

**HB**

**300**

# FISCAL NOTE

STATE OF ALASKA  
1998 LEGISLATIVE SESSION

BILL NO. HB 300

Revision Date (2/17/98) \_\_\_\_\_ Dept. Affected Commerce & Economic Development  
 Title An Act relating to Health Insurance BRU Insurance  
 Component Insurance  
 Sponsor Representative Bunde  
 Requester House HES Component Serial No. 354

**Expenditures/Revenues** (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY98) cost: 0.0

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

This bill has no fiscal impact on this component.

Prepared by Marianne K. Burke, Director *Marianne K. Burke* Phone 465-2515  
 Division Insurance Date 2/17/98  
 Approved by Commissioner Deborah B. Sedwick *Deborah B. Sedwick* Date 2-18-98  
 Agency Commerce and Economic Development

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# HOUSE COMMITTEE REPORT

(7)  
Date Referred to Committee: January 12, 1998

FURTHER REFERRALS: Labor and Commerce

Date of Committee Action: 2/24/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 300

HOUSE BILL NO. 300

HEALTH CARE INSURANCE

"An Act relating to health insurance; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB 300 (HES)  the same title  a new title

additional referral to \_\_\_\_\_ Committee  
 attached amendment(s)

ADOPTS: \_\_\_\_\_ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) \_\_\_\_\_


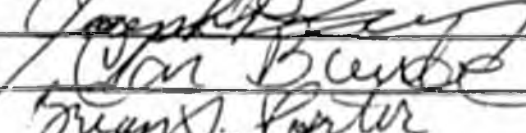
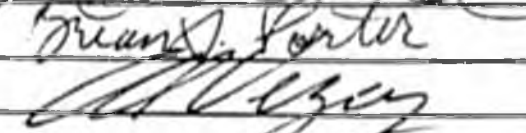
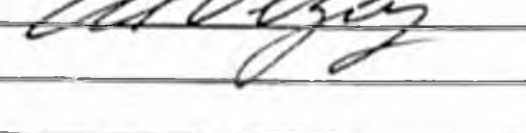
APPROVES PREVIOUS: (Dept/Date) \_\_\_\_\_

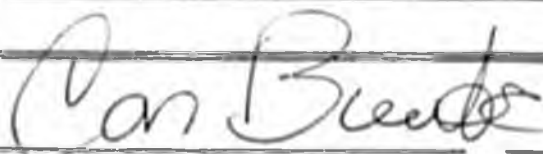
fiscal note(s) \_\_\_\_\_

fiscal note(s) \_\_\_\_\_

zero fiscal note(s) CED

zero fiscal note(s) \_\_\_\_\_

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
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CHAIR'S SIGNATURE 

## CHANGES CONTAINED IN CSHB 300 ( )

The title is changed to reflect the emphasis of the bill, which is patient's rights.

Sect. 1 is changed, adding a new short title section that reflects the emphasis of the legislation.

Sect. 2 (b) is changed to require physician to physician contact in cases where a patients is denied care, reduced care, or terminated health care benefits.

The remainder of the bill is the same.

CS FOR HOUSE BILL NO. 300( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVES BUNDE, James

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to patients' rights under health insurance; relating to review of  
2 health insurance treatment plans; prohibiting certain health insurance practices."

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

4 \* Section 1. SHORT TITLE. This Act may be known as the Alaska Patients' Bill of  
5 Rights.

6 \* Sec. 2. AS 21.42 is amended by adding a new section to read:

7 Sec 21.42.390. Required health insurance coverage provisions. (a) A  
8 health care insurer may not include in the health care insurance plan or contract a  
9 provision that

10 (1) prohibits a covered person from obtaining health care services from  
11 a health care provider of the person's choice, including a specialist;

12 (2) restricts a covered person's right to receive full information from  
13 the person's health care provider regarding the care or treatment options that the health  
14 care provider believes are in the best interests of the person.

1 (b) A health care insurer may not deny, reduce, or terminate health care  
2 benefits for a covered person unless the denial, reduction, or termination is approved  
3 by a physician who is licensed to practice in the United States.

4 (c) A health care insurer may not

5 (1) directly or indirectly reimburse a covered person at a different rate  
6 because of the person's choice of provider;

7 (2) deny coverage, cancel a health care insurance plan or subscriber  
8 contract, or otherwise take action against a covered person or a health care provider  
9 because the person has asserted a right described under this section.

10 (d) A covered person may bring a civil action against a health care insurer to  
11 enforce the person's rights under this section.

12 (e) In this section,

13 (1) "health care provider" means a person licensed in this state to  
14 provide health care services;

15 (2) "health care services" means treatment of an individual for an  
16 injury, illness, or disability and includes preventative treatment of an injury or illness.

