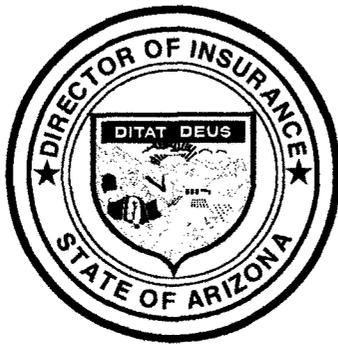


**RECOMMENDATIONS OF THE  
DIRECTOR OF INSURANCE  
CONCERNING THE CONSOLIDATED  
REGULATORY OVERSIGHT OF  
MANAGED HEALTH CARE ORGANIZATIONS**



**Jane Dee Hull**  
Governor

**Charles R. Cohen**  
Director



**STATE OF ARIZONA**  
**DEPARTMENT OF INSURANCE**

**JANE DEE HULL**  
Governor

2910 NORTH 44th STREET, SUITE 210  
PHOENIX, ARIZONA 85018-7256

**CHARLES R. COHEN**  
Director of Insurance

December 28, 1999

Mr. Stuart Goodman  
Executive Assistant  
Office of the Governor  
1700 West Washington  
Phoenix, AZ 85007

Re: Recommendations Concerning Consolidated Regulatory Oversight of  
Managed Health Care Organizations

Dear Stuart:

As you will recall, after the failure of SB1165 in the 1999 legislative session, you instructed me to form an advisory group of representatives of impacted constituencies and to formulate recommendations based on discussions with that group for the implementation of a program for regulatory oversight of managed health care organizations that consolidates the functional responsibility and activity within the Department of Insurance. That process has been completed, and my report is enclosed.

I would like to commend the members of my Advisory Group and my staff for the dedication with which they addressed this project. I make my recommendations with confidence as a result of their assistance.

I look forward to discussing these recommendations with you and other interested persons as the dialogue continues on these issues of vital importance to our state. Thank you for the opportunity to provide this input.

Sincerely,

A handwritten signature in black ink, appearing to read "Charles R. Cohen".

Charles R. Cohen  
Director of Insurance

Enclosure

Cc: Vista Brown

**RECOMMENDATIONS OF THE DIRECTOR OF INSURANCE  
CONCERNING THE CONSOLIDATED REGULATORY OVERSIGHT OF  
MANAGED HEALTH CARE ORGANIZATIONS**

**CONTENTS**

<b>SECTION</b>	<b>PAGE</b>
I. BACKGROUND .....	1
II. PROPOSED SENATE BILL 1165 .....	2
III. ADVISORY GROUP ON CONSOLIDATED REGULATORY OVERSIGHT OF MANAGED HEALTH CARE ENTITIES .....	3
IV. WORK OF THE ADVISORY GROUP.....	4
V. OVERVIEW AND SCOPE OF CONSOLIDATED REGULATORY STRUCTURE.....	5
VI. TIMELINE.....	9
VII. SOURCES OF FUNDING .....	10
VIII. ESTIMATED GENERAL FUND RESOURCE REQUIREMENTS.....	11

## I. BACKGROUND

Like most states, Arizona enacted its regulatory scheme governing “health care services organizations” (HCSOs) (commonly referred to as HMOs) in the early 1970s. See A.R.S. § 20-1051, *et seq.*<sup>1</sup> At that time, there was a low degree of HCSO penetration into the health insurance marketplace. Most HCSOs operated on the “staff model,” meaning they employed a health care provider staff, operating within an HCSO-owned facility, to render services due under their health care plans. Compared to today, it was a simple system.

An HCSO is a hybrid entity that both finances the cost of health care, like an insurance company, and provides and arranges for health care delivery, like a health care provider. Consequently, the original regulatory scheme, still in effect, bifurcates regulatory responsibility between the Department of Insurance (DOI) and the Department of Health Services (DHS). DOI is the lead, or enforcement, agency. DOI is the licensing authority, oversees financial condition, certain aspects of market conduct, policy forms and advertising, and disciplinary matters. DHS oversees the health services content of the health care plan, and whether the HCSO constitutes an “appropriate mechanism to achieve an effective health care plan.” In 1975, DHS promulgated rules defining “basic health care services” and standards to determine whether an HCSO is an effective health care plan. The rules and standards have never been amended.

The modern marketplace is much different. HCSOs have achieved a high degree of market penetration. Eleven HCSOs do commercial business in Arizona, with an enrollment of approximately 1.6 million members. Further, HCSOs have become extremely complex systems for the financing and delivery of health care, utilizing numerous methods of managing the delivery and cost of health care beyond the basic “staff model.” HCSOs enter into complex business relationships with health care providers and others in which responsibility for financing and providing needed healthcare is shared and highly integrated. The complexity of this business often exceeds the effectiveness and flexibility of the current regulatory system.

DHS does not actively enforce its rules after initial licensure. DOI has no authority, expertise, or resources to regulate the delivery of health services. This causes gaps in the regulatory system. Certain areas of HCSO activity are effectively unregulated which sometimes impairs the Executive Branch’s ability to assist consumers. Development of new legislative policy is hampered by lack of an effective, comprehensive regulatory structure to implement the policy. High levels of frustration, confusion, and ignorance regarding the regulatory scheme are commonplace. See **Exhibit 1** for a more detailed description of the current regulatory scheme.

---

<sup>1</sup> This report will discuss both HCSOs and hospital or medical service corporations (non-profits) to the extent that the service corporation offers an HCSO-type product. Therefore, the term “managed health care organization,” rather than HCSO, is often used to refer to the regulated entities.

## II. PROPOSED SENATE BILL 1165

During the 1999 legislative session, lawmakers considered several measures regarding health insurance reform. Many of those efforts were ultimately consolidated into a single bill: SB 1165.

SB 1165 included provisions to transfer DHS's current statutory responsibilities to DOI and completely delete DHS from the field. The bill did not, however, appropriate any new resources to DOI to fulfill those responsibilities. DHS has no dedicated resources available for transfer. The final version of SB 1165 left the current regulatory system intact, but established a committee to study the issue of a consolidated regulatory structure. A conference committee version of SB 1165 passed the Senate, but failed to pass the House .

Despite the failure of SB 1165, there is growing consensus that regulatory responsibility should be consolidated in a single agency.

### III. ADVISORY GROUP ON CONSOLIDATED REGULATORY OVERSIGHT OF MANAGED HEALTH CARE ENTITIES

After the 1999 legislative session, the Governor's Office instructed the DOI Director to consider and make appropriate recommendations concerning a regulatory structure that would consolidate responsibility and authority within DOI, as proposed in SB 1165. In particular, the Governor's Office instructed the Director to quantify the resources required to establish an effective consolidated regulatory structure. At the further direction of the Governor's Office, the Director appointed an advisory group to assist the Director by providing input from impacted constituencies.

The Director appointed an advisory group whose members included representatives from the provider community (physicians and hospitals), the Arizona Health Care Cost Containment System (AHCCCS), the Department of Health Services (DHS), health care services organizations (the HMOs), a medical service corporation (Blue Cross), and purchasers and users of health plan products. The complete list of members is attached as **Exhibit 2**.

The Director asked the Advisory Group to address the following issues:

1. The design and implementation of a regulatory structure for managed health care entities, that consolidates responsibility for oversight of corporate, financial, marketing, and service delivery operations within the Department of Insurance;
2. The powers and support that the Department of Insurance will require to fulfill its responsibilities under a consolidated regulatory structure;
3. The appropriate scope of responsibility for any other agency or board that currently has or will have regulatory oversight of managed health care entities and providers, including the level of responsibility for at least the following:
  - Inspection, examination, licensure, and ongoing monitoring health care facilities owned or operated by a managed care entity; and,
  - Examination and licensure of health care providers.
4. Any legislation or administrative rules needed to effect the recommendations concerning a consolidated regulatory structure;
5. The time frame and potential sources of funding to implement a consolidated regulatory structure; and
6. Any other issue or topic relating to the role of the Department of Insurance in a consolidated regulatory structure for managed care entities.

(See invitational letter attached as **Exhibit 3**.)

During the latter half of 1999, the Advisory Group, staff from DOI, and the DOI Director met to consider these issues.

#### IV. WORK OF THE ADVISORY GROUP

The Advisory Group held a series of five meetings, reviewed various materials and research papers on the subject of managed care regulation, conducted extensive discussions on the designated issues, developed a survey for other state insurance regulators, and considered the survey results. (See **Exhibits 4 and 5**, respectively.)

With the assistance of the Advisory Group, DOI designed a survey that it issued to all state insurance regulators. (See **Exhibit 6**). The survey requested information concerning the kinds and numbers of managed care entities doing business in each state, the number of enrollees, the activities subject to regulation, the responsibilities of various state agencies, and the dedicated resources. The process of designing the survey revealed that the areas of regulation highlighted by consideration of a consolidated regulatory structure are quality of care, network adequacy, provider contracting, and risk shifting practices, which will be discussed in this report.

Twenty-four states, including Arizona, submitted survey responses. (See **Exhibit 7**). The responses reflect substantial diversity in the way the states address this area of regulation, including differences in the structure and responsibilities of their state agencies, their laws, their funding commitments, and the kind of managed care entities operating within their jurisdictions. This diversity makes it very difficult to draw direct comparisons to Arizona's regulatory scheme. However, the survey was very useful for gaining an overview and general impressions, and for identifying relevant laws in other states.

Generally, the responses revealed that most states have some form of bifurcated regulatory system involving both insurance and health services regulators. There are very few examples of a wholly consolidated system. In particular, it is very rare to find an insurance regulator overseeing quality of care and network adequacy issues. Nearly all responding states rely on the health services regulator to oversee those areas. It was notable that the health services regulator appears to be an active participant in ongoing regulation in most states. Many states employ coordinating mechanisms, such as interagency agreements and coordinating councils, to achieve interagency communication and coordination. DOI has been unsuccessful in generating these kinds of arrangements in Arizona.

After considering the survey responses, the Advisory Group selected eight states for more detailed consideration of their laws based on market similarity or other salient features of the regulatory scheme. The committee summarized and reviewed the relevant laws of Colorado, Maine, Maryland, New Jersey, Oregon, South Carolina, Texas and Washington. Again, the laws of these states reflect substantial diversity in approach. The Advisory Group ultimately concluded that there is no ideal model for Arizona and that we must use the overview gained from our discussion to independently envision the best scheme for this state based on its particular characteristics. (See **Exhibit 8**.)

## V. OVERVIEW AND SCOPE OF CONSOLIDATED REGULATORY STRUCTURE

### A. General Considerations

To project the resources needed to establish a consolidated program for regulatory oversight of managed health care organizations within the DOI, it is necessary to project the nature and degree of regulatory activity that will be conducted through the program. The following analysis and discussion of assumptions is based upon the data reviewed and issues discussed by the Advisory Group, and the experience and instinct of the DOI representatives involved in this project. This discussion is not intended in any way to preempt or supercede policy decisions by elected officials as to the shape and extent of managed care regulation. It is merely a statement of assumptions and projections upon which a resource analysis is based. The conclusions in this report would undoubtedly be altered by any subsequent policy developments.

The resource projection is based upon certain general assumptions:

- The objective is full and appropriate implementation of existing law and policy. The projection does not contemplate the enactment and effectuation of new laws, policies, or programs. For example, proposals to make DOI responsible for selecting the independent external medical reviewer for a health care appeal, to establish a health insurance information web site, or to create a health insurance ombudsman within the DOI are beyond the scope of this projection. Implementation of these or other new proposals would presumably require additional resources.
- The projection encompasses consolidated regulation of “health care services organizations” and hospital or medical “service corporations” (e.g., Blue Cross Blue Shield) to the extent the latter offers HCSO products. It does not contemplate inclusion of dental “service corporations” or “prepaid dental plans,” for which there is an established, active regulatory program within DHS. Presumably, expansion to include dental managed care organizations would require additional resources in the form of a transfer of resources from DHS to DOI.
- The DOI will continue to pursue the same regulatory objectives in the areas of licensing, financial condition, market conduct, and policy form and advertising oversight, for which it is already responsible.
- The area of health service delivery will be a new area of regulation for DOI. There will be no opportunity for DOI to rely upon existing resources or expertise. DHS has no existing program or resources which could be transferred to DOI or relied upon by DOI for assistance and support.
- The DOI’s role as consolidated regulator of managed health care organizations will be distinct in material respects from the role of a public purchaser of group health insurance (e.g., DOA, AHCCCS, HCFA) or a regulator of health care providers and facilities (e.g., DHS, BOMEX). The DOI will be focused on regulation at the organization level of the managed health care organization that contracts with enrollees to provide health care.

- As is the case in other areas of DOI regulatory activity, except for its specific statutory responsibilities within the Health Care Appeals program, the DOI will not function as a claims adjudicator (e.g., a court or arbitrator) or as a medical peer review organization.

## **B. Regulation of “Quality”**

The principal effect of a consolidated regulatory structure will be to bring new responsibilities to the DOI for regulation of managed health care organization “quality”. In the context of the debate concerning regulation of managed care organizations, “quality” is a broad, non-technical term. It is used to refer to everything from the integrity of an organization’s health care delivery systems to the medical decisions made in particular cases. For purposes of this resource projection, regulation of “quality” is taken to mean that the DOI will assume from the DHS the responsibility to maintain, make determinations under, and enforce rules that establish whether an HCSO provides for “basic health care services” and whether it “constitutes an effective mechanism to achieve an effective health care plan.” See A.R.S. §§ 20-1051(1) and (6); 20-1053(A)(5) and (11); 20-1054(A)(2); 20-1058(D); 20-1064(A); and 20-1065(A)(3). In short, the general issues in this area are:

- the appropriateness and effectiveness of the organization’s systems, policies and procedures related to health care delivery (such as provider credentialing, utilization review, medical decision-making, grievances and appeals, corrective and remedial procedures, customer satisfaction measurement, and record keeping) and
- the adequacy of the provider network and overall access to health services (such as geographic distribution and availability of network providers).

As a practical matter, this will require the DOI to assume new responsibilities related to promulgation and ongoing enforcement of rules, review of applications for licensure, desk audit and field examinations related to quality assurance systems, and rendering consumer assistance on “quality” issues. The existing Health Care Appeals program within the DOI is regarded as a key component of “quality” regulation, and will be integrated with the new responsibilities to form the DOI’s quality regulation program.

The DOI will use certain external resources with respect to oversight of an organization’s quality systems. Many organizations submit to quality systems review by private, quality accreditation organizations, such as NCQA (National Committee for Quality Assurance), American Accreditation Health Care Commission/URAC (Utilization Review Accreditation Commission), and JCAHO (Joint Commission on Accreditation of Healthcare Organizations). The resource projections contemplate that the rules promulgated and enforced by the DOI relative to quality systems will incorporate this private accreditation review through “deemed” compliance provisions. In other words, managed health care organizations will be required to establish that they have achieved and continue to achieve compliance with certain minimum quality assurance standards, either those set forth in DOI’s rules or by a recognized quality accreditation organization. In addition to maintenance of these minimum systemic standards, each managed health care organization will also be required to perform in conformance with its quality assurance systems on an ongoing basis. The DOI will rely upon its existing authority to use contract examination personnel to conduct field assessments of ongoing compliance with quality system requirements. Existing law provides the DOI with authority to charge examinees for the cost of these field reviews. The DOI will have related infrastructure needs with respect to

procurement of these contract services, administration of the contractual relationships, and billing and payment. Of course, any regulatory action following up on examination findings must be performed by DOI internal personnel rather than contractors.

With respect to individual consumer complaints and requests for assistance related to quality issues, the DOI assumes that it will provide the same kind and level of assistance that it renders for other lines of insurance. We will provide consumer-oriented public information and publications, promote self-help, and facilitate resolutions of disputes. We will maintain and analyze complaint statistics to assess organizations' overall compliance with quality systems requirements and to determine the need for field examinations. Other than our responsibilities with respect to the Health Care Appeals program, we will not adjudicate claims or review medical decisions.

### **C. Regulation of Provider Contracting**

The DOI assumes that consolidation of regulatory authority over managed health care organizations will not create substantial new regulatory responsibilities for oversight of contractual matters between managed health care organizations and providers. The basis for this assumption is that the DOI is a consumer protection agency, and that our limited resources should be directed to protection of the interests of consumers under insurance contracts. An "insurance contract," for purposes of this analysis, is between a consumer and a managed health care organization whereby the latter assumes from the former the risk to provide and finance health care if the consumer needs it. In order to perform its obligation under the insurance contract, the organization enters into numerous and various business contracts, such as provider contracts, which are not "insurance contracts" in the regulatory sense. Notably, of the laws of other states reviewed by the Advisory Group, several explicitly provided that the local insurance regulator shall have no responsibility for enforcement of provider contracts or to adjudicate disputes thereunder. To proceed otherwise would greatly expand the scope and cost of the consolidated regulatory structure, as well as alter the fundamental role and orientation of the DOI.

However, the DOI will oversee certain provider contracting issues above the individual contract enforcement level. The DOI will continue to enforce legal form requirements applicable to provider contracts, such as prohibitions against gag clauses and the requirement of enrollee hold harmless provisions. The DOI will also enforce quality system requirements applicable to provider relations, such as assuring that an HCSO has an appropriate and effective mechanism in place to address provider grievances. Further, the DOI will also continue to monitor and maintain information concerning provider contract disputes to identify indicators of regulatory problems. For example, a high degree of provider payment disputes may indicate a liquidity problem, or the potential for network deterioration.

### **D. Regulation of Risk Sharing**

Due to the high degree of integration of the health services delivery and health services financing functions in modern managed health care organizations, a consolidated regulatory structure will facilitate a more comprehensive and effective approach to regulation of risk sharing arrangements. This refers principally to "capitation," in its many forms, whereby a managed health care organization shifts financial risk to a contract provider by pre-payment of an amount certain as consideration for a contingent level of service. It also refers to the use of "fiscal intermediaries." These are non-providers, or providers not qualified to render the service in question, who accept capitation from a managed care organization to arrange for the provision of

services by others. The lack of interactive regulation by both DHS and DOI has impeded the development of a regulatory approach to these hybrid issues.

Based upon review of other states' laws, and discussion of these complex issues within the Advisory Group, the DOI has based its resource projection on the assumption that its regulatory oversight of risk sharing issues will focus on requirements applicable to the managed health care organization rather than directly to contract providers or fiscal intermediaries. For example, the DOI anticipates enactment of risk based capital (RBC) requirements for managed care organizations. RBC requirements will replace "static" capital and surplus requirements (currently \$1,000,000) with "dynamic" requirements that vary based on the nature and degree of an organization's insurance and business exposures. Analysis of RBC requirements takes into account a managed care organization's financial arrangements with providers and fiscal intermediaries. In other words, the risk to the public posed by an organization's capitation arrangements is dealt with through the level of capital and surplus required of the organization.

Similarly, for purposes of this resource projection, the DOI believes the soundest regulatory approach is to generally regard capitation arrangements entered into by duly licensed managed health care organizations as "service" contracts, rather than "indemnity" or "insurance" contracts. The DOI does not anticipate the need to license providers or fiscal intermediaries as risk bearing entities, nor to engage in any direct financial regulation of providers or fiscal intermediaries. Consistent with the anticipated approach, the DOI does project the enactment of legislation or the promulgation of rules applicable to a managed health care organization that elects to engage a fiscal intermediary. These standards will likely place the managed health care organization in a quasi-regulatory role by requiring it to establish financial requirements and monitor financial performance of the fiscal intermediary. The DOI's ultimate concern, however, will be the managed health care organization's financial condition and performance, and its compliance with applicable capital and surplus requirements.

The DOI notes that in the context of fiscal intermediaries there is a significant issue as to whether the managed care organization remains ultimately at risk for provider payment. Because this issue does not bear upon the DOI's resource needs, it is not addressed here.

#### **E. Role of Other Regulatory Agencies**

The Department believes that even a consolidated regulatory structure should recognize and allow for a continuing role by other agencies and boards that regulate health care providers and facilities. As stated above, DOI will regulate managed health care organizations, but will not directly regulate health care providers and facilities. For example, DHS will continue to regulate medical facilities, some of which may be owned and operated by HCSOs, and the Board of Medical Examiners will continue to regulate the conduct of individual physicians.

SB 1165 would have completely deleted DHS from the area of managed health care regulation, including eliminating its authority to participate in examinations with the DOI. This approach is not advisable. DHS continues to possess expertise in the health services area that could be very valuable to effective regulation of managed health care organizations. DHS should remain authorized to participate in examinations by the DOI. DHS should also serve an express advisory role to the DOI with respect to rulemaking and ongoing regulation in the "quality" area.

## VI. TIMELINE

The following implementation timeline takes into account the anticipated time periods for establishment and hiring of new positions with the expertise needed to implement the described consolidated program. DOI will require at least partial funding for the positions and start up costs prior to the effective date for the transfer of authority and consolidated regulatory structure.

The timeline further assumes that DOI will rely on the existing DHS rules until DOI can adopt temporary rules under an exemption from the lengthy and complex rulemaking process required by the Administrative Procedure Act (APA). At the time of adopting temporary rules under an APA exemption, DOI will also commence the APA rulemaking process, with all attendant public notice and comment requirements, for permanent rules.

July 1, 2000	Funding needed for FY 2000-2001 to establish positions and prepare for consolidated regulatory structure.
July 1, 2000 – January 1, 2001	Establish and fill key positions.
January 1, 2001 – July 1, 2001	Establish and fill remaining positions; Adopt exempt rules and commence APA rulemaking process to adopt permanent rules.
July 1, 2001	Effective date for implementing consolidated regulatory structure within DOI.

## VII. SOURCES OF FUNDING

The available funding sources for a consolidated regulatory structure would appear to be either a general fund appropriation and assessments of managed health care organizations. Because of the level of funding required and the relatively small number of licensed organizations (11 HCSOs and one service corporation), DOI recommends an appropriation. In making this recommendation we are also mindful that the consolidated regulatory structure will include use of contract examiners to assess the compliance of managed health care organizations with quality systems standards. Pursuant to existing law, the cost of these examinations will be charged to the organizations being examined.

We also note that pursuant to A.R.S. § 20-167, DOI is obligated to recover 95-110% of its appropriation through its fees charged to various elements of the insurance industry for licensing and other services. Though the appropriation recommended is not anticipated to cause an immediate increase in fees, it obviously will eventually impact the degree and timing of future fees increases.

## VIII. ESTIMATED GENERAL FUND RESOURCE REQUIREMENTS

The Department of Insurance will require staff, travel, furniture, equipment, supplies, and office space at a cost of between \$773,417 and \$969,222 in the first year, and between \$616,736 and \$791,087 in the second year (with similar costs in subsequent years) to implement the regulatory structure described above. Most of the variation in the range is attributable to salary ranges for FTE personnel. Based on a position by position review, we recommend a first year appropriation in a total amount of \$885,000, and a second year appropriation in a total amount of \$705,000.

The table on the following two pages enumerates the specific General Fund resource requirements for implementing a consolidated regulatory structure. Additional assumptions relied upon to develop the resource requirements can be found in **Exhibit 9**.

*(Balance of this page intentionally left blank)*

**Estimated General Fund Resource Requirements**

<b>PERSONAL SERVICES</b>	<b>GRADE</b>	<b>MINIMUM / MIDPOINT (NC)</b>	<b>MAXIMUM</b>
<b>Office of the Director</b>			
P Rules/Legal Analyst (Executive Consultant II) (NC)	22	46,972	56,739
P Partially fund Public Information Officer position (25%)	23	14,025	14,025
C Reclassify Admv. Secretary I to Admv. Assistant II	15	3,648	5,466
<b>Life and Health Division</b>			
P Quality/Compliance Manager (Medical Consultant I) (NC)	P2	75,236	96,659
P Quality/Compliance Analyst (NC)	22	46,972	56,739
P Quality/Compliance Analyst (NC)	22	46,972	56,739
C Administrative Assistant III	17	24,732	36,953
P Uncover and Reclass Life/Health A/D (NC)	25	5,650	18,277
<b>Consumer Services and Investigations Division</b>			
P Consumer Services Specialist II (Nurse) (NC)	18	36,425	39,850
<b>Corporate and Financial Affairs Division</b>			
P Senior Financial Analyst (NC)	24	56,079	67,649
P Uncover and Reclass Assistant Director (NC)	26	5,395	19,191
<b>Administrative Services Division</b>			
C Reclassify Admv Assistant II to Admv Assistant III	17	1,404	5,559
<b>Information Technology Division</b>			
P Reclassify Network Specialist I to Network Specialist II	22	7,595	9,058
[C: Clerical, P: Professional -- In Minimum/Midpoint column, minimum salary shown for clerical, midpoint salary shown for professional]			
*NC indicates the position is "Not Covered" by (or exempt from) the state personnel rules.			
<b>TOTAL PERSONAL SERVICES</b>	<b>7 FTE's</b>	<b>\$ 371,105</b>	<b>\$ 482,904</b>

**EMPLOYEE-RELATED EXPENDITURES**

@ 26.84% of Personal Services

<b>EMPLOYEE-RELATED EXPENDITURES</b>	<b>\$ 99,605</b>	<b>\$ 129,611</b>
--------------------------------------	------------------	-------------------

**PROFESSIONAL & OUTSIDE SERVICES**

Technical/Medical Services

<b>PROFESSIONAL &amp; OUTSIDE SERVICES</b>	<b>\$ 50,000</b>	<b>\$ 75,000</b>
--	------------------	------------------

**IN-STATE TRAVEL**

Travel for training, on-site conferences

<b>IN-STATE TRAVEL</b>	<b>\$ 500</b>	<b>\$ 500</b>
------------------------	---------------	---------------

**OUT-OF-STATE TRAVEL**

Travel for national/regional conferences and seminars

<b>OUT-OF-STATE TRAVEL</b>	<b>\$ 5,000</b>	<b>\$ 7,500</b>
----------------------------	-----------------	-----------------

**FURNITURE, EQUIPMENT AND SUPPLIES**

	<b>UNIT</b>	<b>EXTENDED</b>	<b>EXTENDED</b>
Desk, double pedestal	332	1,992	1,992
Desk, secretarial	390	390	390
Credenza	332	1,992	1,992
Computer stand	125	875	875
Chair, ergonomic, swivel w/ arms	290	2,030	2,030
Chair, ergonomic, side w/ arms	180	2,160	2,160
Bookshelf, 5-shelf	150	900	900
Bookshelf, 2-shelf	90	90	90
File cabinet, 5-drawer, vertical, legal, locking	220	2,640	2,640
File cabinet, 2-drawer, vertical, legal, locking	149	1,043	1,043
Transcriber, microcassette, desktop	218	654	654
Transcriber, microcassette, hand-held recorder	137	137	137
Calculator, 10-key, printing w/ display	38	114	114
Personal computer w/ software and LAN connection	2,800	19,600	19,600
Training (managed care seminars, et al).	1,500-3,000	1,500	3,000
Postage	1,000	1,000	1,000
Forms/envelopes	1,500	1,500	1,500
Miscellaneous workstation supplies	750	5,250	5,250
Increased telephone maintenance cost	6,750	6,750	6,750
Additional telephone lines (3 ea)	1,800	5,400	5,400
Subscription to A.R.S. Title 20	250	1,500	1,500
Anti-static floor mats	30	210	210
Fax machine, plain paper	539	539	539
Photocopier	8,917	8,917	8,917
Network printer, laser	3,000	3,000	3,000
Power strips	15	105	105
Photocopier maintenance, annual	1,338	1,338	1,338
Fax maintenance, annual	81	81	81
Fax/photocopier/printer toner/supplies, annual	500	500	500
<b>FURNITURE, EQUIPMENT AND SUPPLIES</b>		<b>\$ 72,207</b>	<b>\$ 73,707</b>

**INFRASTRUCTURE**

Office space at remote location (3,000 s.f. to move FU)	17/sf/yr	51,000	51,000
FU relocation costs	20,000	20,000	20,000
Internal relocation and remodeling costs	50K-75K	50,000	75,000
Voice/data wiring at remote location (16 @ 300)	300	4,800	4,800
Local telephone system reprogramming	1,200	1,200	1,200
Remote telephone system replacement (30-user capacity)	45,000	45,000	45,000
LAN expansion (switch) at remote location	3,000	3,000	3,000
<b>INFRASTRUCTURE</b>		<b>\$ 175,000</b>	<b>\$ 200,000</b>

**FIRST YEAR TOTAL**

		<b>\$ 773,417</b>	<b>\$ 969,222</b>
--	--	-------------------	-------------------

Less one-time expenditures	(171,388)	(196,388)
Plus computer maintenance costs	2,940	2,940
Plus 2.5% salary increase (P/S and ERE)	11,768	15,313

**SECOND YEAR TOTAL**

		<b>\$ 616,736</b>	<b>\$ 791,087</b>
--	--	-------------------	-------------------

## A. Personnel

In projecting the resources required to implement a consolidated regulatory structure, DOI considered two alternatives: (1) creating a new Managed Care Division or Section, and (2) incorporating consolidated responsibilities into DOI's existing organizational structure. We decided to propose integration of the responsibilities into the existing structure because we believe that will be more economical and more efficient for DOI as a whole.

