ACIR State Legislative Program

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Health

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Advisory Commission on Intergovernmental Relations
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FOREWORD

ACIR's Legislative Program

The Advisory Commission on Intergovernmental Relations is a permanent, national bipartisan body established by Act of Congress in 1959 to give continuing study to the relationships among local, state, and national levels of government. The Commission does not function as a typical Federal agency, because a majority of Commission members come from state and local government. The Commission functions as an intergovernmental body responsible and responsive to all three levels of government.

It should not be inferred, however, that the Commission is a direct spokesman for any single level or branch of government — whether the Congress, the Federal Executive Branch, or state and local government. Nevertheless, many of the Commission's policy recommendations are paralleled by policies of the organizations of state and local government — including the National League of Cities, U.S. Conference of Mayors, and National Association of Counties — and a substantial number of the Commission's draft legislative proposals are disseminated by the Council of State Governments in its annual volume entitled *Suggested State Legislation.* The National Governors' Conference in its report of the 67th Annual Meeting carries 38 of ACIR's legislative proposals as an appendix entitled *State Responsibilities to Local Governments: Model Legislation from the Advisory Commission on Intergovernmental Relations.*

The Commission recognizes that its contribution to strengthening the federal system will be measured, in part, in terms of its role in fostering significant improvements in the relationships between and among Federal, state, and local governments. It therefore devotes a considerable share of its resources to encouraging the consideration of its recommendations for legislative and administrative action by government at all levels, with considerable emphasis upon the strengthening of state and local governments.

ACIR's *State Legislative Program* represents those recommendations of the Commission for state action which have been translated into legislative language for consideration by the state legislatures. Though ACIR has drafted individual bills from time-to-time following the adoption of various policy reports, its suggested state legislation was brought together into a cumulative *State Legislative Program* initially in 1970. This 1975 edition is the first complete updating of the original cumulative program. It contains a number of new bills as well as major rewrites and minor updatings of previously suggested legislation.

Scope of the Legislative Program. ACIR's reports, over the years, have dealt with state and local government modernization and finances, as well as a variety of functional activities. Commission recommendations to the states, contained in these reports, have addressed all of these subjects. The suggested legislation contained in the Commission's *State Legislative Program* has been organized into ten booklets (parts) in which the draft bills are grouped logically by subject matter. The groupings for all ten booklets are listed in the summary contents of the full legislative program which follows this foreword. Then, the detailed contents of this booklet, including the title of all bills, are listed with the page numbers where they can be found.

Process for Developing Suggested Legislation. Most of the proposals in the *State Legislative Program* are based on existing state statutes and constitutional provisions. Initial drafts were prepared by the ACIR staff or consultants. Individual proposals were reviewed by state officials and others with special knowledge in the subject matter fields involved. The staff, however, takes full responsibility for the final form of these proposals.

How to Use the Suggested Legislation

The Commission presents its proposals for state legislation in the hope that they will serve as useful references for state legislators, state legislative service agencies, and others interested in strengthening the legislative framework of intergovernmental relations. Additional copies of this booklet and the other booklets in the full *Program* are available upon request. Any of the materials in the *Program* may be reproduced without limitation.

The Commission emphasizes that legislation which fits one state may not fit another. Therefore, the following advice is offered to users of the Commission's suggested state legislation.

Fit Proposals to Each State. Many states have standard definitions, administrative procedures acts, standard practices in legislative draftsmanship, and established legislation and constitutional provisions related to new proposals. These differ widely from one state to another, yet they vitally affect the drafting of new proposals for state legislation. No model legislation can possibly reflect the variations which apply in all 50 states. Thus, ACIR strongly recommends that any user of its suggested state legislation seek the advice of legislative draftsmen familiar with the state or states in which such proposals are to be introduced.

Alternative Provisions and Optional Policies. Likewise, the Commission recognizes that uniform policies are frequently not appropriate for application nationwide. Accordingly, its adopted recommendations frequently include alternative procedures and optional policies among which the states should make conscious choices as they legislate. Consequently, the suggested legislation which follows includes bracketed language which alerts the users of these materials to the choices which are to be made. In many cases, the bracketed language is also labeled as an alternative or an option. In the case of alternatives, one (or in some cases more than one) should be chosen and the others rejected. In the case of options, the suggested language may be included or deleted without reference to other provisions unless otherwise noted.