# Alaska State Legislature

**CHAIR**  
HOUSE HEALTH, EDUCATION  
& SOCIAL SERVICES COMMITTEE

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**MEMBER**  
LEGISLATIVE BUDGET & AUDIT COMMITTEE  
HOUSE SPECIAL COMMITTEE ON OIL & GAS  
SELECT COMMITTEE ON LEGISLATIVE ETHICS



**REPRESENTATIVE CON BUNDE**

District 18

*DURING SESSION*  
STATE CAPITOL, ROOM 104  
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(907) 465-4843 (800) 892-4843

*DURING INTERIM*  
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(907) 258-8168

*E-MAIL*  
Representative\_Con\_Bunde@legis.state.ak.us

## SPONSOR STATEMENT

### House Bill 300

"An Act relating to health insurance; and providing for an effective date."

Often, insurers use health care consumers as trading chips in order to obtain services for a lower price. The problem is that the patients involved don't know that they have been traded until they come to use the service, then many times, they become aware that they are not able to go to the provider of their choice.

HB 300 protects the rights of health care consumers to choose appropriate medical care. This legislation prohibits insurers from reimbursing a covered person at a different rate because of the person's choice of health care provider.

SPONSOR STATEMENT

**ALASKA PHARMACEUTICAL ASSOCIATION**

Box 101185 Anchorage, Alaska 99510  
(907) 563-8880

Jan. 16, 1998

Representative Con Bunde  
House of Representatives  
Juneau, Alaska

Dear Representative Bunde,

We have received a copy of House Bill 300 that you have introduced. The Alaska Pharmaceutical Association appreciates your effort to support patients freedom of choice in health care. We look forward to working with you to move this legislation forward

Please feel free to contact me in Ketchikan at 907-225-6186 or you may contact our Executive Director, Erin Carey-Byrne, at our Association office at the above numbers. In addition, we are represented by our lobbyist Geoff Bullock in Juneau

Sincerely,

Barry Christensen  
Chair, Legislative Committee  
Alaska Pharmaceutical Association

SUPPORT

2/11/98

Karen Coombs-Marcey  
6301 Bubbling Brook  
Anchorage, AK 99516

Representative Con Bunde  
Room 104  
State Capital  
Juneau, AK 99801

Dear Representative Bunde:

As a constituent of your district and an individual who has been involved in health care in the state of Alaska since 1981, I am writing in support of HB 300. There are many reasons why HB 300 is needed and makes sense in Alaska. The three main reasons are access, patient rights and economics.

Access to health care remains a primary problem in Alaska. Alaska has a small population base, spread out over a large geographic area, with few health care providers. Many "larger" towns lack basic services. Dutch Harbor does not have a physician, Bethel does not have a pharmacy. The State of Alaska needs to support the inclusion of all current and prospective health care providers in insurance contracts to increase accessibility, not limit or eliminate it. Also, many insurance companies only want to contract with "national providers", especially for pharmacy or infusion services. GEHA wants their patients to use Apna for infusion services, but Apria's infusion business in Alaska lasted less than a year. The State of Alaska employee who lives in Sitka is expected to get prescriptions at Fred Meyer's in Juneau. And this is just the beginning of "managed care".

Every patient should have the right to make decisions that effect their health and well-being, without intrusion. A patient should be able to receive complete information regarding treatment options available to them and should be allowed to choose the health provider(s) that meet their needs. The method by which insurance companies try to second guess medical decisions made between a patient and his physician, is a direct violation of that individual's rights and a direct threat to their health. An insurance agent negates a patient/physician decision from thousands of miles away, often with no medical background and without even knowing the patient.

Economics is the third issue. Many myths abound about the "cost savings" of restrictive health care systems. Cost savings should be more correctly referred to as revenue shifting; insurance companies and their intermediaries have increased revenue, health care providers have decreased revenue and patients' expenses can go up or down.

**\*Myth 1: Specialist care costs more.**

In actuality, **specialist care is more cost effective.** This can be documented in a number of journal articles and in awarded capitated contracts in both cancer and HIV/AIDS care, by both private insurance and Medicaid. Where capitated contracts are awarded to Specialist Clinics because they are more cost effective, and achieve better outcomes.

**\*Myth 2: Restrictive drug formularies or decreased access saves money.**

Susan Horn's study, which originally was designed to show that restrictive drug formularies decreased costs, actually ended up showing that **over all health care costs are significantly increased with strict drug formularies and decreased access.** Once again insurance companies may increase their profits by owning the PBM and accessing drug rebates.