Assumption of the new responsibilities, and the addition of personnel in several divisions to effectuate them, will undoubtedly increase demands on the Office of the Director, the Administrative Services Division, and the Information Technology Division, which provide service to, and derive activity from, all other areas of DOI. We have sought ways to meet these additional demands without the creation of entire new positions when not absolutely necessary. Consequently, we have proposed the reclassification and enhanced funding of certain existing positions where possible. These enhancements will hopefully enable DOI to attract and retain qualified personnel in support positions that will be even more critical in light of our new responsibilities.

We are proposing that the "professional" positions created and revised through this proposal be "non-covered." This enables us to pay higher salaries, recruit and retain a higher level of qualified personnel, and exercise a higher degree of flexibility and discretion with respect to the ongoing management of these positions. Clerical and support positions are proposed as "covered."

The Department requires between \$470,700 and \$612,500 to pay for the salaries, benefits and employer payroll taxes for the following additional staff.

### **1. Office of the Director**

- a. ***One FTE Rules Analyst (Executive Consultant II)*** is needed for the extensive rulemaking responsibilities that will be required to implement and maintain this program. The analyst will draft rules in compliance with the requirements of the Administrative Procedure Act (APA), and the rules of the Governor's Regulatory Review Council (GRRC) and the Secretary of State. The analyst will be fully responsible for coordinating the public participation process required under the APA. It is anticipated that all rulemaking activity will be the subject of extensive public comment and debate from interested stakeholders (consumers and providers as well as the managed health care organizations), and will likely necessitate multiple public hearings throughout the state. There will be intensive rulemaking activity at the outset of the program, as well as substantial follow up activity. Managed care is a dynamic industry and any rules will need to be periodically amended to reflect changing industry practices.

The DOI notes that it currently has no rules analyst on its staff. This is a substantial resource deficiency. Considered cumulatively with the DOI's existing rules responsibilities, these functions will no longer be able to be properly performed without at least one FTE dedicated to rules activities.

- b. ***Partially Fund Public Information Officer (PIO) Position (25%).*** The PIO position will be highly impacted by the assumption of regulatory responsibility for quality issues. There will be a substantial need for development of consumer oriented literature in this area, and for the ongoing handling of media and public inquiries into DOI's activities. In short, there will be great public interest in the program and a responsibility for DOI to satisfy that interest. DOI currently has a PIO position on the Director's staff. However, it is an unfunded position recently created by the Director based purely on the great need for the position. DOI believes attributing 25% of the PIO's activity to managed care quality issues is a reasonable estimate.
- c. ***A reclassification of one Administrative Secretary to an Administrative Assistant II*** is required to provide administrative support to the rules analyst. The state's rulemaking process is highly detailed and complex requiring higher level administrative support. Under the rulemaking analyst's direction, the administrative assistant will maintain the rulemaking record and rulemaking docket, coordinate public hearings, and assist in preparation of rulemaking packages. An upgrade in administrative support for the Director's Office is also necessitated by the additional demands that responsibility for quality regulation will place on the Director and his executive staff to interact with the many interested constituencies and to oversee this new area of operational activity within the DOI.

## **2. Life and Health Division**

- a. ***One FTE Quality/Compliance Manager*** is required to administer the new program for monitoring compliance with standards applicable to the delivery of health care by managed health care organizations and their quality assurance plans. The Manager will develop standards for identifying and correcting deficiencies found in an organization's health care and quality assurance plans and will be responsible for monitoring and reviewing the work of independent contractor examiners. The Manager will be required to communicate and interact directly with the organization's medical directors and executives as necessary. The Quality/Compliance Manager shall be established as a non-covered exempt position giving the DOI greater flexibility with recruitment, compensation, and employment issues.
- b. ***Two FTE Quality/Compliance Analysts and one Administrative Assistant III*** are needed to review and monitor the organizations' health care plans, quality assurance plans, proposed geographic service areas, and medical records systems. Analysts will monitor on an ongoing basis for compliance with corrective action plans as directed by Quality/Compliance Manager. The two analyst positions shall be established as non-covered (exempt) positions.
- c. ***A reclassification of the Life and Health Assistant Director*** from pay grade 24 to pay grade 25, and from a covered to non-covered position, is required to reflect the increasing complexity of issues for which the Assistant Director is responsible, and to enable the Department to establish subordinate positions as non-covered positions pursuant to A.R.S. § 41-771(B)(2).

### 3. Consumer Services and Investigations Division

*One FTE Consumer Services Specialist II* is required to assist consumers and respond to and investigate complaints and inquiries concerning issues relating to quality of health care and network adequacy. DOI anticipates public information and outreach efforts, through the public information officer position, to increase public awareness of consumer rights and DOI's regulatory responsibilities in the quality area, which will increase the demand for consumer assistance.

### 4. Corporate and Financial Division

- a. *One FTE Senior Financial Analyst* is required to analyze financial statements and target financial examinations to ensure that each managed health care organization has and maintains a sound financial condition, and to ensure that each organization is continually able to meet its liabilities and obligations to policyholders and enrollees. The Analyst will specialize in financial issues unique to managed health care organizations, such as the impact of provider network structure on financial soundness. The Analyst will monitor and review work performed by independent contractor examiners and will correspond with the organization's executives as necessary about concerns, findings, and corrective action plans. The Senior Financial Analyst position shall be established as a non-covered position, giving the Department greater flexibility with recruitment, compensation, and employment issues.

The DOI notes that it currently has no employee financial analyst position dedicated to oversight of managed care organizations. This is a substantial resource deficiency. This area requires specialized knowledge due to the service (as opposed to pure indemnity) nature of the managed care business and the high degree of integration of health services delivery and financial functions. An effective consolidated regulatory structure must address this deficiency.

- b. *A reclassification of the Assistant Director* from pay grade 25 to pay grade 26, and from covered to non-covered status, is required to reflect the growing complexity of issues for which the Assistant Director has become responsible, and to enable the Department to establish subordinate positions as non-covered positions pursuant to A.R.S. § 41-771(B)(2).

As the Department adds employees, other Divisions are impacted, such as Administrative Services and Information Technology. These Divisions become more stressed with new programs. Therefore, it is necessary to make the following reclassifications.

### 5. Administrative Services Division

- *A reclassification of one Administrative Assistant II to Administrative Assistant III* is required to enable the Administrative Services Division to attract and retain staff capable of delivering centralized administrative services to the DOI amidst the growth of the agency, both in terms of population and function.

## **6. Information Technology Division**

- *A reclassification of one Network Specialist I to Network Specialist II* is required to enable the Information Services Division to attract and retain staff capable of developing complex computer applications. Applications and systems maintenance are especially difficult because of interfaces among the DOI's IBM AS/400 midrange computer, its local area network, and external databases and information sources. The reclassified position shall also create and support Internet-based applications that will facilitate electronic information transfers and processing. Obviously, regulation of quality issues will require development of new applications and databases at DOI, and handling of associated hardware maintenance. Further, DOI may be required to interface with automated systems of managed health care organizations and other outside entities.

### **B. Professional and Outside Services**

DOI requires between \$50,000 and \$75,000 to pay for professional, medical, and technical services that may be required as the program is developed and implemented, and as unusual, complex and unanticipated issues arise from the additional responsibilities added to the DOI. Such professional and outside services may include consultation by medical professionals with respect to the development and implementation of quality standards, contractors procured by the Attorney General to provide guidance on legal issues, information technology consultants with expertise specific to the managed care industry to suggest ways to most efficiently and effectively transfer and process information, etc. These services are necessary to provide a smooth transition with uninterrupted oversight during the consolidation process.

### **C. Out of State Travel**

The DOI requires between \$5,000 and \$7,500 to enable the Quality/Compliance Manager to travel to regional and national meetings concerning managed care regulation.

### **D. Furniture, Equipment and Supplies**

The DOI requires approximately \$73,700 in the first year to pay for the furniture, equipment, maintenance, telephone lines, and supplies required by adding six new employees. In subsequent years, the DOI shall require \$26,300 to pay for increased supplies, communications, and equipment maintenance costs. A detailed listing of required furniture, equipment, and supplies is provided in the Estimated General Fund Resource Requirements above.

### **E. Infrastructure**

The DOI does not have sufficient office space to house additional staff. The DOI Life and Health Division and Consumer Services and Investigations Division already have a number of offices shared by employees in very tight quarters. DOI recently divided one of its meeting rooms into three offices to mitigate the overcrowded conditions in its Consumer Services and Investigations Division. The State Fire Marshall has criticized the DOI for inadequate passageways because furniture, equipment, and staff too densely occupy existing office space. In its main Phoenix office, the DOI has 138 employees, and 13 on-site contractors and field examiners who use space when conducting research or finalizing examination reports. The DOI also maintains a six-person satellite office in Tucson and rents privately owned office space at the Phoenix Financial Center for the seven staff members of the Arizona Insurance Guaranty Funds.

The DOI considered four office space alternatives:

1. Relocate the main Phoenix Office into adequate office space at a total additional first-year cost of \$491,900 and \$161,900 in additional rent in subsequent years.
2. Expand the DOI by 7,000 square feet into additional Sun State Building office space at between \$191,200 and \$216,200 in additional first-year costs and \$109,000 in increased annual rent thereafter.
3. Expand the DOI by 3,000 square feet into additional Sun State Building office space at between \$116,900 and \$131,900 in additional first-year costs and \$109,000 in increased annual rent thereafter.
4. Rent 3,000 square feet of privately owned office space at between \$175,000 and \$200,000 in additional first-year costs and \$51,000 in increased annual rent thereafter.

For a more detailed look at the four alternatives, see **Exhibit 10**.

Each of the alternatives presented has benefits and drawbacks. However, Alternative 4 appears to be the most feasible and has been presented in the Estimated General Fund Resource Requirements above. For a more detailed look at the Evaluation of Alternatives and Recommendation, see **Exhibit 11**.

#### **F. Conclusion**

The resource projections above are not overstated with the expectation that they will be reduced through the legislative process. We have made this projection as forthrightly as possible. In fact, DOI believes, and many Advisory Group members expressed the view, that these projections are conservative.

We also note that these projections are as accurate as we can make at this time, before we have begun to encounter actual implementation issues and gain experience in a wholly new area of regulation. As this program unfolds, the need for additional resources may be revealed, particularly in the Life and Health Division and the Consumer Services and Investigations Division. If that occurs, we hope our conservatism at this time will be appreciated and that any requests for additional resources will be regarded as credible and favorably considered.

# EXHIBIT 1

---

## CURRENT REGULATORY SCHEME

### 1. Department of Insurance

#### *a. Licensing*

Pursuant to A.R.S. §20-1054, HCSOs may be issued a certificate of authority if the director finds that the following conditions are met:

- a. The persons responsible for conducting the affairs of the HCSO are competent and trustworthy and are professionally capable of providing or arranging for the provision of health and medical services being offered.
- b. The HCSO constitutes an appropriate mechanism to achieve an effective health care plan, in accordance with rules adopted by the director of DHS, which shall include at least the basic health services.
- c. The HCSO is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees.
- d. Each officer responsible for conducting the affairs of the HCSO has filed with the Director, a fidelity bond in the amount of \$50,000.

#### *b. Financial Requirements*

Arizona law does not impose dynamic, or risk based, capital requirements on HCSOs. HCSOs must possess and maintain unimpaired capital or surplus, or both, in the amount of \$1.5 million at the time of obtaining a certificate of authority, and \$1 million thereafter. In addition, the HCSOs are required to maintain on deposit with the State Treasurer through the Director's office an amount of not less than \$500,000. Also, the DOI has set reserve requirements, wherein the HCSO must at all times maintain a financial reserve consisting of two per cent of charges collected from enrollees for the health plan, until the reserve totals \$1 million. The State Treasurer shall hold the reserve in trust for the protection of the HCSO's enrollees.

Each HCSO is required to submit an insolvency plan to DOI. The actuarially approved plan for the risk of insolvency must cover continuing benefits for enrollees for the duration of the contract period (or at least sixty days after insolvency, whichever is longer) and continuation of benefits for those enrollees confined in an inpatient facility on the date of insolvency.

The plan for the risk of insolvency must include an actuarial memorandum describing the basis on which the actuary concludes that the HCSO will meet its continuation of benefits requirements, as stated above.

The HCSOs are required to submit quarterly and annual reports to DOI including its financial statements.

#### *c. Examinations*

DOI is responsible for examining the HCSOs' financial condition, its ability to meet its liabilities and compliance with Title 20. DOI may perform these financial examinations at any time.

DOI has the power to conduct market conduct examinations of the HCSOs, although it is not a mandatory responsibility. DOI may examine an HCSO to assure that the contracts issued by the

HCSO to individuals and groups contain coverage for services as required in DHS regulations and Title 20. (DHS may share in this examination responsibility, as discussed later.)

Examinations typically involve the review of an HCSO's claims handling, underwriting, HIPAA compliance, appeals procedures, Accountable Health Plan compliance, utilization review, marketing and advertising, mandated benefits, form filing, complaints and Privacy Act compliance. While we do not evaluate the quality of care delivered within an HCSO, given the examination authority under A.R.S. §20-1058 (A), we have examined a company's compliance with some DHS rules and its own utilization review plan.

*d. Grievance and Appeals*

In July, 1998, DOI's Health Care Appeals Program became effective, giving consumers the ability to appeal adverse decisions by HCSOs, as well as other insurers.

The mandatory appeals process generally must include four separate levels of review. To begin the review process, the member must make the request to their HCSO. Appeals may involve cases in which an insurer denies a request for a service or a request for payment of a claim for a service already received.

The four levels of review are:

- a. Expedited Medical Review
- b. Informal Reconsideration
- c. Formal Appeal; and
- d. External Independent Review.

Cases that reach the External Independent Review stage are evaluated by either the DOI (to determine coverage issues) or an External Independent Reviewer (to determine medical necessity issues).

*e. Utilization Review*

DOI issues certificates to utilization review agents meeting all of the requirements of Title 20, Chapter 15. DOI must examine the affairs, transactions, accounts and records of each utilization review agent before issuing an initial certificate. However, the DOI does not make any determinations of quality of care, appropriateness of utilization review recommendations or medical necessity relating to any plan of care or treatment.

*f. Forms and Advertising*

HCSOs must submit all advertising and solicitation material, as well as forms, to the DOI for approval prior to their use.

Advertisements must be truthful and not misleading in fact or in implication. Words or phrases, whose meaning is clear only by implication or by familiarity with insurance terminology cannot be used. Words or phrases which mislead or have the capacity and tendency to deceive as to the extent or any policy benefit payable, loss covered or premium payable, shall not be used.

Evidence of Coverage and contracts are reviewed to assure they contain all of the benefits, services and provisions required by law.

## 2. Department of Health Services

### a. *Licensing*

In addition to its application for a certificate of authority submitted to DOI, an HCSO must submit a statement describing its health care plan or plans, facilities, personnel and geographic area to DHS for approval. DHS notifies the HCSO of its approval or denial of the statement. DHS forwards a copy of this notification to DOI.

### b. *Examinations*

DHS is also provided authority to examine HCSOs. DHS may examine the HCSO to verify existence of an effective health care plan and to review the delivery of health and medical services. In addition, HCSO facilities and any primary care physician with whom the HCSO contracts for services on a continuing basis is subject to inspection by DHS.

## **Interagency Coordination**

### 1. Licensing

An HCSO must submit a copy of its application for a certificate of authority, as well as the aforementioned statement, to both DOI and DHS for approval. DHS provides the HCSO with a letter to confirm that the HCSO constitutes an appropriate mechanism to achieve an effective health care plan. DHS provides DOI with a copy of this letter, in order for DOI to complete the issuance of the certificate of authority.

### 2. Examinations

DOI has attempted to initiate joint examination activity with DHS, but has been unsuccessful.

### 3. Other Coordination

From time to time, when DOI receives a large number of complaints regarding an HCSO's quality of care or network adequacy, DOI has attempted, without substantial success, to obtain DHS' assistance.

DHS undertakes no further managed care oversight activity, with the exception of an HCSO's request to change its statement regarding its health plan or its description of the geographical area to be served.

### 4. Intergovernmental Agreements

There are currently no intergovernmental agreements or operational coordinating mechanisms between DOI and DHS in place. DOI has attempted to initiate such coordinating activity, but has been unsuccessful to date.

# **EXHIBIT 2**

**ADVISORY GROUP ON REGULATORY OVERSIGHT OF MANAGED CARE**

<b>NAME</b>	<b>ORGANIZATION</b>	<b>ADDRESS</b>	<b>PHONE #</b>	<b>FAX #</b>
Steve Barclay	Barclay & Goering	1001 N. Central, #600 Phoenix, AZ 85004	(602) 340-1010	(602) 340-1515
Mary Ellen Dalton/ Debra Nixon	Health Services Advisory Group	301 E. Bethany Home Rd., Ste, B157 Phoenix, AZ 85012	(602) 665-6101 (602) 665-6108	(602) 241-0757
Sheri Farr, Sr. Director of Policy & Regulatory Affairs Bob Reddemann	Arizona Hospital and Healthcare Association	1501 W. Fountainhead Pkwy., Ste. 650 Tempe, AZ 85282	(480) 968-1083	(480) 967-2029
Samantha Fearn, Executive Director Replaced by Michelle Covell	National Federation of Independent Business	2907 N. 2 <sup>nd</sup> Street Phoenix, AZ 85012	(602) 263-7690	(602) 263-7790
David Landrith VP for Policy & Political Affairs	Arizona Medical Association	810 W. Bethany Home Rd. Phoenix, AZ 85013	(602) 246-8901	(602) 242-6283
Branch McNeal, Assistant Director Kari Price	Arizona Health Care Cost Containment System	801 E. Jefferson Phoenix, AZ 85034	(602) 417-4458	(602) 256-6421
Anthony Mitten Executive Director	Maricopa County Medical Society	326 E. Coronado Road Phoenix, AZ 85004	(602) 252-2015	(602) 256-2479
Sue Navran General Counsel	Blue Cross Blue Shield of Arizona	2444 W. Law Palmaritas P.O. Box 13466 Phoenix, AZ 85002-3466	(602) 864-4179	(602) 864-4084
Mike Schaiberger Benefits Manager	Arizona Department of Administration	1624 W. Adams Phoenix, AZ 85007	(602) 542-5008	(602) 542-4744
Don Schmid	Arizona Department of Health Services	1740 W. Adams, Rm. 407 Phoenix, AZ 85007	(602) 542-1020	(602) 542-1062
Don Hughes Executive Director	Arizona Association of HMOs	2415 E. Camelback Rd., Ste. 700 Phoenix, AZ 85016	(602) 508-6077	(602) 508-6078

# **EXHIBIT 3**



**STATE OF ARIZONA**  
**DEPARTMENT OF INSURANCE**

**JANE DEE HULL**  
Governor

2910 NORTH 44th STREET, SUITE 210  
PHOENIX, ARIZONA 85018-7256  
602/912-8456 (phone) 602/912-8452 (fax)  
*<http://www.state.az.us/id>*

**CHARLES R. COHEN**  
Director of Insurance

June 11, 1999

ADDRESS  
Phoenix, AZ 85

re: Advisory Group for Regulatory Oversight of Managed Health Care Entities

Dear \_\_\_\_\_:

The Department of Insurance and the Department of Health Services currently share statutory responsibility for regulatory oversight of managed health care entities. During the last legislative session, there were some proposals to consolidate responsibilities within the Department of Insurance. Senate Bill 1165, which ultimately failed to pass, proposed creation of an advisory board on consolidated licensure and regulatory oversight of health care plans.

In keeping with its ongoing commitment to improve administration of state government, the Governor's Office has instructed me to consider and make appropriate recommendations concerning a regulatory structure for managed health care entities that consolidates responsibility and authority in the Department of Insurance. I have been directed to appoint an advisory group that will assist me by providing input from impacted constituencies. I appreciate your willingness to serve on this Advisory Group and to contribute your experience and expertise to this project.

The Advisory Group will assist me in studying and developing recommendations on the issues outlined in the enclosed summary and will include representatives from the following areas: the managed care industry, providers (hospitals and physicians), enrollees, employers, AHCCCS Office of Managed Care, and Department of Health Services. I anticipate that the group will meet several times between now and the end of the year. Someone from my office will contact you shortly to arrange a mutually convenient date for the first meeting, which we hope to schedule for the early part of July.

Knowing that time is short, I have already directed my staff to develop a survey instrument to gather information from other states concerning their regulatory structures for managed health care entities. Although we are anxious to get the survey out to other states, we feel that the members of the Advisory Group should have a chance to review and comment on the instrument. So that we can make the most productive use of the limited time we have available, I ask that you review the enclosed survey prior to the group's first meeting and come

prepared to comment on it. We expect to send it out immediately after the first meeting in the hope of getting responses by late August.

Thank you again for your willingness to participate on the Advisory Group. Please feel free to convey any observations that might improve these plans.

Sincerely,

Charles R. Cohen  
Director of Insurance

Enclosures

c: Mr. Stuart Goodman, Office of the Governor

**EXHIBIT 4**

**Managed Care Oversight Advisory Committee  
Minutes of the July 23, 1999 Meeting**

Advisory Group Attendees:

Chuck Cohen, DOI  
Vista Brown, DOI  
Tony Mitten, Maricopa County Medical Society  
Debbie Nixon (for Mary Ellen Dalton), Health Service Advisory Group  
Steve Barclay, CIGNA Health Care/Mayo Health Plan  
Sue Navran, Blue Cross/Blue Shield  
Sheri Farr, AZ Hospital & Healthcare Association  
Mike Schaiberger, DOA  
Kari Price (for Branch McNeal), AHCCCS  
Bea Casey (for Don Schmid), DHS  
David Landrith, AZ Medical Association  
Tammi Goldberg, DOI  
Mary Butterfield, DOI

The meeting commenced at 9:00 a.m.

I. Opening Remarks:

Chuck Cohen welcomed everyone to the first Advisory Group meeting. Attendees introduced themselves and informed the group of the organization he/she represents.

II. Background:

Chuck Cohen provided background for the issues to be addressed by the group.

III. Discussion of Issues:

- What kind of regulatory structure for managed care should we have in Arizona?
  - Title 20 covers HCSOs, Hospital, Medical, Dental and Optometric Service Corporations.
  - Laws from the 1970's set up a dual regulatory system between DOI (regulating forms & advertising, licensing, financial regulation, and market conduct) and DHS (regulating quality and effective health care services of these organizations).
  - Today, health care financing and service delivery are much more integrated and complex.
  - Current laws are too antiquated to deal with current issues.
  - DHS's rules are over 20 years old and not up to modern standards.
  - DOI does not have the authority, expertise, or resources to regulate the delivery of health services.

- There are gaps in the current system.
  - Managed care is a largely unregulated industry.
  - Consumers and providers have no where to turn for help.
  - If new laws were passed, there is inadequate regulatory infrastructure to implement them.
- Proposed Senate Bill 1165 (Patient Protection Act)
  - Bill did **not** pass.
  - Proposed deleting DHS from Title 20
    - All regulatory responsibility would be given to DOI, but no resources were allocated.
- What should the regulatory framework look like?
  - Should DOI be responsible for all the regulation, or should it be a multi-agency system? If the latter, how will it be coordinated?
  - Should we give more resources to DHS, or should the DOI be a “super agency” and have all the authority and the resources?
- Do we know what other States’ agencies do to regulate managed care?

#### IV. Materials

- Chuck Cohen handed out the “Iceberg” Chart – describes the DOI’s current responsibilities and the proposed DOI responsibilities, pointing out the resource deficiencies.
- Chuck Cohen handed out a report entitled “Quality Oversight in Managed Care: The Role of Interagency Coordination”, prepared by the National Academy for State Health Policy. This report describes the efforts undertaken in Washington, New Jersey and Maine to coordinate interagency health care quality oversight functions. The report indicates that other states are grappling with the same issues.

#### V. Issues to think about for the next meeting

- What kind of work product should we put together? (A formal report? A draft bill?)
- How will this affect the state’s budget? Are we anticipating a supplemental budget request in the next session?
- Interim report.

#### VI. Discussion

- Debbie Nixon suggested that we make a matrix to see the overlap of all agencies (state and federal).
- Steve Barclay commented that that may be too much to sort out.