Three types of bracketed information [ ] are provided in the suggested legislation. Brackets containing *italicized* information indicate wording that is essential to the legislation, but must be rewritten to conform to each particular state's terminology and legal references. Information in regular type within brackets presents alternative or optional language. The third type of brackets contains blank space and requires the insertion of a date, amount, time span, quantity, or the like, as required by each state to comply with its individual circumstances or recommendations.

Caution About Excerpting. Frequently one provision in the suggested legislation may be related to another in the same bill. Thus, any state wishing to en-

act only certain portions of the suggested legislation should check carefully to make sure that essential definitions and related provisions are taken into account in the process of excerpting those portions desired for enactment.

ACIR Assistance

Each item of suggested state legislation in this *Program* is referenced to the ACIR policy report upon which it is based. These reports may be obtained free of charge in most cases, by writing to ACIR, and usually may also be purchased from the U.S. Government Printing Office (especially if multiple copies are required). In those cases where a policy report is out of print, copies may be found in ACIR's numerous depository libraries throughout the nation as well as in many other libraries. In addition, where copies are otherwise unavailable, the ACIR library will arrange to loan a copy.

The ACIR staff, though limited in size, is available upon request to answer questions about the suggested legislation, to help explain it to legislators and others in states where it is under active consideration, and to assist the legislative process in other appropriate ways.

Robert E. Merriam
Chairman

September 1975

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ACIR
STATE LEGISLATIVE PROGRAM

ACKNOWLEDGMENTS

The suggested state legislation in this part of ACIR's *State Legislative Program* is based largely upon existing state statutes. Robert N. Alcock acted as consultant to the Commission in tailoring these enactments to ACIR policy.

The following persons served diligently on a panel which reviewed each proposal: Richard Carlson, director of research, Council of State Governments; Honorable Charles A. Docter, Maryland House of Delegates; Marcus Halbrook, director, Arkansas Legislative Council; David Johnston, director, Ohio Legislative Service Commission; William J. Pierce, executive director, National Conference of Commissioners for Uniform State Laws; Bonnie Reese, executive secretary, Wisconsin Joint Legislative Council; Honorable Karl Snow, Utah state senator; and Troy R. Westmeyer, director, New York Legislative Commission on Expenditure Review.

The suggested legislation was also circulated in draft form to the following national organizations for their review and comment:

Council of State Governments
International City Management Association
National Association of Counties
National Conference of State Legislatures
National Governors' Conference
National League of Cities
U.S. Conference of Mayors

The Commission acknowledges the financial assistance of the U.S. Department of Housing and Urban Development in updating and publishing this new edition of the *State Legislative Program*.

The Commission is grateful to all who helped to produce this volume, but the Commission alone takes responsibility for the policies expressed herein and any errors of commission or omission in the draftsmanship.

Wayne F. Anderson
Executive Director

Part VIII

HEALTH

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INTRODUCTION

The adequacy and availability of health services is obviously of major concern to the American public. Central to the issue has been the growing belief that individuals have a right to high quality health care regardless of personal circumstances.

Two major health problems presently confronting state and local governments are the uneven distribution of available medical services and the rapidly escalating cost of adequate health care. Not only have hospitals and physicians become overly concentrated in metropolitan areas, but the quality of service often varies markedly between the large teaching hospitals of medical schools to the small community hospital. Within central cities, low income neighborhoods are especially disadvantaged in access to quality health care. For the individual, a minor hospital stay often becomes a severe strain on the family budget, and a major illness is often financially catastrophic. Increased costs also are affecting publicly funded state and local health programs. In Fiscal Year 1974, for example, state governments spent about $4.5-billion for medicaid, and in several states, local governments are required to supplement the state funds.

In its concern with two aspects of the health problem — (1) intergovernmental relations in the Medicaid program, and (2) the distribution of state aid to local government for health and hospital services — the Advisory Commission on Intergovernmental Relations has recommended several state legislative actions. First is the removal of statutory barriers against, and subsequent encouragement of, prepaid group medical practice, and second is the provision of state financial assistance to local governments for health and hospital purposes.

Following is a policy statement for the consideration of state legislative bodies with regard to the formulation of a health maintenance organization act. This is presented rather than draft legislative language because concensus has not yet developed about the best approach despite the availability of two model bills from other sources.

With respect to the second policy area, draft legislation is presented for a state supported minimum program for health and hospitals.

