ or health maintenance organization on a prepaid individual

or group basis.

Sec. 35. Section five hundred nine A point six (509A.6), Code 1973, is amended to read as follows:

509A.6 CONTRACT WITH INSURANCE CARRIER. The governing body may contract with a nonprofit corporation operating under the provisions of this chapter or chapter 514 or with any insurance company having a certificate of authority to transact an insurance business in this state with respect of a group insurance plan, which may include life, accident, health, hospitalization and disability insurance during period of active service of such employees, with the right of any employee to continue such life insurance in force after termination of active service at such employee's sole expense; ~~and~~ may contract with a nonprofit corporation operating under and governed by the provisions of this chapter or chapter 514 with respect of any hospital or medical service plan; and may contract with a health maintenance organization authorized to operate in this state with respect to health maintenance organization activities.

Sec. 36. EFFECTIVE DATE. The provisions of this Act shall become effective January 1, 1974.

EXPLANATION

Under this bill, any person may apply for and obtain a certificate of authority from the Commissioner of Insurance to establish and operate a health maintenance organization in compliance with the provisions of the bill. The health maintenance organization must, at a minimum, be able to provide or arrange for the provision of medical services and hospital care for a fixed prepaid sum which is unaffected by the actual amount or type of services which the individual actually receives. Other health care services which may be provided by a health maintenance organization either on a prepaid basis or through the payment of indemnity or service benefits include "all services for the purpose of preventing, alleviating, curing, or healing human illness or injury."

The flexibility provided in the bill to health maintenance organizations in piecing together the package of coverage through direct and indirect services and indemnity benefits is meant to enable health maintenance organizations to meet health care needs in a wide variety of circumstances and through various organizational structures.

The latitude given in the bill to the Commissioner of Insurance in regulating the establishment and operation of health maintenance organizations corresponds to the goal of the bill. In determining to what extent fiscal reserves should be required of a health maintenance organization, the Commissioner may consider among other criteria: the number of enrollees to be served; the restrictions on indemnity benefits to be offered by the health maintenance organization; the contracts entered into between the health maintenance organization and insurance companies or health service prepayment corporations for indemnity against the cost of services not available through a health maintenance organization.

Key sections of the bill override existing legal barriers to the formation and development of health maintenance organizations, including:

1. The law requiring incorporation under Chapter 514 of the Code which is in itself restrictive.

2. Insurance laws which are inappropriate to the preventative aspect of health maintenance.

3. Laws which prohibit solicitation or advertising by health professionals.

4. The legal doctrine that a lay-controlled corporation providing health care services to the public through physicians employed by it is engaging in the practice of medicine without a license to do so.

The bill provides for regulation of agents who engage in solicitation of enrollees for health maintenance organizations, requires that the Commissioner of Public Health make

all determinations with regard to quality of care review, and provides that insurance companies and health service prepayment corporations are exempt from existing laws only with respect to their health maintenance organization activities authorized under the bill.

The bill also authorizes the Commissioner of Social Services to contract with health maintenance organizations for the provision of health care services to Medicaid recipients.