- Steve Barclay asked whether any thought had been given to deemed status relying on the work of quality accrediting entities.
- Chuck Cohen agreed, reliance on accrediting entities would be appropriate, to some extent.
- Chuck Cohen passed around a chart from the NAIC that diagrams the regulation of managed care.
- David Landrith remarked that we need the resources in order to make a new system and we need resource allocation.
- Chuck Cohen passed out the “Iceberg” breaking down the current DOI responsibilities from the proposed DOI responsibilities, pointing out resource deficiencies.
- Steve Barclay asked if the NAIC had any model acts that we could look at.
  - Chuck Cohen said we would check with the NAIC, but suspected that there was little available other than a very general white paper from a working group called CLEAR (Consolidated Licensure of Entities Assuming Risk).
- Steve Barclay mentioned that Ohio has functional managed care regulatory laws, and suggested the group look at Ohio’s system.
- Chuck Cohen handed out a report entitled “Quality Oversight in Managed Care: The Role of Interagency Coordination”, prepared by the National Academy for State Health Policy. This report describes the efforts undertaken in Washington, New Jersey and Maine to coordinate interagency health care quality oversight functions. The report indicates that other states are grappling with the same issues.
- David Landrith asked if the phrase “health care providers” in 3b of the issues handout, was referring to individual physicians and nurses.
  - Chuck Cohen answered that the “health care providers” is referring to facilities, not physicians and nurses. However, it was included more for the idea that there were limits as to how far the “super agency’s” authority should extend.
- Someone asked if we could get information on what Ohio has done, how much they have budgeted for this oversight, what resource deficiencies they have in their current system and what weaknesses they have found in their current system. The Department agreed to request this information.
- Kari Price asked what does DOI do if it does not have the authority and resources to handle something for a consumer.
  - Chuck Cohen answered that DOI always tries to identify if there is any help we can give the consumer. Sometimes we can intervene and resolve an issue even though we have no formal authority to mandate a particular solution. The recent situation with Premier illustrates the limitations and problems DOI faces.
- Some problems that have occurred: people in rural areas cannot get in to see specialists and call DOI for help. However, under statute, DHS regulates the effectiveness of the health care delivery plan, including geographic network and adequacy issues.
- Kari Price asked if we could categorize the complaints DOI receives, grouping necessary resources with the complaints.
- DOI will describe the current regulatory system similarly to the format utilized in the NASHP paper to identify current problems and deficiencies.

- Chuck Cohen described one type of problem DOI has faced: health care providers bearing risk; HMO capitates with fiscal intermediaries who contract with the doctors. Essentially the HMO contracts away its risk. (FPA, RBP)

DOI does not have the authority to do anything about this situation. DOI needs authority to address this issue, which would require new law.

- David Landrith said that his group is very interested in seeing law to address the issue of fiscal intermediaries, but it is also important for us all to educate Legislators on the need for the resources that will be required to put an effective regulatory structure in place.

- Chuck Cohen pointed out that DOI has recently included managed care specialists in its teams of market conduct examiners, but that the DOI would still be limited by an absence of authority to regulate risk sharing mechanisms.

- Survey Discussion

- Survey will be sent to all states.

- Add to question No. 2, and everywhere else where appropriate, Grievance and Appeals, Utilization Review, Rates, and Forms and Advertising.

- Include a question asking what type of multi-agency coordination does your state have.

- Change No. 14 to include a scale of 1-10, with a space for comments.

- Include a follow up question after No. 14 asking if the state has any planned enhancements or improvements.

- Have the Arizona DOI fill out the survey.

- Once results are received, ask a few states what they do regarding accreditation.

- Address the rural network problem in the second phase of the survey.

- Survey procedure

- Get the survey out within the next two weeks.

- Give the state 30 days to complete the survey.

- Give DOI two weeks to compile the data.

## VII. Next Meeting

- Meet in Mid August to discuss Arizona's answers to the survey and what Ohio has been doing.

- Meet during the second half of September to discuss the survey results and other issues.

Meeting adjourned at approximately 10:45 a.m.

**Managed Care Oversight Advisory Committee  
Minutes of the August 23, 1999 Meeting**

Advisory Group Attendees:

Chuck Cohen, DOI  
Vista Brown, DOI  
Mary Butterfield, DOI  
Tammi Goldberg, DOI  
Gary Torticill, DOI  
Erin Klug, DOI  
Tony Mitten, Maricopa County Medical Society  
Herb Rigberg (for Mary Ellen Dalton), Health Service Advisory Group  
Steve Barclay, CIGNA Health Care/Mayo Health Plan  
Sue Navran, Blue Cross/Blue Shield  
Sheri Farr, AZ Hospital & Healthcare Association  
Mike Schaiberger, DOA  
Kari Price (for Branch McNeal), AHCCCS  
Don Schmid, DHS  
David Landrith, AZ Medical Association  
Samantha Fearn, NFIB

The meeting commenced at 2:45 p.m.

I. Opening Remarks

Chuck Cohen welcomed everyone to the second Advisory Group meeting.

II. Minutes of July 23, 1999 Meeting

The Advisory Group reviewed and adopted the Minutes of the July 23, 1999 meeting.

III. Materials

The following materials were sent to Advisory Group members prior to this meeting:

- Agenda for August 23, 1999 meeting.
- Minutes of the July 23, 1999 meeting.
- Managed Care Oversight Survey – partially completed by ADOI.
- Arizona Managed Care Oversight Summary.
- HIAA paper entitled “Federal and State Regulation of Health Insurance and Health Benefits”.

- Letter dated August 3, 1999 from Representative Barbara Leff regarding managed care improvement work groups.
- Letter dated August 3, 1999 from Senator Edward Cirillo regarding the Senate Select Task Force on Managed Care Reform.

#### IV. Discuss Timeframe of Advisory Group

The Governor's office has informed Chuck Cohen that the Advisory Group should create a written report containing recommendations for the regulatory structure, including costs, that should be implemented in Arizona. The report will likely be shared with interested legislators. At least a preliminary report should be issued in time to be part of the discussion in the upcoming legislative session. Chuck Cohen established January 2000 as a target.

#### V. Review and Discussion of Partially Completed Arizona Survey Results

- Mary Butterfield discussed the DOI's partial answers to the Managed Care Oversight survey.
- Steve Barclay suggested that the DOI eliminate Dental and Optometric Service Corporations from its response to question Number 1. Including these organizations may give an inaccurate picture of managed care in Arizona.
- In question Number 2, under Market Conduct, Corporate and Financial needs to be removed and replaced with Market Conduct. DHS needs to be added under Quality of Care and Network Adequacy for HMOs.
- Arizona's full-time employee staff dedicated to regulation of managed care entities is comprised of 75% of each of six positions. However, these positions were added to DOI as part of the enactment of the Health Care Appeals laws. As such, these positions work specifically in Health Care Appeals.
- Arizona employs field examiners in its market conduct and financial exams. DOI procures examiners through DOA's procurement process and bills the insurer for the costs associated with the exams.

#### VI. Discussion of Arizona Managed Care Oversight Summary

- David Landrith volunteered to provide the Advisory Group with a glossary and other background information distributed at the recent Town Hall meeting.

#### VII. Overviews of Current DOI Regulatory Activity

##### A. Financial Overview (Gary Torticill)

- An HMO may receive a Certificate of Authority if financially responsible and if it constitutes an effective health plan pursuant to the DHS rules. DOI typically receives a letter from DHS stating that the HMO is an effective health plan.
- Arizona law provides static, rather than dynamic net worth requirements. The requirements are as follows:
  - Plans must have a \$1.5 million net worth at licensure, and maintain \$1 million thereafter.
  - Plans must establish and maintain a minimum statutory deposit of \$500,000.
- Plans must establish a balance sheet reserve equal to 2% of enrollee remittances, up to \$1 million.
- In addition, plans must develop an insolvency plan providing for two months continued operations.
- Financial requirements are enforced via required filing of financial statements and financial examinations.
- HMOs in Arizona are generally exempted from the provisions of the Holding Company Act.
- Arizona does not directly regulate “fiscal intermediaries” which accept risk from HMOs and further manage it through contracts with providers. There is no reporting structure or regulatory scheme to oversee this area.

#### B. Financial Discussion

- Sue Navran asked whether HMO financial statements include liabilities for costs that may arise when fiscal intermediaries or providers fail to perform. Chuck Cohen and Gary Torticill explained that unless and until a failure to perform develops, the only liability would be the capitated cost of the contract. As additional liabilities develop due to failure to perform, they must be added to the financial statement. HMOs are not specifically required to actuarially justify the prospective costs assigned to provider services.
- Chuck Cohen commented that DOI has expertise regulating legal reserve financial institutions (indemnity insurers). HMOs are not merely indemnitors, but also, specialized service providers. Integration of financial and service functions makes regulatory oversight more complex. DOI lacks jurisdiction, expertise and resources to oversee all HMO fiscal and service arrangements.
- Kari Price commented that AHCCCS stays out of HMOs’ contracts with providers. AHCCCS holds health plans accountable for providing services even

if an intermediary, who already received capitation from the health plan, goes under. In addition, AHCCCS requires stop loss insurance and conducts member surveys to make sure members are receiving services.

- Sue Navaran mentioned AHCCCS' performance bond requirement which provide assurance that the HMO will be able to continue paying claims.
- Chuck Cohen noted that another approach would be to regulate all elements of the fiscal and service network depending on the nature and degree of risk sharing.
- Sue Navaran asked if NAIC risk-based capital (RBC) would address HMO risk sharing practices.
- Chuck Cohen responded that DOI is currently analyzing RBC for HMOs. The DOI must determine which HMOs are not in compliance, what the HMOs would need to do to become in compliance with RBC standards, and what the effect will be on rates.
- Chuck Cohen pointed out that the Medicare Competitive Pricing Demonstration also points out the need for RBC standards for HMOs. HCFA is relying on state financial regulation in the demonstration project.
- Chuck Cohen stated that the expected timeframe for enactment of RBC will probably not be in this legislative session, but hopefully in the next one.
- Gary Torticill will get information from the NAIC on the RBC Model.
- Chuck Cohen suggested that for purposes of this Group, we need to generally envision the kind of financial regulation we should have, vis-a-vis provider networks, so that we can make informed decisions about the resources necessary to implement. He suggested that the concepts of RBC, and other regulatory standards that maintain the HMO itself, rather than its service network, as the regulatory focal point may be the most efficient model.

#### C. Market Conduct Overview (Erin Klug)

- Scope of a Market Conduct Examination for an HMO or indemnity insurer:
  - Complaints – Both DOI and HMO receive complaints, and the market conduct examination focuses on the areas of complaint.
  - Appeal & Grievances – Insurer's process must be in compliance with Arizona laws.
  - Marketing & Sales – Scripts and advertising must not be misleading.
  - Producer Licensing – Make sure insurer is paying commissions.
  - Filing – All forms and advertising must be filed and approved prior to use.

- Underwriting – Check individual and groups for compliance with HIPAA Accountable Health Plan laws, Creditable Coverage, Notices, etc.
    - HIV laws – Review application questions, consent forms.
    - Privacy Act – Check to see if giving proper notices and authorization for release.
    - Conversion.
  - Claims – Check for violations of Unfair Claims Settlement Practices Act.
  - Utilization Review – Check to see if the insurer has filed a UR plan or if the insurer is exempt. If the insurer is exempt make sure it has its accreditation by the proper agency.
  - Fraud – Check to see if insurer has reported any fraudulent claims.
- Items not formally reviewed in a Market Conduct Examination for an HMO or indemnity insurer:
    - Quality of Care
    - Adequacy of Provider Network
    - The DOI lacks jurisdiction, expertise and clear regulatory standards in these areas.

D. Market Conduct Discussion

- Erin Klug stated that DOI's Market Conduct Division has six full-time employees, and twenty-five contract examiners that are currently providing examination services.
- When DOI conducts an exam, DHS can join the exam to see if the HMO has an effective health care delivery system, however, DHS, as of yet, has not participated in the exams. The standards that an HMO must comply with are found in the DHS rules regarding quality of care and network adequacy. DOI cannot examine those areas, it is lacking the expert resources and authority to conduct exams of that nature.
- A question was asked regarding the overall market conduct process and finished product. Erin Klug responded that the examiners write a report; the report is sent to the insurer; the insurer has time to respond; the report may be amended; and generally, a consent order is written. The enforcement of this process is performed by the Market Conduct Division, the Director's area, and possibly the Attorney General's Office.

E. Life & Health Division Oversight (Mary Butterfield)

- Mary Butterfield handed out an outline of the Life & Health Division Oversight of Health Care Services Organizations. (See attached.)

VIII. Next Meeting

- Review survey results.
- DHS presentation by Don Schmidt.
- Meet week of 9/27, or as soon thereafter as survey results are compiled and ready for review.

Meeting adjourned at approximately 4:40 p.m.

**Advisory Group for Regulatory Oversight  
of Managed Care Entities  
Minutes of the October 7, 1999 Meeting**

Advisory Group Attendees:

Chuck Cohen, DOI  
Vista Brown, DOI  
Mary Butterfield, DOI  
Scott Greenberg, DOI  
Tammi Goldberg, DOI  
Don Hughes, Arizona Association of HMOs  
Tony Mitten, Maricopa County Medical Society  
Mary Ellen Dalton, Health Service Advisory Group  
Steve Barclay, CIGNA Health Care/Mayo Health Plan  
Sue Navran, Blue Cross/Blue Shield  
Sheri Farr, AZ Hospital & Healthcare Association  
Bob Raddemann, AZ Hospital & Healthcare Association  
Scott Smith (for Mike Schaiberger), DOA  
Kari Price (for Branch McNeal), AHCCCS  
Don Schmid, DHS

The meeting commenced at 1:35 p.m.

I. Opening Remarks

Chuck Cohen welcomed everyone to the third Advisory Group meeting.

II. Minutes of August 23, 1999 Meeting

The Advisory Group reviewed and adopted the Minutes of the August 23, 1999 meeting.

III. Materials

The following materials were sent to Advisory Group members prior to this meeting:

- Agenda for the October 7, 1999 meeting.
- Minutes of the August 23, 1999 meeting.
- Spreadsheet of the Managed Care Oversight survey results received thus far.
- Blank Managed Care Oversight Survey.

IV. Update on 2000 Legislature

Chuck Cohen informed the members that when this Group was initially formed, there was no definite timeline as to when the Group should submit a completed report.

However, now there are several groups anxiously awaiting a report regarding the consolidated regulation of managed care entities.

The Group will need to meet a few more times. DOI is working on a draft proposal. The objective is to have a final report by mid December.

The Group will need to address issues regarding effective dates, rule making, levels of funding during the start up phase and the contours of the regulatory program.

Chuck Cohen informed the Group that the Department will be exploring the feasibility of adopting Risk-Based Capital (RBC) requirements for HMOs in the upcoming legislative session.

#### V. Overview of Current DHS Regulatory Activity (Don Schmid)

DHS authority is statutorily two fold. First, DHS is given the authority and responsibility to establish “basic health care services” that an HMO should provide to ensure enrollees are maintained in good health. In addition, DHS reviews applications to make sure that the plan is an effective health care plan and must also approve the geographic service area. The HMO must also submit any changes to the health plan to DHS for approval.

Second, DHS, in conjunction with DOI, may participate in an examination of an HMO for purposes of verifying the existence of an effective health care plan and reviewing the delivery of health and medical services by the HMO.

The DHS rules have not been amended since they were promulgated in 1975.

DHS does not evaluate the HMOs on an ongoing basis, with the exception of a change in the HMO service area. DHS has no interface with the HMO consumer.

DHS does examine and license medical facilities, but not clinics or physician offices. The reviews are performed by surveyors with nursing backgrounds.

#### VI. Discussion of the Managed Care Oversight survey

Chuck Cohen informed the Group that to date we have received 23 survey responses.

Chuck pointed out that reviewing the spreadsheet of results we can see that many states have bifurcated systems giving both the DOI and DHS authority and responsibilities to oversee managed care. There is a scarcity of models with a unified system.

There are numerous differences in the states in a variety of areas, making it hard to draw direct comparisons. However, it can be noted that it is rare to find an insurance department regulating quality of care and network adequacy.

Sue Navran pointed out that the states probably started out with the NAIC Model Act and not too many states have changed. In addition, Sue pointed out that it is hard to compare the states without the corresponding statutory language.

Chuck Cohen informed the Group that we have collected laws from some of the states and asked for a volunteer to summarize the laws to enable comparison of the different states. Sue Navran agreed to do the summary.

Out of the 23 states that have responded we will review the laws of 8 states (Colorado, Oregon, Maine, Maryland, New Jersey, South Carolina, Texas and Washington), based on similarity of the markets or other salient features of the regulatory scheme.

#### Colorado

Colorado is very similar to Arizona in that there is one big metropolitan area and many rural areas. In addition, the number of managed care entities in Colorado is similar to Arizona.

#### Maine

Maine has a smaller number of enrollees in managed care. It is a bifurcated system with a highly active interagency taskforce. Maine has provided a breakdown of all of their managed care positions with salary ranges.

#### Maryland

Maryland also has a bifurcated system with a total budget similar to ADOI's. We will need to follow up with Maryland to get a breakdown of their budget for managed care oversight. Maryland has numerous positions dedicated to managed care, and they have provided a breakdown of these positions.

#### New Jersey

New Jersey has a similar number of HMOs, with somewhat similar enrollment to Arizona. New Jersey has a bifurcated system, with DOBI working closely with DHSS.

#### Oregon

Oregon is similar to Arizona in that it has one main city and the number of enrollees are comparable. We need to follow up with Oregon to get additional information, such as which areas listed on the survey are the DOI's responsibility and what type of staff they have to perform this regulation.

#### South Carolina

South Carolina has a unified system, the Insurance Department is the sole regulator of managed care entities. We need to get and analyze South Carolina's managed care laws.

### Texas

Texas also has a unified system with close to 8 million enrollees (assuming the number of enrollees in HMOs and Single Service HMOs are not redundant). Texas regulates 49 HMOs, and 21 Single Service HMOs with a division consisting of at least 30 employees.

### Washington

Washington operates under a unified system. We should follow up to get a breakdown of employees dedicated to managed care.

## VII. Open Discussion

Steve Barclay suggested that we use accreditation standards such as NCQA or JCAHO (and JCAHO could do a presentation for us). These would provide benchmark standards which are used by employers.

Sue Navran expressed concern that BCBS exceeds the accreditation standards, but it is not accredited by these organizations. These accreditation standards are a moving set of standards, and she suggested that we use their standards to create a fixed set of standards and develop something with less bureaucracy.

Steve Barclay commented that we need to be sensitive to the cost aspect.

Sue Navran suggested that we use a deemed status for companies that are accredited.

Mary Butterfield expressed concern over the definition of “quality of care”, whether we would be monitoring past results or monitoring on an ongoing basis

Sue Navran mentioned that it is very hard to measure quality, each person has a different perception of what quality means.

Kari Price suggested that DOI summarize its managed care complaints to see what needs to be regulated.

A discussion ensued regarding what quality aspects will be regulated. We need to decide if we are talking about the quality of the HMO and quality of the systems rather than individual customer service. We should look at other states to see what they are doing regarding quality of care and utilization review issues. However, the Group does not want to create a system with additional reporting requirements without any benefit.

Vista Brown mentioned the DHS quality assurance rule. Vista asked if DOI should define “basic health care services”. If we merely move the rule to DOI it will be too onerous, however, if we leave it to rule making we do not know what we will wind up with.

Chuck Cohen stated that we need basic quality assurance, we need plan standards which can be satisfied by outside quality agencies, but do not have to be. We also need to monitor that compliance and handle the consumers.

Chuck also commented that DOI does not want to adjudicate contract disputes, but rather stay on the regulatory side.

Steve Barclay suggested that DOI conduct examinations to make sure quality standards are being met. The cost of these exams can be billed back to the HMO and be performed as often as necessary. If an HMO is doing what it should be doing it will not have to be examined, and therefore, incur no examination fees of this nature.

Another discussion regarding quality of care ensued. Someone commented that in order to regulate quality of care, DOI must go to the providers' offices, just like NCQA does. This is very expensive and time consuming. Chuck Cohen noted that the law would probably have to provide for record keeping by Plans on these matters.

The Group discussed how you can really determine quality. You can look at utilization review and performance measures. We must have some way to look at quality outcomes of health plans.

Sue Navran pointed out that most consumers change plans because of cost and not quality. Large groups have access to NCQA reports, but the determining factor for most groups is cost.

Chuck Cohen raised the issue of a patient advocate or an ombudsman to deal with quality issues at the consumer level as opposed to quality assurance systems at the Plan level.

A discussion regarding record keeping ensued. We need records of complaints so DOI can look to see what area the complaints fall into. In order to be accredited, plans must keep a log of complaints.

Sue Navran stated that we should be looking at quality of coverage, not really quality of care. The plans are not providing the care, but the coverage.

### VIII. Recommendations

Chuck Cohen stated that we need a general consensus of the regulatory scheme and the resources DOI will need.

We need quality requirements and standards that are applicable to plans, not quality standards for health care providers.

We need a system where the plans can be deemed accredited if they already have accreditation or have a DOI accreditation by established standards.

DOI needs to monitor ongoing standards through examination along with a record keeping requirement for the HMOs.

DOI needs to publish the information it collects on quality of HMOs.

DOI may need the following kinds of personnel to perform effectively in this area:

- Quality Manager
- Rules Personnel
- Contract Examiners
- Exam Administrator
- Clerical/Support staff
- Publication Budget
- Consumer Services Personnel

Vista Brown asked if we would need a Medical Director, and the consensus was no, it was not necessary. However, Sue Navran suggested that we may need a nurse.

Bob Raddemann suggested that we find a new word to use instead of quality.

Chuck Cohen suggested that we have a standard for internal control and suggested that we say quality assurance instead of quality of care.

A discussion ensued regarding provider network/provider adequacy.

#### IX. Next Meeting

- Review additional survey results.
- Review and compare laws from select states.
- Meet at the end of October and then again before Thanksgiving.

Meeting adjourned at approximately 4:15 p.m.

**Advisory Group for Regulatory Oversight  
of Managed Care Entities  
Minutes of the October 25, 1999 Meeting**

Advisory Group Attendees:

Chuck Cohen, DOI  
Vista Brown, DOI  
Mary Butterfield, DOI  
Scott Greenberg, DOI  
Tammi Goldberg, DOI  
Sue Navran, Blue Cross/Blue Shield  
Sheri Coulter, Blue Cross/Blue Shield  
Michelle Covell, NFIB  
Bob Raddemann, AZ Hospital & Healthcare Association  
Mike Schaiberger, DOA  
Kari Price (for Branch McNeal), AHCCCS  
Don Schmid, DHS

The meeting commenced at 2:25 p.m.

I. Opening Remarks

Chuck Cohen welcomed everyone to the fifth Advisory Group meeting.

II. Minutes of October 7, 1999 Meeting

The Advisory Group reviewed and adopted the Minutes of the October 7, 1999 meeting.

III. Materials

The following materials were sent to Advisory Group members prior to this meeting:

- Agenda for the October 25, 1999 meeting.
- Minutes of the October 7, 1999 meeting.
- DOI's 1998 Managed Care Complaints by Reason for Complaint.
- Schedule of upcoming meetings.

IV. Action Plan

The Group has two more meetings scheduled for November 18<sup>th</sup> and December 16<sup>th</sup>, both at 2 p.m.

DOI is working on a report with recommendations to present to the Governor's office. A draft of the report will be distributed to the Group prior to the November 18<sup>th</sup> meeting so the Group can provide input. At the December 16<sup>th</sup> meeting the

Group will be asked for its final input in order to send the working draft to Senator Cirillo and Representative Brimhall for their input. Once the report is finalized it will be presented to the Governor's office.

Chuck Cohen gave a presentation to Senator Cirillo's Senate Select Task Force on Managed Care Reform regarding the Advisory Group's activity. Chuck explained to the Task Force the continuum of where managed care regulation can range. Chuck informed the Task Force that his objective is to propose a baseline division to implement existing law according to a reasonable and appropriate regulatory approach and any greater degree of regulation or additional regulatory programs will cost more money.

#### V. Discussion of DOI's managed care complaints (Mary Butterfield)

Mary Butterfield explained that currently DOI has limited authority over access and quality of care issues. Mary described the action DOI takes in handling the various types of written complaints.

Kari Price asked if DOI received many provider complaints. She explained that AHCCCS receives more provider complaints than member complaints. The provider complaints may be regarding quality of care, claim denial and reduced payment. AHCCCS may have more provider complaints than DOI because DOI is only a regulator and AHCCCS is both a regulator and purchaser of health care.

Sue Navran asked if the health care appeals process overlaps with the complaint filing process. Chuck Cohen responded that the two should not overlap, if a consumer is going through the appeals process, Consumer Services should not open a complaint file on the same issue, either contemporaneously or after resolution of the appeal.

Sue Navran commented that a good way to handle quality of care is through an effective appeals process.

#### VI. Review of other states' laws

Sue Navran and Sheri Coulter discussed their review of the statutes and rules from several key states and provided the Group with a summary of their findings.

Sue Navran commented that there did not seem to be a central theme to the states' laws. Some states' rules contained vague standards such as what is reasonable for the community or what constituted an adequate number of providers.

Sue Navran commented that the Group should either take the rules DHS has and provide DOI with the manpower to enforce them, or give DHS the manpower.

There was a general discussion regarding Florida's laws and how Florida is a highly regulated state. Florida's Department of Health continually monitors the HMOs by forcing the HMO to be re-certified every two years.

#### Provider Contracting

The Florida law was discussed. The Group commented that it contained extensive provisions including a gag clause, hold harmless provision, termination provision, timely payment provision, as well as a provision that allows the DOI to order cancellation of a provider contract.

A member of the Group asked if DOI currently enforces a timely payment provision in a contract between an HMO and a provider. Chuck Cohen explained that there is a distinction between an assignment of benefits to a provider in indemnity insurance (where the provider steps into the insured's shoes), and a business contract between a provider and an HMO. He explained that DOI assists consumers with their contractual rights under their insurance policies, but has no direct regulatory jurisdiction over many business contracts of insurers.

A general discussion ensued regarding timely payment of providers and what role should DOI have in this area. DOI noted that when it receives a large volume of provider complaints it may make calls to see what is happening with an HMO. DOI wants to know if the HMO may be having financial problems or systems problems, which are within DOI's jurisdiction and responsibility.

A discussion regarding individual provider claims ensued and whether or not quality assurance plans should have an element to solve individual provider claims. It was suggested that a statute stating that DOI will not get involved in adjudicating or mediating individual disputes be considered.

#### Quality of Care / Network Adequacy

Chuck Cohen stated that one of the things he spoke to Senator Cirillo's Task Force about was the need for a balance between the regulatory role (government control) and the purchaser role (market control).

Sue Navran pointed out that the public looks to the provider directory in determining the adequacy of the network and employers look internally to see if their employees are satisfied, rather than looking at NCQA or HEDIS reports. She commented that NCQA and HEDIS reports could be available upon request or on a web site.

#### Capitation and Risk Shifting

There was a general discussion of the various payment arrangements entered into between HMOs, providers and fiscal intermediaries.

A discussion ensued regarding fiscal intermediaries in Arizona that have entered bankruptcy. Currently, there is no real insurance regulatory role to monitor fiscal intermediaries. The Group discussed whether there should be standards such as

bonding and financial reporting or at a minimum regular reporting to the HMO with whom they have contracted.

Chuck Cohen pointed out that DOI's main concern in dealing with failed fiscal intermediaries in the past has been continuity of care for the members.

Kari Price pointed out that AHCCCS requires the plan to regulate the intermediary. If a health plan is contracting out claims payment, AHCCCS requires quarterly monitoring. If a fiscal intermediary is having solvency problems, AHCCCS does not terminate the fiscal intermediary relationship; the plan must terminate this relationship. When contracting with a fiscal intermediary, the plan becomes liable and may have to pay twice if the intermediary fails to pay.