8.001 HEALTH MAINTENANCE ORGANIZATION ACT[1]

(Policy Statement Only)

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which would provide improved health care and would provide that health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas: (a) in many areas of the country, the *availability* of health care in terms of the quantity of manpower and facilities is inadequate; (b) even where physicians, nurses, clinics, and hospitals do exist, they may lack *accessibility* due to such factors as poor location, poor management, lack of transportation, language or racial barriers, and inconvenient hours; and (c) even if health care is available and accessible, it may not be continuous; that is, a single patient may not be treated as a person with a *continuing* or a variety of problems but rather as a single isolated health care problem incident. The problems of availability, accessibility, and continuity, at least in part, have been attributed to the lack of *responsibility* vested in one person, group, or organization to assure the delivery of health care.

A second problem is the escalating cost of health care services. This stems from the limited supply of health care service facilities which is confronted by an expanded and fragmented financing mechanism and the consequent tremendous increase of demand for such services. This is the classic model for inflation. Traditional reimbursement of providers by the Federal government, insurance plans, and hospital and medical service corporations, because of the inherent difficulties involved, has been accompanied by uneven efforts toward effective cost review or control. Furthermore, services or facilities are often duplicated or used inefficiently. A basic cause of inflation and inefficiency rests with the improper structuring of incentives. Where no individual, group, or organization is responsible for the use of more economical services and facilities, including those relating to preventive care, greater income is generated for providers by the more frequent use of services and facilities and by the use of the more expensive facilities and services available.

A third problem is the quality of health care delivered. Throughout various parts of the country, the quality of health care can range from the very best to very poor. Generally speaking, there is no locus for quality assessments either as to health care processes or health care results. In the absence of a means to measure quality, it is virtually impossible to effectively design and implement programs to rectify defects.

In its 1968 report entitled *Intergovernmental Problems in Medicaid*, the Advisory Commission on Intergovernmental Relations addressed itself to ways in which the states could broaden health services available to Medicaid beneficiaries and possibly reduce the cost of the program. One such possibility it considered was the establishment of health maintenance organizations (HMO's).

There are, of course, both pros and cons on HMO's. Protagonists claim that they facilitate the provision of better quality medical care; significantly lower the rates of hospital utilization; reap the advantages of specialization in medicine; permit development of a predictable annual cost; and can therefore serve as a mechanism for quality control. Critics, on the other hand, allege that HMO's do not always assure patient satisfaction; often must rely on the services of non-plan physicians; are relevant only in certain types of urban areas, restrict freedom of choice, and above all undermine the traditional patient-practitioner relationship.

The ACIR took no position with reference to the pros and cons of HMO's. It found, however, that many states have constitutional and legislative barriers to the establishment and operation of group practice. It was convinced that these barriers arbitrarily narrow the range of alternatives open to consumers, and unnecessarily hamper states in their search for more flexible, effective, and diverse approaches for implement-

[1]Derived from: ACIR, *Intergovernmental Problems in Medicaid*, Report A-33 (Washington, D.C.: U.S. Government Printing Office, 1968).

ing their respective health programs. The Commission therefore recommended that "states eliminate constitutional and legislative barriers to the establishment of prepaid group practice health care."

A health maintenance organization (HMO) may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by, or on behalf of, the enrollees. An HMO can be organized, operated, and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, or insurance companies. Generally speaking, an HMO delivery system is predicated on three principles. (1) It is an organized system for the delivery of health care which brings together health care providers. (2) Such arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability. (3) The payments will be made on a prepayment basis, whether by the individual enrollees, Medicare, Medicaid, or through employer-employee arrangements.

How might the HMO concept contribute to alleviating the difficulties posed by the current health care delivery system? An HMO can directly address itself to the problems of availability, accessibility, and continuity, since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus, the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentive toward lessening costs in delivering health care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses, and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment, and in general provide a monitoring mechanism.

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to, and are accepted by, the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept often contract with an insurer or other prepayment plan (*e.g.*, hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundations establish some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients' viewpoint, from the physicians' viewpoint the fee-for-service practice is maintained.

