REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF ORGANIZED HEALTH SERVICES DELIVERY SYSTEMS PURSUANT TO SJR 126 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 22

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

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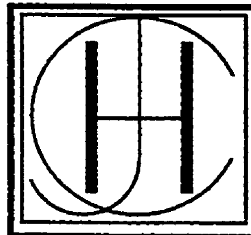


Preface

Senate Joint Resolution (SJR) 126 of the 1994 Session requested the Joint Commission on Health Care, in cooperation with the Commissioner of Health and the Commissioner of Insurance, to continue its study of organized health care delivery systems. The study is a continuation of earlier work conducted by the Commission in 1993 under the authority of SJR 316 from the 1993 Session.

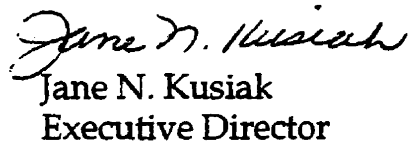
This report examines the "community health network" model of an organized delivery system. The idea of the community health network arose in response to dissatisfaction with the traditional health care delivery system in which purchasers pay ever-increasing prices for health services without real evidence that the services are cost-effective. A community health network would involve a group of health care providers joining together to offer comprehensive health care services for a fixed fee per person or "capitated" fee. The network would develop evaluation systems which would allow purchasers to obtain comprehensive information on the cost and quality of the services they receive. Furthermore, the community health network would assume insurance risk -- and strong incentives for cost effectiveness -- by contracting directly with purchasers rather than with a health insurance company.

The essential policy issue addressed in this report is how to regulate the insurance function of a community health network. Under current law, the primary option available to a group of providers wishing to form a community health network is to be licensed and regulated as a health maintenance organization. However, advocates of the community health network model believe that the financial requirements for HMOs, including net worth, solvency standards, and other requirements, are too stringent to allow the development of viable small-to-medium sized community health networks (particularly in rural areas). They further believe that there are substantive differences between community health networks and HMOs which should be reflected in regulatory requirements.

The report includes three policy options for the consideration of the General Assembly. The first option is the status quo, which would mean that providers wishing to form a community health network would have to be licensed under existing HMO requirements. A second option would be to develop a separate set of requirements for community health networks. A third option would be to amend the existing HMO requirements on a provisional basis to accommodate the development of new community health networks. A detailed explanation of each option is included in the report.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

On behalf of the Commission staff, I would like to thank the State Corporation Commission's Bureau of Insurance, the Virginia Department of Health, and numerous interested parties from the private sector for their contributions to this study.



Jane N. Kusiak
Executive Director

December 30, 1994

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Authority for Study

Senate Joint Resolution (SJR) 126 of the 1994 Session requested the Joint Commission on Health Care, in cooperation with the Commissioner of Health and the Commissioner of Insurance, to continue its study of organized health services delivery systems.

Background

SJR 316 from the 1993 Session requested the Joint Commission to examine the potential of organized delivery systems and the appropriate state role in fostering the development of organized systems of care. During 1993, the Joint Commission formed a voluntary task group consisting of representatives of the physician industry, the hospital industry, the insurance industry, state agencies, and Joint Commission staff. This task group reviewed a wide range of research and held in-depth discussions about the value of organized delivery systems and potential state policies. This background section reviews the major findings from the task group, and describes the focus of SJR 126.

Growing Interest In Organized Delivery Systems

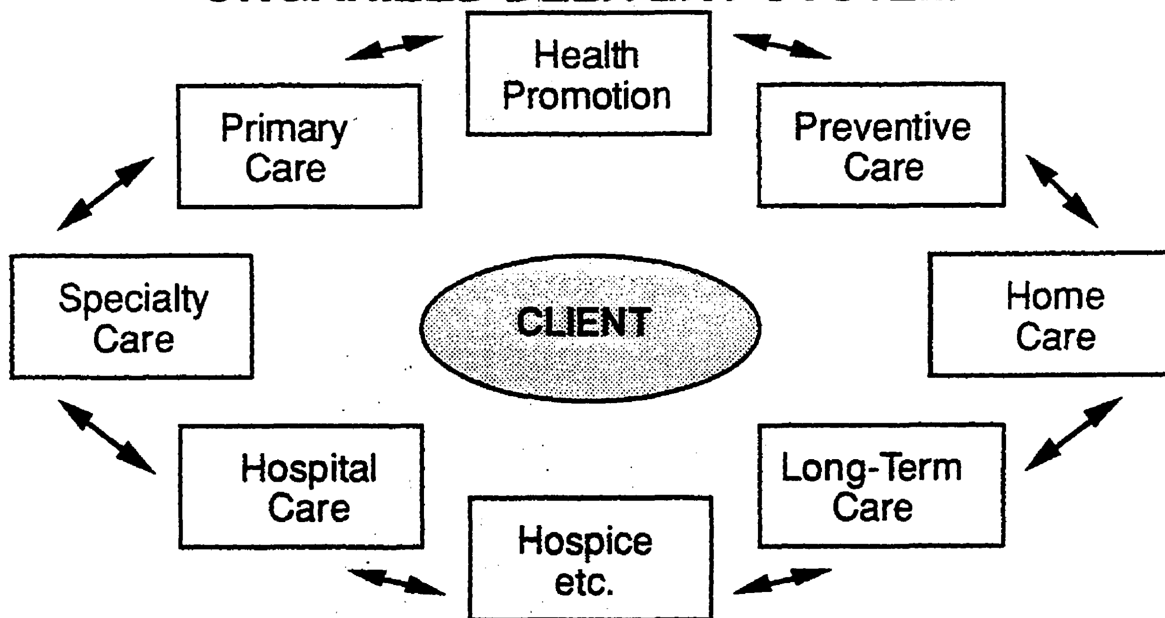
For some time now, the health care delivery system has been reorganizing in fundamental ways. Nationally, over 40 percent of physicians are practicing in groups. Hospitals are joining forces as well -- the American Hospital Association lists approximately 300 hospitals systems among its membership. At the cutting edge of the next generation of organization, physicians, hospitals, other providers, and in many cases insurers are joining together to form organized delivery systems.

