



Joint Interim Study Committee on Health Care Quality

FINAL REPORT

November 30, 1996

MEMBERS

Representative Sue Grace, Co-chairman
Constance Harmsen
Dr. Robert J. Dunn
Representative Susan Gerard
Representative Herschella Horton
Greg Harris
Henry Grosjean
Mary Yarbrough
Barbara Sutton
Representative Paul Mortensen
Steve Barclay
John Nimsky
Dr. Barbara Aung

Senator John Kaites, Co-chairman
Representative Andy Nichols
Senator Mary Hartley
Anne McNamara
Dr. Arlan Fuhr
Sandra Abalos
Dr. John Cruickshank
Senator Ann Day
Senator David Petersen
Senator Sandra Kennedy
Mary Leader
Barbara Keilberg
Marci Hendrickson

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I. AUTHORITY AND SCOPE OF DUTIES

The Joint Interim Study Committee on Health Care Quality was created by the cooperative efforts of both the Speaker of the Arizona House of Representatives Mark Killian, and the Arizona Senate President John Green. The Committee was charged with studying the following areas:

1. The establishment of consistent quality measurement standards, licensing requirements and solvency requirements for providers, including health care services organizations, hospitals, physician hospital organizations, provider service networks, preferred provider organizations, and provider service organizations;
2. The availability, affordability and quality of small group health insurance;
3. Direct patient access to licensed health care specialties;
4. Provider credentialing, contracting, and termination issues;
5. Point of service options;
6. Provider access to managed care networks;
7. Cost implications for patients and employers, and;
8. H.R. 3103, The Health Insurance Portability and Accountability Act of 1996.

In an effort to ease the administrative burden of running a committee comprised of twenty-six members, the committee chose to divide itself up in the following manner:

Subcommittee #1

“establishment of consistent quality measurement standards, licensing requirements and solvency requirements”

(H.R. 3103, The Health Insurance Portability and Accountability Act of 1996)

Subcommittee Chair:

Mr. Henry Grosjean

Members:

Ms. Constance Harmsen
Dr. Robert J. Dunn
Representative Susan Gerard
Representative Herschella Horton
Mr. Greg Harris
Mr. Henry Grosjean
Ms. Mary Yarbrough
Ms. Barbara Sutton, CLU, ChFC

Staff: Kitty Boots

Subcommittee #2

“direct patient access and point of service options”

Subcommittee Chair:

Dr. Anne McNamara

Members:

Representative Paul Mortensen
Mr. Steve Barclay
Representative Sue Grace
Representative Andy Nichols
Senator Mary Hartley
Dr. Anne McNamara
Dr. Arlan Fuhr
Ms. Sandra A. Abalos

Staff: Jim Drake

Subcommittee #3

“provider credentialing, contracting and termination and provider access to managed care networks”

Subcommittee Chair:

Dr. John M. Cruickshank, D.O.

Members:

Dr. John M. Cruickshank, D.O.

Representative Sue Grace
Senator Ann Day
Senator David Petersen
Senator Sandra Kennedy
Ms. Mary Leader (later replaced by Mr. Brian McNeil)
Mr. John Nimsy
Ms. Barbara Keilberg
Ms. Barbara Aung, D.P.M.
Ms. Marci L. Hendrickson

Staff: Lisa Block

II. COMMITTEE ACTIVITY

The Joint Interim Study Committee on Health Care Quality met as a full committee on September 11, 1996 and November 12, 1996. Subcommittee #1 held hearings on September 17, 1996 and October 1, 1996. Subcommittee #2 and Subcommittee #3 held hearings on September 17, 1996, October 1, 1996, October 15, 1996 and October 29, 1996.

III. SUBCOMMITTEE REPORTS

Subcommittee #2 elected to draft a written report on its activity, while Subcommittees #1 and #3 chose to make oral presentations in the November 12, 1996 hearing (see Committee Minutes). The report from Subcommittee #2 is included below in its entirety.

Report from Subcommittee #2 (authored by: Dr. Anne McNamara)

Overview:

The Joint Interim Study Committee on Health Care Quality was established in response to a Strike-Everything Amendment to HB 2228 made in the House Banking and Insurance Committee on February 13, 1996. The purpose of the legislative study committee was to evaluate and make recommendations concerning the quality of health care.

Based on the extensive charge of the Committee and the large number of Members assigned to the committee, three subcommittees were formed. The charge to Subcommittee 2 was *"to study 'direct patient access' and 'point of service options' in terms of their impact on availability, affordability, and quality of small group health insurance as well as cost implications for patients and employers.*

Membership:

Subcommittee 2 consisted of eight members:

Sandra A. Abalos, CPA, Abalos & Associates (representing small business)
Steve Barclay, AZ Association of Health Maintenance Organizations
Arlan Fuhr, DC (representing AZ Association of Chiropractic)
Representative Sue Grace
Senator Mary Hartley
Representative Paul Mortensen
Representative Andy Nichols
Anne McNamara, RN, Ph.D, Chair. (representing AZ Nurses' Association)

Process:

Subcommittee 2 met four times to address issues charged to the group. Due to varying

views and opinions of the Subcommittee members, the following report represents the findings of the Subcommittee for which there was general agreement. The study process used included: review of prior health insurance legislation (1990-1996), statutory language from other states, literature review of relevant studies, public testimony, and committee discussion. The first consensus point was on definitions of “direct access” and “point of service”.

Direct Access: means a system in which enrollees or members in a managed care company can refer themselves directly and without penalty to a specialist within the managed care company’s designated provider network without having to be referred by the enrollee’s or member’s primary care provider.

Point-of-Service: means a delivery system or contact option that permits a member or enrollee of a managed care company to receive health care services outside the designated provider network of the managed care company under the terms and conditions of the member’s or enrollee’s contract with the managed care company, with higher co-insurance payments and deductibles associated with the point-of-service option typically borne by the enrollee or member.

The purpose of the agreed-upon definitions was for a point of reference by the Subcommittee during deliberations and discussion. The meaning of the term “specialist” in the direct access definition was identified as a potential obstacle for the group to complete its charge and therefore, the group moved beyond this stumbling block to the bigger issues of consumer access.

Subcommittee members were encouraged to submit materials for critical review and analysis to the committee. In addition, members were encouraged to invite experts to share information with the committee. Many experts presented to the group, they included; the CEO from United Health Care, the Medical Director from Samaritan/Health Partners, the Executive Director from the AZ Pharmacy Association, a Chiropractic Physician, the Chairman of the AZ Nurse Practitioner Council, a patient and Medicare beneficiary, and a Physical Therapist.

Frequently, the testimony received by the subcommittee appeared to be in conflict with regard to the accessibility to certain specialists, namely chiropractic care providers. Conflict in testimony was also heard with regard to the cost of specialty care. However, it was generally agreed that managed care companies appear to be increasingly open to offering their members a wider variety of health care options. These increased options are driven by competition in the health care marketplace. Several members of the Subcommittee believe that while changes are occurring, it is arriving at a pace that is far

too slow.

After researching statutes from other states, it was generally recognized by members of the Subcommittee that solutions implemented in other states will not always provide solutions to the problems facing Arizonans. Arizona is unique in terms of the number of enrollees and members in managed care companies as well as the layout of Arizona's statutory scheme.

Current Models:

Health Care Services Organizations, frequently called HMOs, represent one of a variety of models providing health care to individuals and businesses in Arizona. Most models use the medical doctor/doctor of osteopathy (MD/DO) as the "gatekeeper" or "coordinator of care" for persons enrolled in health plans. Consumer demand has initiated changes in "direct access" opportunities for consumers. Therefore, some new HMO products are allowing consumers to make direct appointments with certain pre-determined MD/DOs without the prior approval of the primary care provider. A report prepared by the American Association of Health Plans, revealed twenty-one states have some form of direct access availability. This report brought to light the fact that thirteen states currently have direct access to OB/GYN, two to Chiropractic, one to Podiatry, one to Optometry/Ophthalmology, one to Dermatology, and one to registered nurse practitioners (nurse midwives/nurse anesthetist, nurse practitioners). Although most direct access options are offered on a limited basis in HMO models, these options are available to consumers. At this time, few HMOs are prepared to completely abandon the traditional MD/DO gatekeeper model.

Point-of-service options are offered by most of the HMOs in Arizona, as well as by other types of managed care entities such as PPOs. These options are available to virtually all employers, typically with an increased premium to cover the anticipated higher out of network costs.

The reality of Medical Savings Accounts (MSA) was discussed with passage of the *Health Insurance Portability and Accountability Act* (Kennedy/Kassebaum bill). The Subcommittee reviewed a chart that outlined existing state laws applicable to 1) accountable health plans, 2) individual health insurance in Arizona, and 3) definitions and key terms in the federal law (Kennedy/Kassebaum). MSAs will provide employers and employees the most liberal option related to choice of providers and direct access to specialists. Arizona will need to be prepared for compliance with the federal law by January 1, 1997.

Recommendations:

- Submit this report to the full Committee for discussion and deliberation
- Encourage “MD/DO gatekeepers/coordinators of care” to be true integrators of care. Gatekeeper models may limit, rather than truly integrate patient care. Gatekeepers may be financially penalized for referrals to specialists. Those that may experience the trauma related to delayed decision-making are often patients/families.
- Encourage integration of other health care professionals (non MD/DO) in the delivery of health care within managed care associations. A growing number of studies suggest that other health care professionals may provide cost effective, quality care to their patients. Attached are examples of studies that the Subcommittee reviewed. We recognize that this is not an exhaustive list and that many studies were not made available to the subcommittee and subsequently not analyzed.
- Continue to strengthen options for small business owners to access quality, cost effective health insurance that is affordable.
- Integrate the concept of “Medical Savings Accounts” in Arizona to assure compliance with federal mandates. We recognize that MSAs have the potential to increase consumer/member participation in health care decision making.
- Encourage the full Committee to recognize that Arizona has an opportunity to create state specific laws that assure compliance with the Kennedy/Kassebaum bill. Request a presentation to the full Committee from the AZ Department of Insurance regarding any needed changes to current law.
- Encourage communication mechanisms for employers and employees to make their desires and needs known to managed care associations in regard to services and benefits.
- Encourage further development of long-term products.

Summary:

Subcommittee 2 submits this report to the full Committee recognizing the time constraints and limitations of the members involved. We recognize the importance of these topics to the health and well-being of Arizonans. The philosophy of managed care as the predominant health benefit payment system is admirable. The goals of cost containment, patient satisfaction, and quality outcomes are consistent with the charge given to this Subcommittee. We recognize that the health care marketplace is dynamic and must be responsive to consumer/provider demands. This report recognizes that contributions can be made by other health care providers (non MD/DO) in the delivery of health care and suggest that such providers may enhance the economic and quality goals of managed care associations.

Members of the Subcommittee would like to stress the importance of employers educating their employees with regard to health care options, the importance of long-term care, and the increased use of "Medical Savings Accounts" for individuals truly seeking unfettered choice. In addition, consumers of health care must recognize that managed care organizations can respond to the desires of their enrollees only when those desires are effectively communicated to the managed care organization.

IV. COMMITTEE RECOMMENDATIONS

On November 12, 1996, the Joint Interim Study Committee on Health Care Quality recommended that legislation be drafted to ensure Arizona's statutory alignment with the provisions of the Health Insurance Portability and Accountabilty Act of 1996.

V. COMMITTEE MINUTES

Handouts and other distributed materials cited in the committee minutes are on file in the Office of the Chief Clerk.

ARIZONA STATE LEGISLATURE
JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY

Minutes of the Meeting

Wednesday, September 11, 1996
2:00 p.m., Senate Hearing Room 1

Members Present

Ms. Abalos
Dr. Aung
Mr. Barclay
Dr. Fuhr
Mr. Grosjean
Ms. Harmsen
Mr. Harris
Ms. Keilberg
Mr. Landrith for Dr. Dunn
Ms. McNamara
Ms. Sutton
Representative Mortensen
Representative Grace, Co-Chair
Senator Kaites, Co-Chair

Members Absent

Dr. Cruickshank
Dr. Dunn
Ms. Hendrickson
Ms. Leader
Mr. Nimsky
Ms. Yarbrough
Senator Day
Senator Hartley
Senator Kennedy
Senator Petersen
Representative Gerard
Representative Horton
Representative Nichols

Staff

Ellen Poole, Research Analyst, Senate Banking and Insurance Committee - 542-3171
Lisa Block, Research Analyst, House Health Committee - 542-1989
Jim Drake, Research Analyst, House Banking and Insurance Committee - 542-3862

Co-Chairman Kaites convened the meeting at 2:05 p.m. and turned the meeting over to Co-chairman Grace. He introduced her as the party who will take the lead in directing the Committee.

Co-chairman Grace welcomed members and noted Committee recommendations are due at the end of November, 1996, necessitating that members meet every other Tuesday until that time. She acknowledged the Committee charge seems rather broad (filed with original minutes) but emphasized her wish to see the Committee as a place to focus on annually recurring concerns and the controversy that surrounds them.

Representative Grace indicated that members would be divided into three Subcommittees according to their expressed interests, as listed on a handout (filed with original minutes). She noted that each Subcommittee would deal with a separate aspect of the charge, as listed on another handout, (filed with original minutes) and requested that Subcommittee

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STUDY COMMITTEE ON
HEALTH CARE QUALITY

#1 additionally review the federal Kennedy-Kassebaum legislation to see if it requires conforming legislation on the state level and also noted that Senator Day will be visiting Subcommittee #1 to insure it does not duplicate legislation she is developing.

Representative Grace further requested that members try to look at concerns in a fresh perspective and not bring back old ideas for more mandates, as the sitting Legislature would not be sympathetic to this approach. Representative Grace encouraged members to develop fresh perspectives on how to better use existing resources without adding new costs.

Senator Kaites requested that the full Committee receive a briefing on the Kennedy-Kassebaum legislation to determine whether state statutes need to be brought into conformance. Representative Grace asked that Subcommittee #1 review the legislation and provide its recommendations on necessary conformities to the full Committee.

Representative Grace asked that members next break out into their designated Subcommittees to elect chairmen, reminding them to call upon legislative staff for assistance and information. She announced subsequent meetings will be held in House Hearing Room 3 as scheduled on a third handout (filed with original minutes) distributed to members.

Legislative staff, Ellen Poole, Jim Drake and Lisa Block, introduced themselves and related that Ms. Poole will be staffing Subcommittee #1, Mr. Drake will be staffing Subcommittee #2 and that Ms. Block will be staffing Subcommittee #3. They each invited members to contact them for assistance and Mr. Drake distributed a brief summary of health insurance legislation in Arizona from 1990 to 1996 (filed with original minutes).

Without objection, the meeting was adjourned at 2:25 p.m. and members grouped themselves in designated Subcommittees to elect chairmen.

Respectfully submitted,



Alice Kloppel
Committee Secretary

ARIZONA STATE LEGISLATURE
JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY

Minutes of the Meeting
Tuesday, November 12, 1996
1:00 p.m., Senate Hearing Room 1

MEMBERS PRESENT

Representative Grace, Co-chairman
Senator Kaites, Co-chairman
Senator Hartley
Senator Kennedy
Senator Petersen
Representative Gerard
Representative Horton
Representative Mortensen
Dr. Barbara Aung
Mr. Steve Barclay
Dr. Alan Fuhr
Mr. Henry GrosJean
Ms. Constance Harmsen
Mr. Greg Harris
Ms. Marci Hendrickson
Ms. Anne McNamara
Mr. Brian McNeil
Ms. Barbara Sutton

MEMBERS ABSENT

Senator Day
Representative Nichols
Ms. Sandra Abalos
Dr. John Cruickshank
Dr. Robert Dunn
Ms. Barbara Keilberg
Mr. John Nimsky
Ms. Mary Yarbrough

STAFF

Ms. Kitty Boots, Senate Analyst
Ms. Lisa Block, House Analyst
Mr. Jim Drake, House Analyst

Co-chairman Grace convened the meeting at 1:15 p.m. and the attendance was noted. She next called upon Subcommittee chairmen to report their recommendations to the full Committee.

Henry GrosJean, Chairman, Subcommittee #1, reported this Subcommittee discussed issues surrounding health care quality measures and noted that progress is being exhibited in this area with reporting requirements and performance measurements developed by the National Committee for Quality Assurance (NCQA). He indicated the Subcommittee has a wait-and-see position relative to these national measures as it is still in its infancy. Mr. GrosJean also related that Senator Day informed the Subcommittee of her proposed appeals legislation, that Arizona Health Care Cost Containment System (AHCCCS) representatives reported on its quality indicators program and that the medical director of the Health Services Advisory Group, currently known as the Quality Improvement Organization, explained its program to develop medical standards based on patient perception with the aim of creating a more personal approach to health care delivery.

Mr. GrosJean indicated Subcommittee #1 also heard testimony from the Department of Insurance (DOI) on the Kennedy/Kassebaum bill and that the Subcommittee recommends no legislative action be taken relative to its deliberations.

Anne McNamara, Ph.D., Chairman, Subcommittee #2, submitted a four-page report (filed with original minutes) in response to its charge to study direct patient access and point-of-service options in terms of affordability, availability, quality of small group health insurance and cost implications for patients and employers. She related the Subcommittee recommendations, which also require no specific legislation at this time: 1) submit Subcommittee report to full Committee, 2) encourage Medical Doctor/Doctor of Osteopathy (MD/DO) gatekeepers/coordinators of care to be true integrators of care, 3) encourage integration of other health care professionals (non MD/DO) in the delivery of health care within managed care associations, 4) continue to strengthen options for small business owners to access high quality, cost effective health insurance that is affordable, 5) integrate the concept of "Medical Savings Accounts" (MSAs) in Arizona to assure compliance with federal mandates, 6) encourage the full Committee to recognize that Arizona has an opportunity to create state-specific laws that assure compliance with the Kennedy/Kassebaum bill and request a presentation by DOI to the full Committee regarding such, 7) encourage communication mechanisms for employers and employees to make their desires and needs known to managed care associations in regard to services and benefits and 8) encourage further development of long-term care products.

Dr. McNamara also related the Subcommittee's wish to stress the importance of employers educating their employees with regard to health care options, the importance of long-term care options and the importance of increasing the use of MSAs for individuals truly seeking unfettered choice. In addition, she emphasized consumers of health care must recognize that managed care organizations can respond to the desires of their enrollees only when those desires are effectively communicated to the organization.

Dr. McNamara suggested that the concept of "integrator of care" is a good one, but it is often jeopardized, as gatekeepers may be financially penalized for making referrals to specialists. She emphasized not losing sight of incentives which may have a negative impact on patients and their families.

In response to Senator Kaites' request to be provided with examples of how such penalties are created in the system, Dr. McNamara referred to articles the Subcommittee reviewed which looked at capitation models which recognized that referrals are deducted from the primary care providers' full capitation.

Mr. Barclay clarified that some forms of compensation may create financial incentives or penalties to cause providers to think twice before making referrals to specialists. He

emphasized the Subcommittee did not intend to condemn the practice altogether, but to raise the issue that it needs to be watched.

In response to Senator Kaites' request to hear examples or see statistics of how this procedure drives down quality of care, Mr. Barclay responded he would provide some of the numerous studies which have been published. Mr. Barclay further acknowledged the studies are inconclusive and that most of them suggest there has not been a marked decrease in the quality of care.