At the present time, few states have a statutory framework tailored to the supervision of health maintenance organizations. The limitations generally stem from constitutional and statutory provisions that regulate the practice of the health arts, public powers, insurance, protection of public health, and taxation. They exist in differing degrees among the states and may be classified broadly under the following categories:

> restrictions on the right to organize group practices to provide comprehensive medical care which includes, in addition to physician services, the talents of others in health professions;
>
> restrictions on the right to establish insurance or other prepayment corporations offering comprehensive health benefits;

restrictions on the right to establish organizations that combine group practice with prepayment to provide comprehensive health services;

restrictions on the right of consumers or their agents to run such organizations;

restrictions on the size of areas that might be served by group practice organizations; and

restrictions on the functioning of group health plans that arise out of the application of insurance principles to the regulation of direct service health plans.

After many years of debate and study, the Congress in 1973 enacted the *Health Maintenance Organization Act* (P.L. 93-222) which authorizes $375-million in Fiscal Years 1974-78 to aid the development of HMO's. The law requires assisted HMO's to offer enrolled members "basic health services" and provide "supplemental services" to enrollees contracting for them at additional cost per service. A supplemental service is not required if the health manpower to provide it is unavailable in an HMO's service area. Funds appropriated for the program are available to public or private non-profit entities in the form of grants for feasibility and planning studies, as well as in the form of loans for limited initial operation expenses. HMO's aided under the Federal law need not comply with state laws hindering their development or operations.

Two forms of suggested state legislation have been developed. In its 1974 issue of *Suggested State Legislation,* the Council of State Governments published a *Health Maintenance Organization Act* developed by the National Association of Insurance Commissioners. In addition, the U.S. Department of Health, Education and Welfare has developed suggested HMO legislative language, which may be obtained by writing to Dr. Frank Seubold, associate bureau director for health maintenance organizations, Bureau of Community Health Services, Room 7-39, Parklawn Building, 5600 Fisher's Lane, Rockville, Maryland 20852.

Twenty-three states have enacted specific legislation governing the formation and operations of HMO's. The specific citation for each state's law is set out following this statement. The absence of legislation, either restrictive or expeditious, as in Hawaii and Indiana, leaves HMO's to the general corporation law, statutes governing medical practice, interpretation of the insurance laws, and the interplay of economic and political forces.

When considering HMO legislation, state legislatures will almost necessarily confront a number of significant issues. The suggested acts and individual state enactments resolve these issues in varying ways. Each state must tailor its legislation to its particular needs. The following is a discussion of the issues which will be important during consideration of HMO legislation.

Issue 1. — Definition of Organization

What may be called the "plan" entity is defined, in various states, as a corporation or association which contracts with health practitioners and/or health care facilities for services to be rendered to subscribers of the corporation. Subscribers' contracts entitle them to services to be rendered at the expense of the corporation or plan, or to indemnification for services which have been rendered to subscribers, and for which the subscribers have paid. The plan organization may be required to comply with both the non-profit corporation law and the service corporation enabling act, and, where the plan functions in much the same manner as an insurer, it must comply with many provisions of the insurance code. The distinguishing characteristic of insurance type plans contrasted with the HMO model is the separation of the plan from the actual rendering of care, including liability and obligation to provide care. The insurance type plan is mostly a financing mechanism. Nevertheless, inclusion or exclusion of certain benefits in subscribers' contracts and limitation of services to licensed practitioners or facilities affects utilization patterns through financial pressure to make greatest use of included benefits, whether warranted by the medical facts or not.

Issue 2. — Problems and Limitations on Incorporation

Requirements for formal incorporation are determined by the provisions of the enabling act for service corporations and service plans. Many such organizations are to be incorporated under the general non-

profit corporation law, and some are subject, in addition, to the insurance law. Certain characteristics of incorporators are required by enabling acts, for example, residency, minimum and maximum number.

Issue 3. — Membership of Governing Body

Provisions regarding the composition and function of the governing body vary greatly among the state service corporation and service plan laws. Some laws require only the same general qualifications as to incorporators, others set out specific numbers and percentages of the board of directors to be filled by persons of certain classes, such as physicians, hospital trustees or representatives, subscribers, and the public.

Issue 4. — Approval, Certification, or Licensure of Organization

Before articles of incorporation may be filed with the secretary of state, the enabling laws of most states require approval of the commissioner of insurance, or, in a few cases, the attorney general. Certification is conditioned upon compliance with requirements of minimum amounts of working capital, contracts with providers, paid-in premiums from subscribers, or other specifications.