An organized delivery system (ODS) may be generally defined as a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population, and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served (Figure 1). The ODS may be owned by a single entity, or it may be based on a series of contractual arrangements. The ODS may be organized around physicians, hospitals, or an insurance company. Perhaps more than anything else, the defining characteristic of an ODS is clinical and fiscal accountability for a defined population.

The concept of organized delivery systems is a response to fragmentation and adverse incentives in the traditional health care system. The traditional system of indemnity insurance and fee-for-service medicine has created financial incentives for providers to deliver more services rather than promote wellness.

Figure 1

ORGANIZED DELIVERY SYSTEM



- UNIVERSAL COVERAGE AND ACCESS
- ORGANIZED CONTINUUM OF SERVICES/PROVIDERS
- SERVICE INTEGRATION AND LINKAGES
- CARE COORDINATION FUNCTION
- UNIFORM DATA AND ACCOUNTABILITY

SUPPORTIVE INCENTIVES: FINANCING AND STRUCTURE

At the same time, independent providers in the same market have often competed by expanding capacity beyond the needs of the community. The fragmentation within the system has made it difficult to develop norms of professional practice, and as a result there are wide variations in the practice of medicine. Consequently, purchasers and patients must negotiate their way through a fragmented system of providers with little or no useful information on the cost and quality of services.

Advocates believe that organized delivery systems can provide the organizational and economic discipline needed to remedy many of the problems in the health care system. The belief is that if physicians, hospitals, and other providers are jointly responsible for providing services to a defined population, they will have strong incentives to keep people well. Furthermore, when people become sick, the system will have incentives to treat the patient in the most cost effective fashion. By sharing clinical and financial data, the cooperating

providers will have the necessary information to monitor their own cost-effectiveness and report to their customers on the cost and quality of their services.

While no one knows exactly how many organized delivery systems exist across the country, case study reports indicate that the number is growing. For instance, a 1992 study published by the National Committee for Quality Health Care included 19 case studies of organized delivery systems, including a case study of Sentara Health System in Norfolk, Virginia.

The research on organized delivery systems indicates that they are not easy to develop and operate. An essential requirement is for doctors and hospitals to work together for the economic good of the organization. This is a shift from the traditional physician/hospital relationship which is not always easy to achieve. The ODS must adopt new management and governance models, and develop a strategic plan to compete in the marketplace. This may involve painful decisions related to "right-sizing" the system -- that is, making sure the system has an efficient number of hospital beds, physicians, and other resources. In addition, major expenditures may be required to develop systems for monitoring health care costs and quality.

It is important to recognize that most of today's organized delivery systems are in their infancy compared to the role that advocates would have them play in a reformed health care system. For instance:

* Most of the systems that exist today are focused on providing traditional physician and hospital services, whereas under the ideal model, organized delivery systems would provide a full continuum of health care services including preventive care, long-term care, home health care, and other services.

* Most of today's systems are focused on developing systems to demonstrate clinical and fiscal accountability to those who directly purchase their services. Under the ideal model, organized delivery systems would assess the needs of the community-at-large, and develop programs to provide immunization, preventive health care, prenatal care, education, and other services aimed at promoting wellness and alleviating social problems such as teenage pregnancy, violence, addictions, etc. Moreover, organized delivery systems would be held accountable for addressing the health care needs of the community through licensure requirements, payment policies, tax policies, or other measures.

* Most of today's systems involve hospitals, physician groups, other providers, and insurers. Under the ideal model, organized delivery systems would develop cooperative relationships with local health departments, community health centers, schools, and social service organizations in an effort to address the community's health care needs.

The continued evolution of organized delivery systems will require change on the part of those with a stake in the health care system. Providers, and in many cases insurers, will have to work together to build cost-effective delivery networks. Purchasers will have to be satisfied that the organized delivery system model will meet their needs for choice, quality, and affordability. Governments will have to make policy decisions about the kind of health care system they want to promote, and pass legislation to make those systems possible. In this context, a number of states have adopted policies to promote the development of organized delivery systems, as described in the following section.