Dr. Barbara Aung, substituting for the Chairman, Dr. John Cruickshank, Subcommittee #3, reported on credentialing and recredentialing, the licensure process, provider termination issues and provider impact on small business and employers. She reported that Subcommittee #3 recommends no legislation, but would like to impart information to managed care organizations regarding coordinating the credentialing process so as to avoid duplication and to reduce costs. Dr. Aung indicated information-sharing among organizations would limit the amount of work providers have to undertake to maintain credentialing and recredentialing. She also emphasized that sharing information should extend to providers, employers and that employees, patients employers should also be educated about regulations which managed care organizations expect providers to follow and about what is expected in terms of providing services under their contracts.

In response to Representative Grace's request for more information on the current credentialing process, Dr. Aung acknowledged the Subcommittee is encouraged that the process which formerly has seemed to be hidden is now sharing information more openly, especially through the Greater Arizona Centralized Credentialing Program. She indicated the Program is using set criteria based on NCQA guidelines for all providers in Arizona and is sharing this information with the managed care companies in the State.

In response to Representative Grace's inquiry about the credentialing turnaround time for the average practitioner, Dr. Aung indicated it is currently six months to one year and the Program now has a mandate of 90 to 120 days which is an improvement. Dr. Aung noted testimony revealed one hold-up in credentialing is trying to obtain past histories of practitioners going back 20 years or obtaining histories from another country or state.

Mr. Barclay acknowledged this centralized clearinghouse has received certification as a Centralized Verification Organization (CVO) and is a very encouraging improvement, noting that currently the primary source checks for practitioners are duplicated by every plan, consuming lots of time and requiring sources to provide information on one practitioner many times over.

Senator Kaites moved to accept the Subcommittee reports. Representative Horton seconded the motion. The motion CARRIED by a voice vote.

DEPARTMENT OF INSURANCE PRESENTATION

Greg Harris, Assistant Executive Director, DOI, distributed handouts (filed with original minutes) comparing key elements of the federal legislation, the Kennedy/Kassebaum bill, to existing Arizona laws applicable to accountable health plans, MSAs and long-term care insurance. He highlighted misconceptions about what the Kennedy/Kassebaum bill does and discussed provisions that the Arizona Legislature will need to consider under insurance laws and also noninsurance law issues which will need to be addressed.

Mr. Harris indicated the key piece of the federal legislation is one that addresses group coverage and the ability of individuals who have been in group coverage to convert to individual coverage. He noted that the Legislature will need to move legislation to comply with the federal mandate defining small groups as two to 50 lives, eliminate the current 90-day waiting period for groups to become eligible and change the current 12-month look-back period to six months.

Mr. Harris explained the federal law now allows employers to establish a two-month "affiliation period" before employees become eligible to enroll in a health maintenance organization (HMO). He further explained that federal legislation prohibits the consideration of pregnancy as a preexisting condition, requires no waiting period for preexisting conditions if the employee had been previously covered by a group plan for 12 months before changing employers with no more than a 63-day break in employment and allows an employee to carry waiting time forward if he changes employers.

Mr. Harris indicated there are no significant changes to Arizona's guaranteed renewability laws, continuing to provide for renewal except where there are violations such as fraud or deceit on an application. He related disclosure requirements will now be extended to indemnity plans as well as managed care plans under the federal legislation and this will need to be addressed by the Legislature.

Mr. Harris explained the federal legislation requires that if an insurer wants to exit a particular segment of the market, it must stay out of the market for five years. He noted there is no federal requirement for tie-in between participation in small, large or individual markets as there is currently in Arizona law. In regard to the insurer's inability to serve a specific market, it would need to withdraw from this segment only for 180 days and would not need to withdraw from the insurance market altogether.

Mr. Harris indicated that federal legislation requires all individual coverage be guaranteed renewable. In regard to converting from group to individual coverage, he explained the federal legislation provides this option once a person has exhausted any COBRA (Congressional Omnibus Reconciliation Act) benefits available to him and can prove he is not eligible for Medicaid or Medicare.

Mr. Harris explained federal long-term care provisions and viatical settlement provisions use tax incentives as a way to encourage people to purchase products in a certain direction. He also explained the federal MSA legislation creates a pilot project with a nationwide cap of 750,000 participants. Mr. Harris indicated these will be administered by the Department of Revenue in Arizona and the Federal Treasury will provide oversight to insure the caps are maintained. He explained that the primary result of federal legislation on long-term care policies is that benefits paid out will not be taxable income. He also noted there will be no changes necessary in Arizona law in response to this provision. Mr. Harris explained that federal legislation relating to viatical settlements mandates that any cash-out of a policy used to pay for the costs of a catastrophic or life-ending illness are tax exempt. He also indicated there is no need to change Arizona laws to comply with the federal legislation in regard to viatical settlements.

In response to Representative Gerard's inquiry about federal mandates regarding mental health parity, Mr. Harris explained that H.R. 3666, signed a couple of weeks after the Kennedy/Kassebaum bill, does not require that a health plan include a mental health benefit, establishing that if the cost to include a mental health benefit exceeds a one percent increase in premium cost, the insurer is not required to include that benefit. He confirmed Representative Gerard's understanding there is no mental health parity included in the federal legislation.

Mr. Harris clarified that the Kennedy/Kassebaum bill and H.R. 3666 address not only state insurance plans but also ERISA (Employment Retirement Income Security Act) plans. He explained the U.S. Department of Labor will continue to insure compliance of ERISA plans with federal law, whereas DOI will continue in this role for the State. Mr. Harris clarified that legislation or another mechanism will need to be adopted to affirm that DOI has the specific regulatory authority in this area.

In response to Senator Petersen's inquiry about how the federal preexisting conditions provisions affect congenital birth defects, Mr. Harris explained that if a child is covered under an existing plan for the condition at birth and before moving to a new policy, the federal legislation would not allow a preexisting condition exclusion if the family moves to a new plan.

In response to Senator Petersen's inquiry about simple interest on long-term care benefits, Mr. Harris explained he could not answer the question specifically today, but indicated the

federal legislation addresses this area on a per diem or lump sum basis which may have some bearing on the issue. In regard to income thresholds in long-term care, Mr. Harris explained the federal legislation establishes a mechanism that would allow a person to choose between a lump sum or per diem payout of benefits with variable tax consequences.

Representative Grace inquired about the relationship between health conditions which may affect pregnancy and federal preexisting conditions provisions. Mr. Harris explained that pregnancy, which cannot be treated as a preexisting condition, would be taken out of consideration, the ancillary condition would be treated separately and it would be determined by further inquiry whether the ancillary condition was pregnancy-related or preexisting.

In response to Dr. McNamara's concern about self-employed people with potential health issues being denied coverage, Mr. Harris confirmed the Kennedy/Kassebaum bill does not address eligibility, but emphasized that Health Care Group, already in existence, provides programs for self-employed groups from one to 40 with no preexisting condition exclusion, but with a limitation on benefits for preexisting conditions.

Dr. McNamara also inquired about protection for the individual when an insurance company decides not to renew and Mr. Harris explained this issue is left, in part, for the states to address. He further explained that under S.B. 1109, passed in 1993, if an insurer wants to pull out of a line of business or rid itself of a particular group, the consequences are high; it must be out of the market for a long while and a six-month notice must be given to customers.

Mr. Barclay added that the Kennedy/Kassebaum bill will also apply to the public plans, such as Health Care Group. In response to his request to know if the State needs to do anything to comply with federal MSA provisions, Mr. Harris explained this needs more study but noted the Department of Revenue is the agency through which MSA companies must register and that DOI has not thoroughly studied the issue.

Mr. Barclay noted the federal legislation makes it possible for federally qualified HMOs to participate in the high deductible coverages that would overlay the MSAs and suggested there may be a need for a change to the state HMO laws to allow this flexibility. Senator Kaites acknowledged the need to address this issue in a separate piece of legislation affecting Title 42 rather than Title 20.

Mr. Barclay likened an MSA to a financial product such as an Individual Retirement Account, but asserted since the high deductible coverage is the piece that needs to be reworked, this would require a Title 20 change as well. He acknowledged the entire issue may require two pieces of legislation.

Representative Grace related that Senator Day has opened a bill file to address issues relating to health care quality and agreed it is appropriate that a bill be moved in the next session.

Mr. Barclay commented there will be a rush to participate in the MSA pilot project which has an effective date of January 1, 1997 and that his Subcommittee suggests any legislation affecting this should be fast-tracked, while legislation affecting other Kennedy/Kassebaum compliance issues can wait a little longer.

Senator Kaites moved the Committee recommend legislation be drafted to deal with the main issues relating to Medical Savings Accounts as well as the general issues outlined by the Department of Insurance relating to implementation of the federal Kennedy/Kassebaum bill. Representative Mortensen seconded the motion. The motion CARRIED by a voice vote.

Senator Kaites instructed staff to coordinate with Senator Day, who is already working on related legislation, and asked staff to distribute all draft legislation to Committee members as it is developed.

Representative Grace announced there would be no more meetings scheduled and adjourned at 2:15 p.m.

Respectfully submitted,

Alice Kloppel,
Committee Secretary

(Tapes and attachments on file in the Office of the Senate Secretary)

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JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY

MINUTES OF
SUBCOMMITTEE #1 OF THE
STUDY COMMITTEE ON HEALTH CARE QUALITY

DATE: Tuesday, September 17, 1996

TIME: 10:00 a.m. - noon

PLACE: House Hearing Room #3

Members Present:

Dr. Robert Dunn
Ms. Constance Harmsen
Mr. Greg Harris
Ms. Mary Leader
Ms. Barbara Sutton
Representative Herschella Horton
Mr. Henry Grosjean, Chairman

Members Absent:

Ms. Mary Yarbrough
Representative Susan Gerard

Senate Staff:

Ellen Poole

House Staff:

Mark Bogart
Jim Drake

Chairman Grosjean called the meeting to order at 10:10 a.m. and explained the meeting agenda calls for discussion of the federal Kennedy-Kassebaum Bill and the current status of the establishment of quality measurement standards, licensing requirements, and solvency requirements.

Ms. Poole stated the Arizona Health Care Cost Containment System (AHCCCS) is presently reviewing the Kennedy-Kassebaum Bill and will be preparing an analysis and recommendations. She added the Department of Insurance (DOI) is conducting a similar review. Ms. Poole explained she was unable to get in touch with AHCCCS personnel to make a presentation to the subcommittee today, but hopes to do so by the next meeting.

Mr. Harris explained DOI has not completed its review of the Kennedy-Kassebaum Bill and would prefer to wait for that information before giving a formal presentation.

Chairman Grosjean opened the discussion to the quality of health care and what "quality" means in terms of hospitals and providers.

Ms. Harmsen referred to the following handouts (filed with original minutes) relating to hospitals and their definition of quality:

- *Quality Indicator Project - Maryland Hospital Association (MHA)*
In 1985 Maryland was the initial group to make the effort to provide indicators for quality and most states look to Maryland when trying to develop effective indicators.
- *Exhibit 2 - Acute Care Nursing Quality Indicators*
Examples of quality nursing that the American Nursing Association (ANA) is attempting to establish in all of the states. Arizona received a grant and a number of the acute care facilities in the state will be participating in the ANA project over the next three years.
- *Samaritan Health System Clinical Quality Indicators Results by Facility*
Example of the indicators for the Samaritan facilities which is presented to the board on a quarterly basis.
- *Samaritan Health System - Definitions For All Performance Indicators*
Gives an idea of the challenge in gathering data to insure an accurate indicator is obtained.
- *Samaritan Health System Quality Plan*
Example of definitions of quality and how hospitals are viewing quality.
- *HEDIS 2.0: Executive Summary*
(Health Plan Employer Data and Information Set) Source used by managed care plans and out-patient settings in demonstrating quality indicators.

Chairman Grosjean stated he understood there is a new HEDIS 3.0 version. Ms. Harmsen indicated she did not know and was not an expert in the area.

In responding to Chairman Grosjean, Ms. Harmsen indicated Maryland's information is public, however, individual states make their own decisions to publicize information. She added it was her understanding that Arizona's is not public.

Ms. Harmsen indicated there were two journals published this year rating Health Maintenance Organizations (HMOs) using the HEDIS information.

Representative Horton, a registered nurse for many years, stated quality means different things to different people, is very difficult to measure, and needs to be defined as far as balancing quality with cost. In response to Chairman Grosjean, she stated she did not think the Legislature has any preconceived notions regarding this issue.

Dr. Dunn stated he has a fee-for-service practice in Mesa, and also contracts with 32 HMO/PPO's. He apologized for not attending the first meeting and questioned if the subcommittee is concerned only with quality of managed care as opposed to physicians, hospitals, managed care insurance companies, etc. He stated he has

experience in quality review and pointed out that some hospitals take care of more critically ill people and therefore have a higher instance of mortality.

Ms. Sutton stated quality of care is a big issue and carriers and consumers define it differently. She noted as more people are moving to a managed care environment, they are concerned about their accessibility to a physician they prefer and most managed care companies have accommodated those concerns to some extent. She added she also serves on the HMO task force which is attempting to address complaint procedures. Other problems she identified are the inability to obtain health care and the ability to retain health benefits at an affordable cost when a person leaves their employment.

Ms. Sutton suggested the subcommittee look closely at outpatient studies in terms of establishing standards and conceded it was a tremendous challenge for one committee.

Mr. Harris stated DOI receives complaints addressing the quality issue, both with respect to managed care plans and indemnity plans. He stated the issue prompting the establishment of the task force was whether there needs to be a mechanism within state government, and if so, where should it be located.

Mr. Harris noted under current law DOI has the responsibility for the solvency of insurance companies and for managed care organizations like HMOs. He suggested the subcommittee should determine whether there is a need for new legislation, or if the legislation in place is sufficient, and proceed from there. He emphasized it is important not to lose sight of the distinction in the way people receive their health care (i.e. indemnity versus managed care).

In response to Ms. Sutton, Mr. Harris stated the number of complaints against HMOs as opposed to fee-for-service providers is probably comparable, but the public perceives HMOs as having more complaints.

Dr. Dunn stated a problem he encounters is that patients do not understand what is offered in plan brochures and would suggest a program to educate the consumer. Ms. Sutton stated that should be the responsibility of insurance agents or consultants and employers should provide employee informational meetings. She added the mechanism is in place, but perhaps is not being followed, and ultimately it is the employee's personal responsibility to study the options available.

Chairman Grosjean suggested insurance provider brochures should be more consumer friendly.

Dr. Dunn stated that problems also arise when a patient chooses an HMO and then finds out that a particular treatment is not a covered expense (i.e. transplants).

Representative Horton stated people cannot predict future medical needs, and they do not expect to be "dumped" when a catastrophic illness arises after paying premiums for many years.

In response to Ms. Sutton, Dr. Dunn stated the Medical Association does not set out protocols. Ms. Harmsen indicated some professional associations do have protocols that are monitored through their own quality review departments.

Ms. Harmsen suggested the subcommittee discuss the ways available to assure safe, quality health care and submit recommendations to the Legislature. She stated to effectively study the issues, expertise from other states should be gathered and presented to the subcommittee.

Dr. Dunn proposed first establishing a mission statement. Representative Horton read what she believed to be the mission statement of the subcommittee: *To establish quality measurement standards, licensing requirements and solvency requirements.*

Representative Horton suggested the next meeting's agenda address the existing state requirements regarding consistent quality measurements, licensing and solvency.

Mary Leader, Governor's Policy Advisor for Health and Human Services, suggested DOI and DHS as information resources and noted AHCCCS is in the process of developing outcome measurements for their health plans.

Representative Horton stated it's "kind of hard to know how you're going to get there when you don't know where you are right now" and suggested the subcommittee develop a baseline of what the State has in place presently for licensing and solvency requirements.

Mr. Harris, addressing the solvency issue, stated DOI is well equipped to measure the financial strength of companies. He suggested one of the issues the subcommittee may want to look at are entities that deliver health care that are not licensed as insurance companies, such as provider hospital groups or other groups that share in the commerce of health care. He explained an area untouched by legislation is an

entity (i.e. doctor, hospital), not in the business of assuming risk, that is not required to be licensed by DOI. The only license required is that relating to medical practice. He added some states have considered solvency requirements since the doctor or hospital could potentially fail.

Representative Horton agreed there should be some kind of solvency requirements because some hospitals and clinics have filed bankruptcy. She suggested the next meeting could address what baselines are presently in place addressing these issues.

In response to Ms. Sutton, Mr. Harris stated legislation would be required for DOI to establish any additional licensing criteria for any entity that does not already fall under the scope of Title 20. He indicated DOI works with the Governor's Office to develop programs and recommendations.

Representative Horton emphasized that one of the complaints she hears from providers is that the more licensing requirements imposed, the more the cost is driven up and the Legislature has looked very carefully at that issue as a means of keeping down the cost of health care.

Mr. Harris stated DOI does look at solvency when regulating HMOs and has shared regulatory responsibility over HMOs with the Department of Health Services (DHS).

Representative Horton suggested a representative from DHS present information on licensing requirements at the next subcommittee meeting.

In response to Chairman Grosjean, Mr. Harris stated there is no statute defining or regulating a Physician Hospital Organization (PHO). He added if a PHO is assuming insurance risk, then they would be subject to licensing requirements as an insurer.

Chairman Grosjean called for a ten-minute recess at 11:10 a.m.

The meeting reconvened at 11:20 a.m.

Representative Horton suggested that at the next meeting representatives from DHS, DOI and AHCCCS present a briefing on Arizona licensing, solvency and quality measurement standards compared to other states and a review of the Kennedy-Kassebaum Bill.

Mr. Harris stated he would not be able to attend the next meeting on October 1, 1996, however, if available, Mary Butterfield from DOI could take his place in the discussions.

Ms. Poole stated she was informed by Lisa Block, the House Health Analyst, that because of Senator Day's schedule, this subcommittee meeting time would be moved to 3:00 to 5:00 p.m. Representative Horton stated she prefers the 10:00 to noon schedule and has some of the same concerns as Senator Day.

Ms. Sutton suggested both subcommittees could meet at the same time since the same members were not on both subcommittees. Mr. Poole suggested the subcommittee members discuss it with the Study Committee cochairpersons, Senator Kaites and Representative Grace. Ms. Sutton agreed, so that everyone can be accommodated.

In response to Ms. Harmsen, Ms. Poole indicated Senator Day had a conflict with another committee meeting and could not address the subcommittee today regarding HMOs. Ms. Harmsen suggested that Senator Day's presentation also be added to the next subcommittee meeting agenda.

Chairman Grosjean stated he wanted to keep the 10:00 a.m. time and would contact the subcommittee members as to where the next meeting would be held.

Ms. Sutton suggested if Senator Day is unable to attend the October 1, meeting she could provide written material for distribution to the members.

Representative Horton suggested the Directors of DHS, DOI and AHCCCS be contacted to select the person they want to speak to the subcommittee. Ms. Leader stated she would be meeting with the agency directors this afternoon and would ask at that time.

Ms. Harmsen asked for the background materials on the Kennedy-Kassebaum Bill which was to be provided at today's meeting, based on last week's discussions. Representative Horton stated she has a brief summary which she obtained by calling the National Conference of State Legislatures. Chairman Grosjean asked Ms. Poole if she would get a copy of the summary and make it available to the members.