Issue 5. — Applicability of Insurance Laws

Restrictions on entry into the health care service market may take the form of high capital requirements or other financial responsibility mechanisms imposed by state insurance commissioners. The hospital and medical service corporation acts usually bestow at least a modicum of regulatory jurisdiction to such officers because Blue Cross and Blue Shield, although denominated service plans, are not readily distinguishable in their financial aspects from health insurance of the indemnification variety. Unfortunately, HMO's, though usually different in appearance and functions from Blue Cross and Blue Shield plans, may find themselves subject to this requirement. If so, the application of reserve and liquidity requirements may require the new HMO to raise and keep available large amounts of liquid capital which remains unused in the business. It is usually thought that the capital markets are imperfect enough that high capital requirements would be a substantial barrier to market entry.

The usual argument against applying insurance type regulation to HMO's is that, even more than Blue Cross and Blue Shield, HMO's render services in kind rather than make indemnification payments and that therefore ready cash is not so important. Nevertheless, HMO's may not be solely in the business of providing services in-house and may in fact refer a large number of their patients to fee-for-service physicians for specialized care, paying those physicians' bills when submitted. Additionally, any HMO which does not have its own hospital may be forced to pay to independent hospitals a great deal of the money that it collects in premiums. Obviously, such plans do perform an insurance type function, and it is therefore not enough to argue that they trade in services rather than indemnification. To single out such plans for special reserve requirements proportioned to their need for ready cash might be a possible compromise, but it would not solve the entry problem. These plans would remain significantly handicapped and plans seeking to provide all services in-house would have extensive organizational problems of other kinds. The net effect of such insurance regulation is a weakening of valuable potential competition from smaller enterprises.

Issue 6. — Controls on Rates and Fees

The schedules of rates to be paid by subscribers and fees to be paid to providers are generally subject to the approval of the regulating officer. In most cases, this is the commissioner of insurance.

Issue 7. — Requirement of Reserve or Financial Responsibility

As discussed above in connection with applicability of the insurance laws, reserve requirements are the usual regulatory measure of financial responsibility. State enabling acts vary greatly in the amount and specificity of required reserves.

Financial responsibility for the HMO model can be achieved by means other than large reserve and liquidity requirements. Posting of a bond which, in the event of plan failure, would cover unearned premiums and provide permanently for the then uninsurable patients might be entirely sufficient to protect the essential interests of enrollees. Also, reinsurance against bad experience can be used to reduce the risks of failure. New legislation and administrative decisions in this field should reflect consideration of reserve requirements and effects on entry possibilities to innovative health care delivery and financing plans such as HMO's.

Issue 8. — Non-Profit versus Profit Operation

The argument for allowing for-profit plans to exist is simply that their entry is essential to obtain the benefits of competition namely, better performance by *all* providers. Although it is possible that the profit (salary) potential to physicians from the formation of an ostensibly non-profit plan will stimulate a good deal of desirable competition, non-profit enterprises are not likely to provide enough of an entry threat to have a very profound effect. More often, non-profit plans will be offshoots of enterprises with a primary stake in fee-for-service medicine hospitals, medical societies, and medical schools, and will usually be oriented toward protecting established plans. Specialized regulatory control of proprietary HMO's may minimize the possible abuses some fear are inherent in for-profit operation of health care service plans, rather than outright prohibition, which denies both desirable and undesirable effects.

Issue 9. — Taxation

Non-profit service corporations and service plans are generally exempt from state and local taxes, with some exceptions for certain fees and property taxes.

Issue 10. — Constraints on Marketing

The HMO's prospects are greatly affected by its ability to quickly enroll subscribers. Access to large groups is practically essential because individual consumers cannot easily be attracted in sufficient numbers. Employment groups must be approached through the employer, which must be persuaded to offer its employees "dual choice," that is, an HMO alternative to the group health insurance already provided. A requirement that all health benefit programs offer such "dual choice" is incorporated in Federal law, and could be easily adopted at the state level, though no state has done so yet. State law will also govern the availability of Medicaid beneficiaries and members of the state employee health benefits plan as potential HMO enrollees. Federal law permits beneficiaries of Federal employee health plans to join HMO's which the Civil Service Commission contracts with or approves.

Issue 11. — Liability for Corporate or Professional Negligence; Responsibility for Provision of Care

Aside from their affect on the ability of HMO's to organize, state laws will also bear heavily on the HMO in matters relating to the quality of the care it renders, particularly its exposure to liability for professional negligence or malpractice. Quality of service issues are prominent in policy discussions about HMO's, and substantial uncertainty surrounds the potential impact, on the HMO sector, of malpractice law, which has developed primarily with respect to fee-for-service providers. Of course, the law of professional negligence remains applicable to care rendered by HMO's, and should not present problems unique to HMO's.