Organized Delivery System Policies In Other States

Five states in particular have made organized delivery systems a central feature of their comprehensive reform efforts.

Florida has established health insurance purchasing cooperatives known as Community Health Purchasing Alliances (CHPAs). Plans that are offered through the CHPAs would have to be certified organized delivery systems called Accountable Health Partnerships.

Iowa is attempting to establish health insurance purchasing cooperatives which will pay for care provided through organized delivery systems called Accountable Health Plans.

Minnesota has passed universal access legislation requiring that providers either operate under an all-payer system or join an organized delivery system called Integrated Service Networks.

Vermont continues to study two options for achieving universal access -- one a single-payer model and the other a regulated multi-payer model. Care would be delivered through organized delivery systems called Integrated Systems of Care.

Washington has enacted universal access legislation calling for the creation of organized delivery systems called Certified Health Plans.

In addition to the decision to purchase services from organized delivery systems, these states have enacted or are considering enacting a variety of different policies to promote and regulate their respective models of organized delivery systems, such as:

* **Integration of service delivery and insurance.** (FL, IA, MN, VT, WA) Under these models, the organized delivery system would be responsible for providing or arranging for both service delivery and insurance.

* **A uniform benefit package to be offered by all organized delivery systems.** (IA, MN, VT, WA)

* **Required report cards.** (FL, MN, WA) Organized delivery systems would be required to publish outcome measures as well as cost data.

* **Required internal continuous quality improvement program.** (VT, WA) Organized delivery systems would be required to maintain internal continuous quality improvement programs which would produce the data needed for required report cards.

* **Required service to Medicaid and other publicly-supported populations.** (FL, IA)

* **Exemption from certificate of need requirements.** (IA) This would apply to capitated organized delivery systems which already have economic incentives to restrain the use of high-cost facilities.

* **Selective protection from anti-trust challenges.** (IA, WA) The intent is to facilitate collaboration among providers in situations where the threat of an anti-trust suit might inhibit the creation of a cost-effective organized delivery system.

* **Requiring community representation on the organized delivery system governing board.** (MN, VT) Intended to assure accountability to enrollees and the community-at-large, particularly in areas with little or no competition.

* **Development of alternative HMO licensure requirements.** (MN) Intended to stimulate the development of new organized delivery systems.

Visions Of Organized Delivery Systems In Virginia: Community Health Networks

The Virginia Hospital Association (VHA) and the Medical Society of Virginia (MSV) both envision organized delivery systems as being a fundamental part of health care reform in Virginia (Figure 2). Based on each organization's guidelines for health care reform, both see the need to move toward organized systems of care established at the community level. These organizations would be called community health networks. The MSV and the VHA agree that these networks would use managed care, and be willing to be held accountable for the costs and quality of care they deliver.

Figure 2
Visions Of Community Health Networks:
Medical Society of Virginia and Virginia Hospital Association

	MSV Vision	VHA Vision
Organization	Collaboration of health care providers within a community to form an integrated network.	Same
Managed Care	Care coordination by a primary care practitioner.	Same
Accountability	Accountability to the community for outcomes and costs.	Same
Payment	Fee for service payments directly to providers.	Capitated payments to the network which allocates reimbursement among network participants.
Economic Discipline	Economic discipline through internal review of medical practice decisions.	Limitations on available financial resources through use of capitated payments.
Insurance Function	Third party payers as separate entities.	Insurance function blended into network.

The two groups diverge on the issues of payment, economic discipline, and the insurance function. The MSV approach advocates fee-for-service payment, and economic discipline via internal review of medical practice decisions. The insurance function would remain outside the provider network. This approach reflects a concern that the assumption of too much financial risk

could interfere with the physician's capacity to serve the best interests of the patient.

By contrast, the VHA vision assumes that strong financial incentives are required to encourage health care providers to improve the cost effectiveness of health care. This is reflected in the VHA's support of pre-paid, or capitated financing, as well as the assumption of insurance risk by the network. Under the VHA vision, any financial incentives to underserve patients would be adequately balanced by requirements to publish data on cost and quality performance.

Research indicates that capitated managed care systems can achieve cost savings and provide high quality care. It is too early to tell whether systems structured along the lines of the MSV model can be equally cost-effective. The technology required to make such systems possible is relatively new, and has not been widely demonstrated and studied.

Virginia State Policies Which Support The Development Of Community Health Networks

Virginia has enacted various state policies which support the development of both the MSV and VHA versions of community health networks. These include:

> **Strengthening the primary care workforce.** Community health networks require a strong primary care workforce to manage patient care. Virginia has enacted a number of policies designed to improve the supply and distribution of primary care practitioners in the Commonwealth. These include the Generalist Initiative, the Practice Sights Initiative, various scholarship and loan repayment programs, the Area Health Education Centers program, and other initiatives.
>
> **Evaluation of health care costs and quality.** Accountability for costs and quality is an essential feature of community health networks. Virginia has taken a number of steps to build its capacity to disseminate public information on the cost and quality of health care providers and health plans. These include a new Health Services Cost Review Council methodology designed to identify the most efficient and productive hospital and nursing home providers; a patient level data base which will ultimately be used to assess the cost effectiveness of health care providers; and an ongoing study of the feasibility of developing public report cards on health plans.