Ms. Harmsen inquired whether there is agreement that the overall charge or goal of the subcommittee is to assure the public safe, quality health care and to establish a baseline. Representative Horton read the charge of the subcommittee from a letter she received from Senator Kaites and Representative Grace: "This subcommittee will address the issue cited in the committee charge as item #1, specifically, the

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SUBCOMMITTEE #1 OF THE
STUDY COMMITTEE ON HEALTH CARE QUALITY

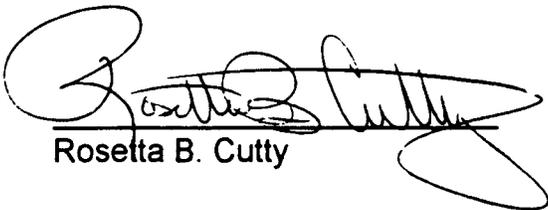
establishment of consistent quality measurement standards." She added this includes licensing requirements and solvency requirements. Ms. Sutton stated her notes from the first meeting indicate that the subcommittee is supposed to discuss the issue of a quality measurement standards "report card".

Representative Horton explained this is a Joint Interim Study Committee, established to make recommendations to the Legislature that possibly will result in legislation. The Committee may find that only administrative changes are required.

Ms. Leader clarified that the subcommittee is looking at all aspects of health care, not just managed care. Chairman Grosjean and Representative Horton agreed.

Chairman Grosjean adjourned the meeting at 11:35 a.m.

Respectfully submitted,



Rosetta B. Cutty

Tapes on file with the Secretary of the Senate's Office.

ARIZONA STATE LEGISLATURE
JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY
SUBCOMMITTEE #1

Minutes of the Meeting

Tuesday, October 1, 1996
10:00 a.m., House Hearing Room 3

MEMBERS PRESENT

Mr. Henry GrosJean, Chairman
Dr. Robert Dunn
Representative Susan Gerard
Ms. Constance Harmsen
Representative Hershcella Horton
Mr. Brian McNeil
Ms. Mary Yarbrough

MEMBERS EXCUSED

Mr. Greg Harris
Ms. Barbara Sutton

STAFF

Ellen Poole, Senate Analyst

Chairman GrosJean convened the meeting at 10:10 a.m. and the attendance was noted.

PRESENTATION ON THE HMO TASK FORCE

Senator Ann Day, HMO Task Force, related accomplishments of the Task Force which, she noted, has finished its work. She indicated the Task Force agreed upon a health care appeals bill which develops internal mechanisms insuring that quality health care is delivered to all customers in the State. Senator Day noted the bill provides for government procedures only when internal mechanisms do not accomplish their goal. She explained the formal appeals process is for customers of all health plans in the State, including indemnity plans, who have been denied health care services. It requires that the health plans relate what factors they are going to rely upon to provide services and to adopt written, objective and clinically valid standards and criteria to determine when medical services must be provided. Senator Day noted these determinations of what is medically necessary have been left up to the plans and will be applied in any denial of a covered service and used as a basis for reviewing the denial. Once a patient and physician are informed of a denial, they are also informed of their right to request an appeal and may ask the Department of Insurance (DOI) to set up an independent review panel to determine compliance and fairness. Senator Day stated that a requirement to refrain from retaliation against physicians and providers who inform their patients of other treatment options is also being set forth.

Senator Day emphasized the proposed legislation deals with quality of health care delivery, explaining that the Board of Medical Examiners will look at complaints against physicians for "quality of care," that DOI will provide recourse to customers in reviewing

the delivery of care appeals processes and determining when patterns or systemic problems occur; and that the Department of Health Services (DHS) which will engage its statutory oversight authority, to include visiting and investigating its licensees to insure compliance with the quality assurance plans they file in order to receive certificates of authority to deliver health care in Arizona.

Senator Day reviewed the timeline for the appeals process which begins with a reconsideration after the initial denial within 30 days, followed by an independent external review by contacting DOI or another formal internal review within the health plan. If the patient is denied treatment in this process, he or she can request that DOI set up an external appeal by a panel of experts. Senator Day explained the panel could be made up of one, two or three board certified physicians. She also noted there is a provision for expedited appeals, which would probably only require one medical expert to review.

Representative Gerard noted she is also a member of the Task Force and emphasized the goal was to establish flexibility in naming a panel of experts which would be determined by what is being treated, e.g. to also address instances where a rare disease or condition exists that only one expert in the nation may be able to address.

Mr. GrosJean asked if the appeals process is designed to complement the grievance procedures that are already set up in the health plans.

Senator Day explained it establishes consistency so that all health plans are included under this law and will handle appeals under the same timeline. She noted that any direct or indirect denial of a covered medical service is the trigger which activates the appeals process.

Senator Day also defined *appeal* as the external process used when a covered medical service is denied and *grievance* as being something the health plan handles internally.

Ms. Harmsen asked if the Task Force performed an analysis of volume expectations, i.e., the number of customers who would utilize this process.

Senator Day indicated this was not discussed on the Task Force and **Steve Barclay, Arizona Association of Health Maintenance Organizations (HMOs)** provided input at her invitation.

Mr. Barclay indicated the volume is an unknown, however expressed his view it will not be excessively large and that most of the issues will be resolved internally. He explained language has been designed not to address coverage issues, but to address issues where there is a legitimate difference of opinion as to what is medically necessary. Mr. Barclay expressed his hope the proposed legislation will codify existing practice and not add to it.

In response to Mr. GrosJean's request to know if any health carriers would be excluded from the proposal, Senator Day expressed her understanding all plans which assume risk are included.

DISCUSSION OF KENNEDY-KASSEBAUM BILL

Mary Butterfield, Assistant Director, Life and Health Division, DOI, distributed a summary (filed with original minutes) comparing specific aspects of current Arizona law and the new federal law effective July 1, 1997. She reviewed the primary components of the Kennedy-Kassebaum Bill which will require modification of Arizona statute, noting the most significant components are the guaranteed renewability, portability and guaranteed issue to small employers of two to 50 employees.

In response to Mr. GrosJean's inquiry about offering one or two like policies, Ms. Butterfield acknowledged a higher and a lower benefit policy must be offered based on an actuarial assumption of the value of the benefits.

Mr. GrosJean asked if this will apply to group policies as well as individual policies, and Ms. Butterfield expressed her understanding it would not.

Mr. GrosJean asked if Ms. Butterfield foresees any regulatory actions becoming necessary in order to comply. Ms. Butterfield acknowledged DOI will be making recommendations for revisions in the group health laws which conflict with or inhibit the application of the new federal law.

In response to Mr. GrosJean's request for further elaboration on preexisting conditions provisions, Ms. Butterfield explained that if a group health plan does not have a preexisting waiting period, an HMO may have an affiliation, or waiting, period requirement where a member must be enrolled, but not yet be paying a premium, for two or three months.

Ms. Harmsen questioned the role of the Study Committee in addressing conformity with the Kennedy-Kassebaum Bill.

Ms. Butterfield indicated DOI will be making recommendations to the Governor's Office for legislation to be introduced in the upcoming legislative session. She additionally noted a report on Arizona conformity measures must be made to the federal government by July, 1998.

Mr. GrosJean agreed the Committee may not be in existence that long and may not be privy to these measures.

Colleen Schroeder, Administrator, Healthcare Group (HCG) of Arizona, explained HCG is a separate organization within the Arizona Health Care Cost Containment System (AHCCCS) program offering health care coverage to small businesses with 40 or fewer employees, including the self-employed. Ms. Schroeder distributed a handout (filed with original minutes) highlighting the impact of the Kennedy-Kassebaum Bill on HCG and reviewed the provisions in Arizona statute which will need revision to conform.

In response to Representative Horton's inquiry, Ms. Schroeder confirmed Medicare would be included in the portability expansion of Medicaid.

Mr. McNeil asked if HCG has studied how premiums may be impacted by the conforming changes. Ms. Schroeder responded that this work has not yet begun.

In response to Mr. McNeil's further inquiry about an HCG timeframe for accomplishing this work, Ms. Schroeder indicated she would be attending a conference in Los Angeles next week, after which work would begin, recognizing the limited timeframe HCG is under.

DISCUSSION OF SOLVENCY ISSUES

Debi Wells, Assistant Director, Office of Policy Analysis and Coordination, AHCCCS, discussed the capitalization, financial viability standards and reporting requirements for AHCCCS health plans. She distributed a handout (filed with original minutes) specifying requirements.

Ms. Butterfield additionally reviewed the financial requirements for an Arizona Certificate of Insurance listed on the last page of her original handout.

Ms. Harmsen asked how many of the insurance companies as well as HMOs are not able to meet these state requirements.

Ms. Butterfield responded that if insolvency does occur, DOI puts the company under supervision or into receivership. She indicated she could not provide a specific number, expressing her understanding there are no current difficulties. Ms. Butterfield acknowledged that in the 1980's one or two companies were put under some sort of supervision, merged with another company or went out of business.

Ms. Harmsen asked if enrollees of health plans are made aware of financial problems. Ms. Butterfield indicated they are not specifically made aware, unless perhaps, their enrollment is affected. She acknowledged there may be a need to notify enrollees if their company was going to be reviewed in a public hearing or if very serious events were going to take place.

Mr. GrosJean asked if a physicians' organization would fall under the financial parameters discussed. Ms. Butterfield indicated these parameters would apply only if the organization was licensed. She explained the level of activity is reviewed to determine whether or not the organization needs a license, clarifying that if they are not assuming risk or transacting insurance they do not need a license.

In response to Mr. GrosJean's further inquiry, Ms. Butterfield indicated Premiere Health Plan is physicians' organization that obtained a license and would fall under the financial requirements outlined.

Representative Horton asked if the two percent deposited in the Treasurer's Office by HMOs serves the same purpose as the guaranty fund does for indemnity plans.

Ms. Butterfield indicated this two percent does not act in the same way as the guaranty fund, but provides protection for a specific period of time. She also noted that HMOs are required to take on the enrollees of any HMO which might become insolvent.

Mr. Barclay related that the national failure of Maxi Care in the mid 1980's spurred the tightening of solvency requirements, but that the HMO industry decided at that time it would rather increase its solvency requirements than participate in the guaranty fund. He related that all the Maxi Care enrollees were absorbed by other HMOs on a "blind" basis upon the failure of this company. Mr. Barclay also noted early warning mechanisms have been instituted, such as monthly reports of the numbers of providers dropped from a network, suggesting a large number might be a sign the company is in trouble and needs review. He asserted the increased efforts by the HMO industry are an adequate substitute for participating in the guaranty fund.

DISCUSSION OF HEALTH CARE QUALITY MEASUREMENT STANDARDS

In response to Representative Gerard's request for input on the ongoing efforts of the National Committee for Quality Assurance (NCQA), Ms. Wells explained AHCCCS is using NCQA's Health Plan Employer Data and Information Set (HEDIS) as a baseline for development of its activities, though indicated she could not speak to its impact on the private sector. She noted that HEDIS has gone through a few revisions, indicating AHCCCS is currently looking at the cumulative HEDIS 3.0 to see how it can comply.

Ms. Wells discussed the AHCCCS Quality Indicators Program, reviewing its purpose, the indicators, timelines and specific acute care, long-term care, developmentally disabled, and behavioral health related quality indicators as outlined in a handout (filed with original minutes).

Ms. Wells emphasized the Program is not intended to be punitive, but a vehicle for continuing improvement and a focal point for future efforts among AHCCCS plans, noting these quality measures can be reviewed during contract cycles and used to help determine if and when sanctions are needed. She indicated that looking at outcomes is key and is accomplished by compiling encounter data, e.g., the services received by a member on a specific date, since AHCCCS does not use billings.

Ms. Wells discussed the current status of the Program, indicating AHCCCS is furthest long with the Acute Care Program and emphasized the need to interpret data carefully, not misconstruing a high number of low birth rates as a negative for a particular health plan where high-risk pregnancies may be referred because this happens to be its area of expertise.

Ms. Yarbrough asked if AHCCCS risk-adjusts its data and Ms. Wells confirmed this is the intent.

Representative Gerard acknowledged risk is a critical determinant and must be adjusted for. She expressed her hope AHCCCS does use risk adjustment.

Ms. Hamsen commended the AHCCCS Quality Indicators Program and asked when it will become part of the contracting process. Ms. Wells responded there is no date certain and that AHCCCS would probably not be able to use it in the March 1997 contracting cycle.

Ms. Wells commented on the lessons AHCCCS has learned in the process; emphasizing that it is essential to have collaboration among all parties involved, that it is important that everyone involved understands each others' languages and clinical systems and that it is necessary to view things from a variety of perspectives, making refinements along the way. Ms. Wells noted that Arizona is further along than any other state in the development of quality indicators in its AHCCCS Medicare program, so the Health Care Finance Administration (HCFA) has indicated it will continue to be partners with it.

Ms. Yarbrough asked how it will become apparent the State is doing a good job. Ms. Wells responded it will become known when AHCCCS members respond on surveys that information they received on health plans was helpful and when the health plans indicate they are being treated fairly, or in summary, when all parties are satisfied.

Mr. Barclay related there is also an accreditation effort being driven by national entities such as NCQA, which has focused on bringing quality measurements and provider credentialing to managed care. He referred to articles on NCQA which were distributed to members (filed with original minutes) which state 35 percent of the accreditation decision is on quality management and improvement and 25 percent of the decision deals with credentialing. He noted accreditation is becoming known as a benchmark of quality

and customers are demanding it. Mr. Barclay indicated HEDIS is the measuring tool and continues to evolve and expand quality benchmarks, becoming more outcome-based than in the past.

Mr. Barclay noted there has been no similar system for indemnity plans and emphasized managed care has facilitated the collection of data to initiate the measurement of quality. He also noted that the Accountable Health Plan Act of 1993 contains provisions that require health plans to file a quality assurance program with DOI. Mr. Barclay recommended leaving this process of quality assessment to the private sector, Medicare and Medicaid as opposed to putting it into legislation, as the area is evolving too fast for legislation to keep up with.

Representative Gerard agreed with Mr. Barclay that it is not appropriate for the State to be trying to set up a quality indicator program because the private sector is moving forward with it. She also cautioned against the potential to develop different standards in each state, and emphasized the need to allow the free market to do its job as it currently is in developing national standards.

Mr. GrosJean distributed a handout entitled "Quality Compass," available on the Internet, (filed with original minutes) which discusses national averages of childhood immunization rates, mammography screenings, percentage of readmissions of mental health patients, etc., and compares providers in specific regions to national averages for the benefit of the consumer. He suggested this type of information becoming available may encourage carriers to become involved with HEDIS to adopt standards.

Herb Rigbert, Medical Director, Health Services Advisory Group, explained his group is the peer review organization for Medicare in Arizona and is currently known as the Quality Improvement Organization. He related he was a member of the committee which developed HEDIS 3.0 in Washington, D.C., explaining it has come a long way in linking indicators to outcomes as measured by patient perception and will create a much more personal approach to health care delivery. Dr. Rigbert indicated that for the past three years under a waiver from HCFA, the medical directors of Medicare plans in Arizona have been meeting every four to six weeks to establish a program which is apt to become a paradigm for the nation.

Dr. Rigbert confirmed Ms. Yarbrough's observation that disease-oriented critical paths were being standardized across health plans, adding this has been accomplished based upon the health plans' own data along with a patient complement. Dr. Rigbert confirmed this information will become available when standardized and it will be in a format decipherable by lay people.

October 1, 1996
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**STUDY COMMITTEE ON HEALTH
CARE QUALITY - SUBCOMMITTEE #1**

Chairman GrosJean announced the next meeting will be held October 15, 1996 at 10:00 a.m. in House Hearing Room 3.

Without objection, the meeting was adjourned at 11:45 a.m.

Respectfully submitted,

A handwritten signature in cursive script that reads "Alice Kloppel".

Alice Kloppel,
Committee Secretary

(Tape and attachments on file in the Office of the Senate Secretary)

ARIZONA STATE LEGISLATURE

**JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY
Subcommittee #1**

NOTICE TO MEMBERS:

**THE OCTOBER 29, 1996 MEETING OF SUBCOMMITTEE #1,
INITIALLY SCHEDULED IN THE OVERALL PLAN FOR THE STUDY
COMMITTEE ON HEALTH CARE QUALITY, WILL NOT BE
CONVENED.**

MEMBERS:

Mr. Henry Grosjean, Chairman
Dr. Robert Dunn
Representative Susan Gerard
Ms. Constance Harmsen

Mr. Greg Harris
Representative Herschella Horton
Mr. Brian McNeil
Ms. Barbara Sutton
Ms. Mary Yarbrough

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10/24/96

ARIZONA STATE LEGISLATURE
Forty-second Legislature - Second Regular Session

**JOINT INTERIM STUDY COMMITTEE ON
HEALTH CARE QUALITY
Subcommittee #2**

Minutes of Interim Meeting
Tuesday, September 17, 1996
House Hearing Room 3 - 1:00 p.m.

(Tape 1, Side A)

The meeting was called to order at 1:06 p.m. by Chairman Anne McNamara and attendance was noted by the secretary.

Members Present

Sandra A. Abalos, CPA, Abalos & Associates
Steve Barclay, Arizona Association of Health Maintenance Organizations
Dr. Arlan Fuhr, Vice President, Arizona Association of Chiropractic
Representative Sue Grace
Senator Mary Hartley
Representative Paul Mortensen
Representative Andy Nichols
Anne McNamara, Ph.D., representing Registered Nurses, Chairman

Members Absent

None

Speakers Present

Kathy Boyle, Executive Director, Arizona Pharmacy Association, Tempe
Jim Drake, Banking and Insurance Analyst, House of Representatives

Chairman McNamara noted that she was elected to chair Subcommittee #2 at the orientation meeting. She reviewed the Subcommittee's charge to study direct patient access and point of service options (see Attachment 1). An excerpt from a National Conference of State Legislatures (NCSL) 1994 publication on maternal and child health legislation was made available (Attachment 2), together with background information on stand-alone point-of service products (Attachment 3).

Mr. Barclay distributed an American Association of Health Plans direct access chart (Attachment 4), and reviewed a staff guide entitled "*A brief summary of Health Insurance Legislation in Arizona 1990-1996*" (Attachment 5, filed in Office of Chief Clerk). He commented on those licensed entities overseen by the Arizona Department of Insurance (DOI) and noted the three different categories under Title XX:

1. Insurers (noting that in Arizona health insurance is known as disability insurance)
2. HMOs (Health Care Services organizations)
3. Hospital, medical, optometric and dental service corporations (i.e. Blue Cross)

Mr. Barclay reviewed significant statutes, including mandated benefits and disclosure forms in regard to coverage, and compared S.B. 1109, accountable health plans (Laws of 1993, Chapter 231) with the federal Kennedy/Kassebaum bill. He noted that all group provisions include guaranteed renewability, restrictions on the use of pre-existing conditions and portability of coverage.

Responding to a query by Dr. Fuhr, Mr. Barclay pointed out that although there is no mandate to disclose specialists as there is for primary care physicians, most organizations do so.

Dr. Fuhr asked which providers are covered by S.B. 1109. Mr. Barclay explained that although all preexisting conditions were originally wiped, most were later reincorporated, with the exception of the mandate to cover certain providers, including chiropractors.

Chairman McNamara responded to questions and pointed out that the Committee's output could take many forms.