**\*Myth 3: Consolidation or merging health care providers are more cost effective and hence reduce health care costs.**

Alaska should pay attention to what's happened outside as the push for managed care works its way into our state. **Competition is what brings prices down.** As the Anchorage Daily News reported last week, what is happening in larger cities, where managed care pressure has caused providers to merge and become one, they have been left with only 1 or 2 providers and now even the HMO's that cause this phenomenon, are unable to stop the large increases that the remaining providers are demanding. Who can they turn to? There is no one left. Remember, even Anchorage only has 2 hospitals...the minimum requirement for competition!

We need HB300 to protect the health of all Alaskans. Without it, we will be at the mercy of insurance companies, who don't know or understand our state and are not looking out for the health of anyone but their stockholders or "non-profit" CEO's. Please do not hesitate to call me, if you would like copies of journal articles or published studies mentioned above.

Thank you,



Karen Coumba Marcuy

# Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

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February 17, 1998

Honorable Con Bunde  
State of Alaska  
House of Representatives  
Health, Education, and Social Services Committee  
Room 106, Capital  
Junction, Alaska

RE: HB 300

Dear Representative Bunde:

The Alaska State Medical Association (ASMA) represents nearly 500 private practice physicians and their patients. Thank-you for the opportunity to provide commentary on HB 300.

ASMA's governing body, the House of Delegates, has long supported the concept of a patient's reasonable choice in the physician that provides his or her medical care. This concept is included in HB 300.

ASMA's interest in any health care plan focuses on what impact it would have on the quality of medical care and the patient/physician relationship. Generally, the physician community is interested in assuring that:

1. patients have a reasonable choice in which physician provides their health care;
2. patients have a clear understanding of all material benefits and restrictions involved with any health plan;
3. each physician desiring to participate as a contracted provider of care has a fair opportunity to do so;
4. any physician contract criteria, contracting procedures, and contract termination be on a fair and equitable basis;
5. any utilization review or medical necessity determination be accomplished on a peer review basis; and finally
6. patients aren't unreasonably denied benefits after receiving emergency care in a hospital or other emergency facility.

Section 1 of AS 21.42.390 (b) provides that a utilization review or review of a treatment plan must be done by a licensed health care provider. It is not clear that such review must be done by a peer. ASMA suggests this language be modified to make this clear. The same "peer" approach was adopted in HB 98, the tort reform measure, enacted last year in regards to expert witness qualifications (see AS 09.20.185).

Thank you for this opportunity.

Sincerely,



By: Kevin Tomera, MD, President

For: Alaska State Medical Association  
Board of Trustees

cc: Representative Joe Green, Vice Chair, HESS  
Representative Fred Dyson, HESS  
Representative Brian Porter, HESS  
Representative AJ Vezev, HESS  
Representative Tom Brice, HESS  
Representative Allen Kempler, HESS

# Does Managed Care Really Save Money?

By David S. Hiltzenrath

A Washington Post Staff Writer

**W**hen Charles W. Turner underwent a coronary triple bypass at Washington, D.C.'s Georgetown University Hospital in December 1992, the hospital was paid \$28,113.

When Shelby A. Fowler had the same operation at the same hospital less than three months later, the hospital was paid only \$10,297.

Turner, a retired road construction worker from rural Loudon, Md., was covered by a traditional fee-for-service insurance plan, which paid the hospital's full charges. Fowler, an engineer at a high-tech company in Tysons Corner, Va., was covered by a health maintenance organization, which paid a negotiated fee.

The hospital said it made a profit of \$12,181 on Turner but lost \$7,160 on Fowler because the deal it made with Fowler's HMO amounted to a below-cost discount. Georgetown lost \$62 million during its past fiscal year on inpatients covered by HMOs and other managed care plans that received discounts, the hospital says.

The story of Turner and Fowler, and a broader analysis of Georgetown Hospital's finances over a one-year period, show how many HMOs and other health insurance plans that are cited as models of cost effectiveness save money largely by shifting costs to their insurers.

**PRIVATE INSURANCE COMPANIES** have long complained about cost shifting, by which they pass on extra charges they pay to make for the money hospitals lose treating uninsured patients and are covered by government insurance programs for the poor and disabled.

Now many private health plans—chiefly those run by managed care companies and big employers—benefit from a new form of cost shifting in which they receive discounts while other private insurers pay inflated rates for sick-care services.

The discounts may look as if they are helping to solve a nation's problem of rising medical costs. But many critics, including the Congressional Budget Office, say they merely redistribute the burden of paying for health care.

"You can't give everyone a discount," says health economist Harold S. Luft of the University of California at San Diego.