Issue 12. — Contracts with Other Organizations, Corporations, Agencies, Providers, Practitioners

Some provisions of law governing service corporations and service plans permit organizations to provide health care to their subscribers through contracts with other health care organizations as well as with phy-

sicians and hospitals. The organization may be required to guarantee that a certain percentage of the physicians or hospitals in the operating area have agreed to be participating providers.

Many states forbid any interference by the plan organization with the practitioner-patient relationship in matters of diagnosis and treatment.

Issue 13. — Contracts with Subscribers

Forms of subscribers' contracts are generally subject to the approval of the commissioner of insurance. Varying provisions include right of free choice of physician, coverage for dependent children after majority, and in some cases, minimum specified services which must be provided.

Issue 14. — Limitations on Activities, Investments

Some service corporations are permitted to act as agents for other service corporations, both in and out of state, for groups or organizations of health care providers, and for public agencies, to deliver health care. Many service corporations are allowed to make only those investments which are permitted to insurance companies.

Issue 15. — Restrictions on the Practice of Medicine by Corporations

The rule against corporate practice of a profession, usually judicially made and partially abrogated in many states by recent professional corporation acts, still may be invoked to prevent providers from establishing for-profit plans.

States Having HMO Legislation

Arizona	Chapter 138, *Laws 1973*
California	*Health and Safety Code* § 1175
Colorado	S.B. 230, *Laws 1973*
Florida	Chapter 72-264, *Laws 1972*
Idaho	Chapter 177, *Laws 1974*
Illinois	S.H.A. 111½, § 1401
Iowa	S.B. 25, *Laws 1973*
Kansas	H.B. 1630, *Laws 1974*
Kentucky	S.B. 254, *Laws 1974*
Michigan	M.C.L.A. § 325.901
Minnesota	Chapter 670, *Laws 1973*
Nevada	Chapter 677, *Laws 1973*
New Jersey	Chapter 337, *Laws 1973*
Oklahoma	S.B. 243, *Laws 1975*
Pennsylvania	Act 364, *Laws 1972*
South Carolina	C.L.S.C. 37-1131
South Dakota	S.D.C.L. 58-41
Tennessee	*Tennessee Code Annotated* § 56-4101
Texas	Chapter 214, *Laws 1975*
Utah	Chapter 571, *Laws 1973*

8.002 STATE EQUALIZATION OF MINIMUM PROGRAMS FOR HEALTH AND HOSPITALS[1]

The financial practices of state governments in providing public health and hospital services reveal that, with few exceptions, those states using intergovernmental transfers take no cognizance of the variations in local fiscal capacity. Equalization provisions would help to aim this state financial assistance predominantly at those jurisdictions where needs are greatest in relation to resources. At the same time, differences in local tax rates to finance comparable programs would be minimized.

Greater equalization would help the poorest areas of a state to provide more adequate personnel and facilities. Where public health and hospital facilities currently are financed from state as well as local resources, explicit recognition of variations in local fiscal capacity would provide more comparable facilities throughout the state without requiring disproportionate tax efforts in poorer jurisdictions.

The following suggested state legislation takes a minimum basic program approach to the support of public health and hospital facilities. It requires a minimum local contribution beyond which the state will "fill in" the sums necessary to maintain an adequate public health and hospital program. The bill bases the local contribution on a specified percentage of the property tax base, but leaves to the option of the local government whether to impose such a property tax levy or to obtain the funds from such other local revenue sources as may be legally available.

The draft bill *(Section 4)* lists a number of services that may be included in a comprehensive local health program. Some states may wish to exclude services relating to mental illness, narcotic addiction and drug abuse, or alcoholism, where these are separate programs administered independently of the general health program.

States considering enactment of this bill may wish to consider it in conjunction with legislation establishing a statewide health planning system or commission on rates for institutional services.

Section 1 sets forth the purpose of the proposed legislation. *Section 2* requires the state health department to prepare a local public health support plan for inclusion in the budget submitted by the governor to the legislature.

Section 3 requires each appropriate local government agency to make available any information the state health department may need to develop the local public health support plan. *Section 4* requires each local government to submit a proposed public health and hospital program budget to the state health department 60 days prior to the time budgets are finally adopted.