Mrs. Grace requested information in regard to the direct access chart (Attachment 4). Dr. Fuhr said he is aware that Maine began about one year ago. Mr. Barclay noted that many states allow direct access to obstetrician/gynecologists (OB/GYNs), and further discussion ensued.

Mrs. Grace remarked that one law does not fit all fifty states.

Jim Drake, Banking and Insurance Analyst, House of Representatives, offered to obtain further information on the Maine experience.

Chairman McNamara observed that Minnesota is also very prominent in the managed care field, and she proposed that as much information as possible be assembled on other states' experiences.

Mr. Barclay noted that the Arizona law contains a specific nondiscrimination mandate that applies only to Health Care Services organizations.

Chairman McNamara asked if definitions for "point of service" and "direct access" are needed. Mr. Barclay opined that while "direct access" is easily understood, "point of service" could be clarified.

Dr. Fuhr pointed out that chiropractors have fought to be qualified as licensed physicians for many years, and said he believes clarification is needed.

Chairman McNamara confirmed that definitions will be evaluated at the next meeting.

Mrs. Grace proposed a review of obstacles that prevent access to specialties, and roadblocks to preventative health care. She suggested soliciting input from employers on how decisions are made.

Ms. Abalos pointed out that the decision is largely cost-driven, with benefits structure considered second. She observed that small business owners have been forced to enter into preferred provider organization (PPO) networks, premiums increase every six months, and lack of portability is a significant problem.

Mr. Barclay said while he believes people should have a choice of products, employer provided coverage is down to approximately seventy percent nationwide, and increasing numbers of dependents are losing coverage. He added that there have been no premium increases over the past couple of years.

Kathy Boyle, Executive Director, Arizona Pharmacy Association, Tempe, stressed the importance of access to pharmacy services and noted a change in focus toward dispensing information as well as services. She called attention to what she described as an alarming trend toward a requirement that patients use mail order prescriptions as a cost saving measure, and said she believes patients should have direct access to a pharmacist. Ms. Boyle pointed out that Arizona's hot summers create a problem when drugs are delivered to mail boxes.

Mr. Barclay said it is his understanding that options are provided for, and he located and cited the relevant statute which states that an organization cannot require mail order service drugs exclusively. He pointed out that pharmacy is not a mandated benefit for employers.

Dr. Fuhr asked to see a study on the savings involved with mail order drugs.

Chairman McNamara reviewed the agenda for the next meeting, to include definitions, an update from Maine and Minnesota, and information on employer satisfaction based on factors other than cost.

Mrs. Grace requested information on savings realized by use of preventative services, the number of people covered, and dealing with long term care.

(Tape 1, Side B)

Mr. Barclay offered to locate speakers for the next meeting.

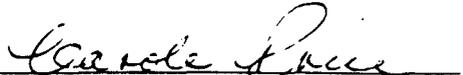
Chairman McNamara solicited credible wellness data.

Ms. Abalos offered to report on any available small business community studies.

Dr. Nichols pointed out that long term care and assisted living facilities are becoming increasingly important.

Chairman McNamara announced that the next meeting of Subcommittee #2 is scheduled for October 1, 1996 at 1 p.m.

Without objection, the meeting adjourned at 2:11 p.m.


Carole Price, Committee Secretary

(Original minutes with attachment and tape on file in the Office of the Chief Clerk. Copy of minutes on file with the Secretary of the Senate.)

ARIZONA HOUSE OF REPRESENTATIVES
Forty-second Legislature - Second Regular Session

JOINT INTERIM STUDY COMMITTEE ON
HEALTH CARE QUALITY
SUBCOMMITTEE #2

Minutes of Meeting
Tuesday, October 1, 1996
House Hearing Room 3 - 1:00 p.m.

TAPE 1, SIDE A

Chairman McNamara called the meeting to order at 1:05 p.m. and the attendance was noted.

Members Present

Steve Barclay
Dr. Arlan Fuhr
Senator Mary Hartley

Representative Sue Grace
Representative Paul Mortensen
Anne McNamara, Chair

Members Absent

Sandra Abalos

Representative Andy Nichols (excused)

Speakers Present

Jack Towsley, Chief Executive Officer, United Health Care of Arizona (UHC)
Dr. Jay Mayes, Vice President, Medical Affairs, Health Partners Health Plans
Dr. Leonard Rudnick, Chiropractic Physician, representing himself, Tucson

Chairman McNamara asked if there were any changes or additions to the September 17, 1996 minutes (Attachment 1). Mr. Barclay noted the following changes:

- Page 2, second to last paragraph should read: "Mr. Barclay noted that the Arizona law contains a specific nondiscrimination mandate that does not apply to Health Care Organizations (HMOs)."
- Page 3, fifth paragraph, last sentence should read: "He added that there have been no premium increases over the past couple of years in the HMO market in Arizona."

Mr. Barclay moved, seconded by Dr. Fuhr, that the minutes of September 17, 1996 as corrected be adopted. The motion carried.

Chairman McNamara referred Members to the September 25, 1996 memorandum from Jim Drake, Majority Research Analyst, relating to definitions of "direct access" and "point-of-service" (Attachment 2). For the benefit of the public, she read each definition and asked for comments from Members.

- **Point-of-Service:**

Mr. Barclay stated his belief that the reference to "managed care association" is an inappropriate and misleading term. He recommended that language be changed to "managed care plan" or "managed care company." In addition, he proposed to append the following to the definition: "the person could receive services outside of the provider network typically at higher coinsurance and deductible levels."

McNamara asked if there is a definition for company or plan. Mr. Barclay responded that the terms are not defined. He noted that most people understand managed care but suggested that perhaps the definition could include "use definition of managed care."

Chairman McNamara solicited comments from the public on the definition. No public participation was forthcoming.

Mr. Mortensen moved, seconded by Mrs. Grace, that the definition as amended be presented to the Joint Interim Study Committee on Health Care Quality. The motion carried.

- **Direct Access:**

Mr. Barclay requested that the reference to "managed care association" be amended to read "managed care company." Mr. Barclay recommended that after "penalty," insert "to all or selected specialists." He said that this will allow for both of the direct access products to be considered.

Dr. Fuhr questioned whether reference to selected specialists limits the company again back to almost controlling direct access. He stated that some obstacles are that one would have to be on the panel of the company, and that the utilization criteria of the company is unknown.

Chairman McNamara asked Dr. Fuhr to provide a recommendation. Dr. Fuhr deferred making any recommendation until he has time to work on a suitable definition.

Mr. Barclay noted that these are simply definitions for purposes of discussion. He maintained that if the definition is changed to require someone to go to any specialist in order

for it to be called a direct access product, a lot of good products will be cut out of the market that are helping address the issue of going through the gatekeeper.

Chairman McNamara recommended changing "enrollee's" to "provider's."

Chairman McNamara announced that the discussion of the definition of "Direct Access" will be deferred to the next meeting pending further work.

Chairman McNamara referred to handouts distributed to Members on Minnesota where point of service options were put into statute (Attachment 3); and Maine's legislation relating to chiropractic care (Attachment 4), and basic health care needs of women (Attachment 5).

Representative Grace noted that Minnesota has the most advanced HMO system in the country; however, she pointed out that one has to look at other states' legislation in the context other states are working under. She questioned how extensive Maine's HMO system is. Dr. Fuhr advised that Maine is small in managed care compared to Minnesota.

Representative Grace commented that it would be good to look at other states' models of managed care that have experience in the area. She maintained that Arizona is very different in managed care compared to other states.

Mr. Barclay concurred with Representative Grace. He stated that review of other states' statutes should consider the regulatory framework in place which may be different from state to state. He pointed out that Arizona has an extra regulatory barrier that other states may not have. Under Arizona's licensing laws, an HMO is not permitted under its own license to offer a point of service plan; it must partner up with an indemnity insurer. He said that something can be gleaned from other states but the question is how it fits Arizona's circumstances.

Chairman McNamara suggested using Minnesota's legislation for purposes of background information. She asked staff to get more data from other states and to note the differences that exist within those states.

Representative Grace recommended that study be limited to the subjects of direct access and point of service which have been addressed here.

Representative Mortensen stated that there might be a tendency to drift if too much material is presented. He opined that the Committee should stay with the topics being discussed: point of service and direct access.

Chairman McNamara asked Members how they would like to proceed. The consensus was to limit the topic to the two issues being considered here.

Chairman McNamara stated that specific information will be requested from Minnesota for background information. She asked whether other states would be sources of information. Mr.

Barclay said he is skeptical about how much valuable information can be obtained from other states because every state tends to look at things a bit differently. He said that Arizona is ahead of other states in terms of the managed care market place. He stated that the charts indicate that the pattern is clearly on the direct access side to not make it direct access to all specialties but rather to selected specialties.

PRESENTATIONS

Jack Towsley, Chief Executive Officer, United Health Care of Arizona (UHC), testified that his company has been doing business in Arizona since 1985. UHC is under the umbrella of United Health Care Corporation. He advised that UHC is a for-profit corporation, and has 40 million enrollees nationwide in a variety of health care products. Enrollment in Arizona totals 140,000: 17,000 in HMO products, 62,000 in point-of-service, and 75,000 in PPO and indemnity-type products.

Mr. Towsley said that United Health Care Corporation has had a history of direct access or open access-type products since 1982, and currently serves over 2 million members with open access type HMO products. United Health Care has a variety of ways how it defines open access: the type of specialists it includes and the types of referrals or mechanisms to have particular types of treatment.

Mr. Towsley stated that in Arizona, UHC offers different plans but has found that the market is asking for direct access to all participating physicians. Based on research and what the participating and prospective customers have requested, UHC launched its open access HMO product in Arizona about sixty days ago. UHC offers two plans: (1) an open access HMO where a member is limited to stay within a panel of participating providers or contracted physicians, and (2) a point of service type product. In Arizona, UHC has defined open access as two physicians, M.D.s and D.O.s, who are participating under contract with the company.

Relating to point of service, Mr. Towsley said that it is a product that is very healthy for UHC and one that it offers as an option. He said that UHC continues to offer a wide variety of other products to provide choice to the market.

Dr. Fuhr questioned the availability of physicians in allied health. Mr. Towsley replied that under the HMOs, UHC has services for ancillary providers to be referred through one of the participating physicians, but does not have direct access. Dr. Fuhr asserted that UHC's open access is really not open access. Mr. Towsley said it depends on how open access is defined.

Dr. Fuhr asked whether UHC has data to support the statement that it costs more to have the allied professions included. Mr. Towsley said he will have to check to see if that information is proprietary to the company.

Chairman McNamara mentioned that she knows many people who choose to use somebody other than an M.D. or a D.O. as their primary provider. She asked if the company has done research on utilization or has cost data that could be helpful to the Committee. Mr. Towsley replied that D.C.s

are available under the company's indemnity-type programs. Experience has shown that in terms of cost in an open access type program, cost effectiveness is maintained by limiting to M.D.s and D.O.s.

Dr. Fuhr asked if the company has chiropractic panels in any other states under HMO products. Mr. Towsley replied in the affirmative. Dr. Fuhr asked for data on what states have chiropractic panels. He said he would like to know if there is history someplace else.

Mr. Barclay asked Mr. Towsley if there is a large migration from the more traditional products and more traditional HMO-designed primary care gatekeeper products to the new point of service and open access products being offered in Arizona. Mr. Towsley replied that with only 68 days of experience in the new service, there is no history yet.

Mr. Barclay asked for further comments on the issue of limiting open access to M.D.s and D.O.s. He said he understands one of the fundamental principles of the way HMOs operate is that coverage comes down to a question of having a medical professional make a determination of medical necessity. He asked if that is the determining factor in the design of the product. Mr. Towsley answered in the affirmative. He stated that in order for the program to be successful, medical necessity determinations are left to the participating physicians.

Dr. Fuhr asked whether a patient who is not happy is allowed to go, under his own referral, to a specialist who is on the panel. Mr. Towsley responded that the specialist would be referred through the gatekeeper. He declared that all patients are allowed to change gatekeepers if they are not satisfied with the results.

Representative Grace commended staff on the material prepared on health insurance changes since 1990. She raised the question of legislative change dealing with fairness and applying the standards across the board, and said she will look up the statute to see whether it applies to the above situation.

Mr. Barclay also applauded staff on putting together the material. He remarked that an interesting point is that employer acceptance may be an obstacle to the notion that a nongatekeeper HMO work in a cost-effective manner.

Dr. Fuhr declared that even though it is a changing marketplace, the evidence is that there is still bias for people in his profession: D.C.s, O.D.s and psychologists. He asked if there are plans to consider the allied profession in UHC's plans in Arizona. Mr. Towsley remarked that UHC currently offers a wide variety of allied professionals within its plans in Arizona. He said UHC is constantly investigating and evaluating what the consumer demand is, as well as how to use its cost-effective tools.

In answer to Dr. Fuhr, Mr. Towsley replied that prior-authorization plans are available that HMO clients can purchase separately which allow for visits to a chiropractor. He said he believes there are 10 chiropractors in the network for the city of Phoenix.

Dr. Jay Mayes, Vice President, Medical Affairs, Health Partners Health Plans, testified that the company has a membership of about 380,000. About 85 percent of its members are in the HMO product in the tiered access or direct access model. Health Partners Health Plans's model is direct access to physicians primarily. There is a service model which does include direct access to doctors of chiropractic. On the HMO model, there is direct access for chiropractic, vision benefits, mental health, etc., depending on whether employers choose to purchase those options. The physician network totals about 2,000. As a provider-owned and sponsored health plan, one of the things that is important is that the physicians helped design the products.

TAPE 1, SIDE B

Dr. Mayes revealed that the tiered access model is about four to six percent more expensive than a tightly-controlled gatekeeper-physician model.

Dr. Mayes stated that Health Care Health Plans is the fastest growing health plan in Arizona. Much of that is because of choice. The tiered access model allows a higher level of choice in that members can make more decisions about their personal health care. Although the tiered access model affords more choice, not all physician specialities are immediately available.

In response to Dr. Fuhr who pointed out that direct access leaves out the allied profession. Dr. Mayes answered that D.C.s are directly accessible under the service plan. He stated that Health Care Health Plans has contracted with Landmark Chiropractic Network which has a network of about 100 chiropractors. He said he is not sure of the number in Arizona. Dr. Fuhr asked for utilization numbers, as related to Doctors of Chiropractic specifically.

In response to Chairman McNamara, Dr. Mayes related that if individuals are using services which, determined retrospectively, could have been taken care of in a different way, it becomes an out-of-pocket expense for the physician, not the member.

Mr. Barclay cautioned against the use of utilization data. In looking at such data, concern should be what is it being compared to. He asserted that a point of reference is needed, and said that utilization data is not meaningful unless it compared to something else.

Dr. Mayes stated that point of service means that a member can access anyone who is on the network. Members, at their own cost, can go outside of the network if they choose. He said going outside of network is increasingly not the choice because of cost.

Dr. Leonard Rudnick, Chiropractic Physician, representing himself, Tucson, testified that in 1992, he was one of three chiropractic physicians approached by Intergroup. He said he went through the application process and a very thorough credential process. He became a part of a program called Interflex in August 1992. Since that time, he said he has had no patients; he has never had a referral in four years. He stated that he has consulted with other chiropractors and they have had no referrals.

Representative Grace asked whether there is data available, other than from other chiropractors, that no referrals have been made. Dr. Rudnick replied in the negative. Representative Grace asserted that the Committee needs to work from factual data. She said it might be helpful for Dr. Rudnick to construct his own data based on how many patients he has and how many of them are in HMOs.

Mr. Barclay observed that there has been a breakdown of some of the barriers to include chiropractors in health plans on a voluntary basis. He asked Dr. Rudnick if chiropractors should be classified as primary care physicians. Dr. Rudnick stated that he has personally referred patients back to the primary care physician. He said he has acted as a primary care physician.

Mr. Barclay mentioned the debate that has been going on relating to what chiropractors can and cannot treat. He asserted that some chiropractors need to know their limitations as treating providers. Dr. Rudnick said that he would compare the education of D.C.s with any primary care physicians that have graduated in the past five years.

Dr. Fuhr maintained that the chiropractors of today are not treating out of the scope of their practice.

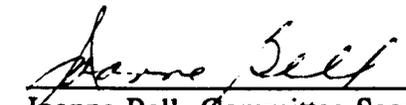
Representative Mortensen asked if Dr. Rudnick ever confronted Intergroup about the lack of referrals. Dr. Rudnick advised that the response he was given was that "they were working on it." He noted the prejudice and reluctance of primary care physicians to refer patients.

Mr. Barclay said he will try to get some data on one program he is aware of that offers chiropractic without a mandate on their HMO products.

Dr. Fuhr referred to the distributed package of material which will be discussed at the next meeting (Attachment 6). He said it is an overview of the gatekeeper and how it is changing.

Mr. Barclay agreed with Dr. Fuhr that lines of communication need to be improved. He also distributed material that might be helpful: National Governors' Association's Policy "Managed Care and Health Care Reform" (Attachment 7), American Association of Health Plans "*Consumers with a Choice Among Health Plans Are Choosing Network-Based Plans*" (Attachment 8), and a letter from State Fund Claims Administration to Senate President John Greene dated August 3, 1995 (Attachment 9).

Without objection, the meeting adjourned at 2:55 p.m.



Joanne Bell, Committee Secretary

(Attachments and tape on file in the Office of the Chief Clerk.)

ARIZONA STATE LEGISLATURE
Forty-second Legislature - Second Regular Session

**JOINT INTERIM STUDY COMMITTEE ON
HEALTH CARE QUALITY
Subcommittee #2**

Minutes of Meeting
Tuesday, October 15, 1996
House Hearing Room 3 - 1:00 p.m.

(Tape 1, Side A)

The meeting was called to order at 1:05 p.m. by Chairman McNamara and attendance was noted by the secretary.

Members Present

Senator Hartley
Representative Grace
Representative Mortensen
Representative Nichols

Dr. Arlan Fuhr
Ms. Sandra Abalos
Mr. Steve Barclay
Ms. Anne McNamara, R.N., Chairman

Speakers Present

Anthony Ballew, Family Nurse Practitioner; President, Arizona Nurse Practitioner Council, Mesa
John Grubka, representing himself, Mesa
Al D'Appollonio, Physical Therapist

The Members introduced themselves.

Approval of Minutes

Chairman McNamara suggested that the following change be made in the minutes of October 1, 1996:

- Page 3, second indented paragraph should read: "Chairman McNamara recommended changing "physician" to "provider."

Dr. Fuhr moved, seconded by Ms. Abalos, that the minutes of October 1, 1996 be approved. The motion carried.

Discussion of Meta-Analysis of Studies of Nurses in Primary Care Rolls

Chairman McNamara noted that the Members should have received information entitled, "Nurse Practitioners and Certified Nurse-Midwives *A Meta-Analysis of Studies on Nurses in Primary Care Roles* (Attachment 1).

Anthony Ballew, Family Nurse Practitioner; President, Arizona Nurse Practitioner Council, Mesa, testified that his main concern with managed care is access to nurse practitioners as providers. He related that 25 years ago people did not know what a nurse practitioner was but that has changed. He now has an office, and a physician stops by and consults with him a half day each week. If he has a problem beyond his experience or expertise, he sends patients to the physician. He expressed frustration because he has had to change practices twice in the past few years due to problems encountered regarding payment from previous employers. When this happens, his patients do not have access to his services. He added that managed care organizations will not list nurse practitioners or physician assistants as providers, not even under the Primary Care Physician (PCP) despite repeated requests.