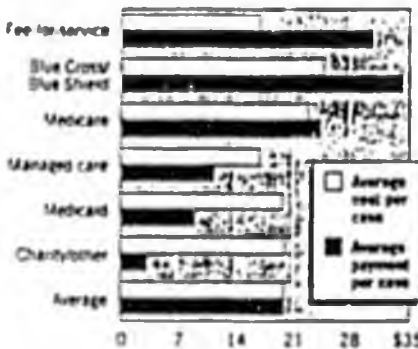
No portion of discount prices works only as long as certain can compensate by cutting costs, lowering prices or raising somebody else's charges, industry analysts say. And hospitals are running out of ways to raise somebody else's, because HMOs and other

## SHIFTING THE COSTS

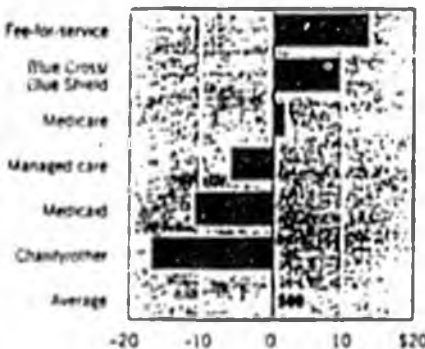
Some health insurers pay more than others for hospital care. Here's a look at Georgetown University Hospital's inpatient business in its 1993 fiscal year, broken down by insurance type.

### CORONARY BYPASS OPERATIONS

The hospital's cost per procedure was similar for each group, but actual payments varied widely... IN THOUSANDS OF DOLLARS



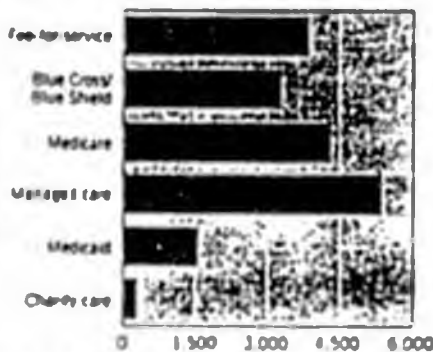
...so its average profit per case was far greater for patients with traditional insurance coverage AVERAGE PROFIT PER CASE, IN THOUSANDS OF DOLLARS



### ALL INPATIENT BUSINESS

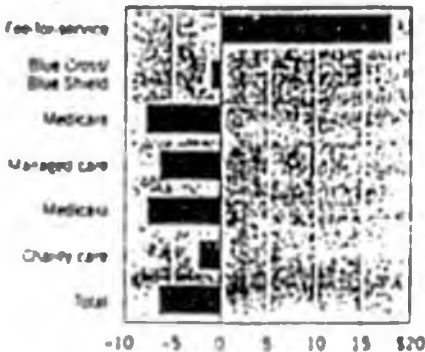
While only a minority of patients had traditional fee-for-service coverage...

1993 INPATIENT ADMISSIONS



...these patients were the sole major group on which the hospital made a profit

PROFIT OR LOSS, IN MILLIONS



SOURCE: Georgetown University Hospital

NOTE: Managed care patients are defined as those whose health plans have negotiated special rates with Georgetown. Fee-for-service patients are defined as those who, along with their health insurers, are obligated to pay Georgetown's full charges. Charity inpatient figures are based on 232 patients who underwent the procedure without cardiac catheterization, a related diagnostic test.

types of managed care are rapidly expanding their share of people covered by private insurance.

If the Georgetown example is any guide, the reliance of many health plans on discount prices poses two challenges for health care in the United States:

■ As HMOs and other plans that benefit from discounts grow, people already enrolled in those plans could find their insurance costs rising in relation to other people's premiums, because they could be forced to assume costs now shifted to others.

■ For the same reason, a new national health care system designed to save money by steering people into large purchasing groups, such as the systems proposed by President Clinton and many lawmakers, could experience an "erosion of diminishing returns."

Unlike traditional insurance plans, which provide the same coverage wherever their members seek treatment, HMOs and other managed care plans steer patients to approved doctors and hospitals that accept discounted rates.

Admission of HMOs, which coordinate patients' care

through medical gatekeepers, discounts can lead to lasting savings for all patients because it drive hospitals to operate more efficiently.

They say HMOs also save other ways, such as by emphasizing preventive medicine, controlling patients' access to expensive medical specialists, cutting down on unnecessary surgery, reducing hospital stays, and by urging the use of more cost-effective treatments.

"There is a tremendous potential savings from quality management and emphasis on prevention," says Karen Ignagni, president of Group Health Associates of America Inc., an HMO lobby.

However, a recent study by the Healthcare Leadership Council health care industry group that supports managed care, found that those medical management techniques account for only about a fifth of the savings that the most popular form of HMO offers over typical fee-for-service insurance.