Purchasing health care from managed care plans. Managed care is a cornerstone of the community health network model. In fact, the concept of the community health network is a natural outgrowth from the market's commitment to managed care. The Commonwealth has supported the development of managed care as an option through its purchasing decisions for state employees and Medicaid patients. State employees have a choice of managed care programs ranging from preferred provider organizations to health maintenance organizations. Virginia Medicaid offers the Medallion managed care program, and plans are underway to offer HMO coverage to Medicaid patients.

The Focus Of SJR 126

The SJR 316 task group considered a wide range of options for the state role in the development of community health networks. It was decided that there is no need for the state to step in and directly regulate community health networks developed along the lines of the MSV model, primarily because they would not assume insurance risk. These types of organizations should be free to develop in response to market forces. However, the state must regulate community health networks developed along the lines of the VHA vision -- that is, networks that assume insurance risk. The question is how these risk-bearing community health networks should be regulated under the insurance code, as will be discussed in the following section.

Issues

As a consequence of assuming the insurance function, risk-bearing community health networks would have to be subject to Virginia's insurance laws and regulations. The available option for a group of providers wishing to assume insurance risk would be to form a health maintenance organization (HMO) and be regulated as such. However, during the course of this study, representatives of the Virginia Hospital Association have maintained that the organizational and financial requirements of operating as a licensed HMO in Virginia might be an unnecessary impediment to the development of community health networks. Hospital industry representatives also have maintained that the special characteristics of community health networks (to be discussed shortly) might justify a policy of easing the organizational and financial requirements for licensure of these entities.

The policy question is how risk-bearing community health networks should be regulated under the insurance provisions of the *Code of Virginia*. The answer to this question is dependent upon judgments regarding:

The extent to which risk-bearing community health networks are conceptually and operationally different from HMOs;

The extent to which HMO licensure requirements are a real barrier to the development of risk-bearing community health networks; and

The value of certain controversial aspects of risk-bearing community health networks.

Risk-Bearing Community Health Networks Compared To HMOs

For the purpose of crafting legislation, the VHA developed a specific operational model of a risk-bearing community health network. An examination of this risk-bearing community health network model leads to comparisons with HMOs. HMOs are health care plans which accept pre-payment for financing comprehensive health benefits. The Appendix contains additional background information on HMOs in Virginia.

Risk-bearing community health networks are most comparable with staff-model HMOs, which generally own all of the clinical facilities that enrollees are required to use. Figure 3 summarizes the similarities and differences between risk-bearing community health networks and staff-model HMOs.

Similarities. As indicated in Figure 3, the risk-bearing community health network would look like a staff-model HMO in fundamental ways. Both organizations would be organized by provider networks. Both would integrate the service delivery and insurance functions. Both would operate on pre-paid revenues, utilize managed care, and have the power to limit provider participation based on demonstrated capacity.

Differences. The risk-bearing community health network model would differ from the staff-model HMO in three general ways. First, a risk-bearing community health network would be allowed to offer a narrower scope of services than a licensed HMO. HMO service requirements extend beyond the scope of services covered by the Essential plan. Second, a community health network would be required to report to its customers on the cost and quality of services. There are no legal requirements for HMOs to provide such reports. Third, the risk-bearing community health network would be required to have a board with a majority of members from the community if it were the only such organization in the community. There are no such requirements for HMOs.

Figure 3
Comparison Of Risk-Bearing Community Health Networks And Staff-Model HMOs

	Community Health Network	Staff-Model HMO
Organizer/ Owner	Health care providers	Health care providers
Integrated Delivery and Financing	Yes	Yes
Subscriber Payment Method	Capitation	Capitation
Managed Care	Yes	Yes
Limits on Provider Participation	Cannot unreasonably discriminate, but can limit participation to the number required to deliver services to enrollees.	Same
Scope of Services	Essential and Standard benefits at a minimum.	"Basic health care services" as defined in 38.2-4300.
Accountability for Costs and Quality	Required to report on the quality and cost effectiveness of health care services.	Not a requirement.
Governance	Majority of board members from community at large if there is only one community health network in the geographic area.	May include health care providers, other individuals, or both, but cannot exclude any class of provider from eligibility.
Solvency Requirements	Not established yet.	Minimum net worth, minimum deposit, guaranteed coverage, other.

Solvency Requirements. Solvency requirements for risk-bearing community health networks have not been established yet. One of the key issues in the study is the contention that HMO solvency requirements may be an unnecessary impediment to the development of risk-bearing community health networks. The VHA has expressed concern about the burdensome nature of HMO requirements, although it has not articulated which specific requirements are problematic. The major HMO licensure requirements are outlined below:

* Each HMO must establish a net worth of at least $300,000 prior to licensure.