Chuck Cohen noted that there is no legal definition of "capitation" and that a definition could be considered where capitation would be permitted only to those actually providing a service. Those not providing a service, but accepting risk, would be considered insurers and would then be required to obtain a license from DOI.

Chuck Cohen pointed out that Ohio regulates risk bearing on the degree of risk shifting. However, Chuck pointed out that this is apparently an unfunded law.

Chuck Cohen pointed out that when an insurance company goes bankrupt, DOI steps in to liquidate the company while looking out for the consumers. Whereas, when a fiscal intermediary goes bankrupt, it goes to federal bankruptcy court.

#### IX. Next Meeting

At the next meeting, the Group will discuss the timeframe for implementation and the level of medical and information system expertise DOI will need.

Scheduled for November 18<sup>th</sup> at 2 p.m.

Meeting adjourned at approximately 4:00 p.m.

**Advisory Group for Regulatory Oversight  
of Managed Care Entities  
Minutes of the November 18, 1999 Meeting**

Advisory Group Attendees:

Chuck Cohen, DOI  
Vista Brown, DOI  
Mary Butterfield, DOI  
Scott Greenberg, DOI  
Tammi Goldberg, DOI  
Don Hughes, Arizona Association of HMOs  
Don Schmid, DHS  
Tony Mitten, Maricopa County Medical Society  
Steve Barclay, CIGNA/Mayo  
Sue Navran, Blue Cross/Blue Shield  
Debbie Nixon, Health Services Advisory Group  
Bob Raddemann, AZ Hospital & Healthcare Association  
Kari Price, AHCCCS  
Michelle Covell, NFIB

The meeting commenced at 2:10 p.m.

I. Opening Remarks

Chuck Cohen welcomed everyone to the fifth Advisory Group meeting.

II. Minutes of October 25, 1999 Meeting

The Advisory Group reviewed and adopted the Minutes of the October 25, 1999 meeting.

III. Materials

The following materials were sent to Advisory Group members prior to this meeting:

- Agenda for the November 18, 1999 meeting.
- Minutes of the October 25, 1999 meeting.
- First **Draft** Managed Care Oversight Report.

IV. Action Plan

DOI has been working on a draft report with recommendations to present to the Governor's office. DOI plans on finalizing the draft after today's meeting, and delivering the draft in early December to Senator Cirillo and Representative Brimhall for comment. Chuck Cohen will eventually go before Senator Cirillo's Task Force

and explain the budgetary projection, as Senator Cirillo is waiting for the budget numbers to put in his Bill.

The final report will likely be presented to the Governor's office in December, before the holidays.

#### V. Review Draft Report

Chuck Cohen explained that the draft sets out the background of managed care regulation in Arizona, the meetings of the Advisory Group and the data the Group examined and discussed (including the survey, survey results, and other states' laws).

##### Assumptions

The Overview and Scope section of the draft begins by laying out the assumptions upon which the resource projection was compiled.

The first assumption establishes that it is not the objective of this projection to make new policy, but full and appropriate implementation of existing law and policy. Another general assumption is that dental "service corporations" and prepaid dental plans will not fall under the consolidated regulation of managed care entities.

Chuck Cohen explained that right now if DHS was struck from the rule, dental would not be included in the oversight. The law would have to be changed to include dental and currently, DHS has an active program regulating the dental organizations.

Chuck Cohen explained that DOI will continue to function as a regulator of plans, not as an adjudicator of claims.

##### Quality

Chuck Cohen explained that DOI will be taking over responsibility for the DHS rules, including whether a health care plan provides for basic health care services and whether a managed care organization constitutes an effective mechanism to achieve an effective health care plan. DOI will look at the systems, policies and procedures related to health care delivery.

Outside resources, such as examiners, will be used by DOI with respect to oversight of an organization's quality system. Due to the fact that many organizations submit to quality review by private organizations, DOI will use a "deemed" compliance provision.

DOI will provide the same kind and level of assistance to individual consumer complaints as it does for other lines of insurance. In addition, DOI will provide consumer-oriented information and publications, promote self-help, and facilitate, not adjudicate, resolutions of disputes.

### Provider Contracting

DOI assumes that consolidation of managed care oversight will not create a new responsibility for enforcement of plan-provider contracts. DOI will continue to be involved in reviewing the way a plan deals with contracting issues such as grievance and appeals of provider complaints. DOI will monitor the number of grievances filed, financial issues, and network problems.

### Risk Sharing

DOI will continue to regulate the plans' capital and surplus. However, it will be the plans' responsibility to impose requirements when transferring risk, such as bonding and reporting requirements.

### Open Discussion

Steve Barclay asked if the Department will need to promulgate rule standards if no legislation is passed regarding managed care? Chuck Cohen responded that the managed care legislation will be considered in 2000, therefore, DOI should not need to create new rules consolidating managed care regulation, the legislation should transfer the appropriate responsibility to DOI.

A discussion ensued regarding the definition of fiscal intermediaries.

Steve Barclay asked what will happen with accredited entities, will they need to be re-qualified or will they be "deemed" qualified through an examination process. Mary Butterfield responded that this process will be similar to the UR accreditation, wherein, if an entity is accredited by a private organization, they are "deemed" accredited by DOI. However, problems arise when entities are accredited for specific things but their UR activities go beyond that scope. Accreditation must be sufficient to have a "deemed" status.

Sue Navran expressed concern regarding the fact that Blue Cross Blue Shield is not accredited, but has been licensed for some time and they do not want to go through the licensing process again.

### Personnel and Budget

Chuck Cohen explained that we are not proposing the creation of a Managed Care Division, but an allocation of additional resources to existing Divisions to carry out managed care oversight.

Chuck Cohen explained that in the Life and Health Division we projected the need for four new positions, a Quality/Compliance Manager and two Quality/Compliance Analysts, all with medical backgrounds, and an Administrative Assistant III. In

addition, the Life and Health Assistant Director's position will be uncovered and reclassified.

One new Consumer Services Specialist II will be necessary in the Consumer Services Division. One Senior Financial Analyst will be added to the Corporate and Financial Affairs Division, as well as reclassifying and uncovering the Assistant Director's position.

The Office of the Director will need a Rule/Legal Analyst, in addition to reclassifying an Administrative Secretary I to an Administrative Assistant II.

Chuck Cohen explained that as the Department adds employees, other Divisions are impacted, such as Administrative Services and Information Technology. These Divisions get more stressed with new programs. Therefore, it is necessary to reclassify an Administrative Assistant II in the Administrative Services Division to an Administrative Assistant III, and reclassify a Network Specialist I in the Information Technology Division to a Network Specialist II.

In addition, Chuck Cohen explained that DOI wants to be able to hire qualified people and retain these people. Chuck does not want to ask for twice as many positions than are necessary with the idea of getting fifty percent. He would rather take credible numbers to the Governor.

Debbie Nixon asked if we would have any problems reclassifying positions? Scott Greenberg responded that we should not have problems if we provide adequate backup information.

Sue Navran asked if DOI was planning for other legislative changes? Chuck Cohen replied, that we did not plan for it in this proposal. The consolidation of managed care regulation was a charge given by the Governor, not the Legislature. Scott Greenberg added that at the appropriate time, DOI will bring up other resource issues in other proposed Bills.

Sue Navran asked who will answer consumer calls? Chuck Cohen responded that the Consumer Services Specialist will answer these calls, and the Quality Analysts may also help out with consumer questions.

## VI. Timetable

Chuck Cohen explained that if the consolidation is enacted in the next legislative session, it could be effective on January 1, 2001.

Vista Brown explained that the rulemaking would also be effective on January 1, 2001. We will need a provision to protect the current rules or a one year exemption to instantly adopt them, while going through the regular rule making process. Vista explained the rule making process to the Group.

A group member asked how the consolidation of managed care regulation will effect the 2001 budget, since it will be enacted in mid year. Don Hughes added that Senator Gnant has already asked agencies for supplementary appropriation requests. Chuck Cohen replied that this is not the Department's request, it will be part of Senator Cirillo's Bill.

A discussion ensued regarding when the Department would receive the money. Chuck Cohen explained that it will take at least three to four months to establish and fill the new positions.

Bob Raddemann asked why there was no training or education expense in the proposal. Scott Greenberg replied that DOI did not consider training and education in this projection, however, it will consider this expense in the final projection.

Debbie Nixon asked why there was no instate travel in the projection. Chuck Cohen responded that the Department will use examiners to conduct onsite field examinations. These examiners are procured contractors whose expenses are billed to the appropriate plan.

Sue Navran asked if the Quality/Compliance Analysts will be nurses. Mary Butterfield replied that we will use RNs to fill these positions.

Sue Navran commented that the projection seems a little light in the Consumer Services area. Chuck Cohen responded that given the data on the number of consumer complaints, this seems to be an adequate projection for the first year, although, we may need to adjust employment projections in the second year.

## VII. Sources of Funding

Chuck Cohen pointed out that in funding Insurance Departments, some states use assessments and others use a general fund, or some hybrid of the two. Given the fact that we have twelve plans and a projected cost of at least \$750,000 for the first year, this proposal will be presented as a general fund appropriation.

Scott Greenberg commented that DOI's fee schedule will have to be uniformly adjusted.

Kari Price asked what the fees are? Scott Greenberg responded that some of DOI's fees are agent licensing, certificate of authority, brokers licensing, filing charter documents and filing annual statements, among others. Scott pointed out that these fees have not changed in five years. It was noted that the fee issue must be explained in the Report.

### VIII. Information Systems

Chuck Cohen asked the Group if we will need IS people who understand the plans' systems? Kari Price replied that at AHCCCS they do not, with the exception of the Y2K compliance.

Scott Greenberg asked what type of information we will be receiving from the plans. Sue Navran responded that the plans would have the information on their websites and on paper, if need be.

Mary Butterfield asked the Group if providers and plans send things electronically? Sue Navran replied that some send claims information electronically. Steve Barclay commented that electronic filing would be a cooperative adventure between the plans and DOI. Scott Greenberg commented that with only 12 plans, it would not be that difficult to develop.

### IX. Next Meeting

Chuck Cohen asked the Group if they felt we needed one more meeting? The Group did not believe another meeting was necessary.

Chuck Cohen informed the Group that every member will receive a final draft of the Report delivered to the Governor's office.

Meeting adjourned at approximately 3:40 p.m.

# **EXHIBIT 5**

## Contents

1. A.R.S. §20-821 *et seq.*
2. A.R.S. §20-1051 *et seq.*
3. A.A.C. R9-12-101 *et seq.*

other persons, but including the reasonable cost of the liquidation. 1955

### 20-792. Ownership of real property

Legal title of real property acquired as an eligible investment in accordance with section 20-556 must be held in the name of the reciprocal insurer. Notwithstanding any other provision in this section, all deeds, notes, mortgages or other documents relating to the purchase, sale, lease, encumbrance or other interest in such real property may be executed in the name of the reciprocal insurer by its attorney-in-fact. 1995

## ARTICLE 3. HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATIONS

### 20-821. Scope of article; rules; authority of director

*See Laws 1997, Ch. 100, § 22 for applicability guidelines*

A. Hospital service corporations, medical service corporations, dental service corporations, optometric service corporations and hospital, medical, dental and optometric service corporations incorporated in this state are governed by this article and are exempt from all other provisions of this title, except as expressly provided by this article and any rule adopted by the director pursuant to section 20-143 relating to contracts of such service corporations. No insurance law enacted after January 1, 1955 is deemed to apply to such corporations unless they are specifically referred to therein.

B. Sections 20-1133, 20-1377, 20-1408, 20-1692, 20-1692.01, 20-1692.02 and 20-1692.03 and chapter 17 of this title apply to this article. 1997

### 20-822. Definitions

In this article, unless the context otherwise requires:

1. "Department" means the department of insurance.  
2. "Director" means the director of the department of insurance.

3. "Hospital service corporations", "medical service corporations", "dental service corporations", "optometric service corporations" and "hospital, medical, dental and optometric service corporations" mean corporations organized under the laws of this state for the purpose of establishing, maintaining, and operating nonprofit hospital service or medical or dental or optometric service plans, or a combination of such plans, whereby hospital, medical or dental or optometric service may be provided by hospitals, which within the meaning of this article may include extended care facilities and home health agencies, or by physicians, which within the meaning of this article may include professional and technical personnel under the direction of a physician, or by podiatrists, or by dentists which may include those engaged in the general practice of dentistry as well as the specialized or restricted practice of dentistry, or by optometrists which may include those engaged in the general practice of optometry as well as the specialized or restricted practice of optometry, with which the corporations have contracted for such purpose, to such of the public as become subscribers to the corporations under contracts which entitle each subscriber to certain hospital, medical, dental or optometric service, or in the case of hospital service corporations or medical service corporations, all such services, or whereby as operating expense or refunds, payments may be made to subscribers with respect to any such service that is rendered by a hospital, physician, podiatrist, dentist or optometrist with which the corporations have not so contracted. 1975

### 20-823. Incorporation of hospital, medical, dental and optometric service corporations

The corporation as defined in § 20-822 shall be organized under the laws of this state relating to private corporations

not for pecuniary profit, insofar as such laws are not inconsistent with any of the provisions of this article. 1955

### 20-824. Application for certificate; fee

Such a corporation may issue contracts to its subscribers only when the director of insurance has, by certificate of authority, authorized it so to do. Application for a certificate of authority shall be made on forms supplied or approved by the director containing such information as he deems necessary. Each application for a certificate of authority shall be accompanied by the fee prescribed by article 2 of chapter 1 of this title for medical, hospital, dental and optometric service corporations and copies of the following documents:

1. Articles of incorporation.
2. Bylaws.
3. Proposed contracts between the applicant and participating hospitals, physicians, dentists or optometrists showing the terms under which service is to be furnished to subscribers.
4. Proposed contracts to be issued to subscribers.
5. A table of rates to be charged to subscribers.
6. Financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital, and the name or names of each contributor and the terms of each contribution.
7. A statement of the area in which the corporation proposes to operate. 1975

### 20-825. Certificate of authority; requirements

The director shall issue a certificate of authority authorizing the applicant to issue contracts to its subscribers when it is shown to the satisfaction of the director that:

1. The applicant is established as a bona fide, nonprofit hospital service corporation, medical service corporation, dental service corporation or optometric service corporation or combination thereof.
2. The contracts between the applicant and the participating hospitals, physicians, dentists or optometrists obligate each hospital, physician, dentist or optometrist executing them to render service to which each subscriber may be entitled under the terms of the contract to be issued to the subscribers.
3. The amounts provided as working capital of the corporation are repayable, without interest, out of operating expenses.
4. The amount of money actually available for working capital is sufficient to carry on the plan for a period of six months from the date of issuance of the certificate of authority.
5. The applicant has secured contracts of participation from sufficient hospitals, physicians, dentists or optometrists or any combination thereof to provide ample protection for its subscribers within the area proposed to be served by the applicant. 1975

### 20-826. Subscription contracts

*Laws 1998, Ch. 91, § 8 applies to policies, contracts and plans issued or renewed on or after Jan. 1, 1999*

A. No contract between such a corporation and its subscribers shall be issued unless the form of such contract is approved in writing by the director.

B. Each contract shall plainly state the services to which the subscriber is entitled and those to which the subscriber is not entitled under the plan, and shall constitute a direct obligation of the providers of services with which the corporation has contracted for hospital, medical, dental or optometric services.

C. Each contract, except for dental services or optometric services, shall be so written that the corporation shall pay benefits for each of the following:

1. Performance of any surgical service which is covered by the terms of such contract, regardless of the place of service.

2. Any home health services which are performed by a licensed home health agency and which a physician has prescribed in lieu of hospital services, as defined by the director, providing the hospital services would have been covered.

3. Any diagnostic service which a physician has performed outside a hospital in lieu of inpatient service, providing the inpatient service would have been covered.

4. Any service performed in a hospital's outpatient department or in a freestanding surgical facility, if such service would have been covered if performed as an inpatient service.

D. Each contract for dental or optometric services shall be so written that the corporation shall pay benefits for contracted dental or optometric services provided by dentists or optometrists.

E. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall, as to such coverage of family members, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth, to a child adopted by the insured, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the insured and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

F. Each contract which is delivered or issued for delivery in this state more than one hundred twenty days after August 27, 1977 and which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the subscriber for support and maintenance. Proof of such incapacity and dependency shall be furnished to the corporation by the subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the corporation, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

G. No corporation may cancel or refuse to renew any subscriber's contract without giving notice of such cancellation or nonrenewal to the subscriber under such contract. A notice by the corporation to the subscriber of cancellation or nonrenewal of a subscription contract shall be mailed to the named subscriber at least forty-five days prior to the effective date of such cancellation or nonrenewal. Such notice shall include or be accompanied by a statement in writing of the reasons for such action by the corporation. Failure of the corporation to comply with the provisions of this subsection shall invalidate any cancellation or nonrenewal except a cancellation or nonrenewal for nonpayment of premium.

H. A contract which provides coverage for surgical services for a mastectomy shall also provide coverage incidental to the

patient's covered mastectomy for surgical services for breast reconstruction, and for at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

I. A contract which provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

1. A baseline mammogram for a woman from age thirty-five to thirty-nine.

2. A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

3. A mammogram every year for a woman fifty years of age and over.

J. Any contract that is issued to the insured and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the insured if all of the following are true:

1. The child is adopted within one year of birth.

2. The insured is legally obligated to pay the costs of birth.

3. All preexisting conditions and other limitations have been met by the insured.

4. The insured has notified the insurer of his acceptability to adopt children pursuant to section 8-105, within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

K. The coverage prescribed by subsection J of this section is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29 but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 4, subdivisions (d), (e), (f) and (g). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The insured adopting parents shall notify their insurer of the existence and extent of the other coverage.

L. The director may disapprove any contract if the benefits provided in the form of such contract are unreasonable in relation to the premium charged.

M. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status, including:

1. Conditions of eligibility.

2. Coverage of dependents.

3. Preexisting conditions.

4. Termination of insurance.

5. Probationary periods.

6. Limitations.

7. Exceptions.

8. Reductions.

9. Elimination periods.

10. Requirements for replacement.

11. Any other condition of subscription contracts.

N. Beginning on January 1, 1998, any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a caesarean section. The contract shall not require the provider to obtain authorization from the corporation for prescribing the minimum length of stay required by this

subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The corporation shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection O of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

O. Nothing in subsection N of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a corporation from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection N of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a corporation from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection N of this section.

P. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider, including:

1. Blood glucose monitors.  
2. Blood glucose monitors for the legally blind.  
3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.

11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.

12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

Q. Nothing in subsection P of this section prohibits a medical service corporation, a hospital service corporation or a hospital, medical, dental and optometric service corporation from imposing deductibles, coinsurance or other cost sharing

in relation to benefits for equipment or supplies for the treatment of diabetes.

R. As used in subsection E of this section, the term "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under the age of eighteen years.

1998

#### 20-827. Participating hospitals, physicians, dentists, optometrists, psychologists and chiropractors

*See Laws 1997, Ch. 100, § 22 for applicability guidelines*

A. A corporation holding a certificate of authority under this article may enter into contracts only with licensed hospitals approved for participation by the board of directors of the corporation, and with physicians, surgeons, dentists, optometrists, certified registered nurses, registered nurse practitioners, psychologists and chiropractors duly licensed and qualified to practice in this state, and may enter into contracts of participation with any hospital maintained and operated by the state or any political subdivision thereof.

B. No person subject to this article may restrict or prohibit, by means of a policy or contract, whether written or otherwise, a licensed health care provider's good faith communication with the health care provider's patient concerning the patient's health care or medical needs, treatment options, health care risks or benefits.

1997

#### 20-828. Deposit for protection of members

A. Corporations governed by this article shall at all times have on deposit with the state treasurer the following amounts:

1. If newly formed under this article, two hundred thousand dollars.

2. If formed under prior law, such amount as was so required under prior law.

B. Every such corporation each year shall deposit with the state treasurer, not later than February 1, an amount equal to two per cent of the gross subscriptions collected during the preceding calendar year, until the deposit of the corporation reaches a total of five hundred thousand dollars. All such deposits shall be held by the state treasurer in trust for the benefit and protection of the subscribers of the corporation making the deposit.

C. The deposit prescribed by this section shall be subject to withdrawal in whole or in part on the order of and as directed by the director, but may, with the approval of the director, be invested pursuant to section 25-313. Interest earned on the deposits shall be payable to the corporation making the deposit.

D. An unsettled final judgment, arising upon a certificate of participation against such a corporation, shall be a lien on the deposit prescribed by this section, subject to execution after thirty days from the entry of final judgment. If the deposit is reduced thereby, it shall be replenished within ninety days.

E. Upon the liquidation or dissolution of the corporation and the satisfaction of all its liabilities, any balance remaining in the deposit in the hands of the state treasurer and any other assets of the insurer shall be distributed to the holders of certificates of participation in good standing at the time proceedings for the liquidation or dissolution of the corporation were commenced, prorated according to the gross amount of subscriptions which have been paid on the certificates up to the time such proceedings were commenced.

1990

#### 20-829. Directors

The directors of such a corporation shall at all times include representatives of:

1. Administrators or trustees of hospitals which have contracted with the corporation to render hospital service to subscribers, if the corporation is a hospital service corporation or a hospital and medical service corporation.

2. Physicians and surgeons licensed to practice in this state who have contracted with the corporation to render medical service to subscribers, if the corporation is a medical service corporation or a hospital and medical service corporation.

3. Dentists licensed to practice in this state who have contracted with the corporation to render dental service to subscribers, if the corporation is a dental service corporation.

4. Optometrists licensed to practice in this state who have contracted with the corporation to render optometric service to subscribers, if the corporation is an optometric service corporation.

5. The general public, exclusive of hospital representatives and physicians, dentists and optometrists. 1975

#### 20-830. Expenses and investments

A. The operating and administrative expenses of any such corporation, including all costs in connection with solicitation of subscribers to the corporation and capital expenditures, shall not exceed thirty per cent of paid subscriptions during the first year of operation, twenty-five per cent of paid subscriptions during the second year of operation, and twenty per cent of paid subscriptions in any year thereafter.

B. All funds not set aside for operating expenses shall be placed in a reserve that may be expended only for payment to participating hospitals, physicians, dentists, optometrists, certified registered nurses, registered nurse practitioners, psychologists and chiropractors for services to subscribers, for payment to subscribers for coverage on prescription drugs when provision is so made in subscription contracts, or as a refund to the subscribers. The funds of the corporation shall be invested as prescribed by article 2, chapter 3 of this title for domestic insurers. 1990

#### 20-831. Annual report and examination

A. Not later than March 31 of each year every such corporation shall file with the director a statement verified by at least two of its principal officers showing its condition on the last day of the next preceding calendar year. The director may appoint an examiner, deputy examiner or other person to examine into the affairs of the corporation who has the power of visitation and examination, is entitled to free access to all the books, papers and documents relating to the business of the corporation and may summon the officers, agents or employees or any other persons and require them to testify under oath concerning the affairs, transactions and condition of the corporation. An examination shall be conducted at least every three years.

B. The corporation shall pay the cost of the examination and audit, but the corporation is not required to pay for more than one such audit or examination in any one year. The corporation shall pay the costs as provided for insurers pursuant to § 20-159. 1982

#### 20-832. Limitation on salaries

No such corporation shall pay any salary, compensation or emolument to any officer, agent or employee thereof amounting in any year to more than five thousand dollars, unless such payment be first authorized by the board of directors of the corporation, nor shall any such corporation make any agreement with any officer, agent or employee whereby it agrees that for any services rendered or to be rendered he shall receive a salary, compensation or emolument for a period of more than three years from the date of such agreement. No bonus, commission or dividend shall be paid to any director, officer, agent or employee of the corporation. 1953

#### 20-833. Relationship of health care provider and patient

See Laws 1997, Ch. 100, § 22 for applicability guidelines

A. Nothing in this article shall be deemed to alter the relationship of physician and patient, dentist and patient or optometrist and patient.

B. No such corporation shall in any way influence the subscriber in his free choice of hospital, physician, dentist or optometrist other than to limit its benefits to participating hospitals, physicians, dentists and optometrists.

C. Nothing in this article shall be deemed to abridge the right of any physician, hospital, dentist or optometrist to decline patients in accordance with the standards and practices of such physician, hospital, dentist or optometrist, and no such corporation shall be deemed to be engaged in the corporate practice of medicine, dentistry or optometry.

D. No person subject to this section may restrict or prohibit, by means of a policy or contract, whether written or otherwise, a licensed health care provider's good faith communication with the health care provider's patient concerning the patient's health care or medical needs, treatment options, health care risks or benefits. 1997

#### 20-834. Dissolution; unfair practices

Such a corporation shall be subject to the provisions of article 4 of chapter 3 of this title (rehabilitation and liquidation) and article 6 of chapter 2 of this title (unfair practices). 1955

#### 20-835. Judicial review of decisions of director

All orders of the director of insurance made pursuant to this article shall be subject to the provisions of article 2 of chapter 1 of this title, including the right of hearing, rehearing and appeal. 1955

#### 20-836. Limitation on liability

No liability shall attach to any corporation holding a certificate of authority under this article by reason of the failure on the part of any of its participating hospitals, physicians, dentists or optometrists to render service, except as provided by this article, to any of its subscribers, nor for the negligence, malpractice or other acts of its participating hospitals, physicians, dentists or optometrists. 1975

#### 20-837. Tax exemption; exceptions

Every corporation doing business pursuant to this article is declared to be a nonprofit and benevolent institution and to be exempt from state, county, district, municipal and school taxes, including the taxes prescribed by this title, and excepting only the fees prescribed by section 20-167 and taxes on real and tangible personal property located within this state. But each such corporation shall be subject to a state tax of 1.7 per cent through June 30, 1989 and from and after June 30, 1989 2.0 per cent on net premiums which are received to effect or maintain its subscription contracts, except that such tax shall not apply with respect to any coverage concerning which the corporation's relationship is as administrative or fiscal agent for national, state or municipal government or any political subdivision or body thereof, and such tax shall not apply with respect to any premiums received from funds of national, state or municipal government or any political subdivision or body thereof. Such tax shall be determined, filed and reported in the manner prescribed in section 20-224. The failure by a corporation to pay the tax on or before the prescribed payment dates results in a civil penalty determined pursuant to section 20-225. 1988

#### 20-838. Subscribers and employees exempt from corporate indebtedness

The private property of the subscribers, agents, officers, directors, members and employees of any corporation holding

a certificate of authority under this article shall be wholly exempt from any of the debts, obligations and liabilities of the corporation. 1955

#### 20-839. Exemption of certain hospital plans

A. This article shall not apply to any corporation operating or maintaining a hospital service plan, medical service plan, dental service plan or optometric service plan, participation in which is limited to its employees and the employees of other persons or corporations with which such corporation may have contracted to provide such services.