The remaining 78.9 percent of the network-style HMOs' savings result from discounts from insurers and hospitals, according to the study, prepared by HMR research firm Lewis-VIII Inc. and based on internal data from Arts Health Businesses.

Many health care networks known as preferred provider organizations rely almost entirely on discounts for their cost advantage.

**GEORGETOWN, A LARGE** teaching hospital, knows all too well what discounts do in the network of cost shifting.

Georgetown finished its most recent fiscal year, which ended June 30, \$4.7 million in the red even though it made a profit of \$17.9 million on inpatients who had fee-for-service insurance.

That profit was erased by the \$62 million the hospital lost on managed care inpatients, combined with millions of dollars of losses on Medicare, Medicaid, Blue Cross/Blue Shield and charity care inpatients.

Although the hospital made an average profit of \$4.64 each time it admitted a fee-for-service patient, it lost an average of \$1,139 each time it admitted a managed care patient to the hospital.

Georgetown lost almost three times as much money on inpatient managed care as the \$2.1 million it lost on inpatient charity care.

Differences in patients' needs or treatments may account for part of the gap between Georgetown's profit on fee-for-service business and its loss on managed care. But the overriding explanation appears to be that the two groups paid different prices, as reflected in data on more than 700 surgeries done at Georgetown provided at The Washington Post's request.

For example, among 202 Georgetown patients undergoing the coronary bypass operation without cardiac catheterization,

# Health Policy

BY STEVE KALMEYER

## Guardians of patient care



**A**bsent major federal health-care legislation, most health policy took place in statehouses in 1997. Patient consumer protection topped a legislative agenda that also included hospital conversions, partial-birth abortions, expanding Medicaid to include more children, medical savings accounts, workers compensation and gag clauses.

The granddaddy of them all, however, was patient protection, especially for participants of managed care organizations. While not as comprehensive in regulating managed care organizations as some would have liked, the bills suggest a trend toward states being a watchdog over the growth of managed care.

In January 1997, nine states introduced a Managed Care Consumer Protection Act based on a model created through Women in Government, a bipartisan educational association. Nine Democratic and Republican state lawmakers in the group developed the model bill for states to establish consumer protection and quality-of-care standards for managed care organizations. Colorado, Kansas, New Jersey, Oregon and Texas passed versions similar to the model in 1997. Delaware, Georgia, Ohio and Tennessee should address pending legislation this year.

Additional patient protection legislation focused on banning gag clauses. At least 17 states addressed contractual clauses that prohibit doctors in managed care contracts from disclosing certain medical information to patients. Several states also included legislation that banned incentives for physicians to not refer patients to certain specialists or perform certain procedures. States looking to implement a similar measure have praised Kansas' S.B. 204. The Kansas law prohibits gag clauses in managed care contracts, bans incentives that might keep physicians from referring patients to specialists for further care, requires continuity of care provisions for terminated enrollees and requires the establishment of grievance procedures. Montana, Utah and Wyoming passed laws that focus exclusively on banning gag clauses.

At least 15 states passed legislation requiring managed care organizations to have written

standards for both utilization review and grievance procedures. Most notable are Connecticut's H.B. 6883, Missouri's H.B. 335 and New Hampshire's S.B. 122. Connecticut requires the commissioners of the departments of Insurance and Public Health to develop and distribute annual consumer report cards on all managed care organizations, beginning in 1999. The Missouri bill requires health maintenance organizations to develop procedures to allow an enrollee who needs ongoing care from a specialist to receive that care without first obtaining a referral from a primary care physician for each visit.

At least seven states passed legislation under which subscribers can select from among different delivery systems, including HMO, preferred provider organizations or fee-for-service when needed, rather than choosing between delivery systems during open enrollment periods at places of employment. Iowa's H.B. 133 requires carriers that offer a limited network plan with small employers to offer a point-of-service option allowing such choice. Large employers must offer a point-of-service plan in which the price is actuarially determined, a managed care plan that does not limit providers or an indemnity plan.

Virginia may consider similar proposals in 1998. Lawmakers in 1997 passed H.J.R. 631, which created a task force to explore point of service options for Virginia's businesses. The task force included legislators, consumers, providers, businesses and insurers. The state's Joint Commission on Health Care will submit its findings and recommendations to the governor and the 1998 General Assembly.

The federal government also is following the health advisory commission route. President Clinton, who in March 1997 appointed an Advisory Commission on Consumer Protection and Quality in the Health Care Industry, announced a Health Care Consumer Bill of Rights in late November 1997. While it has made only recommendations so far, the commission has received mixed reviews. Some states view it as federal intrusion, while others see it as a watered-down version of several state laws already in place.