* Each HMO must maintain a deposit of at least $300,000 with the State Treasurer.

* Each HMO must maintain adequate liability insurance to protect the interests of all subscribers and enrollees.

* Each HMO must require its providers to serve subscribers for the duration of the subscriber contract even if the HMO becomes insolvent.

* Each HMO must require its providers to hold subscribers harmless in the case of insolvency or any other payment problems between the HMO and the provider.

* If an HMO becomes insolvent, all other carriers serving the same group(s) as the insolvent HMO must offer the HMO's enrollees the same coverage and rates then in effect for the carrier's enrollees in the group.

* The SCC must examine the affairs of each HMO at least once every five years.

* The State Health Commissioner is empowered to examine the quality of health care services of any HMO as often as is considered necessary to protect the interests of the people of the Commonwealth.

The statutory and regulatory requirements placed upon HMOs are primarily intended to protect consumers from financial and health risks arising from the insolvency of a licensed HMO. Experience has shown that these requirements must extend beyond the guaranteed delivery of services by HMO providers in the case of insolvency. Therefore, the requirements also include minimum net worth and minimum deposit regulations in order to assure enrollees of the viability of the HMO before they enroll. Moreover, while these requirements are primarily intended to protect consumers, they also are of great

importance to other carriers which are required by law to step in and cover the former enrollees of an insolvent HMO.

Other Characteristics Of Risk-Bearing Community Health Networks

Public discussions about risk-bearing community health networks have raised concern about potential characteristics of these entities. These issues should be understood as background for deciding policy options.

Essential And Standard Services. Under the proposed model, risk-bearing community health networks would be allowed to offer Essential and Standard benefits to all market segments. Virginia already has enacted policies to require health plans to make the Essential and Standard health benefits packages available to the small group market beginning July 1, 1994. Health plans must offer a different array of mandated benefits to other segments of the market.

Allowing risk-bearing community health networks to offer Essential and Standard benefits to all market segments would create an unbalanced playing field. This has implications for fair competition for enrollees among risk-bearing community health networks, HMOs, and other health plans. It also has implications for the process of dealing with insolvent health plans. Under current law, if an HMO becomes insolvent, the other carriers serving the same group must step in and enroll the customers of the insolvent HMO. Assuming that risk-bearing community health networks would fulfill the same role in the case of an insolvent HMO, there would be a legitimate concern about the ability of community health networks to step in and provide the HMO's enrollees with HMO-type benefits.

Limits On Provider Participation. The exclusion of providers from network participation has sparked a national debate in health policy circles. On the one hand, provider groups are concerned about being forced out of a market which is evolving toward managed care services delivered by networks of providers. Consumers, too, are concerned about maintaining their choice of providers. On the other hand, managed care plans and HMOs point out the efficiencies to be gained by limiting the number of participating providers.

Under current law, Virginia's HMOs are allowed to limit the number of providers in the organization if they can demonstrate that they already have enough providers to meet the service demands of their enrollees. At the same time, insurers are not allowed to exclude providers from participation in preferred provider arrangements so long as the providers are able to meet the terms and conditions offered by the insurer. The Joint Commission has been

asked to study the impact of this statute on the health care system under Senate Joint Resolution 158. The SJR 158 report will discuss the pros and cons of allowing health plans to limit provider participation.

Local Governance In Certain Cases. The community health network proposal would require that the majority of network board members be from the network's service area if the network were the only one in the area. This approach is intended to ease concerns about monopolistic activity in situations of little or no competition. Mandatory community governance could be a cause for concern from two perspectives. First, some providers within a network might be concerned that local purchasers could in effect set their own prices through majority representation on the board. Second, provider organizations with national or regional governing boards would be deterred from developing networks in service regions that could only support one network.

Accountability For Costs And Quality. Under current circumstances, the proposed risk-bearing community health networks would be the only health plans required to report to their customers on the costs and quality of their services. However, this could possibly change as a result of a legislative study. The Joint Commission recommended that the 1994 General Assembly pass a resolution requesting the Health Services Cost Review Council to study the feasibility of developing "report cards" on all Virginia health plans. It is hoped that such report cards could be used by purchasers to compare the costs and quality of competing health plans. The General Assembly passed House Joint Resolution 267 requesting the Health Services Cost Review Council to conduct such a study and report to the Joint Commission prior to the 1995 Session.

Policy Options

There are three major policy options for regulating risk-bearing community health networks. One option is to take no action, and maintain the status quo. A second option is to create a separate statutory framework for risk-bearing community health networks. A third option is to consider amending the HMO law to accommodate the development of risk-bearing community health networks.

Option 1: Status Quo

This option reflects a judgment that there is no compelling reason to modify state regulatory requirements for the sake of risk-bearing community health networks. The major differences between risk-bearing community health networks and staff-model HMOs -- a narrower scope of required services, mandatory reporting on costs and quality, and community governance in certain

situations – are either undesirable or not significant enough to justify regulatory changes. Providers who wish to form a network, provide comprehensive services, and assume the insurance function would have to obtain an HMO license by meeting existing requirements.