He submitted that good quality care is being provided as nurse practitioners work in collaboration with physicians. The Meta-Analysis contains statistics, and emergency room physicians in Mesa appear to be pleased with nurse practitioners and physician assistants working in the emergency room and in the community. He related the fact that if he calls the emergency room in the middle of the night, he has no problem being recognized as a professional; however, he cannot see the patient in the hospital because he does not have hospital privileges.

Referring to utilization and cost effectiveness, Mr. Ballew noted that the Meta-Analysis states that nurse practitioners and physician assistants spend more time with patients than doctors. He agreed with that finding. He conveyed that in 1975 he saw three to four patients in an hour. Today he needs to see six or seven patients an hour in order to generate enough income to support the doctor's practice (pay staff, draw blood, overhead expenses, etc.). Once a physician realizes the utility of nurse practitioners and physician assistants, two, perhaps three, are hired, depending on circumstances, and it becomes cost-effective.

He concluded by referring to a "fight" with the Mesa School District about athletic physicals. The rules have been changed to allow nurse practitioners and physician assistants to give athletic physicals. The school district decided that it was not allowable but eventually changed its stand. Now it has discovered that their physical exams are more thorough; some patients have been disqualified from athletics, upsetting some of the coaches. The doctors never disqualified anybody.

Mr. Barclay asked if the use of hospital privileges by nurse practitioners and physician assistants has been discussed with the Hospital Association. Mr. Ballew answered that there is a working group. The hospital and health care association are working on it. The process is ongoing but slow.

Discussion of Revised Definitions

Chairman McNamara referred to the October 9, 1996 memo from Jim Drake, Majority Research Analyst (Attachment 2). She noted that the Members have agreed on the "point-of-service" definition so discussion today will focus on "direct access."

Mr. Barclay submitted that both are good definitions for a point of reference. Dr. Fuhr commented that he was unable to find a better "direct access" definition.

Mr. Barclay moved, seconded by Senator Hartley, that the definitions be accepted by the Committee. The motion carried.

Discussion of Enabling Legislation from Minnesota

Chairman McNamara explained that the Subcommittee, at the last meeting, reviewed legislation from the states of Maine and Minnesota. The Members decided that the activity of managed care in Minnesota is, percentagewise, more like Arizona. Additional information was requested from staff regarding legislation passed in Minnesota in 1995 relating to point-of-service (POS) options. A document was distributed to the Members before the meeting which addresses supplemental benefits available to HMO members in Minnesota (Attachment 3).

Mr. Drake stated that the State of Minnesota is very progressive in terms of managed care but this is one of those cases in which legislation enacted in another state is not workable in Arizona. He explained that POS benefits are referred to as supplemental benefits in Minnesota. Minnesota HMOs are allowed to offer POS options and do assume some insurance risk. There are a variety of heightened financial requirements and hoops to jump through in order to offer these options. Whereas, Arizona's Department of Insurance (ADOI) prohibits Health Care Services Organizations (HCSOs) from engaging in this practice.

Mr. Barclay expressed his appreciation of Mr. Drake's research. He added that many HMOs are federally qualified, i.e., licensed and regulated by the United States Department of Health and Human Services. Federal law also limits the ability to offer POS-type products, and there is a restriction requiring that 10 percent of utilization be out of network (otherwise, the organization resembles an insurance company rather than an HMO). In Arizona, because of the Insurance Department's rule being even more restrictive, it is a moot issue. However, if that is changed, federal laws would still apply in some cases.

Dr. Fuhr asked how many HMOs are federally qualified. Mr. Barclay estimated that at least half are federally qualified. He added that it is not quite the seal of approval it used to be because that has been supplanted with accreditation rules.

Testimony from Guest Speakers

John Grubka, representing himself, Mesa, stated that he has been a member of an HMO-type organization for about 15 years. Until 1986, he and his wife were residents of California and pleased with their health care plan (Kaiser). Before moving to Arizona, he attempted to find other areas to live where similar-type care is offered but was unsuccessful. He is disabled, with a mental disability for manic depression, and a provider could not be found because of preexisting conditions. His wife accepted a job with the State of Arizona. He opted for Intergroup because it was offered by the state, then he moved into Senior Care High Option.

He said it has been two years since he has been on Intergroup which has contracts with different providers. He would get comfortable with a psychiatrist or psychologist, and suddenly, he/she would no longer be a member of the plan. He said it has been difficult but it has been a good group for him. He has reached the maximum of care with his PCP, who has sent him to a neurologist, psychiatrist, psychologist, orthopedic specialist, etc.

Mr. Grubka submitted that it was not until he was offered the opportunity to access chiropractic services three times a week that he actually obtained relief for his physical pain which means that he no longer has to take numerous medications which make him drowsy and prohibit him from driving. He said he did not believe in chiropractic medicine until he used the service but 25 chiropractic visits over the last two years have helped him. He added that he had expected a quicker change but he does have degeneration of the spine and other problems.

He stated that the chiropractic counselor has been very helpful but he will have to start paying him out of his own pocket because he has used up his allotted visits. However, he continued, he has experienced better results from this counselor than from changing medications suggested by different psychologists and psychiatrists. He stated that his PCP is planning to retire in ten years. At this point, he is very comfortable with the PCP and the chiropractic services. He stated that a physical therapist wrote a five-page report which was referred to his PCP but his PCP said he has already done everything the physical therapist recommended and will not refer him to her. The PCP said if he wants that kind of service, he will have to pay for it himself.

He clarified for Mr. Barclay that he is Medicare eligible and is on Senior Care High Option which offers gymnastic facilities but it is limited in terms of who is authorized to provide those services. He lives in East Mesa and the facilities are not nearby.

Mr. Barclay pointed out that since Mr. Grubka is Medicare eligible, there is a grievance process through the Health Care Financing Administration (HCFA) to handle complaints and problems. Mr. Grubka answered that he has just become aware of that but he has a fear of being dropped as a subscriber. Mr. Barclay stated that he has rights and protections under the law to pursue these matters and encouraged him to do so.

Mr. Grubka said he has gone outside Intergroup for trigger point injections suggested by an osteopath who is no longer in private practice. He went to his PCP who said he does not believe in the

injections. His current chiropractor is recommending intervention with injection of steroids, and Intergroup is refusing to pay for that so he will have to pay for it himself, and it can be expensive. Mr. Grubka interjected the fact that he did apply to CIGNA and several other plans before his wife obtained state employment but he was not accepted because of preexisting conditions. He said he is glad that she was able to obtain a state job and he could get into the plan.

Al D'Appollonio, Physical Therapist, referred to the "direct access" definition which states that patients would have access to specialists without going through primary care, and asked how "specialist" is defined. Chairman McNamara answered that "specialist" has not been defined, adding that testimony was taken at the last meeting from two different health plan representatives who shared their definitions; however, the definitions were not the same.

Mr. Barclay indicated that Mr. Appollonio's question points out a concern that people will perceive the definitions as something other than points of reference for the Members. He pointed out that no insurer is mandated to offer a direct access or POS product. He indicated that testimony was given last week that there is not even direct access to all M.D.s and D.O.s. He said he thought that one of the speakers testified that referral decisions for ancillary services (lab work, x-rays, chiropractic or physical therapy, etc.) need to be funnelled through M.D.s or D.O.s.

Mr. D'Appollonio testified that in Arizona physical therapists are licensed to see, evaluate, and treat patients without a referral; however most insurance companies require a physician's referral. He contended that this does not make sense. When legislation was passed in 1982, the whole concept was to give the consumer the ultimate choice and reduce health care benefit costs, with the logical assumption that someone with back pain can go to a physical therapist without seeing a physician first. However, that is not the way it is. He remarked that it only increases the cost when a patient goes to a physician who refers him/her to a physical therapist, and he does not perceive this as direct access. He contended that cost containment is possible without preauthorization of treatment. He said his philosophy and treatment will differ from that of a D.O., M.D., or a chiropractor, and if an insurance product is going to offer physical therapy services, there should be access to that service without going through hoops.

Dr. Fuhr said he relates to Mr. D'Appollonio's testimony. Chiropractors fought for direct access and insurance equality for 25 years, and attained that. Along came the HMOs, and the access right was lost. He said recent data entitled, "Cost Effectiveness of Chiropractic Care in a Managed Care Setting" (Attachment 4) shows that direct access to chiropractic care costs about half the price of conventional care. This is under a managed care setting with preauthorization. He added that chiropractors refer patients to physical therapists many times because physical therapists perform services that chiropractors do not. He encouraged the Members to read the document.

Discussion

Chairman McNamara asked the Members what they would like to take forward to the full Committee. She noted that there will be one Subcommittee meeting before the full Committee meets.

Mr. Barclay stated that he has information on alternative medicine and how freedom of choice is finding its way into managed care. He also has an actual policy from a company (not an HMO) located in Salt Lake City which offers the country's only holistic-oriented managed care plan. He spoke in favor of providing a variety of choices for the consumer. He remarked that this is a competitive marketplace, and innovativeness and responsiveness are needed in order to keep consumers happy. He said he believes that the marketplace will respond, and has, in a way to maximize choices available to employers and employees, which is much more effective than enacting legislation.

Dr. Fuhr submitted that he does not think the marketplace is moving that way at all because employers are still controlling it. He noted that Dr. Rudnick testified at the previous meeting that he had been with Intergroup for four years, and even though chiropractic service is offered, it is not being utilized. Dr. Fuhr contended that there must be some kind of accountability to the plans. He said freedom of choice can be discussed but he still believes there is a direct access problem because the nurse practitioner and physical therapist both said they are having a problem. He noted that the chiropractic profession is certainly having problems with direct access, and once they receive direct access, problems are encountered regarding payments. He added that CIGNA is now paying \$13 for an office call, and practitioners are dropping out of the plan because they cannot afford to take patients. He stated that this is not the marketplace running correctly. People do not sign up for holistic plans but what is offered by the employer from the large plans in Arizona.

Mr. Barclay explained that CIGNA has a contract with a national provider network (PCMC) which provides the panel of chiropractic physicians in the state. He related the following statistics regarding CIGNA's usage of chiropractic services from the period October 2, 1995 to February 29, 1996 in Northern Arizona:

- There were 4,426 chiropractic visits and 745 patients which averages out to 5.7 visits per patient. Of the 745 patients, 392 x-rays were taken.

He said this is certainly different from the Intergroup experience. He commented that it is far beyond the purview of the Subcommittee to address provider compensation issues as alluded to by Dr. Fuhr. He said he does not know what CIGNA pays the chiropractors but he has been informed that it receives one request per week from chiropractors interested in joining the network. He surmised that if it was so bad, there would not be such interest. He reiterated the fact that the Subcommittee should not discuss the issue of provider compensation, etc. He added that he believes the chiropractor who testified several weeks ago did say things have changed with Intergroup, and he is starting to see a glimmer of hope.

Dr. Fuhr, referring to PCMC, stated that the reason people are calling in is because they have not been in the plan and do not know what they would get paid. He affirmed the fact that chiropractors in Mesa, with about a year's experience, are averaging \$13 per office call and cannot afford to take patients. He suggested that the Subcommittee owes it to the main Committee to make them aware of what is happening.

Ms. Abalos stated that she has survey results from the small business community regarding health care coverage. The information is taken from a state ballot sent out every year by the National Federation of Independent Business (NFIB) to Arizona small business owners (groups of employees from 3 to 40):

- Small business owners believe that the responsibility for insurance purchasing decisions should be borne equally by the employer and the employees.
- In 1995, 33 percent of the business owners responding said they offered coverage to all of their employees. This does not mean the business owner was paying for the coverage. Twenty-one percent said they offered coverage to some of their employees (probably the business owner and not the rest of the staff).
- In 1994, 38 percent of the business owners said they actually paid for health coverage for their employees.
- Small business owners believe tax incentives should be given to encourage small business owners to provide health insurance coverage.
- Small business owners believe that hospitals and physicians should be required to charge health insurance companies no more than what they would receive under Medicare.
- Over 86 percent said they do not want mandated health insurance coverage but freedom of choice. In that freedom of choice, they would like to decide whether or not to provide coverage to employees and the ability to decline certain benefits.
- Small business owners believe that the business marketplace or the consumer, not the government, should determine what is included in health insurance policies. Instead of mandated coverages, perhaps there could be a provision for options so they could choose and customize the insurance policy based on the employees' needs, cost considerations, etc.

Mr. Barclay asked if there is a trend in terms of whether the employer cost of coverage is going down or remaining stable. Ms. Abalos answered that she tried to make a determination but the question was not asked consistently over the last five years so she was unable to obtain a sense for that. She added that in 1990, 46 percent of the respondents said they provided employee health insurance. Sixty percent of those who did not provide health insurance said it was too costly. As of 1995, 33 percent are providing for all employees; 20 percent for some.

Mr. Barclay advised the Members of a discussion in another meeting relating to notch group coverage for people above the AHCCCS poverty line. He indicated that health care coverage is extremely price driven in the small group market, and it is very tough for small employers in a voluntary

environment to continue to provide coverage. He advised the Committee to keep that in mind if attempts are made to add any additional layers to coverage.

(Tape 1, Side B)

Chairman McNamara noted that the small employers do not want mandated benefits but do want the option to decline certain benefits with the consumer making the decision as to what should be included in health insurance policies. She asked if the consumer would be the employer. Ms. Abalos replied that it would be a joint decision by the employer and employees.

Representative Grace asked Ms. Abalos how many small business employers offer flexibility in health care plans. Ms. Abalos replied that she does not know if the products that the small business community are eligible for are very flexible. She surmised that the small business owner, in making a decision, will first insure that the insurance product covers his/her own family to the degree that they need or want; secondly, determine if it is acceptable to the employees; and thirdly, consider the cost.

Chairman McNamara referred to POS and direct access. She asked if recommendations need to be made from a small business perspective. Ms. Abalos conveyed a concern that if something is mandated that would increase the cost of health insurance to the employer, it could hinder small businesses from providing insurance for the employees. She noted that if people have options, even with POS, and it means they will bear an additional cost on their own, it is all right as long as that is understood.

Ms. Abalos indicated that another health care survey has been sent out by NFIB. As soon as she receives the results, she will share it with the group.

Chairman McNamara suggested that a position statement be prepared reflecting the discussion concerning consumer choice and availability of services but not necessarily recommending legislation, to be presented to the full Committee for decision making among the Legislators. Mr. Barclay said it may be appropriate to have Mr. Drake prepare a draft for the Subcommittee to review. Representative Grace agreed that this would be a good course to take. She sensed that the Members are not comfortable with mandates and requested that Mr. Drake prepare a draft.

Chairman McNamara referred to the Kennedy Kassenbaum bill and asked the Members if they wish to discuss its implications for the state.

Mr. Barclay said he believes it is being reviewed by Subcommittee #1, and ADOI has been reviewing what needs to be done as a state in order to be in compliance in the next six months to one year. He speculated that everyone agrees that the state plan should be customized to Arizona's needs. He said the Kennedy Kassenbaum bill stipulates that if the state does not develop its own plan by a certain date, federal regulations apply.

Ms. Abalos conveyed the fact that Medical Savings Accounts (MSAs) are included in the Kennedy Kassenbaum bill. The accounts have been in existence in Arizona for several years but small business employers have not taken advantage of them because of associated administrative costs, etc. However, since there is now a federal product, and Arizona has a program in place, she said she is curious to see how the health care industry will be affected and what choices the small business owners will make.

She explained that these accounts provide a choice for the consumer. A medical savings account is set up, and the employer could choose a health insurance plan with, for example, a \$2,000 deductible to reduce the cost of the insurance product substantially. That \$2,000 per employee would be placed into an MSA, and the employee could see a physician and pay out of that account for health care needs. At the end of two years, if that money is not spent, it belongs to the employee. Discussion followed concerning specifics of the program. Mr. Barclay stated that it might be feasible to recommend enabling legislation allowing state-regulated HMOs to offer a high deductible product. More discussion followed concerning policing of the program, and long-term care implications of the bill.

Chairman McNamara asked if this discussion should be included in the position paper, and the Members agreed that it should.

Public Testimony

There was no public testimony given.

(The following information was distributed to the Members from Dr. Fuhr before the meeting: Letter from Dr. Rudnick, Tucson Chiropractic Center, Inc. (Attachment 5); Special Article *Does Increased Access to Primary Care Reduce Hospital Readmissions?* (Attachment 6); Chiropractic Patients Are More Satisfied with their Care (Attachment 7); Health of the Public *The Private-Sector Challenge* (Attachment 8); Special Communications *The Expanding Scope of State Legislation* (Attachment 9); and Health Care Policy: A Clinical Approach *Capitation or Decapitation - Keeping Your Head in Changing Times* (Attachment 10).

Without objection, the meeting adjourned at 2:25 p.m.


Linda Taylor, Committee Secretary

(Original minutes, attachments, and tape are on file in the Office of the Chief Clerk.)

ARIZONA STATE LEGISLATURE
Forty-second Legislature - Second Regular Session

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**JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY
Subcommittee #2**

Minutes of Interim Meeting
Tuesday, October 29, 1996
House Hearing Room 3 - 1:00 p.m. to 3:00 p.m.

(Tape 1, Side A)

The meeting was called to order at 1:05 p.m. by Chairman McNamara and attendance was noted by the secretary.

Members Present

Representative Grace
Representative Mortensen
Ms. Sandra Abalos
Mr. Steve Barclay
Arlan Fuhr, D.C.
Ms. Anne McNamara, Chairman

Members Absent

Senator Hartley
Representative Nichols

Speakers Present

Jim Drake, Majority Research Analyst, House of Representatives
Carol Cure, Registered Lobbyist, representing Golden Rule Insurance Company

* * *

At the request of Chairman McNamara, the Subcommittee members briefly introduced themselves.

Joint Interim Study Committee
on Health Care Quality
Subcommittee #2
10/29/96

Approval of Minutes

Representative Grace moved that the Subcommittee minutes dated October 15, 1996 be approved as written (Attachment 1). The motion was seconded by Mr. Mortensen.

Testimony from Guest Speakers

Jim Drake, Majority Research Analyst, House of Representatives, advised that Carol Cure would be arriving at 1:30 p.m. to speak about medical savings accounts (MSA).

Discussion and Review of Proposed Subcommittee Report

Chairman McNamara explained that a preliminary summary report was developed by Mr. Drake (Attachment 2) based on deliberations in previous meetings, and mailed to Committee members along with an invitation to make any desired changes. She mentioned that she took the liberty of modifying the report extensively (Attachment 3). She opened the floor to discussion on Mr. Drake's report.

Mr. Barclay said that given the disparate views among Subcommittee members, it would be difficult to reach any consensus on a single report. Given this, he stated his feeling that Mr. Drake's report captures the essential elements of previous discussions while Chairman McNamara's report goes into greater detail and may be considered inappropriate for blending purposes.

Chairman McNamara briefed Dr. Fuhr, who arrived late, on the actions of the Subcommittee.

Mr. Barclay approved of the opening paragraph under Findings in the "Drake Report" (Attachment 2) and noted that the "McNamara Report" (Attachment 3) lacks similar language. He suggested such disclaimer language be included in the McNamara Report because of the vastly divergent views of the Subcommittee members.