B. As used in this section, the term "employees" shall include members of the families of employees. 1975

#### 20-840. Continuation of existing certificates, licenses and rights

This article shall not be construed in any manner to abrogate, amend or annul any certificate, license or right acquired prior to January 1, 1955 by any corporation, insurer, hospital, physician, dentist, optometrist, individual or subscriber under or pursuant to Laws 1945, 1st special session, chapter 13, and all of such certificates, licenses and rights shall be and they are continued in full force and effect. 1975

#### 20-841. Prohibiting denial of certain contract benefits

A. Notwithstanding any provision of any subscription contract of a hospital and medical service corporation, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11, if the service performed is within the lawful scope of such person's license, and if the service is surgical, such person is a member of the staff of an accredited hospital, and if such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

B. If a subscription contract of a hospital and medical service corporation provides for or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or a physician and surgeon skilled in diseases of the eye to provide the examination, care, or treatment for which the subscriber is eligible and which falls within the scope of practice of the optometrist or physician and surgeon. Unless such subscription contract otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances thereto.

C. If any subscription contract of a hospital and medical service corporation is written to provide coverage for psychiatric, drug abuse or alcoholism services, reimbursement for such services shall be made in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 13 or 19.1 or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution. 1987

#### 20-841.01. Prohibiting denial of chiropractic contract benefits; direct reimbursement

If a subscription contract of a hospital and medical service corporation provides for or offers reimbursement for any service which is within the lawful scope of the practice of a chiropractor holding a certificate or license issued by the state in which the services are rendered, a subscriber covered under such contract may select either a physician or duly certified or licensed chiropractor to provide the examination, care or treatment for which the subscriber is eligible and which falls within the scope of practice of the chiropractor or physician. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 8 or 13 who has a participation contract with the

hospital and medical service corporation or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution. 1987

#### 20-841.02. Prohibiting denial of psychologist contract benefits

If a subscription contract of a hospital and medical service corporation provides for or offers reimbursement for any service which is within the lawful scope of the practice of a psychologist holding a certificate or license issued by the state in which the services are rendered, a subscriber covered under such contract may select either a physician or duly certified or licensed psychologist to provide the examination, care or treatment for which the subscriber is eligible and which falls within the scope of practice of the psychologist or physician. 1987

#### 20-841.03. Prohibiting denial of contract benefits; nurses; reimbursement

If a subscription contract of a hospital and medical service corporation provides or offers reimbursement for any service which is within the scope of the practice of a registered nurse practitioner or a certified registered nurse qualified under the rules adopted by the state board of nursing regarding extended nursing practice and licensed pursuant to title 32, chapter 15, the hospital and medical service corporation shall not deny benefits to a subscriber who receives the services of the certified registered nurse or registered nurse practitioner. The cost of the service may be reimbursed directly to the certified registered nurse or registered nurse practitioner if the certified registered nurse or registered nurse practitioner has a participation contract with the hospital and medical service corporation or to the subscriber if another provider or health care institution was not reimbursed for the cost of the service. 1990

#### 20-842. Prohibition against excluding coverage because of previous tests for a condition

An insurance contract offered by a hospital, medical, dental or optometric service corporation shall not exclude coverage of a condition if the insured person has previously had tests for the condition and the condition was not found to exist. There must be evidence that a condition actually existed before the insurance contract was entered into in order to exclude coverage of the condition. 1986

#### 20-843. Eligibility; prohibiting cancellation because of eligibility for certain benefits

A. Except as specifically provided in sections 20-1379 and 20-1380, with respect to the determination of whether a person is an eligible individual, a hospital and medical service corporation shall not consider the availability of or a person's eligibility for medical assistance pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396a (1980)) when considering eligibility for coverage or calculating payments under a plan for eligible subscribers.

B. To the extent that payment for covered expenses has been made under the state program pursuant to title XIX of the social security act for health care items or services that are furnished to an individual, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. On presentation of proof that the state program pursuant to title XIX of the social security act has paid for covered items or services, the hospital and medical service corporation shall pay the state program pursuant to title XIX of the social security act according to the coverage provided in the contract.

C. A hospital and medical service corporation may not impose on a state agency that has been assigned the rights of an individual who is eligible for medical assistance and who is

covered for health benefits from the insurer any requirements that are different from the requirements applicable to an agent or assignee of any other covered individual.

D. A hospital or medical service corporation shall not cancel or fail to renew the contract of any person based on that person's eligibility for or enrollment in a program funded under title XIX of the social security act or title 36, chapter 29 or 34. Nothing in this section prohibits cancellation or failure to renew for nonpayment of monies due under the contract.

1998

#### 20-844. Right to open enrollment period; subscribers; definition

A. With respect to subscribers who are members of a group with more than one carrier, if there is an insolvency of a hospital service corporation, medical service corporation, dental service corporation, optometric service corporation or hospital, medical, dental and optometric service corporation, all other carriers that participated in an open enrollment period shall offer subscribers of the insolvent corporation who are members of that group a thirty day open enrollment period beginning on the date the insolvency is declared. Each carrier shall offer these subscribers the same coverages and rates that it currently offers to other subscribers in the group without any waiting periods or preexisting conditions, exclusions, limitations or restrictions. On declaration of insolvency, the corporation shall notify each group contract holder of the insolvency. Each group contract holder shall notify its remaining carrier or carriers of the insolvency and notify its members of their rights to open enrollment as provided in this section.

B. Sections 20-1069.01 and 20-1409 apply to all corporations within the scope of section 20-821.

C. For purposes of this section, "carrier" means an insurer, health care services organization, a hospital service corporation, a medical service corporation, a dental service corporation, an optometric service corporation or a hospital, medical, dental and optometric service corporation or any combination.

1990

### ARTICLE 4. FRATERNAL BENEFIT SOCIETIES

#### 20-861. Definitions

In this article, unless the context otherwise requires:

1. "Benefit contract" means an agreement for the provision of benefits.

2. "Benefit member" means an adult who is a member of a fraternal benefit society and who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

3. "Certificate" means a document that is issued as written evidence of the benefit contract.

4. "Fraternal benefit society" means a society, order or supreme lodge without capital stock, including an incorporated or unincorporated society that is exempt under section 20-893, that is conducted solely for the benefit of its members and their beneficiaries, is not for profit, operates on a lodge system with a ritualistic form of work, has a representative form of government and provides benefits according to this article.

5. "Laws" means the articles of incorporation, constitution and bylaws of the society.

6. "Lodge" means a subordinate member of the society, including any camp, court, council, branch or other designated unit.

7. "Premiums" means rates, dues or other required contributions that are payable under the certificate.

8. "Rules" means the rules, regulations and resolutions that are adopted by the supreme governing body or board of directors and that are intended to apply to the members of the society.

9. "Society" means a fraternal benefit society. 1994

#### 20-862. Lodge system

A. A society operates on the lodge system if the society has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted according to the society's laws, rules and ritual. The laws of the society shall require subordinate lodges to hold meetings at least once in each month in furtherance of the purposes of the society.

B. A society may organize and operate lodges for children who are under the minimum age for adult membership. A local lodge shall not require membership or initiation for children, and children shall not have a voice or vote in the management of the society. 1994

#### 20-863. Representative form of government

A society has a representative form of government if:

1. It has a supreme governing body constituted in one of the following ways:

(a) The supreme governing body is an assembly that is composed of delegates who are elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates that may be prescribed by the society's laws. A society may provide for the election of delegates by mail. The elected delegates shall constitute a majority in number and shall have not less than two-thirds of the votes and not less than the number of votes that is required to amend the society's laws. The assembly shall be elected and shall meet at least once every four years. The assembly shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors that occur between elections may be filled in the manner prescribed by the society's laws.

(b) The supreme governing body is a board that is composed of persons who are elected directly by the members or their representatives in intermediate assemblies, together with any other person that may be prescribed by the society's laws. A society may provide for the election of board members by mail. Board members shall serve not more than one four year term. Vacancies that occur on the board between elections may be filled in the manner prescribed by the society's laws. Time served by a new board member while filling a vacancy for the first time shall not count toward the one term limitation. The persons elected to the board shall constitute a majority in number and shall have not less than the number of votes required to amend the society's laws. A person who fills the unexpired term of an elected board member is considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

2. The officers of the society are elected either by the supreme governing body or the board of directors.

3. Only benefit members are eligible for election to the supreme governing body and the board of directors.

4. Each voting member has one vote, and no vote may be cast by proxy. 1994

#### 20-864. Purposes and powers

A. A society shall operate for the benefit of its members and their beneficiaries and shall:

1. Provide benefits pursuant to section 20-875.

2. Operate for social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes. This benefit may also be extended to other persons.

B. The society may carry out its purposes directly or indirectly through subsidiary corporations or affiliated organizations. A subsidiary corporation or affiliated organization shall not transact insurance business or engage in any other activity regulated under this title unless the subsidiary corporation or affiliated organization complies with all of the applicable provisions of law. A society or a subsidiary corporation or affiliated organization through which a society carries out its

the other laws of the state of Arizona which are applicable to them, the certificate of authority issued to such attorney shall be revoked and the right to do business in Arizona shall be cancelled. 1967

### 20-1033. Laws applicable to Lloyd's association

A. The provisions of this article are applicable to domestic and foreign Lloyd's associations.

B. To the extent not modified by the provisions of this article, Lloyd's associations shall be subject to and governed by the other applicable provisions of this title. 1967

## ARTICLE 9. HEALTH CARE SERVICES ORGANIZATIONS

### 20-1051. Definitions

In this article, unless the context otherwise requires:

1. "Basic health care services" means those health care services which an enrollee might reasonably require as determined by the director of the department of health services in order to be maintained in good health which shall include at least the following:

- (a) Emergency care.
- (b) Inpatient hospital and physician care.
- (c) Outpatient medical services, which shall include laboratory, radiological and other special diagnostic examinations, and suitable alternatives to active care in a general hospital such as in skilled nursing homes or organized home care programs, but not including care which is solely custodial in purpose.

2. "Director" means the director of the department of insurance.

3. "Enrollee" means an individual who has been enrolled in a health care plan.

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

5. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

6. "Health care plan" means any contractual arrangement whereby any health care services organization undertakes to provide directly or to arrange for all or a portion of designated basic health care services and to pay or make reimbursement for any remaining portion of such basic health care services on a prepaid basis through insurance or otherwise. A health care plan shall include basic health care services.

7. "Health care services" means any services for the purpose of diagnosing, preventing, alleviating, curing, or healing human illness or injury.

8. "Health care services organization" means any person that undertakes to conduct one or more health care plans. Unless the context otherwise requires, health care services organization includes a provider sponsored health care services organization.

9. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health care services organization including:

- (a) Health status.
- (b) Medical condition, including physical and mental illness.
- (c) Claims experience.
- (d) Receipt of health care.
- (e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

10. "Network plan" means health care services that are provided by a health care services organization under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers under contract with the health care services organization.

11. "Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, providers of health care, trusts, insurers, hospital or medical service corporations or other corporations, prepaid group practice plans, foundations for medical care and health maintenance organizations.

12. "Provider" means any physician, hospital, or other person which is licensed or otherwise authorized to furnish health care services in this state.

13. "Provider sponsored health care services organization" means a provider sponsored organization that provides at least one health care plan only to Medicare beneficiaries under the Medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

14. "Provider sponsored organization" means an entity that:

(a) Is a legal aggregation of providers that operate collectively to provide health care services to Medicare beneficiaries under the Medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

(b) Acts through a licensed firm or corporation that has authority over the entity's activities and responsibility for satisfying the requirements of this article relating to the operation of a provider sponsored health care services organization.

(c) Provides a substantial proportion of the health care services required to be provided under the Medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859) directly through providers or affiliated groups of providers. 1998

### 20-1052. Establishment of health care services organizations

A. No person shall establish or operate a health care services organization in this state, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with a health care plan without obtaining and maintaining a certificate of authority therefor pursuant to this article.

B. A health care services organization shall be incorporated under the laws of this or any other state.

C. A health care services organization shall possess and maintain unimpaired capital or surplus, or both, in the amount of one million five hundred thousand dollars at the time of obtaining a certificate of authority. A health care services organization which is subject to the unimpaired capital or surplus requirements of this section shall maintain unimpaired capital or surplus, or both, in the amount of one million dollars after one year immediately following obtaining a certificate of authority.

D. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1052.01. Establishment of provider sponsored health care services organizations; rules; limitations**

A. No person shall establish or operate a provider sponsored health care services organization in this state, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with a health care plan without obtaining and maintaining a certificate of authority pursuant to this article.

B. To operate as a provider sponsored health care services organization in this state, the firm or corporation shall:

1. Be a provider sponsored organization as defined in this article.

2. To the extent that the requirements are not preempted by federal law, meet the requirements prescribed in this article that apply to health care services organizations.

C. In addition to the general rule making authority vested in the director pursuant to chapter 1, article 2 of this title, the director may also adopt rules that:

1. Are necessary to implement the provider sponsored health care services organization provisions of this article.

2. Impose solvency requirements of a provider sponsored health care services organization that are the same as the requirements pursuant to the Medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859) and any rules adopted under the Medicare-plus-choice program.

D. A certificate of authority issued to a provider sponsored health care services organization pursuant to this article is a limited certificate of authority that authorizes the provider sponsored health care services organization to provide coverage for health care services only to Medicare beneficiaries pursuant to the Medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

E. The solvency standards adopted by rule pursuant to this section apply only to a provider sponsored health care services organization that provides coverage for health care services only to Medicare beneficiaries pursuant to the Medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

F. Nothing in this section applies to an insurer, health care services organization, hospital service corporation, medical service corporation, dental service corporation, optometric service corporation or hospital, medical, dental and optometric service corporation or any other person licensed under this title other than a provider sponsored organization that is licensed as a provider sponsored health care services organization. 1998

**20-1053. Application for certificate of authority**

A. An application for a certificate of authority to operate as a health care services organization shall be filed with the director in a form prescribed by the director, shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

1. A copy of the articles of incorporation and all amendments to the articles.

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

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other govern-

ing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association.

4. A copy of any contract made or to be made between any providers or persons listed in paragraph 3 and the applicant.

5. A statement generally describing the health care services organization and its health care plan or plans, facilities, and personnel, as approved by the director of the department of health services.

6. A copy of the form of evidence of coverage to be issued to the enrollees.

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

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the director determines that additional or more recent financial information is required for the proper administration of this article.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding.

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

11. A statement reasonably describing the geographic area or areas to be served, as approved by the director of the department of health services.

12. The fee prescribed by section 20-167 respecting issuance of a certificate of authority to a hospital or medical service corporation.

13. Such other information as the director may require.

B. Within ten days following any significant modification of information previously furnished pursuant to subsection A of this section, a health care services organization shall file notice thereof with the director.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1054. Issuance of certificate of authority**

A. Issuance of a certificate of authority shall be granted within the time prescribed in section 20-216 by the director if the director is satisfied that the following conditions are met:

1. The persons responsible for conducting the affairs of the health care services organization are competent and trustworthy and are professionally capable of providing or arranging for the provision of health and medical services being offered.

2. The health care services organization constitutes an appropriate mechanism to achieve an effective health care plan, in accordance with rules adopted by the director of the department of health services, which shall include at least the basic health care services.

3. The health care services organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the director may consider:

(a) The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith.

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

(c) Any agreement with providers for the provision of health care services.

4. Each officer responsible for conducting the affairs of the health care services organization has filed with the director, subject to the director's approval, a fidelity bond in the amount of fifty thousand dollars.

B. A certificate of authority prescribed by subsection A of this section shall expire at midnight on June 30 next following the date of issuance or previous renewal. If the health care services organization remains in compliance with this article and has paid the fee prescribed by section 20-167 respecting renewal of a certificate of authority to a hospital and medical service corporation, its certificate shall be renewed.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1055. Deposit requirement

A. A health care services organization at all times shall maintain on deposit with the state treasurer through the director's office cash, or securities eligible for the investment of capital funds of domestic insurers under this title, or other financial security approved by the director in an amount of not less than five hundred thousand dollars.

B. The deposit prescribed by subsection A shall be held by the state treasurer in trust for the benefit and protection of persons covered by a health care plan and for the satisfaction of all debts and liabilities of the health care services organization.

C. Any securities within the description of subsection A, with the approval of the director, may be exchanged for similar securities or cash of equal amount. Interest on securities so deposited shall be payable to the health care services organization depositing them.

D. An unsettled final judgment arising upon an evidence of coverage shall be a lien on the deposit prescribed by subsection A, subject to execution after thirty days from the entry of final judgment. If the deposit is reduced, it shall be replenished within ninety days by the health care services organization.

E. Upon liquidation, dissolution or withdrawal of a health care services organization and the satisfaction of all of its debts and liabilities, any balance remaining of the cash or securities deposit prescribed in subsection A together with any other assets of the health care services organization shall be returned by the director to the health care services organization.

F. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1056. Reserve requirement; exception

A. A health care services organization at all times shall maintain for the protection of enrollees a financial reserve consisting of two per cent of charges collected from enrollees for the health care plan, until said reserve totals one million dollars. Such reserve shall be in addition to the deposit prescribed by section 20-1055.

B. The reserve prescribed by subsection A of this section shall not apply with respect to a health care services organization which is funded by the federal, the state or a municipal government or any political subdivision or body thereof.

C. Beginning January 1, 1991, a health care services organization shall deposit on a quarterly basis the two per cent of charges collected from enrollees under subsection A of this section in trust with the state treasurer through the director's office. This amount shall be deposited in cash or securities eligible for the investment of capital funds of domestic insurers under this title or other financial security approved by the director until the amount reaches one million dollars. The state treasurer shall hold the deposit prescribed by this section in trust for the benefit and protection of persons covered by a health care services organization.

D. Any securities within the description of subsection C of this section, with the approval of the director, may be exchanged for similar securities or cash of equal amount. Interest on securities so deposited is payable to the health care services organization depositing them. The deposited cash or securities shall be considered an admitted asset of the organization for the purpose of meeting the unimpaired capital or surplus requirement of section 20-1052, subsection C.

E. On liquidation, dissolution or withdrawal of a health care services organization and the satisfaction of all of its debts and liabilities, any balance remaining of the cash or securities deposit prescribed in subsection C of this section together with any other assets of the health care services organization shall be returned by the director to the health care services organization.

F. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1057. Evidence of coverage by health care services organizations; renewability

*Text of section as amended by Laws 1998, Ch. 91, § 3 and Laws 1998, Ch. 285, § 12, blended*

A. Every enrollee in a health care plan shall be issued an evidence of coverage by the responsible health care services organization.

B. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall, as to such coverage of family members, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the enrollee from the instant of such child's birth, to a child adopted by the enrollee, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the enrollee and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

C. Any contract, except accidental death and dismemberment, that provides coverage for psychiatric, drug abuse or alcoholism services shall require the health care services organization to provide reimbursement for such services in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital.

D. No evidence of coverage, amendment to the coverage, advertising matter or sales material shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, amendment to the coverage, advertising matter or sales material has been filed with and approved by the director. Such filing shall be accompanied by fees prescribed by section 20-167.

E. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate of contract, of:

1. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

2. Any limitations of the services, kind of services, benefits or kind of benefits to be provided, including any deductible or copayment feature.

3. Where and in what manner information is available as to how services may be obtained.

4. The enrollee's obligation, if any, respecting charges for the health care plan.

F. An evidence of coverage shall contain no provisions or statements which are unjust, unfair, inequitable, misleading or deceptive, which encourage misrepresentation or which are untrue.

G. The director shall approve any form of evidence of coverage if the requirements of subsections E and F of this section are met. It is unlawful to issue such form or publish any advertising matter or sales material until approved. If the director does not disapprove any such form within forty-five days after the filing of the form, it shall be deemed approved. If the director disapproves a form of evidence of coverage, advertising matter or sales material, the director shall notify the health care services organization. In the notice, the director shall specify the reasons for his disapproval. The director shall grant a hearing on such disapproval within fifteen days after a request for a hearing in writing is received from the health care services organization.

H. No health care services organization may cancel or refuse to renew any evidence of coverage without giving notice of such cancellation or nonrenewal to the enrollee and, on request of the director, to the department of insurance. A notice by the organization to the enrollee of cancellation or nonrenewal of any evidence of coverage shall be mailed to the enrollee at least sixty days prior to the effective date of such cancellation or nonrenewal. Such notice shall include or be accompanied by a statement in writing of the reasons as stated in the contract for such action by the organization. Failure of the organization to comply with the provisions of this subsection shall invalidate any cancellation or nonrenewal except a cancellation or nonrenewal for nonpayment of premium, for fraud or misrepresentation in the application or other enrollment documents or for loss of eligibility as defined in the evidence of coverage. A health care services organization shall not cancel a health care plan because of an enrollee's age, except for loss of eligibility as defined in the evidence of coverage, sex, health status-related factor, national origin or frequency of utilization of basic health care services of an enrollee or group of enrollees. Beginning on July 1, 1988, a health care plan shall clearly delineate all terms under which the health care services organization may cancel coverage or refuse to renew coverage for an enrollee or group of enrollees. Nothing in this subsection shall be interpreted to permit the nonrenewal of coverage for an enrollee or group of enrollees other than coverage issued to individuals or to coverage subject to chapter 13 of this title. A health care services organization may cancel or nonrenew coverage issued to individuals or coverage subject to chapter 13 of this title only for the reasons permitted by subsection N of this section.

I. A health care plan which provides coverage for surgical services for a mastectomy shall also provide coverage incidental to the patient's covered mastectomy for surgical services for breast reconstruction and for at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

J. A contract which provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

1. A baseline mammogram for a woman from age thirty-five to thirty-nine.

2. A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

3. A mammogram every year for a woman fifty years of age and over.

K. Any contract that is issued to the enrollee and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the enrollee if all the following are true:

1. The child is adopted within one year of birth.

2. The enrollee is legally obligated to pay the costs of birth.

3. All preexisting conditions and other limitations have been met and all deductibles and copayments have been paid by the enrollee.

4. The enrollee has notified the insurer of his acceptability to adopt children pursuant to section 8-105 within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

L. The coverage prescribed by subsection K of this section is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29 but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 4, subdivisions (d), (e), (f) and (g). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The enrollee adopting parents shall notify their health care services organization of the existence and extent of the other coverage. A health care services organization is not required to pay any costs in excess of the amounts it would have been obligated to pay to its hospitals and providers if the natural mother and child had received the maternity and newborn care directly from or through that health care services organization.

M. Each health care services organization shall offer membership to the following in a conversion plan which provides the basic health care benefits required by the department of health services:

1. Each enrollee including his enrolled dependents leaving a group.

2. Each enrollee and the enrollee's dependents who would otherwise cease to be eligible for membership because of the age of the enrollee or the enrollee's dependents or the death or the dissolution of marriage of an enrollee.

N. A health care services organization shall not cancel or nonrenew a health care plan or evidence of coverage, including a conversion plan, except for any of the following reasons and in compliance with the notice requirements and limitations contained in subsection H of this section:

1. With respect to an individual plan, the individual has failed to pay premiums or contributions in accordance with the terms of the coverage or the insurer has not received premium payments in a timely manner.

2. With respect to an individual plan, the individual has performed an act or practice that constitutes fraud or the individual made an intentional misrepresentation of material fact under the terms of the coverage.

3. The health care services organization has ceased to offer coverage to individuals that is consistent with the requirements of sections 20-1379 and 20-1380.

4. If the health care services organization offers a health care plan in this state through a network plan, the individual no longer resides, lives or works in the service area served by the network plan or in an area for which the health care services organization is authorized to transact business but only if the coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

5. If the health care services organization offers health coverage in this state in the individual market only through one or more bona fide associations, the membership of the individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

O. A conversion plan may be modified if the modification complies with the notice and disclosure provisions for cancellation and nonrenewal under subsection H of this section. A modification of a conversion plan which has already been issued shall not result in the effective elimination of any benefit originally included in the conversion plan.

P. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who was enrolled in a health care plan shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the health plan within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of the application by the health plan.

2. The health plan may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

Q. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with the provisions of subsection P of this section, including:

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of evidences of coverage.

R. Beginning January 1, 1998, any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the health care services organization for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the

minimum length of stay required by this subsection. The health care services organization shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection S of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

S. Nothing in subsection R of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a health care services organization from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection R of this section.

T. Any contract or evidence of coverage that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider, including:

1. Blood glucose monitors.
2. Blood glucose monitors for the legally blind.
3. Test strips for glucose monitors and visual reading and urine testing strips.
4. Insulin preparations and glucagon.
5. Insulin cartridges.
6. Drawing up devices and monitors for the visually impaired.
7. Injection aids.
8. Insulin cartridges for the legally blind.
9. Syringes and lancets including automatic lancing devices.
10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.
11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.
12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

U. Nothing in subsection T of this section:

1. Entitles a member or enrollee of a health care services organization to equipment or supplies for the treatment of diabetes that are not medically necessary as determined by the health care services organization medical director or the medical director's designee.

2. Provides coverage for diabetic supplies obtained by a member or enrollee of a health care services organization without a prescription unless otherwise permitted pursuant to terms of the health care plan.

3. Prohibits a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

V. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

W. As used in subsection B of this section, "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under the age of eighteen years. 1998

#### 20-1058. Examination of health care services organizations

A. The director may once in each six months for the first three years after organization and once each year thereafter, or more often if deemed necessary by the director, visit each health care services organization organized under the laws of this state to examine its financial condition, its ability to meet its liabilities, and its compliance with the laws of this state affecting the conduct of its business. The director may annually similarly visit and examine, either alone or jointly with representatives of the insurance supervising departments of other states, each health care services organization not organized under the laws of this state but authorized to transact business in this state.

B. The director may in like manner examine each health care services organization applying for an initial certificate of authority to do business in this state.

In lieu of making his own examination, the director may accept a full report of the last recent examination of a foreign or alien health care services organization, certified to by the insurance supervisory official of another state, territory, commonwealth or district of the United States.

D. The director of the department of health services may participate in the examinations and visits described in this section to verify the existence of an effective health care plan and to review the delivery of health and medical services by the health care services organization.

E. All examinations and examination related expenses shall be borne by the health care services organization and shall be paid by the insurance examiners' revolving fund in accordance with sections 20-156 and 20-159.

F. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1059. Annual report to director

A. Every health care services organization annually on or before March 31 shall file with the director a report covering its activities for the preceding calendar year, verified by at least two principal officers of the corporation. A copy of the report shall be sent by the health care services organization to the director of the department of health services.

B. Such reports shall be on forms prescribed by the director and shall include:

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

2. Any material changes in the information submitted pursuant to section 20-1053.

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

4. Such other information relating to the performance of the health care services organization as is necessary to enable the director and the director of the department of health services to carry out their duties under this article.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1060. Taxes; exemption

A. Except as provided in subsection C of this section, on the tax payment dates prescribed in section 20-224, each health care services organization shall pay to the state treasurer through and in a form prescribed by the director a tax for transacting a health care plan in the amount of 1.7 per cent through June 30, 1989, and from and after June 30, 1989, 2.0 per cent of net charges received from enrollees.

B. The failure by an organization to pay the tax imposed by this section results in a civil penalty determined pursuant to section 20-225.