Option 2: Develop A Separate Statute For Risk-Bearing Community Health Networks

This option reflects a judgment that the distinctive features of risk-bearing community health networks justify the creation of a separate licensing mechanism for these organizations. A new statute would lay out the key requirements of community health networks, including organizational and financial requirements for licensure. The SCC would be given the authority to license and regulate community health networks. Presumably, these requirements would be less stringent than the existing requirements for HMOs.

Option 3: Amend the HMO Law To Accommodate The Development Of Risk-Bearing Community Health Networks

This option reflects a judgment that risk-bearing community health networks are essentially like staff-model HMOs, and should be regulated under the HMO law. At the same time, this option reflects a view that the HMO model of delivery and financing is valuable, and the distinctive characteristics of risk-bearing community health networks may bring additional value to the HMO approach. As such, the state should make sure that its HMO requirements are not unduly burdensome.

Operationally, this option would require a review and refinement of existing requirements to identify statutory and regulatory changes which could stimulate the development of HMOs with the most desirable attributes of community health networks. These organizations could be formed by providers or others willing to meet the requirements. Existing requirements could be eased or modified, where appropriate, to make it easier for these types of HMOs to form.

For example, Minnesota is considering the creation of "Community Integrated Service Networks" or CISNs which would be much like community health networks.

CISNs would be limited to fewer than 50,000 members and operate under HMO law. However, they would be given a special provisional status to begin operating between 1994 and 1997. Under this provisional status,

CISN licensure requirements would be identical to those for HMOs with the following exceptions:

* *At least 51 percent of the CISN's governing body must be residents of the CISN's service area.*

* *CISNs may make use of accredited capitated providers (ACPs) in satisfying up to 30 percent of their net worth requirements for licensure. ACPs are capitated providers in the CISN network that agree to provide services, without compensation, to enrollees of an insolvent CISN for up to six months after the CISN has been declared insolvent.*

* *CISNs must offer the same benefits as HMOs, except that they may make the benefits available with individual deductibles of up to $1000.*

* *CISNs are exempt from selected administrative requirements of HMOs.*

As of July 1, 1997, CISNs would no longer be permitted the provisional status and would have to meet all normal licensure requirements. The goal is to use the provisional status period to promote the development of new CISNs which will be able to remain operational after the provisional period.

While the Minnesota example serves the purpose of illustration, Virginia's approach might be very different. The key would be to identify specific HMO requirements which represent barriers to the formation of HMOs. The next step would be to identify the potential for flexibility in the requirements, and how such flexibility might be linked to the distinctive characteristics of risk-bearing community health networks. The experience from other states indicates that the process of revising licensure requirements can be extremely complex and equally controversial. The options must be evaluated to assure that consumers are protected from both the financial risk associated with HMO insolvency and the risk of reductions in quality of care stemming from a poorly managed HMO. The expertise of the Commissioner of Insurance and the Commissioner of Health would be required to make these assurances.

APPENDIX A

SENATE JOINT RESOLUTION NO. 126

Requesting the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, to continue its study of organized health services delivery systems.

Agreed to by the Senate, February 8, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, it is widely recognized that universal access to health care will be unaffordable in the absence of successful cost-containment efforts; and

WHEREAS, it is also recognized that cost containment should not be achieved at the expense of access to high-quality, necessary health care services; and

WHEREAS, various national health care reform proposals envision the use of organized health care delivery systems as a means of delivering cost-effective health care services; and

WHEREAS, a variety of organized delivery systems are developing across the Commonwealth, including hospital systems, physician-hospital organizations, health maintenance organizations, and other types of systems; and

WHEREAS, the Joint Commission on Health Care has studied organized delivery systems pursuant to Senate Joint Resolution No. 316 of the 1993 Session; and

WHEREAS, the Joint Commission on Health Care has specifically reviewed the community health network model of service delivery and financing; and

WHEREAS, this model would feature locally organized provider networks which provide patients with a continuum of health services, are accountable for costs and quality, and possibly assume insurance risk for the provision of services; and

WHEREAS, review and discussion of this model have raised a number of important questions related to the appropriate direction of health care reform in Virginia; and

WHEREAS, such questions must be resolved as part of the Commonwealth's ongoing health care reform efforts; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, be requested to continue its study of organized health services delivery systems; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, examine the following issues: (i) the value of community health network characteristics, such as local organization, managed care, accountability for costs and quality, and the assumption of insurance risk; (ii) the similarities and differences between community health networks and health maintenance organizations; (iii) the extent to which statutory and regulatory requirements for health maintenance organizations should also be applied to community health networks which assume insurance risk, particularly with respect to protection against insolvency; and (iv) the extent to which the most desirable features of the community health network model should be required of health maintenance organizations, health plans, and other modes of health care delivery and finance; and, be it

RESOLVED FINALLY, That the Joint Commission on Health Care, in cooperation with the Commissioner of Insurance and the Commissioner of Health, shall solicit input from health care purchasers, health care providers and third party payers.