There was some question as to which report the Subcommittee should work from. Dr. Fuhr stated his preference to work from the McNamara Report. The consensus was to conduct a paragraph-by-paragraph review of the McNamara Report.

Chairman McNamara said the Overview section states the purpose and establishment of the Subcommittee. There being no disagreement, the section entitled Overview was not modified.

Chairman McNamara noted that the Membership section merely lists members. There being no disagreement, this section was not modified.

The Subcommittee focused on paragraphs 1, 2 and 3 under the Process section. There being no disagreement, this language was not modified.

Focusing on paragraph 4 under the Process section, Chairman McNamara explained that she used the controversial term “specialist” with the understanding that it would be further discussed. Dr. Fuhr confessed that the term “specialist” was a major point of contention for him.

Chairman McNamara explained that paragraph 5 under the Process section lists the names of individuals who testified on their own behalf in previous meetings. She noted that she did not include the names of individuals who seemed to be representing larger organizations.

Mr. Barclay suggested that the second full paragraph from page 2 of the Drake Report be included immediately after paragraph 5 under the Process section in the McNamara Report because it describes the nature of the testimony heard in previous meetings. It was agreed that the first sentence of the paragraph copied from the Drake Report would not be included in the McNamara Report.

Ms. Abalos suggested that the third full paragraph from page 2 of the Drake Report dealing with statutory investigations also be included in the McNamara Report. There was no disagreement from the Subcommittee.

Chairman McNamara focused attention on the Current Models section in the McNamara Report. Mr. Barclay suggested modifications, as indicated below by underline. Ms. Abalos recommended a change as denoted in italics below:

Health Care Services Organizations (HMO's) represent one of a variety of models providing health care plans to individuals and businesses in Arizona. Most of the current HMO models use the MD/DO as the “gatekeeper” or “coordinator of care” for persons enrolled in health plans. Consumer demand has initiated changes in “direct access” opportunities for consumers. Therefore, new HMO products are allowing consumers for some new HMO products to make direct appointments with certain pre-determined MD/DO's without approval of the primary care provider. A report prepared by the American Association of Health Plans, revealed twenty one states have *some form of* direct access availability although most are on a limited basis. This report brought to light thirteen states currently have direct access to OBY/GYN, two to Chiropractic, one to Podiatry, one to Optometry/Ophthalmology, one to Dermatology, and one to registered nurse practitioners (nurse midwives/nurse anesthetist, nurse practitioners). Although the trend is moving toward direct access, very few options are available to consumers, beyond the traditional MD/DO model.

Mr. Barclay questioned the need for the final sentence of the above language, while Dr. Fuhr supported its inclusion and suggested that the words “very few” be changed to “some.”

Mr. Barclay stated that Dr. Fuhr's lack of direct access to patients does not necessarily mean that very few options are available to consumers. He expressed his interest in hearing testimony

about medical savings accounts which are designed to let individuals seek services from the provider of their choice. He shared his belief that the final sentence is misleading.

Representative Grace said that the final sentence may be written so generally that one would be unable to draw a conclusion. Mr. Barclay submitted that language copied from the Drake Report to the McNamara Report which reads, "Several members of the subcommittee believe that if changes are in fact being made, the change is arriving at a pace that is far too slow." adequately relates the unhappiness of some people who feel the market is not changing quickly enough.

Chairman McNamara recommended that the MSA testimony to be presented to the subcommittee by Ms. Cure be included under the Current Model section of the McNamara Report. Dr. Fuhr returned attention to the final sentence dealing with HMO's, and indicated his unhappiness over the idea of HMO's being assigned by employers to employees because it eliminates choice and makes only some options available. Mr. Barclay proposed a more agreeable final sentence, as follows:

Although the trend is moving toward direct access in HMO'S, few HMO'S are prepared to abandon the traditional MD/DO model.

The proposed language brought no disagreement from subcommittee members.

Chairman McNamara said the intent of the second bullet under the Recommendations section was to make "gatekeepers" or "coordinators of care" true integrators of care. She noted that the summary statement taken from Managed Care (April, 1996) is strictly for substantiation and could use some fine tuning.

Mr. Barclay cautioned that the language "making" something happen tends to connote a need for legislation. He instead suggested that the second recommendation be modified to read:

Encourage physician gatekeepers/coordinators of care to be true integrators of care.

Mr. Barclay discouraged the subcommittee from pointedly endorsing any published article because it will create a snowball effect of articles offering counter viewpoints. Mrs. Grace indicated that some type of explanation of Mr. Barclay's suggested sentence would be beneficial.

Discussion ensued between Ms. Grace and Mr. Barclay regarding how best to modify the language in Recommendation 2 of the McNamara Report. Ms. Abalos and Mr. Barclay suggested modifying Recommendation 2 to read:

Encourage physician gatekeepers/coordinators of care to be true integrators of care. Gatekeeper models *may* limit, rather than truly integrate patient care. Gatekeepers *may be* penalized for referrals to specialists, and those that

experience the trauma related to delayed decision making may be parents/families.

Chairman McNamara stated that references are a good idea overall, but agreed to remove the reference contained in Recommendation 2 of the McNamara Report. She suggested the Subcommittee include a statement that Recommendation 2 needs more exhaustive study. Mr. Barclay suggested that the report submitted to the full Committee be prefaced with a statement that the Subcommittee merely scratched the surface in four meetings, and does not profess to have answers to all the questions.

Testimony from Guest Speakers

Carol Cure, Registered Lobbyist, representing Golden Rule Insurance Company, said Golden Rule began using medical savings accounts (MSA) within Arizona in 1994. She asserted that MSA's represent the ultimate in patient choice and shared her belief they will be tremendous cost savers in reducing medical outlays unrelated to health care needs.

Ms. Cure prefaced her presentation with the statement that her information is speculative since companies are still in the process of instituting new products and marketing techniques. She predicted that interest in MSA's will explode once the general public learns of them.

Ms. Cure related that a survey conducted by Blue Cross/Blue Shield (BCBS) determined that 43 percent of employees would switch to an MSA if given the opportunity. She further shared that a study done by the Kiser Harvard Foundation similarly determined that 43 percent of employees would opt for an MSA.

Ms. Cure reported that of the 1,200 employees working for Golden Rule in Illinois and Indiana, 98 percent chose an MSA. Those who declined were insured through a spouse's plan.

Ms. Cure said it is very clear that by the first reporting period of April 30, 1997, the 750,000 cap under the Kennedy-Kassebaum bill will be exceeded. She added that the Treasury Department will then be expected to announce no new enrollments as of September 30 or October 1 of 1997, by which time Congress will hopefully become aware of the booming interest in MSA's.

Ms. Cure highlighted a shortcoming of MSA's as being the plan contribution limit during the first year. She offered to make these figures available to Mr. Drake as soon as they are received.

Mr. Barclay remarked that during debates on the Kennedy-Kassebaum bill and Medicare reform, the issue was raised that MSA's would siphon away only the healthy from traditional health care programs. Ms. Cure said that Golden Rule does not anticipate studying this issue because entities which have previously offered MSA's to their employees found universal acceptance of the program among the healthy and sick.

Mr. Barclay stated that empowering consumers to purchase their own health care services will unfortunately leave them vulnerable to cost shifting and, due to the loss of bulk purchasing power, subject them to nearly full-rate prices for health care services. He questioned how the loss of bargaining power will be addressed. Ms. Cure replied that an examination must be made of the manner in which various plans will be administered.

Mrs. Grace posed the questions:

- ▶ How comprehensive would an MSA be in terms of catastrophic illness?
- ▶ What would entice a sickly person to switch to an MSA?

Ms. Cure shared her understanding that when an individual purchases an MSA, a comprehensive catastrophic policy will kick in at a certain level of account funding.

Ms. Abalos asked Ms. Cure if *employer*-funded MSA's will become the norm. Ms. Cure indicated uncertainty.

Ms. Abalos remarked that if funding is to be provided by *employees*, there would seem to be very little reason for ill people to participate in MSA's. Ms. Cure concurred and expressed her hope that more *employers* will fund MSA's.

Ms. Abalos explained that unexpended monies in an MSA will roll over, as is the case with individual retirement accounts (IRA). Ms. Cure predicted that a large percentage of people will see their MSA investment roll over year after year, and added that unexpended premiums under traditional medical plans benefit only the insurance companies.

Chairman McNamara stated that the concept of MSA's should be shared with the full Committee. She made the recommendation to integrate the concept of MSA's in Arizona to ensure compliance with federal mandates.

Mr. Mortensen pondered the possibility of MSA's being funded jointly by employers and employees. Ms. Cure replied that such an option will be available to employers.

(Tape I, Side B)

Mr. Barclay approved Chairman McNamara's recommendation.

Ms. Abalos asked if Arizona statutes will require modification in order to dovetail with federal legislation. Ms. Cure indicated no knowledge of potential contradictions with federal legislation. Dr. Fuhr mentioned that he casually overheard a Senator say that a certain provision in state statutes would need to be fixed in order to comply with federal standards.

Chairman McNamara said the subcommittee should include a statement requiring an investigation of whether or not additional state legislation should be facilitated before the end of 1996.

Mr. Mortensen questioned what action would be taken if an individual with an MSA exhausts funds available under catastrophic coverage. Mr. Barclay recognized this as a potential problem area for MSA's that are not yet fully funded. He suggested that individuals and employers be encouraged to fund their MSA's as quickly as possible.

Mr. Barclay shared his belief that IRA's can be accessed for health care needs. Mr. Mortensen pondered whether an IRA could function jointly as an MSA. Ms. Abalos explained that an IRA is dedicated exclusively to retirement while an MSA is designated for medical purposes.

Mrs. Grace noted that implementation of the Kennedy-Kassebaum bill is a policy issue, and she questioned whether the Department of Insurance (DOI) will aggressively take the lead or merely await legislative action. Mr. Barclay reported that DOI intends to take its lead from the Governor.

Mrs. Grace emphasized that the full Committee should be encouraged to be proactive with regard to the Kennedy-Kassebaum bill and implement its own laws rather than allow federal standards to take effect. Ms. Abalos advised that time is of the essence.

Mrs. Grace suggested that Greg Harris of DOI be invited to the full Committee hearing for the purpose of helping to develop a recommendation.

Discussion and Review of Proposed Subcommittee Report (continued)

Referring to page 3 of the McNamara Report, Chairman McNamara admitted that the first sentence of the first bullet may be too strong.

Mr. Barclay explained that "basic benefit package" is a defined term under the accountable health plan act and should, therefore, not be referred to casually. He instead suggested the first sentence read: "Encourage the integration of other health care professionals (non MD/DO) into the health care delivery systems of managed care organizations."

Dr. Fuhr agreed with the first sentence as originally drafted in the McNamara Report. He explained that nurse practitioners and chiropractors produce cost savings, yet are consistently thought of as "add-on" care. Mr. Barclay said that low-cost options must be made available to smaller employers who cannot afford the "Cadillac plan." Specifically, he suggested that instead of raising the floor by including other health care professionals, smaller employers should have the opportunity to purchase a minimal plan and select extra options such as chiropractic care, etc.

Dr. Fuhr pointed out that other health care professionals actually save money and therefore do not result in increased costs for insurance companies. He questioned the reasoning behind

categorizing nurse practitioners, chiropractors or optometrists as plan "extras" because they will not result in additional costs to small businesses. Mr. Barelay retorted that the jury is out on this issue.

Mrs. Grace indicated a reluctance to base a decision on the limited information available to the subcommittee. Dr. Fuhr advised that the Agency for Health Care Policy & Guidelines concluded that spinal manipulation was the choice for lower back pain in adults. He strongly urged the subcommittee to recommend that other professions be integrated into the basic benefit package.

Mr. Barelay acknowledged the vastly divergent views of the members and stated that although many sides of the issues have been shared, the subcommittee recommendations should reflect that no definitive conclusions were reached with regard to the differing opinions of himself and Dr. Fuhr. Dr. Fuhr stated that it is the subcommittee's responsibility to provide recommendations for consideration by the full Committee.

In the spirit of compromise, Chairman McNamara suggested that instead of the language contained in the first bullet of page 3 of the McNamara Report, the subcommittee develop consensus language encouraging integration, versus an order to integrate. She also indicated her desire for a statement recognizing variables such as cost-effectiveness, quality and patient satisfaction.

Dr. Fuhr agreed with the first sentence of bullet 1 as originally written on page 3 of the McNamara Report. Discussion ensued with regard to the inclusion of references and cross-references.

Chairman McNamara suggested the first bullet be reworked to begin with Mr. Barelay's suggested sentence, followed by a statement recognizing variables such as cost-effectiveness, quality and patient satisfaction. She said that a reference to various studies could be included as well.

Dr. Fuhr said that because most people do not read references, he would like to have actual examples included in the recommendation. Mr. Barelay said he would not mind language which reads: "A growing number of studies suggest that cost-effectiveness, quality and patient satisfaction can be achieved through services provided by other health care professionals. Attached to this report are copies of some of the studies for further reading." Dr. Fuhr disapproved of this recommended language.

Mrs. Grace suggested the language mention that the subcommittee focused on chiropractors and nurse practitioners. Mr. Barelay objected to lending any type of endorsement to a particular field of practice.

After a bit more discussion, Chairman McNamara indicated her intention to develop and circulate language reflective of the studies reviewed by the subcommittee.

Focusing on the second bullet on page 3 of the McNamara Report, Mr. Barclay said he drafted language recognizing the cost impact to small business and the need to keep an array of low-cost options available to small businesses.

Ms. Abalos suggested the subcommittee adopt the language listed as the last bullet of page 7 of the minutes from the October 15, 1996 meeting. Mr. Barclay withdrew his previous statement in favor of Ms. Abalos' suggestion.

With regard to the third bullet on page 3 of the McNamara Report, Mr. Barclay suggested the language be modified to read: "Integrate the concept of 'Medical Savings Accounts' in Arizona to assure compliance with federal mandates *and increased choices for consumers.*"

Mrs. Grace emphasized that MSA's will result in more choice and allow individuals to be more involved in structuring a personalized health care program.

In response to Chairman McNamara's suggestion that an additional bullet be added to page 3 of the McNamara Report, Mrs. Grace recommended the following language: "The Subcommittee recommends that the legislature take action to implement Arizona's own version of the Kennedy-Kassebaum bill instead of allowing the federal law to take effect."

In response to Mrs. Grace, Mr. Drake explained that the handout entitled Key Elements Comparison Summary of Health Insurance Portability and Accountability Act of 1996 to Existing State Laws Applicable to Accountable Health Plans (Attachment 4) was distributed to Subcommittee #3 and seems to indicate that MSA's currently in place will not require any modification. He added that he personally sees no need for very much change.

In response to Mr. Mortensen, Mrs. Grace said that two meetings of the full Committee have been calendared. She also noted her intention to check on whether a legislator has already opened a file on MSA's.

Chairman McNamara directed attention to the last bullet on page 3 of the McNamara Report. Mr. Barclay modified the language to read: "*Encourage* communication mechanism for *employers and employees* to make their desires and needs known to the managed care company *in regard to services and benefits.*" He mentioned that Representative Nichols (who was absent) firmly supports the further development of long-term care products.

The Subcommittee focused on the Summary statement on page 3 of the McNamara Report. Mr. Barclay suggested the paragraph be modified to read:

"Subcommittee 2 submits this report to the full committee recognizing the time constraints and limitations of the members involved. We recognize the importance of these topics to the health and well being of Arizonans. The philosophy of managed care as the predominant health benefit payment system is admirable. The goals of cost containment, patient satisfaction, and quality

outcomes are consistent with the charge given to this subcommittee. We recognize that *the healthcare marketplace* is dynamic and must be responsive to consumer/provider demands. This report *recognizes that* contributions *are* made by other healthcare providers beyond the MD/DO model and suggests that *further integration* of such providers in the *health care delivery system may serve to* enhance the economic and quality goals of managed care service organizations.”

Dr. Fuhr stated that the paragraph under Recommendations in the Drake Report would make a nice second paragraph under the Summary section in the McNamara Report, provided it is prefaced with the words: “Members of the Subcommittee ...” In the interest of peace, Mr. Barclay agreed and suggested that the word “However,” be stricken from the second sentence.

Chairman McNamara opened the floor to public testimony. There being none, the meeting was adjourned at 2:50 p.m.



Teresa Alvarez, Secretary

(Original minutes, attachments and tape on file in the Office of the Chief Clerk.)

ARIZONA STATE LEGISLATURE
Forty-second Legislature - Second Regular Session

**JOINT INTERIM STUDY COMMITTEE ON
HEALTH CARE QUALITY
Subcommittee #3**

Minutes of Interim Meeting
Tuesday, September 17, 1996
House Hearing Room 3 - 3:00 p.m.

(Tape 1, Side A)

The meeting was called to order at 3:11 p.m. by Representative Sue Grace and attendance was noted by the secretary.

Members Present

Barbara Aung, D.P.M., President, Arizona Podiatric Medical Association
John M. Cruickshank, D.O., Medical Director, Scottsdale Memorial Family Care
Barbara Keilberg, Director, Health and Medical Services, Motorola Semiconductor Products Sector,
represented by Cathe Flynn-McBride
Representative Sue Grace
Senator Sandra Kennedy
Senator David Petersen

Members Absent

Senator Ann Day (excused)
John Nimsky, Vice President, Network Management, Blue Cross and Blue Shield (excused)
Marci L. Hendrickson, Marketing & Contract Coordinator, FHP, Inc.

Speakers Present

Lisa Block, Health Analyst, House of Representatives
Kitty Boots, Health Analyst, Arizona State Senate

Dr. Cruickshank volunteered to chair the Subcommittee following a request by Representative Grace, who also cited the Subcommittee's charge to study provider credentialing, contracting and termination and provider access to managed care networks (see Attachment 1).

The following documents were made available for perusal:

Draft National Association of Insurance Commissioners (NAIC) Health Care Professional Credentialing Verification Model Act (Attachment 2)
Health Insurance Purchasing Alliances (Attachment 3)
The Business Journal article dated August 9, 1996 (Attachment 4)
American Association of Health Plans (AAHP) State Health Policy Survey (Attachment 5)
The Cost Impact of "Any Willing Provider" Legislation by Atkinson & Company dated 6/27/94 (Attachment 6)
American Medical Association "Any Willing Provider" Legislative Overview (Attachment 7)
October 1995 National Conference of State Legislatures (NCSL) article: The Debate Over "Any Willing Provider" (Attachment 8)
Editorial in regard to "Any Willing Provider" laws dated July 1994 (Attachment 9)
Draft NAIC article on Provider Network Adequacy and Contracting Model Act (Attachment 10)
Article on Small Group Market Reforms (Attachment 11)

Noting the inefficient manner in which the credentialing process is handled, Dr. Cruickshank said it currently takes from four months to a year to obtain a provider credential.

Senator Petersen requested an update on the current situation. Dr. Cruickshank said it is unfortunate that Mr. Nimsky was unable to attend the meeting because he is aware that Blue Cross has experienced problems in that regard. He added that complaints have been received from doctors and Health Maintenance Organizations (HMOs), and that patient care is affected, and said he believes a clean package should be processed in sixty to ninety days.