In 1998, state officials should look for federal legislation that would set a national standard for ensuring quality care. To ensure that progress in patient protection continues, an open dialogue with providers, consumers, payers and government officials of all levels will be necessary. □

*Steve Kalmeyer is a health policy analyst with Program, Policy and Membership Services, The Council of State Governments.*

*Source:*

# Major State Health Care Policies

## Fifty State Profiles, 1997

by  
Health Policy Tracking Service

444 North Capitol Street, N.W., Suite 515  
Washington, D.C. 20001

31st Edition  
January 1998

Table 5. Managed Care: Major Legislated Strategies

State	HMO Penetration	Any Willing Provider	Blam On Gag Clauses	Direct Access	Freedom Of Choice	Hold Harmless	Independent Review	Point Of Service
Total No. of States	—	21 states	41 states	33 states <sup>1</sup>	20 states	13 states	13 states	11 states
Alabama	9.8	✓ pharmacy, pharmacist		✓ OB/GYN	✓ pharmacy, pharmacist			
Alaska	—							
Arizona	28.8		✓				✓	
Arkansas	8.7	✓ broad—does not apply to ERISA plans	✓	✓ OB/GYN, optometrist, ophthalmologist				
California	43.8		✓	✓ OB/GYN*			✓	
Colorado	31.1		✓	✓ OB/GYN				
Connecticut	34.7	✓ pharmacy	✓	✓ OB/GYN	✓ practitioner in the healing arts in a health care center		✓	
Delaware	18.8	✓ pharmacist	✓	✓ OB/GYN	✓ pharmacy			
Florida	29.0	✓ independent pharmacy—accountable health partnerships only	✓	✓ OB/GYN*, dermatologist	✓ independent pharmacy—accountable health plan only		✓	
Georgia	12.7	✓ broad—applies only to Blue Cross Blue Shield	✓	✓ OB/GYN, dermatologist	✓ pharmaceutical services			✓
Hawaii	25.0							
Idaho	4.3	✓ broad	✓	✓ OB/GYN	✓ pharmacy	✓		✓
Illinois	17.1	✓ non- and national providers, broad—limited to Public Act		✓ OB/GYN				
Indiana	11.9	✓ hospital, physician, pharmacists or other providers designated in IC 27-8-6-1	✓	✓ OB/GYN*				

<sup>1</sup> OB/GYN: 2; medical specialist: 1; chiropractor: 2; optometrist/ophthalmologist: 1; dermatologist: 2; APNs under the worker's compensation act: 1

Table 5. Managed Care: Major Legislated Strategies

State	HMO Penetration	Any Willing Provider	Bans On Gag Clauses	Direct Access	Freedom Of Choice	Hold Harmless	Independent Review	Point Of Service
Iowa	4.6				✓ pharmacy			✓
Kansas	11.5		✓					
Kentucky	27.4	✓ broad		✓ chiropractor	✓ chiropractor			
Louisiana	14.7		✓	✓ OB/GYN	✓ pharmacy, pharmacist	✓		
Maine	15.9		✓	✓ OB/GYN, chiropractor				
Maryland	18.0		✓	✓ OB/GYN	✓ pharmacy	✓		✓
Massachusetts	44.6	✓ pharmacy	✓					
Michigan	23.5		✓	✓ OB/GYN				
Minnesota	32.7		✓	✓ OB/GYN			✓	✓
Mississippi	2.4	✓ pharmacy, pharmacist		✓ OB/GYN	✓ pharmacy, pharmacist			
Missouri	30.2		✓	✓ OB/GYN		✓	✓	
Montana	3.1		✓	✓ OB/GYN*, APNs under the worker's compensation act*	✓ broad-disability insurance only			✓ HMOs with at least 10,000 enrollees
Nebraska	15.4		✓	✓ OB/GYN*				
Nevada	20.8		✓	✓ OB/GYN				
New Hampshire	23.9	✓ pharmacy	✓			✓		
New Jersey	27.5	✓ pharmacy, pharmacist	✓	✓ OB/GYN*, medical specialist*	✓ pharmacy, pharmacist		✓	✓
New Mexico	21.0		✓	✓ OB/GYN			✓	
New York	35.7		✓	✓ OB/GYN, medical specialist		✓		✓ individuals
North Carolina	14.6	✓ pharmacy	✓	✓ OB/GYN	✓ pharmacy			