The commission shall include its findings and recommendations in its 1994 annual report to the Governor and the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Appendix

Background Information On Health Maintenance Organizations In Virginia

There are four general types of HMOs:

<u>Staff Model</u>: Staff model HMOs generally own all of the clinical facilities that enrollees are required to use. Physicians are typically salaried, with all providers operating out of the same office location.

<u>Group Model</u>: Group model HMOs contract with a multi-specialty medical group which usually serves the HMO population exclusively. The physician group is typically reimbursed on a capitation basis. Internal management and payment of physicians by the medical group is independent of the HMO itself.

<u>Network Model</u>: Like group model HMOs, network model HMOs contract with independent medical groups. However, in the network model HMO, more than one group is under contract to the HMO, and it is customary that the medical groups have substantial non-HMO practices as well. As with the group model HMOs, providers in the network model are generally paid on a capitation basis.

<u>Independent Practice Association (IPA) Model</u>: Under this model, the HMO contracts with individual physicians to provide services to its enrollee population. IPAs typically reimburse physicians on a discounted fee-for-service basis (with some withholding incentive for cost containment), but also reimburse on a capitated basis for some services.

There are 21 HMOs licensed to operate in Virginia. These HMOs are operated by fifteen different companies. Fifteen operate as IPA-model HMOs, three operate as group-model HMOs, and three operate as staff-model HMOs. Seventeen operate on a for-profit basis, and four operate as non-profits. Traditionally, HMO penetration in the South has been low compared to the rest of the nation. According to the Managed Care Digest, in 1993 Virginia ranked third among the Southern states in terms of HMO penetration, with 9 percent of Virginians enrolled in HMO plans.

In Virginia and in other Southern states, there has been little HMO penetration in rural areas. Virginia HMOs operate primarily in the "urban crescent," including Northern Virginia, the Richmond area, and Tidewater. Low HMO penetration in rural areas is a national phenomenon which, according to a 1992 study by Mathematical Policy Research, may occur for several reasons:

* The low population densities and the relatively low proportion of the working population with group health insurance may make it difficult for HMOs to attract a sufficient number of enrollees to support risk-spreading and to cover fixed administrative costs.

* HMOs may have difficulty obtaining risk-sharing contracts from physicians in rural areas because there are relatively few physicians practicing in these areas, and those who do may already have a full registry of patients.

* In sparsely populated areas, staff and group model HMOs may have a difficult time enrolling a sufficient number of patients within a reasonable travel distance.

* HMOs may have difficulty negotiating discounts with isolated, rural hospitals due to their market power and poor financial position.

However, according to a recent issue of the Jenks Healthcare Business Report, HMO penetration in the South may soon be increasing. Several major HMOs have recently signed contracts to begin operations in Southern states. These organizations are being drawn by a relative lack of competition in the South, as well as projections for above-average population growth in Southern states for the coming years.

APPENDIX C

Joint Commission on Health Care

Summary Of Public Comments On Draft Issue Brief 2: Community Health Networks

Three options were presented in this report for regulatory risk-bearing community health networks:

1. Maintain the status quo, meaning that provider networks wishing to assume insurance risk would most likely have to become licensed HMOs.

2. Develop a separate statute for regulation of risk-bearing community health networks, based on the belief that they would be substantively different organizations than HMOs.

3. Amend the HMO law to accommodate the development of risk-bearing community health networks. This would involve reviewing and refining the existing HMO requirements to identify statutory and regulatory changes which could stimulate the development of HMOs with community health network characteristics.

Written comments were received from ten interested parties:

Three respondents commented that Option 3 should be considered, with certain qualifications.

Three respondents commented in favor of Option 1 (status quo) .

One respondent expressed support for the idea of risk-bearing community health networks in concept, but did not support a specific legislative option.

Three respondents did not indicate support of a specific option, but offered opinions on how community health networks might work in practice.

Specific Comments On Options For Regulation Of Community Health Networks

Blue Cross Blue Shield of the National Capitol Area

David F. Peters of the Richmond law firm of Hunton and Williams commented on behalf of Blue Cross Blue Shield of the National Capitol Area, commented that "...Community Health Networks would function much in the nature of health maintenance organizations. They should be subject to the same criteria and operating requirements applicable to HMOs."

Blue Cross and Blue Shield of Virginia

Roderick B. Mathews, Senior Vice President and Corporate Legal and Government Affairs Office for Blue Cross and Blue Shield of Virginia, commented that "BCBSVA's position is that risk-bearing community health networks' solvency requirements should be the same as those applicable to health maintenance organizations in Virginia. Accordingly, Option 1 - 'status quo' - is the preference of BCBSVA because there is no demonstrable material difference between a health maintenance organization and a community health network that justifies different solvency requirements."