Mrs. Grace called attention to the draft NAIC "Health Care Professional Credentialing Verification Model Act" (Attachment 2), which she pointed out, is a model that can be implemented by the states. Dr. Cruickshank expressed interest in the draft and noted that the NAIC, National Committee for Quality Assurance (NCQA) and all other health plans that contract with providers and hospitals are involved in the process.

In regard to provider contracting, Dr. Aung said while providers are told what the managed care organization requires, she is interested in the criteria that must be met in order to become a provider, and which issues cause termination. Dr. Cruickshank opined that while termination is spelled out in the contract, the real issue involves criteria and selection. He questioned whether patient satisfaction surveys are used in credentialing and said he doubts the process is very scientific. Dr. Aung concurred and noted that board certification is not available to younger practitioners. Dr. Cruickshank proposed that the Subcommittee could seek information from some of the top health plans in the market place.

Lisa Block, Health Analyst, House of Representatives, observed that she has arranged for speakers to address the next meeting. Mrs. Grace asked that a representative of the Arizona Department of Insurance (DOI) also be invited to speak to the Subcommittee at that time.

Senator Petersen asked if doctors are being terminated from the plans, or are leaving voluntarily, and requested information on the pervasiveness of the problem. Dr. Cruickshank said while individual health plans would have the information sought, he understands a majority of terminations are due to a difference between specialized and primary care physicians. He said he believes the lack of primary care doctors deserves further discussion, and added that he will be happy to share his opinions on the subject after the speakers have been heard.

In regard to a study of provider access to managed care networks, Dr. Cruickshank pointed out that access is becoming more and more difficult for specialty care physicians.

Dr. Aung reiterated her concern that younger practitioners who are specialized are having a difficult time in becoming board certified, and asked how they can meet the criteria.

Dr. Cruickshank observed that the HMO lock on the market place is causing much lower salaries and less autonomy.

Noting that the focus of care has changed, Mrs. Grace asked how the changes affect nursing.

Senator Petersen asked if the state's medical schools are preparing doctors for the changes. Dr. Cruickshank said he believes the expectations of young doctors are much different than they were just ten years ago; and although he is not aware of the situation in regard to nursing care, there has been a shift from hospital to out-patient care and a change in emphasis from disease management to health care. He added that medical schools now focus on primary care, and nurse practitioners and physician assistants (P/As) are an extension of the primary care doctor.

Mrs. Grace sought information on physicians serving in rural communities, and proposed that a medical school representative be asked to address the Subcommittee. Dr. Cruickshank noted that retraining of specialists to primary care is now taking place at the University of Arizona in Tucson, and discussion ensued.

Kitty Boots, Health Analyst, Arizona State Senate, advised that rural rotation is still required.

Senator Petersen asked to see the findings of a Blue Ribbon Governor's Committee in regard to quality of care issues.

Dr. Cruickshank said it is necessary to ascertain where the trade-off lies between quality and affordability, and at what level of premium quality care cannot be delivered. He noted that although California has premiums ranging in the \$70s, it would not be possible to practice quality care in Arizona at that price. He added that employers have no way to measure quality.

Mrs. Grace remarked that although preventative care lowers long term costs, businesses usually select the product that is the cheapest today. She asked how existing resources can be better spent. Dr. Cruickshank concurred that a redefinition has occurred, managing health rather than disease.

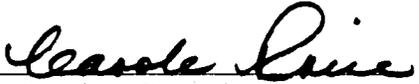
Dr. Aung pointed out that patients frequently do not know what services they will receive, and said it is important that the HMO inform the employer or the employee what items are covered. Mrs. Grace added that people also do not know what they are going to need.

Ms. Flynn-McBride agreed that most people make their decisions based upon the lowest price.

Senator Petersen suggested that it may be possible to come up with a basic set of standard questions to ask. Dr. Cruickshank said it is the responsibility of the health plan and the employer to work together to answer employees' questions. He added that the problem of obtaining insurance with preexisting conditions also needs study.

Ms. Block said Senator Day asked if the Subcommittee could meet earlier in the day, and it was agreed to review the matter.

Without objection, the meeting adjourned at 4:10 p.m.


Carole Price, Committee Secretary

(Original minutes with attachment and tape on file in the Office of the Chief Clerk. Copy of minutes on file with the Secretary of the Senate.)

ARIZONA STATE LEGISLATURE
Forty-second Legislature - Second Regular Session

**JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY
Subcommittee #3**

Minutes of Meeting
Tuesday, October 1, 1996
House Hearing Room 3 - 3:00 p.m.

(Tape 1, Side A)

The meeting was called to order at 3:11 p.m. by Chairman Cruickshank and attendance was noted by the secretary.

Members Present

Dr. Barbara Aung
Ms. Marci Hendrickson
Dr. John Cruickshank, Chairman

Mr. John Nimsky
Senator Petersen

Members Absent

Ms. Barbara Keilberg
Representative Grace

Senator Day
Senator Kennedy

Speakers Present

Steve Barclay, Counsel/Lobbyist, Arizona Association of Health Maintenance Organizations (HMOs)

Dr. James Krominga, Vice President of Medical Affairs, Family Health Plan (FHP)

Dr. Tom Davis, Associate Medical Director, Humana Healthcare Plans

Cindy Corsbie, Director, Planning and Development, Greater Arizona Central Credentialing Program (GACCP)

Joan Johnson, Program Manager, Office of Home and Community Based, Division of Insurance and Licensure, Arizona Department of Health Services (ADHS)

Elaine Hugunin, Deputy Director, Board of Medical Examiners (BOMEX)

JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY - SUBC. #3
OCTOBER 1, 1996

Chairman Cruickshank introduced and welcomed three new members: Mr. Nimsky, Ms. Hendrickson, and Dr. Aung.

Chairman Cruickshank moved, seconded by Dr. Aung, that the minutes of the September 17 meeting be approved. The motion carried.

Steve Barclay, Counsel/Lobbyist, Arizona Association of Health Maintenance Organizations (HMOs), noted that two distinguished medical directors are present to speak on provider selection and credentialing. He added that they are serving on the Governor's Task Force on Health Maintenance Organization (HMO) Quality Issues.

Dr. James Krominga, Vice President of Medical Affairs, Family Health Plan (FHP), stated that a thorough credentialing of physicians for FHP is conducted in order to insure the quality of the FHP physician network and to satisfy the Arizona Department of Insurance (ADOI) statute requiring health care plans to credential physicians.

He explained that the major accrediting body for managed care organizations is the National Committee for Quality Assurance (NCQA) which has established detailed criteria for credentialing physicians (Attachments 1 and 2). One of the hallmarks of credentialing physicians is primary verification of the applicant's education. This is a very lengthy process, especially if the applicant trained out of state or out of the country. This is followed by a check of the National Practitioners Data Bank (a national repository of malpractice problems or serious allegations made against physicians). Any hospital where the applicant has privileges is also queried. It takes approximately three months to complete an initial credentialing process.

Dr. Krominga said many physicians and other providers are concerned about how physicians are chosen for network development. He explained that it varies greatly from plan to plan, depending on the state of development in the geographic area and the penetration of managed care in the particular community. He related that when FHP began building networks in Arizona nine years ago, many physicians hesitated to participate in the plan. Currently, many who chose not to participate are feeling left out, particularly those in specialty practices.

He commented that there is no reason to add a large number of specialty physicians to an existing network if there is not a concurrent increase in membership to keep all of the physicians busy. It is a supply and demand situation. The primary care physicians in Arizona are in limited supply, and thus, in great demand by all of the health care organizations. Some of the specialty areas in medicine are in oversupply, so they are in less demand.

Chairman Cruickshank asked about FHP's attempt to participate in a statewide effort to unify the credentialing process. Dr. Krominga replied that FHP is participating with the Greater Arizona

Central Credentialing Program (GACCP) for primary verifications. He expressed his support of one organization performing these verifications for every health plan. He related that each health plan has to conduct some individual investigating but the major delay is in primary verifications. He added that health plans are not notified when a new physician joins a group until the physician is working in the group. He stated that it would be helpful if notification is provided in advance so credentialing can be done and there is no delay in providing care.

Dr. Tom Davis, Associate Medical Director, Humana Healthcare Plans, said he has been involved with managed care in Maricopa County since 1974. He noted that credentialing has become a very difficult, laborious, and expensive proposition, and there is much opportunity for improvement.

He explained that in the 1970's credentialing with an HMO was rather informal. A doctor filled out an application and submitted copies of his/her license. The documentation was reviewed by the Director, who checked with the applicant's peers, and the applicant was credentialed. However, with the movement by employers toward accountability and value, as well as credentialing through the Joint Commission on the Accreditation of Health Care Organization (JCAHO), credentialing has become an important issue. In the early days of HMOs, it was believed that the participating doctors were second-class citizens, and credentialing and documentation of training, etc. mushroomed from that premise.

Dr. Davis said many physicians question the need for recredentialing. Again, this goes back to accountability. Referring to standards for recredentialing (Attachment 2), he pointed out that accrediting bodies outline the responsibilities that health plans must take in terms of dealing with physicians who may not be meeting quality standards. Another standard requires that the managed care organization provide an appeals process for instances in which an organization chooses to alter the conditions of the practitioner's participation based on issues of quality of care/service.

He conveyed the fact that Humana is applying for accreditation with JCAHO which accredits most of the hospitals in Arizona. He endorsed GACCP's efforts to streamline the credentialing process. He expressed his approval of the health plans ultimately delegating the credentialing process to credentialing organizations with some overseeing to insure that standards are followed.

Chairman Cruickshank acknowledged that there is some confusion within the medical community and by the public with regard to gaining credentialing through JCAHO and NCQA, or both. He asked if problems are encountered by having separate accreditation processes which are duplicating the effort.

Dr. Davis answered that the credentialing and recredentialing standards are almost identical in the two organizations. He said one reason Humana is applying for accreditation with JCAHO is that if a physician is accredited at a Joint Commission hospital, JCAHO will accept that accreditation as

being valid. He opined that it is ludicrous for physicians to go through three or four credentialing processes.

Cindy Corsbie, Director, Planning and Development, Greater Arizona Central Credentialing Program (GACCP), conveyed the history of the development of the GACCP and provided an overhead presentation describing the initial application and reactivation processes, including guidelines established by NCQA and JCAHO, and timelines for verification (Attachment 3).

Chairman Cruickshank asked if a software program or information system is available to manage the process. Ms. Corsbie replied that an internal computerized software system was developed. That system is being reviewed so it can be updated in order to provide quicker turnaround time.

She related to Mr. Nimsky that the organization operates statewide. Credentialists, who undergo a 90-day training program, are continually hired. She indicated that the credentialing process currently does not include site visits. That portion is in the development stage and should be implemented by January 1997. She advised that a client monitor was established in January of 1996. At that time, clients were told that 80 percent of the applications would be processed within a 120-day period, and since then, that threshold has continually been exceeded.

Joan Johnson, Program Manager, Office of Home and Community Based, Division of Insurance and Licensure, Arizona Department of Health Services (ADHS), submitted that the licensure process for health care facilities involves a permit application. This is a series of documents reviewed by the Department which contain architectural or floor plans, building codes, different kinds of approvals and consents, and proof that the facility has adequate financial resources for operation and to finish modifications or construction. Presently this documentation is requested but there is no one in the Department to evaluate it.

The Department also asks for documentation providing the names and addresses of the owners/lessees of any agricultural land within one-quarter mile of the facility. After this information is received and reviewed, a written permit is issued, along with an application for licensure. This process may take several months, depending on circumstances.

The licensure application requires (by statute) proof of the governmental entity requesting the authority, names of the corporate officers, the type of health care institution, and the name of the person who has direct care of the facility. It is a two-page document which needs to be filed with the Department at least 60 but no longer than 120 days prior to the anticipated date of operation of the facility, or the expiration date of an existing license.

Upon review by the Department, the application is assigned to an individual surveyor or a team of surveyors. The surveyor/s contact the facility to set up an announced visit. A walkthrough of the

facility is performed to determine if there are any violations of the statutes or rules over that particular entity of classification/subclassification.

At end of the survey, there is an exit review performed by the surveyors with members of the agency. At that time, any observed deficiencies are discussed and documented. This document is provided to the facility with a request to return it to the Department within 10 days. It asks for a plan of correction, measures taken to prevent the incident in the future, the responsible party, and requires a reviewer's signature (usually the manager or administrative officer).

If deficiencies are corrected and the Department determines that the facility is in compliance with applicable laws and statutes, a license is issued. If problems still exist (environmental, etc.), the facility is revisited for follow-up. At that point, hopefully, it is in compliance, and a license is issued. She added that this process is performed annually. After the initial license, if there are no violations, a two-year license is issued.

Ms. Johnson related to Dr. Cruickshank that a facility with a renewal license which has not met the criteria is considered in substantial compliance (either by the number or nature of the deficiencies). If there are violations that could affect the health and safety of the residents, the Department must determine whether or not the community would benefit by issuing a provisional license. In this case, the Department has to determine that the facility can correct all that is wrong and it would be in the best interest of the persons at the facility to remain. If it is determined that it would not be in the best interest, the application is denied (by legal Administrative Law review). She stated that it takes approximately three months before a hearing is held. She pointed out that the Department does not issue many provisional licenses in proportion to the number of licensed facilities.

(Tape 1, Side B)

Elaine Hugunin, Deputy Director, Board of Medical Examiners (BOMEX), submitted a letter for the Members to review (Attachment 4).

Information from Lisa Block, Majority Research Analyst, was submitted to the Members for review (Attachments 5 through 11).

Dr. Aung asked how the HMOs choose providers for certain locations and determine how many providers of each specialty are needed. Dr. Krominga replied that in Phoenix and Tucson, there is about an 80 percent overlap on all of the health plans for their primary care network (obstetricians, gynecologists, internal medicine, and family practice). As far as primary care, most plans accept any good physician who will join the plan. The choice of specialists is different because there is a surplus. He explained that geographic areas must be covered so the members do not have to travel long distances, hospital privileges must be available in the hospitals that are contracted, and

appointment availability is needed. Appointment availability is monitored by the plans, and if there is not good access to specialty services, the Primary Care Physicians (PCPs) inform the health care plans. He explained that all health plans have certain availability standards but most require 24-48 hour urgent access to care, with routine care varying from three weeks to three months.

Chairman Cruickshank related that the discussion and testimony today have been very helpful. He surmised that the issues raised may not necessarily be legislative. He opined that the policing by GACCP, etc., is beneficial. He added that he had a concern about the quality of the people monitoring the physicians but that has been addressed. He expressed appreciation of the client monitoring that is being conducted by GACCP and congratulated the organization on its NCGQ certification. He indicated that frustration with regard to change and exclusions of some of the providers has not been adequately addressed.

Chairman Cruickshank announced that the next meeting will be held on Tuesday, October 15, from 1:00 to 3:00 p.m. in House Hearing Room 1.

Dr. Aung requested that Ms. Block duplicate some information to be distributed to the Members for review.

Dr. Aung moved, seconded by Mr. Nimsy, that the meeting be adjourned. The motion carried.

The meeting adjourned at 4:23 p.m.

Linda Taylor, Committee Secretary

(Attachments and tape are on file in the Office of the Chief Clerk.)

ARIZONA STATE LEGISLATURE
Forty-second Legislature - Second Regular Session

JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY
Subcommittee #3

Minutes of Interim Meeting
Tuesday, October 15, 1996
House Hearing Room 1 - 1:00 p.m. - 3:00 p.m.

(Tape 1, Side A)

In the absence of legislative committee members, Dr. John Cruickshank called the meeting to order at 2:07 p.m. and noted the attendance.

Members Present

Senator Petersen
Dr. Barbara Aung
Dr. John Cruickshank
Ms. Marci Hendrickson
Ms. Cathy McBride (in place of Ms. Barbara Keilberg)

Members Absent

Senator Day
Senator Kennedy
Representative Grace
Mr. John Nimsky

Speakers Present

Joseph Hanns, practicing Obstetrician/Gynecologist (OB/GYN), Phoenix
Scott Gorman, Associate Medical Director, CIGNA
David Landrith, Arizona Medical Association

Guest List (none)

* * *

Due to the lack of a quorum, the Committee postponed the approval of minutes and instead received testimony concerning provider contract and termination issues.

Joseph Hanns, practicing Obstetrician/Gynecologist, Phoenix, lamented that very few people seem interested in how private practitioners are affected by contracts. He remarked that society's failure to promote lifestyle education is one reason for the disproportionate increase in health care costs.

Dr. Hanns stated that patients have the fundamental right to choose a physician with whom they are comfortable. He discounted the theory that fee-for-service and specialty care are the reasons for increased health care costs, and instead speculated that the increase can be attributed to unreimbursed care provided for undocumented residents and the homeless/uninsured, in addition to cost shifting which began with the federal government and Medicare.

Dr. Hanns stated he resisted joining managed care groups in 1994 because he did not believe he could afford mandatory discounts. However, he said that by 1996, he belonged to over thirty plans in an effort to maintain his practice and offer continuing care to his patients. He complained that making annual application to each plan is an exhaustive effort which results in a non-negotiable contract that fundamentally binds the physician to comply with gag orders, utilize fee scales, use a discount laboratory, and submit to office inspections which focus not on the quality of care given, but on the width of doors, number of fire extinguishers, size of handicapped parking spaces, patient wait times, and the politeness of office staff. Additionally, he questioned the ludicrous requirement that certifications be obtained before allowing a pregnant woman to deliver.

Dr. Hanns reported that Medicare pays between 35 and 37 percent of customary fees, and that payment can increase to 41 percent if a copayment is collected. Unfortunately, he said that because overhead is 57 percent year after year, he basically subsidizes Medicare from his personal income.

Dr. Hanns asserted that medicine is handcuffed and that patients have lost their physicians. He added that confusion about managed care environments, insurance contracts and fine print is causing patients to develop a growing anger toward physicians.

Dr. Hanns claimed that the concept of managed care and contract medicine is ill-founded, fraudulent, and an attempt to control costs by limiting services and discounts. He said the future is not very bright for physicians who are increasingly forced to operate on the edge of bankruptcy.

Dr. Cruickshank questioned how the Legislature can help tackle the problems of undocumented residents, gag orders, shrinking physician salaries, waste, fraud, and abuse within the system. He added that after suffering losses from forced discounts, physicians are further expected to absorb the costs caused by waste, fraud and abuse. Dr. Hanns speculated that the degree of provider abuse is exaggerated. He cautioned, however, that additional discounts will further deplete physician salaries, thus increasing the chances for provider fraud.

Dr. Hanns acknowledged that treatment of undocumented residents is a factor in rising health care costs, but stated that services should not be denied this population in an effort to reduce costs.

In response to Dr. Aung, Dr. Hanns explained that one of his contracts was disassociated within thirty days without cause, reportedly because there were too many obstetricians in his zip code area. He

recalled that some similarly disassociated obstetricians lobbied and were eventually returned to provider status, a system which he felt offered an opportunity for collusion.

Ms. Hendrickson sympathized with Dr. Hanns' frustrations and stated her willingness to offer insight into the reasons for the existence of certain provisions.

In response to Senator Petersen, Dr. Hanns estimated the average annual income for obstetricians as \$120,000 to \$140,000. He remarked that he has been forced to moonlight in order to supplement his practice.