Section 5 requires the appropriate units of local government to budget and appropriate money to provide a comprehensive program of community health services as specified by the plan. The sum, however, shall be no more than the sum of the payments allocated from funds appropriated by the legislature for the purposes of this act plus a percentage, to be determined, of the equalized assessed valuation of taxable property. *Section 6* provides for the basis of payment of funds appropriated by the legislature for carrying out the plan.

Section 7 authorizes the state health department to make an annual evaluation of the cost effectiveness of each local health and hospital program in the state. If the costs are determined to be excessive, the commissioner of the state health department shall notify the local governing body of his findings and recommendations for reducing costs. If the local governing body fails to comply, the commissioner shall allow to that local government only the amount of money from state funds that would have been the amount allowed if the recommendations had been effected. *Section 8* allows any appropriate local government to use its own funds to supplement health services supported by state funds, and provide additional health services.

Sections 9 and 10, respectively, provide for separability and effective date clauses.

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[1]Derived from: Advisory Commission on Intergovernmental Relations, *State Aid to Local Government,* Report A-34 (Washington, D.C.: U.S. Government Printing Office, April, 1969).

[AN ACT PROVIDING FOR AN EQUALIZING STATE MINIMUM SUPPORT PROGRAM FOR COMPREHENSIVE COMMUNITY HEALTH SERVICES AND FACILITIES]

(Be it enacted, etc.)

SECTION 1. *Purpose.* It is the purpose of this act to provide state financial support for a joint state-local comprehensive community health program on an equalizing basis that takes into account both the relative need and the fiscal capacity of each [*appropriate local government*]. The [*legislature*] finds that equalized assessed valuation of property is a suitable basis for determining local fiscal capacity and that needs for health services and facilities can best be determined by the [*state health department*] on the basis of a continuing statewide survey and analysis of state and local health programs.

SECTION 2. *Local Public Health Support Plan.* On the basis of surveys and analyses of local general public health and hospital needs, the [*state health department*] shall prepare a *Local Public Health Support Plan* for inclusion in the budget submitted by the governor to the [*legislature*]. The plan shall set forth the requirements of an adequate public health and hospital program for each [*appropriate local government*] and shall recommend the amount of state funds to be allocated to each [*appropriate local government*] which, when added to [ ] percent of the equalized assessed valuation of property subject to taxation in the local jurisdiction, will provide the amount required for an adequate local public health program. The *Local Public Health Support Plan* shall include, but shall not be limited to, the following services:

(a) public health administration and research laboratories, education, statistics, nursing, and other general health activities;

(b) categorical health programs such as control of cancer, tuberculosis, mental illness, and maternal and child health;

(c) environmental health programs such as inspection of water supply, food handling establishments, health examinations of individuals, sanitary engineering, water pollution control, and other activities for eliminating or abating health hazards;

(d) immunization, treatment clinics, crippled childrens' services, and school health services;

(e) medical vendor payments not identified with public assistance programs;

(f) establishment and operation of hospitals, nursing homes, and intermediate care facilities and institutions for care and treatment of the handicapped, provision of hospital care, nursing home care, and intermediate care facility services, and support of other public or private hospitals;

(g) narcotic addict clinics and rehabilitation facilities;

(h) alcoholism prevention, treatment, and control;

(i) home health care; and

(j) [*other specified public health services*].

SECTION 3. *Local Units to Provide Information.* Upon request of the [*commissioner*] of the [*state health department*], the [*chief executive officer*] of each [*appropriate local government*] shall provide any information, including financial records, which the [*commissioner*] requires for the development of the *Local Public Health Support Plan.*

SECTION 4. *Local Budget to be Submitted.* [Sixty] days prior to the time budgets are finally adopted, the [*local governing body*] in each local government shall submit a proposed public health and hospital program budget to the [*state health department*]. The [*commissioner*] shall consider the proposed budget and return it with his recommendations to the [*local governing body*] within [30] days. If the [*local governing body*] fails to change its proposed budget to incorporate the recommendations in the budget as finally adopted, the [*commissioner*], after affording the [*local governing body*] an opportunity to be heard, may withhold from that local government all or any part of the funds appropriated by the [*legislature*] to carry out the provisions of this act.