C. Payments received by health care services organizations from the secretary of health and human services pursuant to a contract issued pursuant to 42 United States Code section 1395mm(g) are not taxable under this section. 1998

#### 20-1061. Prohibited practices

*See Laws 1997, Ch. 100, § 22 for applicability guidelines*

A. Chapter 2, article 6 of this title relating to unfair trade practices and frauds shall apply to health care services organizations, except to the extent the director determines that the nature of health care services organizations render particular provisions thereof inappropriate.

B. No person subject to this article may restrict or prohibit, by means of a policy or contract, whether written or otherwise, a licensed health care provider's good faith communication with the health care provider's patient concerning the patient's health care or medical needs, treatment options, health care risks or benefits.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1062. Regulation of agents

The director may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents which shall include provisions for examination, licensing, annual fees and disciplinary procedures similar to those proposed in chapter 2, article 3 of this title. 1973

#### 20-1063. Powers of insurers and hospital and medical service corporations

A. An insurer, or a hospital or medical service corporation, authorized to do business in this state either directly or through a subsidiary or an affiliate may organize and operate a health care services organization under the provisions of this article. Notwithstanding any other law to the contrary, any two or more such insurers, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health care services organization.

B. Any such insurer or hospital or medical service corporation may contract with a health care services organization to provide coverage in the event of the failure of the health care services organization to meet its obligations.

C. Any such insurer or hospital or medical service corporation which is in compliance with title 20 generally and which in the judgment of the director shall have complied with provisions of this title that are comparable to or more restrictive than the provisions of this article shall be deemed to have

satisfied all provisions of this article and shall not be required to comply also in any specific manner with this article except §§ 20-1051 through 20-1054 as the director shall deem appropriate, and except as per rules or regulations the director may promulgate to safeguard public health or safety. 1973

#### 20-1064. Examination

A. The director and the director of the department of health services may conduct an examination of the affairs of any health care services organization as often as the director of the department of insurance deems it necessary for the protection of the interests of the people of this state and for this purpose shall have the powers set forth in this title with respect to examinations of insurers.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1065. Suspension or revocation of certificate of authority; penalties

*Text of section as amended by Laws 1997, Chs. 100 and 221, blended*

A. The director may suspend or revoke any certificate of authority issued to a health care services organization under this article if the director finds that any of the following conditions exists:

1. The health care services organization is operating significantly in contravention of its basic organizational documents or in a manner contrary to that described in, and reasonably inferred from, any other information submitted under section 20-1053.

2. The health care services organization issues evidences of coverage which do not comply with the requirements of section 20-1057.

3. The health care plan does not provide or arrange for basic health care services as determined by the director of the department of health services.

4. The health care services organization can no longer be expected to meet its obligations to enrollees or prospective enrollees.

5. The health care services organization, or any authorized person on its behalf, has advertised or merchandised its services in an untrue, misleading, deceptive or unfair manner.

6. The health care services organization has failed to substantially comply with this article.

7. The health care services organization is in unsound condition or in such condition as to render its further transaction in this state hazardous to its enrollees or to the residents of this state.

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

C. When the certificate of authority of a health care services organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs and shall conduct no further business except as may be essential to the orderly conclusion of solicitation. The director, by written order, may permit such further operation of the organization as the director may find to be in the best interest of enrollees to the end that enrollees shall be afforded the greatest practical opportunity to obtain continuing health care coverage.

D. Notwithstanding the provisions of subsections B and C of this section, a health care services organization which has had its certificate of authority denied, suspended or revoked

shall be entitled to a hearing and judicial review pursuant to title 41, chapter 6, article 10.

E. If after a hearing the director finds grounds pursuant to subsection A of this section to suspend or revoke a health care services organization's certificate of authority, the director may impose, in lieu of or in addition to that suspension or revocation, the following civil penalties that shall be remitted to the state treasurer for deposit in the state general fund:

1. For unintentional violations, not more than one thousand dollars for each violation and not more than an aggregate of ten thousand dollars in any six month period.

2. For intentional violations, not more than five thousand dollars for each violation and not more than an aggregate of fifty thousand dollars in any six month period.

F. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1066. Rehabilitation, liquidation or conservation of health maintenance organization

A. Any rehabilitation, liquidation, or conservation of a health care services organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurer and shall be conducted as provided in chapter 3, article 4 of this title. In addition to the grounds set forth in chapter 3, article 4 of this title, failure to comply with section 20-1069 constitutes a ground for the rehabilitation, liquidation or conservation of a health care services organization.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1067. Solicitation

A. Solicitation by health care services organizations to educate members and potential members on the coverage and operation of the organization's health plan shall not be construed to be a violation of any provisions of law relating to solicitation or advertising by health care providers, provided such solicitation:

1. Is approved in advance by the director.

2. Shall not otherwise cause any of such providers to violate any professional ethics or laws prohibiting the solicitation of patients.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### 20-1068. Statutory construction and relationship to other laws

*Text of section as amended by Laws 1997, Chs. 100 and 251, blended and Laws 1997, Ch. 251, applies retroactively to all health insurance coverage, health care plans and health benefits plans that are issued, renewed or modified on or after July 1, 1997, by Laws 1997, Ch. 251, § 37.*

A. Except as they relate to an insurer or a hospital or medical service corporation, the provisions of this title are applicable to health care services organizations only as provided in this article. chapter 1 of this title, chapter 3, articles 1 and 2 of this title, sections 20-1133, 20-1135, 20-1379 and 20-1380, section 20-1408, subsections C through K, chapter 6, article 16 of this title. chapter 15 of this title and chapter 17 of this title.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1069. Contingency for insolvency; plan; contents; definition**

A. Each health care services organization shall have a plan for the risk of insolvency that is approved by the director and that provides for all of the following:

1. Continuation of benefits for the duration of the contract period or for sixty days from the date insolvency is declared, whichever is longer.

2. Continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge.

B. Entitlement to continuation of benefits under subsection A is contingent on timely payment of the premium by the enrollee or by the enrollee's representative to the health care services organization or its agent, administrator, conservator or receiver.

C. Each plan for the risk of insolvency shall include both:

1. An actuarial memorandum describing the basis on which the actuary concludes that the plan for the risk of insolvency will meet the requirements of subsection A.

2. A certification of a qualified actuary that to the best of the actuary's knowledge and judgment the rates charged will support the benefits outlined under the evidence of coverage and that the plan for the risk of insolvency satisfies the requirements of subsection A.

D. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

E. For purposes of this section, "continuation of benefits" includes benefits provided by both affiliated and unaffiliated providers subject to any authorization procedures applicable before the declaration of insolvency. 1998

**20-1070. Right to open enrollment period; enrollees; definition**

A. With respect to enrollees who are members of a group with more than one carrier, if there is an insolvency of a health care services organization, all other carriers that participated in an open enrollment with the insolvent health care services organization at a group's last regular open enrollment period shall offer enrollees of the insolvent health care services organization who are members of that group a thirty day open enrollment period beginning on the date the insolvency is declared. Each carrier shall offer these enrollees the same coverages and rates that it offered to the enrollees at the last regular open enrollment period without any waiting periods or preexisting conditions, exclusions, limitations or restrictions. On declaration of insolvency, the health care services organization shall notify each group contract holder of the insolvency. Each group contract holder shall notify its remaining carrier or carriers of the insolvency and notify its members of their right to open enrollment as provided in this section.

B. For purposes of this section, "carrier" means an insurer, a health care services organization, a hospital service corporation, a medical service corporation, a dental service corporation, an optometric service corporation or a hospital, medical, dental and optometric service corporation or any combination. 1990

**20-1070. Acquisitions and mergers**

A. No health care services organization may merge with another foreign or domestic health care services organization or may be acquired by a person except on approval by the director and by complying with the provisions of general law governing the merger or consolidation of stock corporations and the other provisions of this section.

B. If the health care services organization is being acquired and if more than twenty-five per cent of the stock or ownership or control is being acquired, the acquiring person shall file the

statement described by section 20-481.03 with the director at least thirty days before the effective date of the acquisition.

C. In the case of a merger the plan of merger shall be filed with the director at least sixty days before the effective date of the merger.

D. The director shall approve the acquisition or merger if the acquiring or merging persons have met the requirements for a certificate of authority. The director shall make the decision either to approve or disapprove the acquisition or merger within thirty days of the filing of the acquisition statement pursuant to subsection B of this section or the plan of merger pursuant to subsection C of this section.

E. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1071. Prohibition against excluding coverage because of previous tests for a condition**

A. An insurance contract offered by a health care services organization shall not exclude coverage of a condition if the insured person has previously had tests for the condition and the condition was not found to exist. There must be evidence that a condition actually existed before the insurance contract was entered into in order to exclude coverage of the condition.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1072. Nonliability of enrollees for provider charges**

*Text of section as amended by Laws 1998, Ch. 87, § 1 and Laws 1998, Ch. 285, § 24, blended*

A. Every written contract between a health care services organization and a provider shall set forth that if the organization fails to pay for covered health care services as set forth in the enrollee's evidence of coverage or contract the enrollee is not liable to the provider for any amounts owed by the organization and the provider shall not bill or otherwise attempt to collect from the enrollee the amount owed by the organization.

B. If the written contract between the contracting provider and the organization fails to contain the required prohibition stated in subsection A, the enrollee is not liable to the contracting provider for any amounts owed by the organization.

C. No contracting provider or agent, trustee or assignee of the contracting provider may maintain an action at law against an enrollee to collect any amounts owed by the organization for which the enrollee is not liable to the contracting provider under subsection A.

D. Nothing in this section impairs the right of a provider to charge, collect from, attempt to collect from or maintain an action at law against an enrollee for any of the following:

1. Copayment or coinsurance amounts.

2. Health care services not covered by the organization, including out of area claims that are not paid by an organization on behalf of an enrollee.

3. Health care services rendered after the termination of the contract between the health care services organization and the provider, unless the health care services were rendered during confinement in an inpatient facility and the confinement began prior to the date of termination, or unless the provider has assumed post-termination treatment obligations under the contract.

E. Nothing in this section prohibits an enrollee from seeking health care services from a contracting or noncontracting provider and accepting financial responsibility for these services.

F. No provider may charge an enrollee of a health care services organization more than the amount the provider contracted to charge the enrollee pursuant to the provider's contract with the health care services organization.

G. Nothing in this section prohibits any person from informing an enrollee of either the cost of health care services performed or the status of any bill submitted to an organization in connection with health care services provided to an enrollee. Any information provided to an enrollee pursuant to this subsection shall include a statement that the information is not a bill and is for the enrollee's information only.

H. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1073. Eligibility; prohibiting cancellation because of eligibility for certain benefits**

*Applies retroactively to all health insurance coverage, health care plans and health benefits plans that are issued, renewed or modified on or after July 1, 1997, by Laws 1997, Ch. 251, § 37*

A. Except as specifically provided in sections 20-1379 and 20-1380, with respect to the determination of whether a person is an eligible individual, a health care services organization shall not consider the availability of or a person's eligibility for medical assistance under a program pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396a (1980)) when considering eligibility for coverage or calculating payments under its plan for eligible enrollees.

B. To the extent that payment for covered expenses has been made under the state program pursuant to title XIX of the social security act for health care items or services furnished to an individual, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. On presentation of proof that the state program pursuant to title XIX of the social security act has paid for covered items or services, the health care services organization shall make payments to the state program pursuant to title XIX of the social security act according to the coverage provided in the evidence of coverage.

C. A health care services organization may not impose on a state agency that has been assigned the rights of an individual who is eligible for medical assistance and who is covered for health benefits from the insurer any requirements that are different from the requirements applicable to an agent or assignee of any other covered individual.

D. A health care services organization shall not cancel or fail to renew the contract of any person based on that person's eligibility for or enrollment in a program funded under title XIX of the social security act or title 36, chapter 29 or 34. Nothing in this section prohibits cancellation or failure to renew for nonpayment of monies due under the contract. 1997

**20-1074. Contract termination; duty to report**

A. On a monthly basis, a health care services organization shall submit to the director a list of all written provider contracts that have been terminated during the prior month. The list shall be in writing and shall include the name and address of each provider whose contract has been terminated but shall not include the reasons for termination.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1075. Transactions with affiliates**

A. A health care services organization shall not attempt to sell or otherwise transfer to an affiliate Arizona assets in

excess of ten per cent of the organization's unimpaired capital or surplus as reported in its most recent annual statement, without prior approval by the director. If the director does not disapprove such sale or transfer within forty-five days of the date received by the director, the sale or transfer is deemed approved.

B. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

**20-1076. Health care plans; disclosure form; enrollee notification**

*Applicable to health care plans that are offered, issued or renewed from and after December 31, 1995 by Laws 1995, Ch. 297, § 4*

A. Each health care services organization that offers a health care plan to the public shall provide disclosure forms as required by this section. The disclosure form shall be in a form prescribed by the director and shall include the following:

1. A separate roster of plan primary care physicians who are licensed pursuant to title 32, chapter 13, 17 or 29, including the physician's degree, practice specialty, the year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona.

2. In concise and specific terms:

(a) The full premium cost of the plan.

(b) Any copayment, coinsurance or deductible requirements that an enrollee or the enrollee's family may incur in obtaining coverage under the plan and any reservation by the plan to change premiums.

(c) The health care benefits to which an enrollee would be entitled. The disclosure shall state where and in what manner an enrollee may obtain services, including the procedures for selecting or changing primary care physicians and the locations of hospitals and outpatient treatment centers that are under contract with the health care services organization.

3. Any limitations of the services, kinds of service, benefits and exclusions that apply to the plan. A description of limitations shall include:

(a) Procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians.

(b) Whether services received outside the plan are covered and in what manner they are covered.

(c) Procedures an enrollee must follow, if any, to obtain prior authorization for services.

(d) The circumstances under which prior authorization is required for emergency medical care and a statement as to whether and where the plan provides twenty-four hour emergency services.

(e) The circumstances under which the plan may retroactively deny coverage for emergency medical treatment and nonemergency medical treatment that had prior authorization under the plan's written policies.

(f) A statement regarding whether or not plan providers must comply with any specified numbers, targeted averages or maximum durations of patient visits. If any of these are required of plan providers, the disclosure shall state the specific requirements.

(g) The procedures to be followed by an enrollee for consulting a physician other than the primary care physician, and whether the enrollee's physician, the plan's medical director or a committee must first authorize the referral.

(h) The necessity of repeating prior authorization if the specialist care is continuing.

(i) Whether a point of service option is available, and if so, how it is structured.

4. Grievance procedures for claim or treatment denials, discontinuation with care and access to care issues.

5. Response to whether a plan physician is restricted to prescribing drugs from a plan list or plan formulary and the extent to which an enrollee will be reimbursed for costs of a drug that is not on a plan list or plan formulary.

6. A response to whether plan provider compensation programs include any incentives or penalties that are intended to encourage plan providers to withhold services or minimize or avoid referrals to specialists. If these types of incentives or penalties are included, the health care services organization shall provide a concise description of them. The health care services organization may also include, in a separate section, a concise explanation or justification for the use of these incentives or penalties.

7. A statement that the disclosure form is a summary only, and that the plan evidence of coverage should be consulted to determine governing contractual provisions.

B. A health care services organization shall not disseminate a completed disclosure form until the form is submitted to the director. For purposes of this section, a health care services organization is not required to submit to the director its separate roster of plan physicians or any roster updates.

C. Upon request, a health care services organization shall provide the information required under subsection A to all employers who are considering participating in a health care plan that is offered by the health care services organization or to an employer that is considering renewal of a plan that is provided by the health care services organization.

D. An employer shall provide to its eligible employees the disclosures required under subsection A no later than the initiation of any open enrollment period or at least ten days before any employee enrollment deadline that is not associated with an open enrollment period.

E. An employer shall not execute a contract with a health care services organization until the employer receives the information required under subsection A.

F. Nothing in this section provides any private right of cause of action to, or on behalf of any enrollee, prospective enrollee, employer or other person, whether a resident or nonresident of this state. This section provides solely an administrative remedy to the director of the department of insurance for any violation of this section or any related rule.

G. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization. 1998

#### ARTICLE 10. DOMESTIC LIFE AND DISABILITY REINSURER

##### 20-1081. Domestic life and disability reinsurer

This article applies only to domestic life and disability reinsurers. 1977

##### 20-1082. Domestic life and disability reinsurer; defined

"Domestic life and disability reinsurer" means an incorporated stock reinsurer holding a certificate of authority to accept insurance ceded by any domestic insurer or foreign insurer. 1977

##### 20-1083. Law applicable to domestic life and disability reinsurers

All other provisions of this title not inconsistent with the provisions of this article shall apply to domestic life and disability reinsurers. 1977

##### 20-1084. Articles of incorporation

A. Five or more individuals aged eighteen years or more may incorporate a domestic life and disability reinsurer. Not

less than two-thirds of the incorporators shall be citizens of the United States residing in this state.

B. In addition to the requirements of title 10, chapter 2, article 1, the articles of incorporation shall state:

1. The limitation upon the powers of the corporation consistent with this article.

2. The number of directors, not less than five nor more than fifteen, who shall conduct the affairs of the corporation, and the names and addresses of the corporation's first directors and officers for stated terms of office of not less than two months or more than one year.

3. The time of the annual meeting of shareholders.

4. The city or town in this state in which the principal place of business is to be located, and the counties, states and countries in which business may be transacted.

5. The limitations, if any, on the corporation's indebtedness.

6. The extent, if any, to which stock of the corporation shall be liable to assessment. 1994

##### 20-1085. Capital

To qualify for its initial authority to transact business and thereafter to qualify for renewal of its authority to transact business, a domestic life and disability reinsurer shall possess and thereafter maintain minimum required capital stock in amounts as shown by the following schedule:

July 1, 1977 through June 30, 1978	\$ 25,000
July 1, 1978 through June 30, 1979	30,000
July 1, 1979 through June 30, 1980	40,000
July 1, 1980 through June 30, 1981	50,000
July 1, 1981 through June 30, 1982	60,000
July 1, 1982 through June 30, 1983	70,000
July 1, 1983 through June 30, 1984	80,000
July 1, 1984 through June 30, 1985	90,000
After July 1, 1985	100,000

1977

##### 20-1086. Surplus

A life and disability reinsurer shall have upon organization initial surplus in an amount not less than one-half of its minimum required capital stock and shall thereafter maintain one-half of such initial surplus. 1977

##### 20-1087. Deposits

The director shall not issue a certificate of authority to any life and disability reinsurer unless it has deposited in trust with the state treasurer through the director's office cash or securities eligible for the investment of capital funds of domestic insurers under this title in an amount not less than the minimum paid-in capital stock, required pursuant to this article to be maintained for authority to transact the kinds of insurance to be transacted. 1977

##### 20-1088. Limit of risk

Domestic life and disability reinsurers may be formed, with capital and surplus as specified in §§ 20-1085 and 20-1086 to accept any risk as a reinsurer under which the maximum possible benefits payable on the death or on the disability of any one insured shall not exceed five thousand dollars if the excess over three thousand dollars is reinsured by noncancelable reinsurance authorized under § 20-261. When the reinsurer's paid-in capital reaches one hundred thousand dollars, the reinsurer may reinsure risks without the restrictions of this section and may reinsure as otherwise provided for pursuant to this title. Any risk accepted pursuant to this section shall be a risk under which the ceding life or disability insurer remains liable for the payment of all policyholder claims. 1977

##### 20-1089. Certificates of authority

A. Any domestic limited stock insurer formed and existing pursuant to § 20-708 which does not come within the provi-

Department of Health Services - Health Care Service Organizations

TITLE 9. HEALTH SERVICES

CHAPTER 12. DEPARTMENT OF HEALTH SERVICES  
HEALTH CARE SERVICES ORGANIZATIONS

ARTICLE 1. APPROVAL OF PLANS, FACILITIES,  
PERSONNEL AND SERVICE AREAS

- Section
- R9-12-01. Reserved
- thru
- R9-12-100. Reserved
- R9-12-101. Legal authority
- R9-12-102. Intent
- R9-12-103. Definitions
- R9-12-104. Documentation
- R9-12-105. Service agreements
- R9-12-106. Examination and review
- R9-12-107. Reserved
- R9-12-108. Reserved
- R9-12-109. Reserved
- R9-12-110. Reserved
- R9-12-111. Health care plan
- R9-12-112. Geographic area
- R9-12-113. Chief executive officer
- R9-12-114. Medical director
- R9-12-115. Medical records
- R9-12-116. Quality assurance

ARTICLE 1. APPROVAL OF PLANS, FACILITIES,  
PERSONNEL AND SERVICE AREAS

- R9-12-01. Reserved
- thru
- R9-12-100. Reserved
- R9-12-101. Legal authority
- A. The Arizona Department of Health Services, pursuant to the authority granted in Title 20, Chapter 4, Article 9, Arizona Revised Statutes, particularly Sections 20-1053 and 20-1054 as amended, hereby adopts the following regulations for the purposes of establishing minimum standards and procedures for health care plans, facilities, personnel and service areas of health care services organizations.
- B. In performing its duties related to health care services organizations, the Department of Health Services will coordinate its efforts with the Arizona Department of Insurance which grants the certificate of authority required to operate a health care services organization in Arizona. A copy of the application for a certificate of authority shall be submitted to the Department of Health Services at the same time that the original application is submitted to the Department of Insurance. A request from an existing health care services organization for approval to change its statement describing its health care plan or plans, facilities, and personnel or its statement describing the geographic area or areas to be served shall be submitted to the Department of Health Services and a copy of the request shall be submitted to the Department of Insurance. The Department of Health Services will notify the applicant or health care services organization of its findings and will provide a copy of its findings to the Department of Insurance.
- C. These regulations apply to all proposed and existing health care services organizations. Each proposed health care services organization must meet requirements prior to receiving a certificate of authority from the Department of Insurance. Each existing health care services organization need not refile all information previously filed with the Department or the

Department of Insurance, but it shall on or before the effective date of this Article amend its health care plan and otherwise modify its operations and procedures as may be necessary to comply with this Article and file all additional information necessary to make statements complete and current.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-102. Intent

- A. It is the objective of the Director, in the adoption of the regulations of this Article, to require minimum health care services necessary to maintain persons in good health.
- B. It is the intention of the Director to revise these minimum requirements periodically, based on Departmental experience and recommendations, in order that more comprehensive health care may be achieved.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-103. Definitions

- A. Words defined in A.R.S. §§ 36-401 and 20-1051 (except for the word "Director" which when used in this Article means Director of the Department of Health Services) and Department of Health Services regulations for the licensing of health care institutions (Chapter 10, Article 1), and in Department of Insurance rules for the regulation of health care services organizations (General Rule No. R4-14-405) have the same meaning when used in this Article.
- B. In this Article, unless the context otherwise requires:
  1. "Chief executive officer" means the person who has the authority and responsibility for the operation of the health care services organization in accordance with applicable legal requirements and policies approved by the governing authority.
  2. "Department" means the Department of Health Services.
  3. "Governing authority" means the person or body such as the board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the health care services organization is vested.
  4. "HCSO" means health care services organizations.
  5. "Primary care" means initial treatment or screening of enrollees.
  6. "Primary care physician" means general practitioner, family physician, internist or pediatrician.
  7. "Shall" and "must" means requirements.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-104. Documentation

Where these regulations require a HCSO to have policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, duty schedules, or other similar items, such requirement means written documents compiled and indexed in one or more manuals which shall be readily available for inspection by the Director or his representatives.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-105. Service agreements

Primary care physician services provided on a continuing basis by other than HCSO employees shall be covered by written service

## Department of Health Services - Health Care Service Organizations

agreements which specify the terms and conditions upon which they will provide any or all of those health care services contained in R9-12-111(F).

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

## R9-12-106. Examination and review

Facilities of the HCSO and any primary care physician(s) with whom it contracts for services on a continuing basis shall be subject to inspection by personnel of the Department or other officials by delegation or other authority, pursuant to A.R.S. § 20-1058(D) and A.R.S. § 20-1064.

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-107. Reserved

R9-12-108. Reserved

R9-12-109. Reserved

R9-12-110. Reserved

## R9-12-111. Health care plan

- A. The applicant shall submit a statement which describes the proposed health care plan or plans, facilities, and personnel.
- B. The HCSO shall have an organized system for the delivery of those health care services contained in subsection (F) of this Section which includes physicians, registered nurses and other professional and technical personnel. The system shall include a procedure which promotes a continuing relationship to be established between an enrollee and the same primary care physician and a procedure for effective referrals to assure continuity of care to enrollees.
- The HCSO shall list (using full-time equivalents for providers) the proposed or actual:
1. Enrollment,
  2. Physician staffing for said enrollment, identifying board eligibility or certification of each physician listed when applicable.
  3. Medical support staff, and
  4. Provision for providing specialty medical services.
- D. All care provided by the HCSO whether provided by its own personnel or on a contract basis shall be by licensed:
1. Practitioners of the healing arts;
  2. Health care institutions; or
  3. Clinical laboratories
- when any such licensure is required by law and shall otherwise be in accordance with applicable laws and regulations.
- E. The health care services described in subsection (F), paragraphs (1), (2), (3), and (6) of this regulation shall be provided on a seven day per week and 24 hour per day basis.
- F. The health care plan shall provide within the geographic area served at least the following basic health care services which shall be covered by the monthly charges set forth in the evidence of coverage:
1. Emergency care. Emergency care shall include those services rendered under unforeseen conditions which require hospitalization or services necessary for the repair of accidental injury, relief of acute pain, initial treatment of acute infection, and the amelioration of illness or conditions which, if not immediately diagnosed and treated, would result in extended or permanent physical impairment or loss of life.
  2. Inpatient general hospital care.
  3. Physician care. Physician care shall include necessary diagnostic and therapeutic services provided by a person

who has a current and valid Arizona license to practice medicine and surgery.

4. Outpatient care. Outpatient care shall include preventive, diagnostic and therapeutic services, including primary care, furnished by or under the direction of a physician, and laboratory and radiology services. Primary care may include services provided by a physician's assistant (a person who has a current and valid registration under the applicable provisions of A.R.S. Title 32, Chapter 13, 17 and 25, to provide patient services as specified in his job description or approved program) or by a nurse practitioner in the extended role (a registered nurse certified by the Arizona State Board of Nursing to function in specialty areas, in accordance with the provisions of A.R.S. § 32-1601(B)(6), in collaboration with and under the direction of a physician).
5. Health maintenance care. Health maintenance care consists of care designed to prevent illness and to improve the general health of enrollees. It shall be offered when medically necessary or indicated and shall include:
  - a. Immunizations
  - b. Health education
  - c. Periodic health examinations (excluding certified health examinations for insurance qualification, school attendance, and employment) which include screening for vision and hearing shall be offered when medically necessary or indicated and at least on the following schedule:
    - i. Enrollees aged 0 - 1 year - 1 exam every 4 months
    - 2 - 5 years - 1 exam every year
    - 6 - 40 years - 1 exam every 5 years
    - 41 - 50 years - 1 exam every 3 years
    - 51 - 60 years - 1 exam every 2 years
    - 61 years and over - 1 exam every year
    - ii. A medical history and health examination shall be offered to each new enrollee within 12 months after enrollment.
6. Ambulance services. Emergency ambulance services and other ambulance services when approved by a plan physician.
- G. The HCSO shall provide appropriate coverage for out-of-area emergency care to enrollees when traveling outside the area served by the HCSO.