Senator Petersen solicited opinions for corrective actions. Dr. Hanns stressed that a patient's freedom of choice is of paramount importance. In addition, he supported the concept of using a central medical savings account as an approach to health care reimbursement.

With a quorum present, a motion that the minutes from the October 1 meeting be approved was moved by Dr. Aung and seconded by Ms. Hendrickson. The motion carried by a majority voice vote.

Scott Gorman, Associate Medical Director, CIGNA, reported the number and type of providers offered through CIGNA. He emphasized that his organization does not terminate provider contracts lightly.

Dr. Gorman proclaimed that the managed care industry has matured and is working to make its product more attractive to patients. He related the number of providers who recently joined or chose to leave CIGNA, and stated that because the credentialing process is so time consuming and costly, physicians are not moved in and out of the plan on a regular basis. In addition, he noted that costs are also great if a physician who is popular with his patients decides to leave CIGNA.

Because care is taken not to upset patients and employer groups, Dr. Gorman said that if a particular physician performs below expectations, CIGNA will attempt to correct the deficiency before requesting the physician leave the network. Conversely, he said that a physician involved in illegal acts will be terminated from the plan more quickly in an effort to ensure patient safety.

Dr. Gorman noted that most physicians who leave CIGNA do so in order to practice in rural Arizona or out of state.

In summary, Dr. Gorman emphasized that while managed care is not intended to be evil toward private practices, it does try to encourage physicians to develop cost-efficient patterns that are patient friendly and responsive to employer group premiums.

Senator Petersen remarked that, working part-time for a health maintenance organization (HMO), he frequently hears the complaint from patients that doctors seem rushed and disinterested in taking the time to interact with them. Dr. Gorman replied that because some doctors have begun to feel it necessary to see more patients in an effort to boost their income, CIGNA conducts office visits to ensure that a physician does not schedule more than five patient visits in an hour. He suggested that lack of personal attention from physicians poses a larger problem than managed care systems.

Senator Petersen said he has noticed considerable movement of doctors among the various managed care systems. Dr. Gorman replied that CIGNA has not noticed an exodus of physicians from its plan. He added that nothing could be more unhealthy to the health care industry than physicians who view patients, employer groups and/or insurance companies as enemies.

Chairman Cruickshank opened the floor to general discussion and public testimony.

(Tape 1, Side B)

In response to Senator Petersen, Chairman Cruickshank said the Subcommittee will meet on October 29th, and that the full committee will meet on November 12 and possibly November 26.

Senator Petersen expressed a desire to have the Department of Insurance testify at the next meeting on the number of plans available and the range of premiums.

Chairman Cruickshank moved that the Subcommittee modify its recommendation and focus on the quality, availability and affordability of small health care groups, rather than spend the Subcommittee's last meeting receiving testimony regarding the changing environment of medical schools. Dr. Aung seconded the motion which carried by a majority voice vote.

David Landrith, Arizona Medical Association, suggested that an analysis previously prepared by the Department of Insurance which compares the provisions of the Kennedy-Kassebaum bill and state law might answer many of the Subcommittee members' questions.

Without further objection, Ms. Hendrickson moved that the Subcommittee adjourn.



Teresa Alvarez, Secretary

(Original minutes, attachments and tape on file in the Office of the Chief Clerk.)

ARIZONA STATE LEGISLATURE
JOINT INTERIM STUDY COMMITTEE
ON HEALTH CARE QUALITY
SUBCOMMITTEE #3

Minutes of the Meeting
Tuesday, October 29, 1996
1:00 p.m., House Hearing Room 1

MEMBERS PRESENT

Dr. John Cruickshank, Chairman
Senator David Petersen
Dr. Barbara Aung
Ms. Marci Hendrickson
Mr. John Nimsky

MEMBERS EXCUSED

Senator Ann Day
Senator Sandra Kennedy
Representative Sue Grace
Ms. Barbara Keilberg

STAFF

Lisa Block, House Analyst

Chairman Cruickshank convened the meeting at 1:05 p.m. and the attendance was noted.

APPROVAL OF MINUTES

Mr. Nimsky moved to adopt the minutes of the October 15, 1996 meeting and Dr. Aung seconded the motion. Without objection, the minutes were approved as distributed.

TESTIMONY ON SMALL BUSINESSES AND HEALTH INSURANCE

Greg Harris, Assistant Executive Director, Arizona Department of Insurance (DOI), reviewed the provisions of S.B. 1109 passed in 1973, establishing a basic health benefits plan which he termed "cutting edge reform" in the United States, and much of which is contained in the newly adopted federal legislation, the Kennedy-Kassebaum bill. Mr. Harris noted that Arizona has much of what is being federally mandated already on the books, though there are still some issues the Legislature will have to take up in regard to large groups, small groups and individual conversion coverage.

Mr. Harris explained S.B. 1109 guaranteed issue after 90 days of being bare, defined small groups in graduated steps, first ranging from 25-40 lives and after July 1, 1996 taking small groups down to 3-40 lives. He further explained there are currently 95 accountable health plans serving the small and large group market, and their number is increasing since S.B. 1109 went into effect. Mr. Harris noted that a survey to evaluate participation and sales of the basic health benefits plans was conducted in the summer of 1995 and it identified that plans were sold to only 11 employer groups, covering less than a total of

400 lives, which he acknowledged is not a great deal of participation. Mr. Harris suggested some reasons for this may be due to the expansion of the group size, that the 90-day bare requirement may have discouraged some employers and that other plans and levels of benefits may have been more attractively marketed.

Dr. Cruickshank asked Mr. Harris to comment on the impact of the new federal law on existing Arizona statutes impacting small businesses.

Mr. Harris distributed a chart (filed with original minutes) which compares key elements of the new federal law to existing Arizona laws applicable to accountable health plans. He specifically noted that the federal definition of group size at 2-50 lives and the newly mandated six-month look-back period for preexisting conditions will supersede existing Arizona law which defines small groups as 3-40 lives and the look-back period at 12 months.

In response to Dr. Cruickshank's inquiry about the local perspective on how the federal legislation will affect Arizona law, Mr. Nimsy, of Blue Cross Blue Shield, acknowledged it is currently under review by his company, but indicated he was not prepared to respond on the subject.

Dr. Cruickshank asked if the July 1, 1996 effective date for the federal legislation would require that new provisions be available to policyholders before their next policy renewal date or would go into effect when the policy was next renewed. He especially questioned how the preexisting wait periods would be handled, since it could considerably shorten an insured's wait if the provision was implemented on July 1, 1996 regardless of his or her policy renewal date.

Mr. Harris suggested that at a minimum, policies renewed after the effective date of the federal legislation would have to incorporate the new provisions. He opined that insurers will tailor their marketing plans with the idea of the July effective date in mind and take into account individual needs.

In response to Senator Petersen's questions regarding the portability of conversion policies for someone moving to Arizona from out-of-state, Mr. Harris explained this is an issue that will need to be addressed by the Legislature. He further explained the whole idea in the federal legislation is to provide the maximum freedom for portability that can be established by law, with the idea that freedom be retained to move provisions not only from job-to-job but from state-to-state as well.

Senator Petersen noted that under the current state law, someone moving here from out-of-state who has exhausted COBRA (Congressional Omnibus Reconciliation Act) benefits, is often offered a conversion policy which bears very little resemblance to the benefits of

the prior policy. In response to his further inquiry about preemption of conversion policies issued out-of-state, Mr. Harris indicated the Legislature may need to address the subject of policies issued in other states, as the new federal legislation does not specifically address the cross-state portability issue or preemption. He noted that Arizona authority with respect to policies issued out-of-state has some limits.

Senator Petersen acknowledged the portability provisions help a person who moves to another state to take employment, but really does not help the person who moves to another state to retire.

Mr. Harris acknowledged the conversion provision of the new federal legislation would apply only to those individuals converting after having received group coverage, exhausting COBRA and who are not eligible for Medicaid or other Social Security benefits.

In response to Senator Petersen's request to know if the federal legislation specifies what the conversion policy must provide, Mr. Harris related it is defined as one that "most closely matches" what the group coverage was; explaining that if there are no identical matches, then whatever an insurer can provide which comes closest, is acceptable.

Dr. Cruickshank mentioned that another issue to be considered by the State is affordability, questioning whether an insured would be able to afford the premium for the policy which comes closest to his former group insurer. Mr. Harris acknowledged the federal legislation does not establish any premium standards at all.

Gay Ann Williams, Director, Arizona Physicians Health Care Group, related information on Arizona Physicians Health Care Group's program and provided specific information about its plans. She explained the program was started about five years ago with a grant from the Robert Wood Johnson Foundation in response to a request by the Arizona Health Care Cost Containment System (AHCCCS). Ms. Williams explained it was initially formed for small employers, defined by law as groups of 40 or less, and political subdivisions. Having undergone growth and changes in the past few years, Ms. Williams further explained there are currently three health care groups which are regulated by AHCCCS. She noted these groups are subject to laws in the Arizona Revised Statutes Title 36 which govern the AHCCCS program.

Ms. Williams explained the health care groups resemble insurance companies and compete with them, but are different in important ways; the health care groups offer a guaranteed product, meaning preexisting conditions are not excluded if the group meets eligibility requirements, the health care group rates are governed by AHCCCS and cannot go above certain levels, resulting in no more than a five percent increase in premiums over the past three years. Ms. Williams also indicated the health care group is very comprehensive, is required to offer many of the same provisions as other carriers and also

covers conditions and offers services that are not required but necessary from the standpoints of competition and public policy. She distributed rate sheets for both Arizona Physicians' indemnity product and a product which charges copayments and uses contracted doctors (filed with original minutes).

Ms. Williams further explained that Arizona Physicians contracts with about 35 brokerages around the State, has 10,500 members representing every county and provides a service to some groups who may otherwise not be eligible for insurance policies with other carriers.

In response to Senator Petersen's request to know what is required as proof of self-employment in order to obtain coverage through Arizona Physicians, Ms. Williams explained her plan requires either schedule C from a federal tax return for an existing employer or certification of an appointment calendar or schedule of meetings for a new single employer who has been in business for 90 days. She clarified that something must be submitted which an auditor could verify as evidence of an eligible employer according to the definition in law.

In response to Senator Petersen's request to know who determines the employer's eligibility, Ms. Williams explained a broker contracted by the plan takes the first step to determine the employer meets the eligibility requirement, submits information to a senior sales executive on Arizona Physicians' staff who processes the application internally and submits it to the State. Ms. Williams explained the State has the authority to request additional information or clarification before granting eligibility.

In response to Dr. Cruickshank's inquiry about how long this process takes, Ms. Williams indicated it moves very quickly. She explained that if paperwork is submitted by the 15th of any month, it takes 3 days to process in-house, two to three days at the State and providers can then be capitated so that the new member is insured by the 1st of the following month. Ms. Williams additionally noted that the State undertakes the billing for which the plans pay a \$4 per member fee each month for administrative costs, emphasizing that no state or federal monies are used by AHCCCS to underwrite.

In response to Dr. Cruickshank's inquiry about the number of members in health care groups, Ms. Williams clarified there are 10,500 in Arizona Physicians and about 20,000 covered lives in the entire health care group program consisting of three plans. She noted the Arizona Physicians plan is the largest of the three with an average group size of 2.9 members.

Barbara Sutton, insurance broker, related information published in the *Arizona Republic* on October 23, 1996, noting a Harvard School of Public Health Survey showed 31 percent of Americans are without health insurance or had difficulty getting or paying for health

insurance at some time in the past. She asserted this statistic holds true in Arizona according to a number of studies. Ms. Sutton further related the survey showed the number of uninsured has increased in recent years as employers cut back coverage for employees and hire more part-time workers without providing health benefits. She emphasized this number has risen dramatically in the past few years as employers have downsized and employees are brought back in as contract workers ineligible for health benefits.

Ms. Sutton explained the single employee, working for a company, is not eligible for the type of insurance offered by health care groups and emphasized this is a gap that is growing in Arizona. Additionally, she noted self-employed individuals do not always want the type of benefits offered through health care groups, creating another gap in the number insured.

Ms. Sutton related that research shows four in ten employers would prefer to pay no more than one-half of the cost of health care, whereas a few years ago, most employers picked up 100 percent of this cost. She further noted that in order for a group to be considered a group, it must have 50 to 75 percent of the employees covered and pay 50 percent of the employee cost. Ms. Sutton suggested it is difficult for a broker to obtain group coverage in the situation where an employer is not willing to pay 50 percent of the cost and not enough people sign up due to high cost of coverage, to make it a true group plan.

Ms. Sutton also related she sees dependent coverage as a dramatic problem because the premiums are extremely high in many cases and employer groups will opt not to pay it, shopping for individual employee coverage instead. She quoted the newspaper article which related "if the trend continues, health coverage could be priced out of the range for more working families, especially lower-paid workers."

Ms. Sutton further related the responses to four questions included in the Phoenix Chamber of Commerce's annual survey at the request of the Health Care Council. The responses revealed that 24 percent of employers pay the entire cost of health care premiums, 21 percent pay part and 37 percent pay none. Additionally, responses revealed that 53 percent of the same group of employers who were not currently offering health coverage said they would not offer health coverage even if they could. Ms. Sutton suggested this says something about the mentality of employers and that of the employee population who can not obtain coverage, and raises questions about what needs to be done to help them.

Ms. Sutton indicated that the survey showed 83 percent of employers felt they received adequate information about the types of choices in health coverage, while 74 percent of minority-owned businesses felt the information they were receiving was adequate. Ms. Sutton revealed that the survey showed Glendale and Mesa area businesses were the

most satisfied with information received, with Phoenix, Tempe and Scottsdale being less satisfied. She also noted that most employers preferred to receive information from insurance companies, the next most preferred were agents and brokers and the least preferred was advertising.

Ms. Sutton recommended offering coverage to one life in order to include individuals who cannot receive coverage in a small group or even as self-employed individuals. She commented on the number of people she hears from daily who are recently laid off from high-tech positions and those lower-paid workers who do not elect their employers' group coverage because they cannot afford it.

Dr. Cruickshank asked Ms. Sutton how the federal legislation will affect her ability to offer insurance to the market she spoke about. Ms. Sutton suggested it will help, emphasizing that anything which helps the consumer will also be to the benefit of insurance brokers. She acknowledged that moving coverage to two lives is better than three, though reiterated her wish to see one life covered as well. Ms. Sutton voiced approval for the six-month wait period for preexisting conditions and acknowledged there will be a problem with the high price of even a stripped-down conversion policy. She recommended moving to control the pricing mechanisms in Arizona for these policies in order to make them more affordable.

Senator Petersen questioned how many people choose to be insured by one of the health care plans in the State and Ms. Sutton related it has been her experience most people want a traditional PPO (preferred physician organization), a traditional indemnity plan or an HMO (health maintenance organization). She emphasized that consumers still like to choose their physicians, but acknowledged that younger families with needs for covered well-baby care and immunizations are seeking HMOs for these extra preventive provisions. Ms. Sutton pointed out that people have indicated to her they would rather have no coverage at all than a really stripped-down benefits plan, i.e. they either want some protection in the event of a catastrophic illness or they prefer to take their chances. She noted it becomes a drain on all society when young people choose not to be insured because they feel it is unnecessary at this stage of their lives and then suffer a catastrophe. Ms. Sutton emphasized it is therefore necessary for the broker to educate employers about the necessity to buy insurance.

In response to Senator Petersen's request to know how many people are members of these stripped-down basic health benefits plans. Mr. Harris reiterated that according to the last DOI survey during the summer of 1995, the plans purchased by 11 employer groups cover fewer than 400 people.

DISCUSSION

In response to Mr. Nimsky's inquiry about the profitability of the basic health care plans, Ms. Williams explained that her company is a subsidiary of the Arizona Physicians Independent Physicians Association and it is not profitable. She indicated that her job, which she has performed for the past four years, is to make it more profitable.

Dr. Cruickshank observed that with only 10,500 covered lives, the cost is going to be carried on the back of capitated rates or low per diems and capitated rates with hospitals in order to control in-patient rates. He also observed that the basic health care plans are dealing with an adversely selected group whose costs are a lot higher.

In response to Senator Petersen's request to know how unprofitable Arizona Physicians has been, Ms. Williams responded it has operated at a loss since its inception, acknowledging the adverse selection of members is the biggest contributing problem. She emphasized the need to make the plans competitive so small employers who currently do not have health coverage will find them to be the best choice and to bring in a healthy mix of members to balance the adverse selection.

Dr. Cruickshank asked how Arizona Physicians budgets for a life compared to how commercial rates are set. Ms. Williams responded that many of Arizona Physicians' current rates are more competitive, but noted that one problem identified is that its age bands are too narrow and it needs to create age bands that are more actuarially correct. She indicated in some cases her company's rates are higher than an equivalent commercial rate and in some cases lower.

In response to Senator Petersen's request, Ms. Williams agreed to provide him and the Chairman with information on what the loss ratio is for Arizona Physicians.

Henry GrosJean, benefits manager, Arizona Small Business Association (ASBA), explained his organization is made up of 1,100 employers with about 40,000 employees, and with 89 percent of the employers employing fewer than 50 lives.

He explained the ASBA has its own unique health plan through CIGNA which is based on its own risk pool, insures groups of one or more, provides rates which are unisex age-banded and is based on commercial versus individual policy rates.

In response to Dr. Cruickshank's inquiry about eligibility requirements, Mr. GrosJean explained members must be self-employed or the sole proprietor of a corporation of one life or more and a member of the ASBA.

In response to Mr. Nimsky's inquiry, Mr. GrosJean explained commercial underwriting is utilized, with members responding to questionnaires designed without regard to the size of the group. With regard to the waiting period, Mr. GrosJean indicated since it is a qualified HMO, the waiting period is 30 days.

In response to Senator Petersen's request to know if rates are competitive, Mr. GrosJean explained that for anyone under 30 years old, the rate is \$97 for an employee and \$251 for a family. He noted that benefits include full maternity coverage, a \$10 office visit co-payment, a \$250 hospital co-pay and a \$10 copayment for prescriptions. He also noted that once the applicant's eligibility is determined, all preexisting conditions are covered.

Dr. Aung asked if members of this plan are assured of coverage regardless of health conditions. Mr. GrosJean indicated there are certain underwriting guidelines which must be followed relative to CIGNA. He noted that the coverage is normally available to someone in the first trimester of pregnancy and for most conditions controlled by diet or medication. Mr. GrosJean pointed out another unique aspect of the plan is that ASBA has a separate corporation which acts as the third-party administrator for CIGNA, performing all the billing for ASBA small employers and making it very cost effective for CIGNA.

In response to Dr. Cruickshank's inquiry about how many lives are covered by this plan, Mr. GrosJean responded approximately 1,000 lives, including employees and dependents. Mr. GrosJean further noted the ASBA has been in existence 20 years and the health plan has been in existence for eight years.

Dr. Cruickshank asked if ASBA has experienced any wide fluctuations, since by most actuarial figures, a health insurance plan does not reach a comfort level until it covers 3,000 to 5,000 lives. Mr. GrosJean acknowledged the plan has experienced wide fluctuations, but confirmed it is surviving.

Mr. Nimsky moved for adjournment and without objection the motion was adopted.

The meeting was adjourned at 2:15 p.m.

Respectfully submitted,



Alice Kloppel,
Committee Secretary

(Tape and attachments on file in the Office of the Senate Secretary)