Health Systems Area V Community Service Boards

The Health Systems Area V Community Service Boards (CSBs) did not state a position with regard to regulation of risk-bearing community health networks. However, the CSBs stated that the public mental health system must be adequately represented in the Joint Commission's ongoing study of organized delivery systems. The CSBs believe that Virginia citizens should have maximum choice of providers, including public sector mental health/substance abuse programs. Also, the public mental health system must "...work in a real partnership with private sector physicians, hospitals, and insurers to make sound clinical and support service transitions for patients needing extended care. No artificial barriers -- licensure, solvency, or provider exclusion - should be erected that would stand in the way of improved public-private partnerships." Finally, the CSBs stated that "Given the projections for very limited increases in tax support over the next few years, the public system must not become a dumping ground for those patients with long term needs that are beyond the scope of any health benefits package."

League of Virginia Health Systems

D. Patrick Lacy, Jr., of the Richmond law firm Hazel & Thomas, commented on behalf of the League of Virginia Health Systems. The League wrote in support of Option 3, amending the HMO law to accommodate the development of risk-bearing community health networks, subject to the following principles: (i) the networks must be adequately capitalized; and (ii) oversight of the networks should be divided between the Commissioner of Health (to assure quality) and the Commissioner of Insurance (to assure financial integrity).

Medical Society of Virginia

James A. Shield, M.D., President of the Medical Society of Virginia (MSV), commented on behalf of the MSV. Dr. Shield noted that it is unclear whether CHNs would be for-profit or non-profit entities. Dr. Shield stated that if the CHNs are to be for-profit, it is questionable whether the CHNs should be granted special regulatory treatment, and it is also questionable whether the General Assembly should legislate the composition of a for-profit entity's governing board. On the other hand, if the CHNs were to be non-profit, community-owned entities, then "...there may be legitimate policy reasons to statutorily differentiate between them and HMOs (and other private delivery systems), and the Medical Society is prepared to support legislation recognizing these legitimate legislative differentiations." Dr. Shield added that patient choice and true quality outcomes "are THE primary patient issues" in health care reform, and emphasized that outcomes data should be independently produced and reliable. (Note: At the present time, the risk-bearing CHN as proposed by the VHA is envisioned to be either a for-profit or non-profit entity.)

Medical Society of Virginia Review Organization

Terrence E. Dwyer, Executive Director of the Medical Society of Virginia Review Organization did not state a specific position on regulation of community health networks (CHNs). However, Mr. Dwyer did question whether self-reporting by CHNs would provide an adequate mechanism for maintaining accountability. Mr. Dwyer stated that self-reporting on quality may not be a sufficient standard of accountability. Mr. Dwyer cited additional concerns relating to the administrative burden of self-reporting, and the validity and utility of the data which would be reported. The MSVRO suggests that quality oversight should be conducted by an independent organization that has: (i) no role in providing health care or managing its costs; (ii) a history

of service to consumers; (iii) demonstrated cooperative relationships with the health care community; and (iv) proven expertise in quality assessment. In his letter, Mr. Dwyer provides an example of such a program from Michigan.

Virginia Association of Health Maintenance Organizations

Reginald N. Jones of the Richmond law firm of Williams, Mullen, Christian, & Dobbins, commented on behalf of the Virginia Association of Health Maintenance Organizations (VAHMO). The VAHMO "...has seen no reason to establish new statutory and regulatory provisions for a community health network separate from an HMO. However, if a separate statutory scheme is desired, the standards set for such entities should be virtually identical to those that now exist for HMOs."

Virginia Dental Association

Raleigh H. Watson, Jr., President of the Virginia Dental Association, commented in favor of legislation to immunize cooperating providers from anti-trust challenges "...so that they might develop a community health network." Mr. Watson also expressed the Association's belief that community health networks have the potential to create another desirable option in the marketplace for Virginia.

Virginia Farm Bureau Federation

C. Wayne Ashworth, President of the Virginia Farm Bureau Federation, commented that "the lack of HMO penetration in rural Virginia is indicative of the challenge it will be to develop community health networks that will be large enough to bear the risk yet (be) geographically accessible to residents." Mr. Ashworth also expressed a concern that capitated financing and the assumption of insurance risk by the provider network "...undermines the individual consumer". Mr. Ashworth did not state a specific position on the issue of regulatory requirements for community health networks.

Virginia Hospital Association

The Virginia Hospital Association (VHA) commented in favor of Option 3, wherein Virginia's HMO law could be amended to accommodate development of risk-bearing community health networks (CHNs), but "...only to the extent that this approach also addresses differences between provider-based CHNs

and insurance-based HMOs." The VHA further stated that CHNs and HMOs must meet adequate financial standards to protect purchasers and enrollees, but there are various alternative means for meeting these requirements other than a predetermined amount of cash. The VHA noted that the National Association of Insurance Commissioners is developing recommendation on a: "risk-based capital" approach in which the amount of capital needed by an entity is determined based on formulas assessing the individual degree of risk it bears. The VHA recommended that alternative approaches such as this should be examined to appropriately tailor legislation authorizing development of CHNs.

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