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

## R9-12-112. Geographic area

- A. The applicant shall submit a statement which describes the geographic area or areas to be served. The applicant shall designate a geographic area or areas in which it will have the capability of providing services that are reasonably convenient to prospective enrollees.
1. The applicant shall attach a map or maps to the statement on which are indicated the boundaries of the proposed geographic area or areas and the locations of all facilities in which primary care will be provided under the plan.
  2. The applicant shall describe the proposed geographic area or areas in at least one of the following ways:
    - a. Legal description
    - b. Local governmental jurisdiction such as city or county
    - c. Census tracts
    - d. Street boundaries
    - e. Area within a specified radius of a specified intersection or a specified primary care center.

## Arizona Administrative Code

## Title 9, Ch. 12

## Department of Health Services - Health Care Service Organizations

- B. All advertising matter and sales material provided to prospective enrollees must include a description of the geographic area or areas in terms readily understandable by the general public.

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

## R9-12-113. Chief executive officer

- A. The governing authority shall appoint a chief executive officer who shall have appropriate education and experience to qualify him for the management of the HCSO. The governing authority shall define the authority and duties of the chief executive officer in writing. The chief executive officer shall be the appointed representative of the governing authority and shall be the executive officer of the HCSO. He shall be responsible for the implementation of established policies in the operation of the HCSO and for providing liaison between governing authority, providers of health care and providers of other services for the HCSO. He shall be in charge of the management of the HCSO and shall be authorized and empowered to carry out the provisions of this Article and shall be charged with the responsibility of doing so. The chief executive officer shall establish in writing a plan indicating the line of authority during periods of his absence.
- B. When there is a change of chief executive officer, the governing authority shall notify the Department of Health Services and Department of Insurance within ten days after the effective date of change.
- C. The HCSO shall assure that all HCSO employees and health practitioners covered by service agreements are adequately knowledgeable and qualified to perform the duties assigned to them through employment or by contract. The HCSO shall designate a central place of business within the major geographic area served from which the administrative activities of the plan shall be directed and at which the chief executive officer shall be based.

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

## R9-12-114. Medical director

- A. The HCSO shall designate a physician as medical director.
- B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the chief executive officer provided he has appropriate education and experience to qualify him for the management of the HCSO.
- C. The medical director's responsibility shall include, but not be limited to:
1. Supervision including performance planning and evaluation of medical staff.
  2. Coordination of activities of medical staff.
  3. Development of medical care policies.

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

## R9-12-115. Medical records

- A. The HCSO shall maintain a medical record system which is capable of readily providing necessary information and which assures continuity of enrollee care. A centralized medical record shall be maintained in accordance with acceptable professional standards which includes records covering all symptoms presented, diagnoses made and medical treatment provided to each enrollee by the HCSO during the

term of his enrollment. This requirement applies to all HCSO services provided to enrollees whether provided by employees of the HCSO or non-employees at the request of the HCSO.

- C. There shall be a person designated as having the administrative responsibility for medical records.
- D. Medical records shall be kept confidential. Only authorized personnel shall have access to the records.
- E. Medical records shall be the property of the HCSO and shall not be removed from the premises wherein they are filed except by subpoena or court order. This does not preclude the routing of the record or portion thereof, including X-ray film, to practitioners of the healing arts for consultation or evaluation.
- F. Pursuant to A.R.S. § 20-1058(D) and A.R.S. § 20-1064, the centralized medical records of the HCSO shall be made available for review by representatives of the Department. During routine surveys, the Department representatives will review medical records of the HCSO on a random sample basis. On complaint or special investigations, specific medical records will be reviewed. Title 9, Chapter 1, Article 3 of the Department rules and regulations prohibit employees of the Department from divulging patient names or other information from medical records unless specifically authorized by that Section.
- G. Records shall be preserved in the original or by microfilm for a period of not less than ten (10) years. In the case of a minor, the record must be maintained for at least two years after the person has reached his majority.
- H. If the enrollee discontinues enrollment in the HCSO, it shall furnish, upon his request, a written summary covering all pertinent phases of health care provided during enrollment including copies of pertinent reports and results of diagnostic tests which might be used for comparative purposes, a record of immunizations and the last periodic health examination to another provider of health care services as specified by the enrollee. If requested, this summary shall be furnished within 30 days after the enrollee requests disenrollment. A reasonable charge may be made for the summary based upon the cost of providing it.

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

## R9-12-116. Quality assurance

- A. The HCSO shall provide an effective method for a continuing review and evaluation of the health care provided to ensure that treatment and level of care were appropriate and adequate, that the quality of health care provided met acceptable standards, and that corrective action occurred or will occur if indicated.
- B. There shall be a quality assurance committee consisting of the chief executive officer or his designee, the medical director, practitioners of the healing arts, and allied health professionals. Services performed by practitioners of the healing arts shall be reviewed and evaluated by colleagues within their disciplines. The committee shall adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements for committee reports and their dissemination.
- C. There shall be a quality assurance plan which shall include procedures to be used for each of the following:
1. Establishment of standards for health care.
  2. Surveillance of care provided.
  3. Analysis of problems identified.
  4. Correction of deficiencies including a time schedule for correction and a link to a continuing education program.
  5. Follow-up (periodic reassessment of the plan).

## Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

**EXHIBIT 6**



2. For each type of entity described in response to No. 1, please indicate whether the insurance department or any other state agency has regulatory responsibility for each of the listed subject areas. Please identify the responsible agencies (and a contact person for each agency if that information is available).

Type of Entity	Licensing Agency/Contact	Financial Condition Agency/Contact	Market Conduct Agency/Contact	Quality of Care Agency/ Contact	Network Adequacy Agency/Contact	Provider Contracting Agency/Contact

Type of Entity	Risk Shifting (capitation, fiscal intermediaries) Agency/Contact	Grievance & Appeals Agency/Contact	Utilization Review Agency/Contact	Premium Rates Agency/Contact	Forms & Advertising Agency/Contact

3. Does your state have statutes, rules, requirements or standards that regulate the conduct of managed care entities with respect to each of the listed subject areas? For each type of entity described in response to No. 1, please indicate "yes" or "no" for each subject area. If you are able, please provide the citations.

Entity	Licensing	Financial Condition	Market Conduct	Quality of Care	Network Adequacy	Provider Contracting

Entity	Risk Shifting	Grievance & Appeals	Utilization Review	Premium Rates	Forms & Advertising

4. Are there any subject areas that are not currently regulated, but you believe should be regulated? Yes/No

If yes, please describe those areas as to particular types of entities. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Does your state actively coordinate multi-agency regulation or oversight of managed care entities (i.e. coordinating councils, interagency agreements, etc.)? Yes/No

If yes, please describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. How many consumer complaints do you receive per month concerning the following:

A. Quality of care: \_\_\_\_\_

B. Network adequacy: \_\_\_\_\_

7. How many personnel do you have processing the complaints? \_\_\_\_\_  
 \_\_\_\_\_

8. Please describe the full-time employee staff at your agency that is dedicated to regulation of managed care entities:

Title	Credentials/Qualifications Required	Salary Range	# of Positions (include fractions)

9. Please describe any contract personnel utilized by your agency to regulate managed care entities:

Class of Contractor	Credentials/Qualifications Required	Payment Rate	# of Contractors

10. What is your total annual budget attributable to regulation of managed care entities or any definable part of that regulatory activity? Please estimate if you are unable to provide an exact figure. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. What are all the sources of funding for your regulation of managed care entities, and their approximate proportions? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. Do you need additional staff or resources to be effective, including health care administration resources? Yes/No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much additional funding do you estimate would be required? \_\_\_\_\_  
\_\_\_\_\_

13. Please briefly describe the information systems you use in regulating managed care entities:

A. Hardware: \_\_\_\_\_  
\_\_\_\_\_

B. Software, including any databases and programs specially developed for the regulation of managed care entities: \_\_\_\_\_  
\_\_\_\_\_

C. Personnel:

Title	Credentials/Qualifications Required	Salary Range	# of Positions (include. fractions)

14. Based on what you believe the overall managed care regulatory system should accomplish in your state, how would you assess the effectiveness of your actual regulatory system of managed care entities, on a scale of 1 to 10 (1 being least effective and 10 being most effective)?

1    2    3    4    5    6    7    8    9    10

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Are there any changes to the regulation of managed care entities scheduled to be implemented in your state that would change your responses to any of the foregoing questions? Yes/No

If yes, please describe those changes. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check if you would like to receive a summary of the survey results.

Name & title of person completing the survey:

Phone number:

Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please return surveys to:  
Arizona Department of Insurance, Life and Health Div., 2910 N. 44<sup>th</sup> Street,  
Ste. 210, Phoenix, AZ 85018 or Fax to (602) 912-8453.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EXHIBIT 7**

Managed Care Oversight Survey Results

STATE	Resp Rcvd	Type of Entities Regulated	# of Licensees	# of Enrollees	Licensing	Financial Condition	Market Conduct	Quality of Care	Network Adequacy	Provider Contracting	Risk Shifting	Grievance & Appeals	Utilization Review
Alabama													
Alaska													
Arizona	1	HMOs	12	1,634,071*	DOI	DOI	DOI	DHS	DHS	DOI*	-	DOI	DOI*
		HospMedDntlSvcCorp	1	456,470*	HMO:	§§20-1054-56	§20-441et seq.	AACR9-12-111	AACR9-12-111	§§20-118, 20-1072		§§20-2530-39	§§20-2501-11
		OptmSvcCorp	2	460,766**	ARS§20-1052	AAC R20-6-405	§20-1061	AACR9-12-116	AACR9-12-112	*ltd rev for hold			*ltd to lic of
		Dntl Svc Corp	1	452,126**	Svc Corp:					hrmlss cl&gag cl			UR Agents
		PrepdDntlPlan	8	2,494,633**	ARS§20-825	§§20-828,830,	§20-441et seq.			§20-833		§§20-2530-39	§§20-2501-11
					*approx. as of 12/98	831, 832							*ltd to lic of
					**as of 12/98								UR Agents
Arkansas	1	HMOs	9	271,193	Ins. Dept	Ins. Dept	Ins. Dept	Ins. Dept	Ins. Dept	Ins. Dept			
California													
Colorado	1	HMOs	19	1,581,318	DOI	DOI	DOI/CDPHE	CDPHE	CDPHE	DOI	DOI	DOI/CDPHE	DOI/CDPHE
		NP	4	1,037,186	DOI	DOI	DOI	DOI	DOI	DOI	DOI	DOI	DOI
		PPD	9	267,084	DOI	DOI	DOI	DOI	DOI	DOI	DOI	DOI	DOI
		LSLPN*	8	164,401	DOI	DOI	DOI	DOI	DOI	DOI	DOI	DOI	DOI
		*LSLPN (lmt svc lic prov ntwrk) lic isn't limited to Medicaid prog, however, the currently lic entities are only auth for mntl hith care svcs for Medicaid recip.				CDPHE - Col Dept of Pub Hlth & Environment							
		NP-Nonprft svc corp				Health care including mgd care entites are governed by Title 10, Article 16, along w/ several regulations.							
Connecti	1	HMOs	15	367,000	Ins. Dept	Ins. Dept	Ins. Dept	-	-	-	-	Ins. Dept	Ins. Dept
					860-297-3835	860-297-3814	860-297-3878					860-297-3800	860-297-3859
		All Insurance Dept authority is found in Title 38a of CT General Statutes											
Delaware	1	HMO	10	226,342	DOI/DHSS	DOI	DOI	DHSS	DHSS	DHSS	DOI	DOI/DHSS	DHSS
		HSC	3	266,616	DOI	DOI	DOI	DOI	-	-	DOI	DOI	-
		HMO:			DOI-Title 18	Ch. 64	Chs.23 & 64	Ch. 91	Ch. 91	Ch. 91			
		DHSS - Dept of Health & Soc Services				Del.C.Ch 64		Reg. 69	Reg. 69				-
						DHSS-Title 16		(Title 16)					
						Del.C.Ch 91							
		HSC:			DOI Title 18	Ch. 63	Ch. 23 & 63						
						Del.C.Ch 63		(Title 18)					

Managed Care Oversight Survey Results

	Premium Rates	Forms & Advertising	Areas that should be regulated but, are not	Does state coordinate multi-agency regulation?	Consumer Complts per month Qual. of care/Ntwrk adequ.	# personnel processing complaints	F-T staff managed care Salary/# positions	Contact Personnel Salary/# positions
Alabama								
Alaska								
Arizona	-	DOI §§20-1057(G), 20-1067 AAC R20-6-201 §20-826(L) AACR20-6-607	-	No	N/A	-	*.75Insur An III \$34,097-52,145 *.75Insur An II \$27,901-43,001 *.75Adm Asst II \$23,328-31,394 *.75Adm Asst II (Cons Spec) " " *.75Legal An(JD)\$31,072-47,681 *Added in FY 97-98 as part of the Hlth Care Appls law- specifically for Health Care Appeals.	1 Fid Sprvr \$42.25/hr 1 Sr Exmnr \$37.77/hr 1 Exmnr I \$27.30/hr 1 UR Exmnr \$42/hr 2-3AFE/CFE/CPA\$25-100/hr
Arkansas			No	No	None/None	2 P-T Empl.	None work F-T, have other duties	None
California								
Colorado	DOI	DOI	No	Yes	N/A	8*	No pers are solely dedicated to mgd care reg. In addition to the complaint personnel, there are a min. of 7 staff members performing in house fin & oper reviews, along w/review of other regul entities. Also, examination staff and staff actuaries.	By statute, the Com- missioner has the authority to contract review of various aspects of a managed care entity operations.
	DOI	DOI		Interagency wrkg grp in existence for 2yrs. Mem- bers include DOI, CDPHE, CDHCP&F(Medicaid). Grp meets once every 2 mos. Subgrps review specific areas of mgd care.		*Handle all health care complaints.		
Connecti	Ins. Dept 860-297-3891	Ins. Dept 860-297-3862	No	No	N/A / 3-4	0 dedicated to mgd care	.6 Director \$73K-94K 1 Program Manager \$65K-84K 3.5 Examiners \$41K-60K 1 UR Nurse Coordin. \$55K-61K 1 Attorney \$45K-\$56K 1.5 Ins. Financial Examiner \$65K .6 Actuary \$68K-87K	None
Delaware	DOI	DOI/DHSS	-	Title 16 Del.C.Regulation 69 was effective 1/1/99 Due to the effective date of this DHSS regulation, there has been little coordination betw. our agencies,however it is anticipated that there will be coordination of efforts in the future.	Referred to DHSS	3 people handle life & health complaints.	1 Deputy Ins. Commissioner 1 Ins. Research Senior Analyst 1 Consumer Svcs Supervisor 3 Consumer Svcs Investigator	2 Indep contractors Mkt cond, CIE \$80/hr 50 Indep contractors Fin exam, CFE, AIE, CIE \$65,500 annual

Managed Care Oversight Survey Results

STATE	Total Annual Budget	Sources of Funding	Need additional staffing/funding?	Info. System Hrdwr/Sftwr Personnel	Effectiveness of your system	Changes to mgd care legislation?	Send cpy of results	Cmnts
Alabama								
Alaska								
Arizona	-	Omnibus Appropriations, Insur Exam's Revolving Fund	-	LAC &AS 400 No dedicated systems.	4 Our Syst is deficient in that we hav a dual agency syst w/no coord mech & hlth svc del comp is inactive.	No		-
Arkansas	Unable to determine	Self-support from fees	N/A	Intgrtd w/ other Dept functions	8	No	No	-
California								
Colorado	N/A	N/A	Not presently	Not specifically dedicated to managed care entities.	8	No	No	-
	No one indiv. dedi- cated to oversight of mgd care entities.	Div's budget is not segre- gated by entity type.	However, changes in the market place could result in staff resource changes.		Regulation of mgd care op's appears to be good. New issues arise due to the constant changes in this field.			
Connecti	Not specifically budgeted	Not separately funded	No	-	Difficult to Assess	No	Yes	
Delaware	Can't estimate	General Fund Assessments on the Industry	More appropriate for DHSS to answer.	No systems dedicated to managed care regulation.			Yes	













Managed Care Oversight Survey Results

STATE	Resp Rcvd	Type of Entities Regulated	# of Licensees	# of Enrollees	Licensing	Financial Condition	Market Conduct	Quality of Care	Network Adequacy	Provider Contracting	Risk Shifting	Grievance & Appeals	Utilization Review
Minnesota													
Mississippi													
Missouri													
Montana													
Nebraska													
Nevada	1	HMOs	10	325,288	DOI	DOI	DOI	DHS	DOI	DOI	DOI	DOI	DOI
		PPOs	77	N/A	DOI	DOI	DOI	DHS	DOI	DOI	DOI	DOI	DOI
		SSPHCP	8	N/A	DOI	DOI	DOI	DHS	DOI/DHS	DOI	DOI	DOI	DOI
					Perkins/Carbon	D. Carbon	D. Carbon	Y. Sylva	DOI-G.Perkins	G. Perkins	G. Perkins	G. Perkins	G. Perkins
					HMO	NRS 695C		NRS 695C&G	NRS 695C	NRS 695C	NRS695C&NAC695C	NRS 695C&G	NRS 695C
					PPO	NRS 689B		NRS 695G	NRS 695G	NRS 689B	NRS 695C	NRS 695G	
New Ham													
New Jers	1	HMOs	16Act/10 Inact	2,311,841	DOBI/DHSS	DOBI	DOBI	DHSS	DHSS	DOBI/DHSS	DOBI	DOBI/DHSS	DHSS
		DPOs	21	860,958	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI
		DSCs	2	532,382	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI	DOBI
		PPO (SCA)	34	N/A	DOBI	DOBI	DOBI	DHSS	DHSS	DHSS	DOBI	DOBI	DHSS
		HMOs NJSA 26:2J-1 et seq., NJAC 8:38-1 et seq.											
		DPOs NJSA 17:48D-1 et seq., NJAC 11:10-1 et seq.						DOBI Dept of Banking and Insur. DHSS Dept of Health and Senior Svcs					
		DSCs NJSA 17:48C-1 et seq., No regulations											
		SCAs NJSA 17B:27A-17 et seq., NJAC 11:4-37 et seq.											
New Mex													
New York													
N. Caroli													
N. Dakota													
Ohio	1	HIC-Full Svc	33	2,853,256	ODI/ODH	ODI	ODI	ODI/ODH	ODH	ODI	ODI	ODI	ODI
		HIC-Specialty,	18	862,659	ODI/ODH	ODI	ODI	ODI/ODH	ODH	ODI	ODI	ODI	-
		Supplemental			HIC-Full Svc	ORC1751.01-.06	Yes	Yes	1754.73-.74	1751.04, .05	1751.13, .60	Yes	1751.19,.811-.89
					HIC-Specialty	1751.01-.06	Yes	Yes	-	1751.04, .05	1751.13, .60	Yes	1751.78-.82
												1751.19	
Oklahoma													
Oregon	1	HMOs	7	1,724,328*	The Oregon Ins. Division does not segregate position responsibilities by type of entity for health insurance products.								
		HMDIs	15	94,251*	M. Nunez	R.Latham	J.Goodpaster	K.Barrie	K.Barrie	M.McKibben	M.McKibben	K.Barrie	K.Barrie
		Other**		353,890*	503/947-7247	947-7220	947-7267	947-7269	947-7269	947-7205	947-7205	947-7269	947-7269
					ORS	- See Survey							
					OAR	- See Survey							
		*# of enrollees per entity for carriers w/\$2 mil or more in premium.											
		**Oregon allows indemnity insurers to offer managed care products.											







Managed Care Oversight Survey Results

STATE	Premium Rates	Forms & Advertising	Areas that should be regulated but, are not	Does state coordinate multi-agency regulation?	Consumer Compts per month Qual. of care/Ntwrk adequ.	# personnel processing complaints	F-T staff managed care Salary/# positions	Contact Personnel Salary/# positions
Pennsylv								
Rhode Isl								
S. Caroli	Ins. Dept L.Jones 803/737-6210 Group rates do not require approval. See 38-33-80(7)(B)	Ins. Dept A.Bishop 803/737-6165 38-33-80 38-22-140	The SC Dept of Insur is likely to support any legislation that provides for an external grievance procedure.	Yes Medicaid HMOs.	10-20 (usually a dispute over covered benefits)	May be assign- ed to any of several staff in this area.	1 Supervising Mgd Care Analyst \$37,540 - 69,451 Total 2 - Portions of other posi- tions are devoted to HMO: Legal, Deputy Dir, Chief Fin Analyst, Examiners, Cnsmrs, Frms, Agnts	None
S. Dakota								
Tennesse	DOI	DOI	Yes Trans w/Affiliates	Yes, adequ of delivery system & qual of care - regulated by Hlth Dept. DOI notified of Hlth Dept's findings & actions.	5 / 10	3 Life & Hlth	3 Investigators \$18,800 - 27,800 2 Examiners \$27,500-57,500	Actuaries
Texas	TDI TIC 20A.33, 4.11, 26 & 20A.09(b) TAC 11.700- 11.707	TDI TIC 20A.11& 21.21 TAC Ch. 11	No	TDI has sole regulatory authority for HMOs. TDI coordinates w/other agencies such as Dept. of Hlth & HCFA.	39 / 60	6 F-T 8 P-T	1Dir HMO Qual Assur \$45K-58K 1Dir HMO/URA \$41K-\$50K 8.1Nurse Consultant \$38.5K-50K 14.6 Insur. Specialist \$23K-37K 2.6 Insur. Technician \$12K-23K 5 Financial Analyst \$29K-\$50K	1 Dental Examiner per contract
Utah	-	DOI						
Vermont								
Virginia	BOI J.Cunningham 38.2-316 14VAC5-130-10 et seq. ; 14VAC5- 210-10 et seq.	BOI W.Hazelwood	Yes Some PPOs are not classified as MCHIPs; TPAs are not regulat- ed; HMO premiums are not regulated.	Yes Mtgs & infrml discussions w/BOI,VDH&Legislature- Subcommittee work jntly to provide info to legisla- ture on regulatory over- sight of mgd care entities.	Responsibility of VDH	7 Examiners 4 Secretaries 1 Supervisor	.3Chf Fin.Auditor \$56,048-86,875 1.5Princ Fin Exmr\$46,321-71,797 5 Sr Fin Exmr \$38,282-59,337 .25 Ins. Exmr \$34,802-53,943 1.2 Ins. Tech \$26,670-40,005 4.5 Sr. Mkt Exmr \$38,282-59,337 3.5 Ins. Mkt Exmr\$34,802-53,943 1.5 Princ Mkt Exmr\$46,321-71,797	Actuarial Consultant Varies
Washingt	OIC OIC OIC OIC B. Weidner	OIC OIC OIC OIC B. Weidner	No	No	3 / 12	5.5 FTEs	WA gave org chart for entire Department, not broken down into mgd care staff.	None

Managed Care Oversight Survey Results

STATE	Budget	Annual of Funding	Need additional staffing/funding?	Info. System Hrdwr/Stfwr	Effectiveness of your mgd care system	legislation? results	Changes to Send cpy of Cmnts
Pennsylv							
Rhode Isl							
S. Caroli	\$150,000	State funds	Yes (\$50K-100)	Desktop PC,	9	No, unless	Yes
		50% of one	Like other offices	no dedicated		there is legisla-	
		F-T position,	we always wish	software.		tion to imple-	
		50% Medicaid	we had more			ment an extrnl	
		State funds	resources for			grievance rev.	
		100% of partial	monitoring.			process.	
		positions					
S. Dakota							
Tennessee	\$200,000	60% appro-	Yes	-	4	No	Yes
		prations	\$200,000			regulate HMOs	
		40% fees				other MCOs are regulated indirectly. Insurers	
		State funds,	Yes	CIS-agency com-	8	Yes	No
Texas	-	contacts paid	New legislation	plaint database		Write & implement	
		dir by HMOs	will require regu-	Access database		rules to regulate	
		lation of grtr # of entities				IPAs & other delegated entities	
Utah							
Vermont							
Virginia	\$3,240,000	Assessments	Yes	PCs, laptops	8	No	Yes
		& licensure	Current Mkt Cond	IBM mainframe		found in 38,2-	
		fees generate	staff cannot effec-	Excel, Word,Mail		4200; 38 2-430	
		non-general	tively perform exms	Tracking System		38 2-45,	
		fund revenues.	on all mgd care	Unique data base		38 2-3407	
		entities in VA.				38 2-5800	
Washington	Approx.	100% of fund-	No	In-house IS system	8	No	Yes
	\$3,300,000	ing comes from		Geo Access		Some changes	
		For regula-				pending, but	
		tion of all				will not change	
		types of				answers to	







**EXHIBIT 8**

## OVERVIEW OF HMOS

State	Governance/ Risk Management	Quality of Care	Provider Contracting	Network Adequacy	Other
Colorado	<p>Insurance Commission requires:</p> <ul style="list-style-type: none"> <li>Annual report filings including all policy forms and certification of compliance with law</li> <li>All certificates, rates and evidence of coverage must be filed for approval</li> <li>Complaint system must be approved</li> <li>A system of public input into policies and operations of each Plan</li> </ul> <p>The Insurance Commissioner:</p> <ul style="list-style-type: none"> <li>Sets loss ratios and monitors loss ratios guarantees</li> <li>Conducts examinations of HMOs at least every 5 years.</li> <li>Has right to suspend or revoke certificate of authority for noncompliance</li> <li>Monitors risk adjustment in Small group market through loss ratios. If this book of business exceeds 95%, then the guaranteed issue requirement for small groups can be suspended for one year.</li> </ul> <p>Insurance Commission oversees HMOs</p>	<p>Insurance Commission must approve complaint system. Includes:</p> <ul style="list-style-type: none"> <li># of complaints</li> <li>Underlying causes, number, amount and disposition of malpractice cases</li> <li>A summary report of all written complaints.</li> </ul> <p>Must arrange for ongoing quality of health care assurance program for processes and outcomes</p> <p>See access plan under Network Adequacy</p>	<p>Provider Contract requirements regulated by statute:</p> <ul style="list-style-type: none"> <li>Mutual prohibition on protesting or expressing disagreement with a medical decision, medical policy or medical practice of the carrier or provider</li> <li>Prohibits carrier from terminating provider contract for disagreeing with carrier's coverage decision, assisting covered persons with reconsideration of coverage decisions, or discussing alternative treatments with patients.</li> <li>Termination without cause provisions must be subject to the same notice requirement for each party.</li> <li>Commissioner does not arbitrate or settle disputes between providers and carriers.</li> <li>All provider contracts must comply with the statute and applicable regulations, and must contain a provision stating adherence to the statute.</li> <li>Termination without cause provision must be 60 days minimum</li> </ul>	<p>Network must be sufficient in numbers and types of providers to assure that covered services are available without unreasonable delay.</p> <p>Carrier can use any reasonable criteria to establish network but proximity is to be considered.</p> <p>An access plan must be made available to public. The access plan must demonstrate:</p> <ul style="list-style-type: none"> <li>Adequate number of accessible acute care hospital services within a reasonable distance or travel time or both</li> <li>Adequate number of primary care providers and specialists</li> <li>Procedures for making referral</li> <li>Process for monitoring the sufficiency of the network</li> <li>The carrier's quality assurance standards</li> <li>Carriers efforts to address limited English proficiency</li> <li>Illiteracy, diverse cultural backgrounds and physical or mental disabilities</li> <li>Method for tracking clinical outcomes and consumer satisfaction</li> <li>Method for informing covered persons of grievance procedures</li> <li>Availability of specialty medical services</li> <li>Process for choosing and changing network providers</li> <li>System for ensuring coordination and continuity of care for covered persons to specialty providers</li> <li>Procedures for providing emergency care</li> <li>Continuity of care upon termination of</li> </ul>	<p>HMO obtains a certificate of authority from Insurance Commissioner. Application requires:</p> <ul style="list-style-type: none"> <li>Verification by officer</li> <li>Copy of basic organizational documents</li> <li>Bylaws</li> <li>List of names and addresses of board of directors</li> <li>Copy of any contract with providers</li> <li>General statement describing the health plan, its facilities and personnel</li> <li>Copy of form of evidence of coverage</li> <li>Copy of form of group contract</li> <li>Financial statements with three year projection of operating expenses</li> <li>Marketing plan</li> <li>Statement of geographic area to be served</li> <li>Description of complaint process</li> <li>Description of procedures and programs to be implemented to meet the quality of care requirements</li> <li>Description of mechanism by which enrollees are given opportunity to participate in matter of policy and operation</li> <li>An access plan for each separate network of the</li> </ul>