Health Policy Tracking Service

Table 5. Managed Care. Major Legislated Strategies

State	HMO Penetration	Any Willing Provider	Bans On Gag Clauses	Direct Access	Freedom Of Choice	Hold Harmless	Independent Review	Point Of Service
North Dakota	1.7	✓ pharmacy, pharmacist	✓		✓ pharmacy, pharmacist	✓		
Ohio	17.6		✓				✓	
Oklahoma	12.4		✓		✓ pediatric medicine, psychology and clinical social work			✓ groups > 49
Oregon	47.2		✓	✓ OB/GYN		✓		✓ groups > 25
Pennsylvania	29.9		✓					
Rhode Island	11.6		✓	✓ OB/GYN		✓	✓	
South Carolina	8.4	✓ pharmacist			✓ pharmacy, pharmacist			
South Dakota	3.5	✓ pharmacy, pharmacist			✓ pharmacy			
Tennessee	15.3		✓			✓	✓	
Texas	15.3	✓ pharmacy, pharmacist	✓	✓ OB/GYN, medical specialist*	✓ pharmacy, pharmacist	✓	✓	✓ limited to dental groups > 24
Utah	40.7		✓	✓ OB/GYN				
Vermont	0.0		✓	✓ OB/GYN		✓	✓	
Virginia	15.7		✓	✓ OB/GYN	✓ pharmacy	✓		
Washington	25.1		✓	✓ OB/GYN				
West Virginia	9.4		✓	✓ OB/GYN*				
Wisconsin	24.9	✓ pharmacist	✓					
Wyoming	0.4	✓ any Wyoming provider	✓					

\* These states do not provide direct access but instead allow the designation of specified providers as primary care physicians

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build protections into their Medicaid managed care programs, most of which target children and pregnant women on Aid to Families with Dependent Children.

As the year wound down, compliance with the new Title XXI children's health insurance program—a five-year, \$24 billion federal block grant approved as part of the Balanced Budget Act signed by President Clinton on Aug. 5, 1997—became Topic A for states in order to qualify for their share of the funds. In a few instances, plans were submitted to the Health Care Financing Administration (HCFA) or, at the least, approved by the legislature before the year ended. But with most sessions in adjournment when the law was signed, the issue is likely to take a significant amount of time when lawmakers get back to business in 1998.

Sandwiched in between was a wide range of issues with which legislatures had to acquaint themselves, from nonprofit hospitals and Blue Cross and Blue Shield plans seeking to "convert" to for-profit status to balancing the promises of genetic testing against the possibility of discrimination in health insurance, from physician-assisted suicide to licensure reform, from keeping tobacco out of the hands of youngsters to finding less costly, more consumer-friendly options to nursing home care for elderly and disabled citizens. Here are some highlights of the year, followed by an in-depth report on 10 key policy areas.

### Finance: Managed Care and More

If you had to sum up the most contentious health care issue of the year in just two words, "managed care" would do. In response to consumers' angst about the limits that managed care imposes on the ability to choose a physician and to providers' anger about what they perceive as their ebbing control over patient care to insurance industry "greenshades," 17 states enacted comprehensive laws regulating health plans, while two (New Jersey and New Mexico) issued rules to do the same. That number supplements 13 laws modeled on either the American Medical Association's Patient Protection Act or the Managed Care Consumers' Bill of Rights that were adopted between 1994 and 1996. Designed "to assure fairness to patients and providers," the AMA model requires states to develop standards for certifying managed care plans; spell out utilization review safeguards; and set forth coverage options for patients, including a "point-of-service" option for going outside of the plan for care, subject to higher out-of-pocket costs. The bill of rights, developed by the Public Education Fund of New York, is a more consumer-oriented model with provisions addressing access, choice, quality, confidentiality and nondiscrimination, appeals and so on.

**Comprehensive Reforms:** The 1997 batch of bills addressed an even broader range of issues, including access (e.g., direct access, point-of-service options), bans on gag clauses, consumer grievance and appeals procedures, credentialing and certification, privacy of medical records, disclosure of financial incentives and plan solvency. On access—arguably the most important issue to consumers—for example, 32 states now have laws or regulations that give women in managed care plans direct access to their OB/GYNs, either by letting them bypass a referral from a primary care gatekeeper or by designating an OB/GYN as their primary care physician. A 1997 Florida law also grants direct access to dermatologists and a Montana law to advanced practice nurses under the state's workers compensation act. And New Jersey and Texas joined New York this year in providing direct access to specialists, when an enrollee's medical condition warrants. In addition, 11 states now offer the *point-of-service* option, though often with limits, to people who are willing to pay more out of pocket to see out-of-plan providers (Maryland, New York and Oregon, 1995; Georgia and Minnesota, 1996; and Idaho, Iowa, Montana, New Jersey, Oklahoma and Texas, 1997). Plan use of "gag clauses," or contract language that doctors maintain prohibits them from discussing treatment options and other plan practices with patients, also

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**Overview**

continued to command considerable attention. In 1997, 21 states moved to ban use of gag clauses, on top of 20 going into the year.