SECTION 5. *Local Appropriations.* Each [*appropriate local government*] shall budget and appropriate money to provide a comprehensive program of community health services as specified in the *Local Public Health Support Plan;* provided, however, that no [*appropriate local government*] shall be required by the provisions of this act to appropriate for this purpose more than the sum of the payments allocated from funds appropriated by the [*legislature*] for the purposes of this act, percent of the equalized assessed valuation of taxable property.

SECTION 6. *Basis for Payments.* From the funds provided by the [*legislature*], the [*commissioner*] of the [*state health department*] shall authorize payments to be made to each [*appropriate local government*] to carry out as nearly as may be the *Local Public Health Support Plan.* The [*commissioner*] shall notify the [*state disbursing officer*] of the amounts allocated to each [*appropriate local government*] and shall notify the [*appropriate officer*] of each local government of the amount allocated to it. The [*state disbursing officer*] shall make [quarterly] payments to the local governments of the amounts so allocated.

SECTION 7. *Annual Evaluation of Costs; Reduction of State Aid.*[1] The [*commissioner*] of the [*state health department*] shall review annually each local health and hospital program in the state to determine if the costs are in excess of what is reasonably necessary to maintain in an efficient manner an adequate general public health program. If the [*commissioner*] finds that costs are excessive in any

[1]States having a commission on rates for institutional services should require the commissioner to notify the commission of his findings and recommendations.

[*appropriate local government*] receiving funds pursuant to Section 5 of this act, he shall notify the [*local governing body*] of his findings and recommendations for reducing costs and, after 30 days' notice, shall conduct a public hearing in the locality on his findings and recommendations. Upon completion of the hearing, the [*commissioner*] may set a reasonable period of time, not to exceed [one year], for the [*local governing body*] to comply with his recommendations for reducing costs. If, at the end of the designated period of time, the [*local governing body*] has failed to comply, the [*commissioner*] from that time on shall allow to that local government only the amount of money from state funds that would have been the amount allowed if the recommendations had been effected. The [*commissioner*] shall report to the governor and the [*legislature*] his findings and recommendations, the results of public hearings, and the amount of state funds withheld from any [*appropriate local government*] pursuant to this section.

SECTION 8. *Local Supplements.* Any [*appropriate local government*], with the use of its own funds, may provide other local health services in addition to those supported by state funds, and may supplement the health services supported by state funds.

SECTION 9. *Separability.* [*Insert separability clause.*]

SECTION 10. *Effective Date.* [*Insert effective date.*]

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The Advisory Commission on Intergovernmental Relations (ACIR) was created by the Congress in 1959 to monitor the operation of the American federal system and to recommend improvements. ACIR is a permanent national bipartisan body representing the executive and legislative branches of Federal, state, and local government and the public.

The Commission is composed of 26 members — nine representing the Federal government, 14 representing state and local government, and three representing the public. The President appoints 20 — three private citizens and three Federal executive officials directly and four governors, three state legislators, four mayors, and three elected county officials from slates nominated by the National Governors' Conference, the Council of State Governments, the National League of Cities/U.S. Conference of Mayors, and the National Association of Counties. The three Senators are chosen by the President of the Senate and the three Congressmen by the Speaker of the House.

Each Commission member serves a two year term and may be reappointed.

As a continuing body, the Commission approaches its work by addressing itself to specific issues and problems, the resolution of which would produce improved cooperation among the levels of government and more effective functioning of the federal system. In addition to dealing with the all important functional and structural relationships among the various governments, the Commission has also extensively studied critical stresses currently being placed on traditional governmental taxing practices. One of the long range efforts of the Commission has been to seek ways to improve Federal, state, and local governmental taxing practices and policies to achieve equitable allocation of resources, increased efficiency in collection and administration, and reduced compliance burdens upon the taxpayers.

Studies undertaken by the Commission have dealt with subjects as diverse as transportation and as specific as state taxation of out-of-state depositories; as wide ranging as substate regionalism to the more specialized issue of local revenue diversification. In selecting items for the work program, the Commission considers the relative importance and urgency of the problem, its manageability from the point of view of finances and staff available to ACIR and the extent to which the Commission can make a fruitful contribution toward the solution of the problem.

After selecting specific intergovernmental issues for investigation, ACIR follows a multistep procedure that assures review and comment by representatives of all points of view, all affected levels of government, technical experts, and interested groups. The Commission then debates each issue and formulates its policy position. Commission findings and recommendations are published and draft bills and executive orders developed to assist in implementing ACIR policies.