## OVERVIEW OF HMOS

State	Governance/ Risk Management	Quality of Care	Provider Contracting	Network Adequacy	Other
				a provider	HMO, and requires 30-day notice of modification to plan.
Oregon	<p>Department of Consumer and Business Services (Insurance Division) oversees HMOs and requires insurers to file:</p> <ul style="list-style-type: none"> <li>All rates, schedules and changes</li> <li>Individual rates annually based upon geographic average rate (no individual underwriting allowed)</li> <li>A single geographic rate for each benefit plan offered to small employer groups and must be determined on a pooled basis</li> <li>An annual summary describing all utilization review activities and functions</li> <li>An annual summary of the quality assessment activities relating to quality improvement goals and credentialing of providers.</li> <li>An annual financial audit</li> <li>Results of HCFA reports and accreditation surveys by national accreditation organizations</li> <li>Summary of screening and disease prevention programs and activities related to specific conditions identified by a consortium</li> <li>Annual summary of the scope of the provider network and monitoring activities</li> <li>Disclosure of material transactions within 15 days after the end of the month of transaction</li> <li>Risk based capital report (RBC)</li> </ul> <p>Director can adjust RBC plan, request corrective action plan, enforce with hearing or take over control of insurer based upon RBC report</p> <p>Director has authority to order compliance with rating regulations and may suspend or revoke insurer's license for failure to comply or willful engagement of prohibited or fraudulent acts.</p>	<p>All insurers must have a written policy of grievances and appeals and inform enrollees of following rights:</p> <ul style="list-style-type: none"> <li>At least two appeal levels</li> <li>Right to appear before a review panel</li> <li>Decision written in plan language</li> <li>Method for appealing drug formulary decisions</li> <li>How to obtain referrals and emergency services</li> <li>How to change providers and the network available</li> <li>Disclosure of any risk-sharing arrangement with providers</li> <li>Method for protecting confidential information</li> </ul> <p>Utilization Review</p> <ul style="list-style-type: none"> <li>A doctor of Medicine or Osteopathy must make final determination of medical necessity</li> <li>Appeals of medical necessity must go to a consultant or peer review committee</li> <li>Prior authorization appeals -2 day response time limit</li> </ul> <p>Insurers must have:</p> <ul style="list-style-type: none"> <li>A quality assessment program to measure progress on specific quality improvement goals</li> <li>HEDIS reporting</li> </ul>	<p>Insurer must make available upon request to an enrollee:</p> <ul style="list-style-type: none"> <li>The procedures for credentialing providers and how to obtain information about provider's qualifications</li> <li>A description of the risk-sharing arrangements with providers</li> </ul> <p>Provider contracts shall include provision that provider not bill enrollee for amounts owed but not paid by insurer</p> <p>Insurer cannot penalize provider for communicating to patient:</p> <ul style="list-style-type: none"> <li>treatment options</li> <li>the patient's medical condition</li> <li>general financial relationship with insurer</li> <li>referring patient to another provider</li> </ul> <p>Prior authorizations are binding on the carrier for a minimum of 5 days</p>	<p>Insurers must:</p> <ul style="list-style-type: none"> <li>Offer a point of service product for all groups with more than 25 employees (Federally qualified HMOs exempt)</li> <li>Establish a method to provide enrollees, purchasers and providers with opportunity to participate in the policy and operations of the plan</li> <li>Monitor network to ensure all covered services are reasonably accessible to enrollees</li> </ul> <p>Annual summary on network adequacy must include:</p> <ul style="list-style-type: none"> <li>List of all providers</li> <li>Time frames for access to services</li> <li>Continuity of care during service disruptions</li> <li>Access to services for enrollees with special needs</li> <li>Identification and resolution of access problems</li> <li>Communication with enrollees and providers</li> <li>Program evaluation</li> </ul>	The HMO shall establish a mechanism by which enrollees are given opportunity to participate in matter of policy and operation
Maine	<p>Superintendent of Insurance and Commissioner of Human Services have joint authority over HMOs. Either may initiate proceedings and both have authority</p>	<p>Carrier must establish and maintain a grievance procedure which must contain independent review and second</p>	<p>Every contract between carrier and provider must contain</p> <ul style="list-style-type: none"> <li>An appeal process approved by</li> </ul>	<p>HMO must:</p> <ul style="list-style-type: none"> <li>Provide reasonable access to health care services in accordance with</li> </ul>	<p>HMO obtains a certificate of authority from Insurance Superintendent after approval</p>

## OVERVIEW OF HMOS

State	Governance/ Risk Management	Quality of Care	Provider Contracting	Network Adequacy	Other
	<p>to amend, modify or refuse to renew any certificate of authority</p> <p>Carriers must submit the following annually to the Insurance Superintendent:</p> <ul style="list-style-type: none"> <li>• Benefits and exclusions</li> <li>• Services requiring copayments or deductibles</li> <li>• Restrictions on access to certain provider types</li> <li>• Services available only by referral</li> <li>• Prior authorization requirements</li> <li>• Description of compensation methods to providers</li> <li>• Renewal terms for enrollees</li> <li>• Description of how carrier addresses timely access and grievance issues</li> <li>• Compliant, adverse decision, prior authorization denials, and enrollee overturned appeal ratios</li> <li>• Upon request, HMO must turn over any audit work papers from an audit consultant</li> </ul> <p>Insurer must report material transactions to Superintendent monthly</p> <p>Superintendent may examine HMO not less than once every three years</p> <p>Superintendent has authority to assess civil penalties in amounts of \$2000-\$15,000 per violation, issue cease and desist orders, award equitable relief, issue letter of reprimand or censure, order refunds or restitution for violations of statutes or regulations. Can also revoke or suspend certificate of authority</p> <p>The Commissioner of Human Services:</p> <ul style="list-style-type: none"> <li>• Issues HMO certificate of need to operate HMO (see also Quality of Care Section)</li> <li>• Examines the HMO concerning quality of health care services not less than once every three years</li> </ul> <p>HMO required to:</p>	<p>opinion:</p> <ul style="list-style-type: none"> <li>• Requests for Prior authorizations must be handled in 2 business days</li> </ul> <p>Ongoing quality assurance program with written standards is required (must be available for examination by Superintendent or the Department of Health Services)</p> <p>Once a determination that a particular service is covered, it cannot be denied based on enrollee's age, nature of disability or degree of medical dependency</p> <p>Commissioner of Human Services oversees HMO quality issues. The HMO must:</p> <ul style="list-style-type: none"> <li>• Establish and maintain procedures to assure enrollees receive consistent quality of care—to include availability, accessibility and continuity of care</li> <li>• Monitor and evaluate the health care services provided by its providers</li> <li>• Assess and correct areas identified for improvement</li> <li>• Keep formal minutes of quality assurance program meetings</li> <li>• Ensure adequate maintenance and use of patient record system</li> </ul>	<p>Superintendent</p> <p>Credentialing standards:</p> <ul style="list-style-type: none"> <li>• Must be in writing</li> <li>• Be objective</li> <li>• Be subject to appeal process</li> </ul> <p>Carrier may not terminate or discipline provider for advocating for medically appropriate care for an enrollee</p> <p>Carrier may not terminate or nonrenew a provider's contract until it provides 60 days prior written explanation and opportunity for hearing (even if contract contains a termination without clause provision) Hearing panel must include at least 3 persons and 1/3 must be a clinical peer in the same discipline as the provider under review</p> <p>Provider contract cannot contain a provision requiring the provider to indemnify the carrier for expenses incurred when carrier is at fault</p> <p>Provider contracts must include provision that provider not bill enrollee for amounts owed but not paid by insurer</p> <p>Provider contract must contain a provision for provider to notify HMO between 60 and 90 days prior to termination.</p> <p>HMO network must include chiropractic services and allow self-referrals</p>	<p>standards developed by Superintendent</p> <ul style="list-style-type: none"> <li>• Consider geographical and transportation problems in rural areas</li> <li>• Develop a plan for providing services to rural and underserved populations as a prerequisite for certificate</li> <li>• File report annually with Superintendent</li> </ul> <p>If HMO loses 5 or more PCPs in any county in a 30 day period, it must notify the Superintendent within 10 days</p>	<p>from Department of Human Services approves certificate of need. Application requires</p> <ul style="list-style-type: none"> <li>• Verification by officer</li> <li>• Copy of basic organizational documents</li> <li>• Bylaws</li> <li>• List of names and addresses of board of directors</li> <li>• Copy of any contract with providers</li> <li>• General statement describing the health plan</li> <li>• Its facilities and personnel</li> <li>• Copy of form of evidence of coverage</li> <li>• Copy of form of group contract</li> <li>• Financial statements</li> <li>• Marketing plan</li> <li>• Statement of geographic area to be served</li> <li>• Description of complaint and grievance process</li> <li>• Description of procedures and programs to be implemented to meet the quality assurance requirements</li> <li>• Description of mechanism by which enrollees are given opportunity to participate in matter of policy and operation</li> <li>• Description of procedure to report statistics and utilization</li> <li>• Insolvency plan</li> <li>• List of all providers</li> </ul> <p>HMO must maintain a minimum fidelity bond of \$250,000</p>

## OVERVIEW OF HMOS

State	Governance/ Risk Management	Quality of Care	Provider Contracting	Network Adequacy	Other
<p>Maryland Complete statutes not available on Internet</p>	<ul style="list-style-type: none"> <li>• Make minimum deposit</li> <li>• Deposit for uncovered expenditures for enrollees (greater of \$100,000 or 120% of uncovered expenditures) and satisfy capital and surplus requirements</li> <li>• Have initial surplus of \$1,500,000</li> <li>• Maintain minimum statutory surplus</li> <li>• Possess additional surplus if operating a point of service (POS) product (may not expend more than 29% of annual health expenditures for out-of-plan services of POS product)</li> </ul> <p>Other insurers use Risk Based Capital</p>	<p>Each Carrier must have a certificate to perform utilization review or contract the duties to a certified UR program</p> <p>Each carrier must establish an internal grievance process that includes:</p> <ul style="list-style-type: none"> <li>• Expedited review within 24 hours for emergency care</li> <li>• Final decisions within 45 days for retrospective reviews</li> <li>• Final decision within 30 days for all others</li> <li>• Grievance can be filed by either member or provider</li> <li>• Grievances are appealable to the Commissioner within 30 days of decision</li> </ul> <p>Contracted utilization review agents must have a written plan to review the appropriate and efficient allocation of health resources and services to members. Adverse decisions must be</p>	<p>Carrier may not:</p> <ul style="list-style-type: none"> <li>• Reimburse provider less than the rate negotiated in the provider's contract</li> <li>• Retain any capitated fee attributable to the enrollee for the contract year if it reimburses on a wholly or partly capitated basis</li> <li>• Prohibit provider from discussing alternative treatments, right to appeal with subscribers or express opinions about public policy</li> <li>• Require provider to indemnify carrier from negligent acts or coverage decisions of the carrier</li> </ul>		<p>HMO must provide written information annually to its contract holders of the loss ratios reported to Commissioner</p>

## OVERVIEW OF HMOS

State	Governance/ Risk Management	Quality of Care	Provider Contracting	Network Adequacy	Other
		<p>made by a physician</p> <p>Carriers are not allowed to deny a claim using general terms such as:</p> <ul style="list-style-type: none"> <li>• "experimental procedure not covered"</li> <li>• "cosmetic procedure not covered"</li> <li>• "services included under another procedure"</li> <li>• "not medically necessary"</li> </ul>			
Florida	<p>Agency for Health Care Administration (Agency) and Department of Insurance (Department) jointly govern HMOs.</p> <p>HMO must receive health care provider certificate from the Department of Health (every 2 years) and a certificate of authority from the Department of Insurance</p> <p>HMO must maintain a minimum surplus level of greater of \$1.5 million, 10% of total liabilities or 2% of total annualized premium</p> <p>HMO may instead provide a written guarantee by guaranteeing organization meeting specific requirements.</p> <p>Required deposits for HMO's:</p> <ul style="list-style-type: none"> <li>• \$10,000 for Rehabilitation Administrative Expense Fund</li> <li>• \$300,000 minimum market value up to \$2 million if financial condition deteriorates</li> </ul> <p>Department has right to approval:</p> <ul style="list-style-type: none"> <li>• ASO contracts</li> <li>• provider contracts other than individual providers management services</li> <li>• contracts with affiliated entities</li> </ul> <p>Department has right to require cancellation of contract if detrimental to subscribers, stockholders, investors or creditors of HMO</p>	<p>HMO must have a quality assurance program that:</p> <ul style="list-style-type: none"> <li>• Ensures services are rendered under reasonable standards consistent with medical practice in the community</li> <li>• Contains written goals and objectives</li> <li>• Includes methodology for ongoing monitoring and incorporation of findings</li> <li>• Requires procedures for remedial actions</li> <li>• Contains credentialing procedures</li> <li>• Provides that the professional judgment of a physician cannot be subject to modification by HMO unless inconsistent with prevailing medical practice in community</li> <li>• Subscribers have right to second opinion during disputes (at no cost to subscriber from contracted provider)</li> <li>• Requires HMO to provide to Agency indicators of access and quality of care at least every two years</li> <li>• Conducts standardized customer satisfaction surveys and submit to Agency</li> </ul> <p>HMO must have a grievance procedure for subscribers consisting of:</p>	<p>Provider contracts must contain a provision that contract can be cancelled upon order of the Department.</p> <p>HMO must file with Department financial statements for all contract providers who assume 10% or more of the risk Provider contracts shall include provision that provider not bill enrollee for amounts owed but not paid by insurer</p> <p>All provider contracts must be in writing</p> <p>Providers must give HMO and Department 60 days notice of termination</p> <p>HMO must give 60 days written notice prior to termination without cause of provider unless patient's health is in immediate danger or action by Board of Medicine restricts license</p> <p>HMO contract cannot contain provision restricting communication by the provider of treatment options</p> <p>HMO and provider must allow up to 60 days continuing care for subscriber with certain conditions upon provider termination</p> <p>HMO must pay any provider claim it does not contest or deny within 35 days of receipt and must pay or deny claim within 120 days</p> <p>HMO medical director must be licensed</p>	<p>HMO must have:</p> <ul style="list-style-type: none"> <li>• Policy for determining when exceptional referrals to out-of-network specialists are required for unique medical needs</li> <li>• Written policies for issuing standing referrals to specialists for subscribers with chronic or disabling conditions</li> <li>• Centralized credentialing program</li> </ul> <p>15 days prior to expansion of geographic network, must prove that HMO has adequate provider network for at least first 60 days</p> <p>Network must meet generally accepted industry norms for accessibility to providers with respect to:</p> <ul style="list-style-type: none"> <li>• Locations</li> <li>• Hours of operation</li> <li>• After hours services</li> <li>• Staffing patterns</li> </ul> <p>Subscriber contract must contain provision allowing services from physician assistants, and nurse practitioners</p>	<p>HMO obtains a certificate of authority from Insurance Superintendent. Application requires:</p> <ul style="list-style-type: none"> <li>• Verification by two officers</li> <li>• Copy of basic organizational documents</li> <li>• Bylaws</li> <li>• List of names and addresses of board of directors</li> <li>• Biographical affidavits</li> <li>• Fingerprints</li> <li>• General statement describing the health plan, its operations and grievance procedures,</li> <li>• Copy of form of evidence of coverage along with table of rates</li> <li>• Financial statements</li> <li>• Marketing plan</li> <li>• Statement of geographic area to be served</li> <li>• A feasibility study performed by actuary projecting profitability</li> <li>• Maintenance of minimum surplus levels.</li> </ul> <p>All "fiduciary" or "fiscal intermediary services" companies (who collect money</p>

## OVERVIEW OF HMOS

State	Governance/ Risk Management	Quality of Care	Provider Contracting	Network Adequacy	Other
<p>Department has authority to revoke or suspend certificate of authority for violations or may issue fines at rate of \$2500 per nonwillful violation and \$20,000 per willful violation. If health care provider certificate is revoked or not renewed, Agency will notify Department and Department cancels certificate of authority</p> <p>Department sets medical loss ratios annually</p> <p>HMO files annual report which includes:</p> <ul style="list-style-type: none"> <li>• Financial statement (unaudited quarterly)</li> <li>• Number of contracts issued and terminated</li> <li>• Actuarial certification of soundness</li> <li>• Audit report indicating any material weaknesses and corrective actions to be taken</li> </ul> <p>Department conducts exam at least once every three years, total annual expenses of exam cannot exceed \$20,000 per HMO</p> <p>HMO must file with the Department for approval all changes to:</p> <ul style="list-style-type: none"> <li>• subscriber contract</li> <li>• member handbook</li> <li>• grievance procedures</li> <li>• application form</li> <li>• riders</li> <li>• rates</li> </ul> <p>Report annually to Agency total number of grievances, the categories and final disposition</p> <p>Submit quarterly grievance reports to Department of Insurance and Agency</p> <p>Agency requires HMO to establish a risk management program to investigate and analyze adverse incidents causing injury to patients</p>	<ul style="list-style-type: none"> <li>• Response within reasonable time (defined as 60 –90 days)</li> <li>• Written procedures for expedited review of urgent grievances (within 72 hours)</li> <li>• Accepting grievance within 1 year of occurrence</li> <li>• Notice to subscriber of process and rights</li> <li>• Notice that subscriber may pursue binding arbitration upon appeal or appeal to the Statewide Provider and Subscriber Assistance Program</li> <li>• Assistance to subscriber who are unable to submit a written grievance</li> <li>• An internal review panel to review adverse determinations. Panel to be composed of a majority of providers with appropriate expertise</li> <li>• Final decision letter from HMO that lists appeal procedures</li> </ul> <p>Agency investigates reports of unresolved quality of care grievances identified by reports and requests from subscribers who have exhausted full grievance procedure</p> <p>Agency requires NCOA approval (or its equivalent) within one year of receiving certificate of authority. Agency representative shall accompany accreditation reviewer on site visits. Statute lists specific accreditation standards to meet</p>	<p>physician</p>			<p>for providers and others for health services provided) must register with the Department and maintain a facility bond. They are only allowed to collect deductibles and copayments from subscribers</p> <p>Florida Health Care Purchasing Cooperative Act creates a nonprofit organization with the authority to create pools to purchase health care services for state and local government members</p>

# **EXHIBIT 9**

## ASSUMPTIONS

The *Estimated General Fund Resource Requirements* spreadsheet was prepared applying the following assumptions:

1. No other legislation will be enacted that would have a synergistic effect on the difficulty, complexity or workload associated with administering the provisions of this proposal.
2. The Department will be able to use independent contractor examiners paid from the Insurance Examiners' Revolving Fund (and reimbursed by the examinee) to perform on-site examinations of HCSO quality of care, network adequacy and access to care issues.
3. The state will not change the salary schedule prior to the implementation of the proposal and, on the average, will increase salaries by 2.5 percent in the second year.
4. ERE is estimated at 26.84% of personal services, as provided in the BUDGET SCHEDULES AND INSTRUCTIONS MANUAL: OPERATING BUDGET AND FEDERAL FUNDS FOR FISCAL YEARS 2000 AND 2001, Governor's Office of Strategic Planning and Budgeting.
5. Assumes all causes of workload increases associated with this proposal have been identified and anticipated.
6. Assumes additional space will be available in the Phoenix Financial Center into which the Fraud Unit could be relocated, thereby providing necessary additional office space to accommodate additional staff required for managed care oversight.

**EXHIBIT 10**

## ALTERNATIVES CONSIDERED

The Department has considered the following office space alternatives:

1. **Relocate the agency's main Phoenix Office into adequate office space at a total additional first-year cost of \$491,900 and \$161,900 in additional rent in subsequent years.** We believe the Department requires a total of 36,000 usable square feet, an addition of 7,000 square feet of office space. The Department presently pays \$450,100 for its existing space in the Sun State Building.
  - Assuming \$17.00 per usable square foot per year (rent is usually based on a higher "rentable square footage), the Department would require at total of \$612,000, **an increase of approximately \$161,900 annually.**
  - The Department would need to pay costs of moving furniture, office equipment, telecommunications and computer systems. **The relocation would require \$300,000 in one-time funding.**
  - **The Department would need to incur approximately \$30,000 in costs related to it having a new business address** (i.e. replacement of envelopes, stationery, business cards, forms, etc.).
  
2. **Expand the Department by 7,000 into additional Sun State Building office space at between \$191,200 and \$216,200 in additional first-year costs and \$109,000 in increased annual rent thereafter.** This alternative is predicated on the availability of additional space in the Sun State Building, which we believe is highly unlikely.
  - The Department would need to have its existing facilities and the expanded facilities modified to enable staff to fit properly within the office space. Modifications would likely include demolition and construction of partitions (walls), installation of voice/data/electrical wiring, relocation and adjustment of HVAC components (vents, thermostats, etc.). Based on recent small construction project, we estimate **these modifications would cost between \$75,000 and \$100,000.**
  - The Department would need to procure a moving company to relocate furniture and equipment into their new office locations at a **one-time cost of approximately \$6,000** (based on a \$1,900 cost to relocate 20 workstations in March 1999 and the assumption that 60 workstations would be involved in the office relocations).
  - **The Department would annually require approximately \$109,000 to pay the Department of Administration for the additional office space** (lease-purchase and operating/maintenance payments) assuming extension of current per square foot costs to 7,000 square feet of additional space.

- **The Department would require approximately \$1,200 to have its Sun State office telephone system reprogrammed.**
3. **Expand the Department by 3,000 square feet into additional Sun State Building office space at between \$116,900 and \$131,900 in additional first-year costs and \$109,000 in increased annual rent thereafter.** This alternative would provide the Department the minimum amount of office space necessary for the Department to provide a safe (although cramped) working environment for its employees. This alternative is predicated on the availability of additional space in the Sun State Building, which we believe is highly unlikely.
- The Department would need to have its existing facilities and the expanded facilities modified to enable staff to fit properly within the office space. Modifications would likely include demolition and construction of partitions (walls), installation of voice/data/electrical wiring, relocation and adjustment of HVAC components (vents, thermostats, etc.). Based on recent small construction project, we estimate **these modifications would cost between \$65,000 and \$80,000.**
  - The Department would need to procure a moving company to relocate furniture and equipment into their new office locations at a **one-time cost of approximately \$4,000** (based on a \$1,900 cost to relocate 20 workstations in March 1999 and the assumption that 40 workstations would be involved in the office relocations).
  - **The Department would annually require approximately \$46,700 to pay the Department of Administration for the additional office space** (lease-purchase and operating/maintenance payments) assuming extension of current per square foot costs to 3,000 square feet of additional space.
  - **The Department would require approximately \$1,200 to have its Sun State office telephone system reprogrammed.**
4. **Rent 3,000 square feet of privately owned office space at between \$175,000 and \$200,000 in additional first-year costs and \$51,000 in increased annual rent thereafter.** This alternative would provide the Department the minimum amount of office space necessary for the Department to provide a safe (although cramped) working environment for its employees. Under this alternative, the Insurance Fraud Unit would be relocated to join the Arizona Insurance Guaranty Funds at the Phoenix Financial Center. The Fraud Unit was selected for relocation because it does not rely as heavily on interaction with other agency divisions as other units. This alternative assumes sufficient additional space will be available at that site.
- **Fraud Unit furniture and equipment would need to be relocated and workstations within existing space will need to be relocated at a total cost of approximately \$20,000.**

- The Department would need to have its existing facilities modified to enable staff to fit properly within the office space. Modifications would likely include demolition and construction of partitions (walls), installation of voice/data/electrical wiring, relocation and adjustment of HVAC components (vents, thermostats, etc.). Based on recent small construction project, we estimate **these modifications would cost between \$50,000 and \$75,000.**
- **The Department would require approximately \$4,800 to have voice and data wiring installed in the space to be occupied by the Fraud Unit.**
- **The Department would require approximately \$1,200 to have its Sun State office telephone system reprogrammed.**
- **The Department would require \$45,000 to replace the existing eight-station telephone system with a 30-station phone system.**
- **The Department would require \$3,000 to replace the existing 8-port LAN hub with a 24-port LAN switch.**
- **The Department would annually require approximately \$51,000 to pay additional rent costs** assuming 3,000 square feet at \$17.00 per square foot -- the rate that will be paid by the Arizona Insurance Guaranty Funds after July 1, 2000.

# **EXHIBIT 11**

## EVALUATION OF ALTERNATIVES

Each of the alternatives presented has benefits and drawbacks.

Alternatives 1 and 2 would provide the Department with a sufficient amount of office space to comfortably accommodate its employees; however, these alternatives are relatively expensive.

In addition to the identified costs to the Department, Alternative 1 would also require the state to find another tenant for space vacated by the Department.

Alternatives 2 and 3 would prevent the Department from having to obtain additional privately-owned office space, but are predicated on the availability of additional space in the Sun State Office Building, which is quite unlikely.

Alternative 4 would enable the Fraud Unit, with the identified LAN switch, to share the remote local-area network with the Arizona Insurance Guaranty Funds. This alternative would only partially alleviate the Department's overcrowded conditions and is predicated on the existence of additional space in the Phoenix Financial Center.

## RECOMMENDATION

Because it is unlikely that additional Sun State Office Building space will be available and because of the great expense associated with relocating the entire agency, we have presented Alternative 4 in our *Estimated General Fund Resource Requirements* spreadsheet.