**Mandated Benefits:** The issue of plan coverage of emergency services and maternity and mastectomy hospital stays also garnered continued attention, either as part of the comprehensive reforms or as stand-alone bills. At the end of 1996, 6 states had approved laws that mandate coverage of emergency room visits that meet the "prudent layperson" test—that is, if an individual could reasonably infer that the condition that took them to the ER was, in fact, an emergency. In 1997, another 17 followed suit with laws, while New Jersey and New Mexico addressed the issue through regulations. Since 1995, 41 states (17 of them in 1997) also have moved to mandate extended coverage for hospital stays for mothers and newborns, to avoid a trend toward "drive-thru deliveries," or discharge after 24 hours or less. Since March 1997, states also have moved to discourage "drive-thru," or outpatient mastectomies, by requiring plans to cover inpatient hospital care for mastectomies (13 laws) and/or reconstructive breast surgery (17 laws) for a length of time determined appropriate by the attending physician. Mandated coverage for treatment, education and supplies for diabetes was another popular theme of the year (see Pharmaceuticals section).

**Insurer Liability:** Should managed care plans be liable for medical malpractice if a decision to delay or deny care on grounds it is not medically necessary results in harm to the patient? States grappled with that question in 1997 as they sought to respond to physician and patient pressure to curb the power of the managed care industry. Traditionally, health insurers have been protected by state laws banning "the corporate practice of medicine," which means the patient's only recourse is to sue under a "vicarious liability" theory. The present mood in many states, however, is to extend the scope of malpractice liability beyond individual practitioners to insurance carriers and plans themselves. A Texas law enacted in May without the governor's signature was the first to let patients who say they've been harmed by a plan's decision sue for malpractice. (Almost immediately, insurers filed suit on grounds that the law is preempted by the Employee Retirement Income Security Act (ERISA), a 1974 federal law that exempts self-insured plans from state insurance regulation.) In addition, seven states (Idaho, Louisiana, Missouri, New Hampshire, North Dakota, Tennessee and Texas) approved legislation that bans the inclusion of indemnification, or "hold harmless," clauses that prohibit a provider from shifting liability to an insurer in contracts between the two parties.

**ERISA:** From mandated benefits to high-risk insurance pools to the malpractice question, ERISA continues to be a thorn in the sides of state legislators and insurance regulators. While the federal preemption provision was intended to allow multistate companies to maintain uniform benefits plans across state lines, the effect has been to severely circumscribe state regulation of self-insured plans, which now encompass an estimated 40 percent of insured workers. And, while states have regularly tested the limits of ERISA through both statute and regulation, court rulings on the issue have tended to be variant and piecemeal, which means that any real "fix" will have to come from Congress. In 1996, Congress made a gesture toward broadening the ERISA tent by extending provisions of the Health Insurance Portability and Accountability Act (HIPAA) as well as two clinical mandates (mental health parity and inpatient care after childbirth) to both self- and commercially-insured firms. The trend toward further federal mandates is likely to continue—post-mastectomy hospital stays and regulation of managed care plans are already on tap—but that is something of a mixed blessing for states, which would much prefer that ERISA itself be modified to give them greater regulatory control over the self-insured market.



# National Organization of Physicians Who Care

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## Dissatisfied Physicians

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More and more physicians are allying themselves with managed care organizations in order to keep patients or attract new, insured patients. But a survey of 1,710 physicians finds that many of them believe managed care -- such as that provided by health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point-of-service (POS) plans -- has had a negative impact on their ability to care for patients and their satisfaction with medical practice.

PPOs are plans through which a sponsoring group negotiates price discounts with health care providers in exchange for patients. Members of POS plans can use an HMO provider and have full coverage or go out of their provider network and have part of the cost of their treatment covered.

Among the findings of the survey, taken in 1995 and only recently made public:

- Nearly two in five physicians (38 percent) report that their ability to make the right decisions for their patients has declined in the past three years.
- Forty-one percent report a decrease in the amount of time they spent with patients over the previous three years.
- Almost half of those in plans that pay providers either a discounted price or a fixed annual amount per patient (capitated plans) rate their ability to get necessary treatment for patients -- through referrals, for example -- as fair or poor, and almost two-thirds (62 percent) rate their ability to get immediate approval for care as low.
- Sixty percent report very serious or somewhat serious problems with external review and with limitations on their clinical decisions.

By contrast, among the physicians in traditional fee-for-service plans, nearly two-thirds say they have encountered no serious problems in referring patients to their choice of specialists, and 57 percent have had no serious problems with reviews of clinical decisions prior to a patient's receiving care.

*Source: Karen Scott Collins et al., "The Commonwealth Fund Survey of Physician Experiences with Managed Care," March 1997, Commonwealth Fund, One E. 75th Street, New York, NY, (212) 535-0400.*

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