

**SB**

**299**

# ALASKA STATE SENATE



Session:  
State Capitol  
Juneau, Alaska 99801-1182  
(907) 465-2327  
(907) 465-5241 Fax

Interim:  
119 N. Cushman, Suite 201  
Fairbanks, Alaska 99701  
(907) 456-8161  
Senator\_Ralph\_Seekins@legis.state.ak.us

**Senator Ralph Seekins**  
District D

## MEMORANDUM

Date: February 14, 2006

To: Office of Senator Dyson

*As for RS.*

From: Senator Ralph Seekins

Re: Request for Scheduling of SB 299

---

Attached please find Senate Bill 299 along with a concomitant sponsor statement.

Senate Bill 299 incorporates into Alaska law "any willing provider" language allowing individuals to make their own choices regarding health care providers so long as the service provider is willing to abide by the network terms, conditions and pay scale.

I respectfully request this bill be scheduled for a hearing in the Health, Education & Social Services Committee at your earliest convenience.

Thank you.

# ALASKA STATE SENATE



Session:  
State Capitol  
Juneau, Alaska 99801-1182  
(907) 465-2327  
(907) 465-5241 Fax

Interim:  
119 N. Cushman, Suite 201  
Fairbanks, Alaska 99701  
(907) 456-8161  
Senator\_Ralph\_Seekins@legis.state.ak.us

**Senator Ralph Seekins**  
District D

## **Senate Bill 299 Sponsor Statement**

**“An Act relating to preventing unfair discrimination against a health care provider who is willing to meet a health insurer’s terms and conditions for participation in the insurer’s plan, policy, or contract for health care services; amending the definition of ‘provider’ as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans.”**

Alaska Statute 21.36.090(d) pertains to unfair discrimination against a person who provides services covered under a group health insurance plan. This law comes into play as a function of the relationship between health care providers and group health care systems. Recently the U.S. Supreme Court upheld Kentucky’s “any willing provider” (AWP) law. The language used in this law essentially offers a more robust alternative to Alaska’s current law.

Senate Bill 299 repeals AS 21.36.090(d) and replaces it with case tested AWP language. The move towards AWP verbiage also required a change to the definition of “health care provider”. In so doing, the original definition as it’s used in Title 23 –Labor and Workers’ Compensation – had to be restored. This can be found in Section 2 of the Bill.

Essentially, the AWP concept promotes the individual’s ability to choose his or her own health care provider rather than have this decision be directed via a process far removed from the point of contact. The AWP law says that a health insurer cannot discriminate against any provider who is willing to meet the terms and conditions for participation established by the health insurer assuming the provider is located within the geographic coverage area of the health benefit plan.

The AWP issue is especially pertinent in cases where, for example, a woman, in her second trimester of pregnancy, changes jobs. In this instance she may also be forced to change health care providers if her current provider is not recognized by her new health insurance plan. This same scenario also applies in cases where a person takes a job but the pool of physicians offered by the employer’s health care plan does not include the individual’s long-time family doctor.

In both cases, if the patient’s non-network physician is willing to accept the network fee schedule – and meets the insurance company’s licensing and credentialing standards – the patient should be able to continue to see their known and trusted doctor rather than be forced to establish a relationship with a new and unknown physician.

Senate Bill 299 adopts into Alaska law the “any willing provider” concept thereby promoting and preserving Alaskan’s ability to make their own choices with respect to health care providers.

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: SB 299  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Commerce  
 Title Nondiscrimination Health Care Providers RDU Insurance (116)  
 Component Insurance Operations  
 Sponsor Seekins  
 Requester Senate HES Component No. 354

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

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
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>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES ( )</b>						
-------------------------------	--	--	--	--	--	--

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
<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 (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

This legislation addresses unfair discrimination against a health care provider who is willing to meet a health insurer's terms and conditions for participation in the insurer's plan, policy or contract for health care services. It also amends the definition of provider as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director  
 Division: Insurance  
 Approved by: William C. Noll, Commissioner  
 Agency: Commerce, Community, and Economic Development

Phone: 907-269-7900  
 Date/Time: 2/21/06 5:21 PM  
 Date: 2/21/2006

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: SB299-LAW-C&FB-2-22-  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: LAW  
 Title "An Act relating to preventing unfair discrimination RDU CIVIL  
against a health care provider who is willing to meet a health..." Component Commercial & Fair Business  
 Sponsor Senator Seekins  
 Requester Senate Health, Education and Social Services Component No. \_\_\_\_\_

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

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
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>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES ( )</b>						
-------------------------------	--	--	--	--	--	--

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
<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 (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

This bill repeals AS 21.36.090(d) relating to prohibiting discrimination against health care providers by health insurers, and reenacts it to emphasize that discrimination against a provider is prohibited when the provider is located in the geographic coverage area of a health plan and will to meet the terms and conditions established by the insurer.

Passage of this legislation will have no fiscal impact on the Department of Law.

Prepared by: Kathryn Daughhete, Director Phone 465-3673  
 Division Administrative Services Division Date/Time 2/22/06 11:05 AM  
 Approved by: Kathryn Daughhete for David Márquez, Attorney General Date 2/22/2006  
 Agency Department of Law

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: SB 299  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Commerce  
 Title Nondiscrimination Health Care Providers RDU Insurance (116)  
 Component Insurance Operations  
 Sponsor Seekins  
 Requester Senate HES Component No. 354

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

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
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>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES ( )</b>						
-------------------------------	--	--	--	--	--	--

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
<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 (FY2006) cost: 0.0  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

This legislation addresses unfair discrimination against a health care provider who is willing to meet a health insurer's terms and conditions for participation in the insurer's plan, policy or contract for health care services. It also amends the definition of provider as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director Phone 907-269-7900  
 Division: Insurance Date/Time 2/21/06 5 21 PM  
 Approved by: William C. Noll, Commissioner Date 2/21/2006  
 Agency: Commerce, Community, and Economic Development



## Alaska Senate Bill 299

### Any Willing Provider Provisions

**JIM ASHTON**  
Business Manager/  
Secretary-Treasurer

**ROBERT JOHNSON**  
President

**HEADQUARTERS**  
2510 Arctic Blvd.  
Anchorage, Alaska 99503  
FAX (907) 279-7171  
(907) 276-7211

2122 Airport Way  
Fairbanks, Alaska 99701  
FAX (907) 456-1771  
(907) 452-5024

710 West 9th Street  
Juneau, Alaska 99801  
FAX (907) 586-5757  
(907) 586-6993

SB299 would impact the ability of health plans to obtain favorable negotiated discounts for health care services, because it would open up the health plan's provider network to all providers willing to meet the terms and conditions for participation established by the health insurer.

The increase in health care costs due to AWP statute would likely reduce the number of employers offering health insurance to their employees, or reduce the benefits provided by employers or health plans.

The definition of "health insurer" is sufficiently broad to impact many health plans throughout Alaska, including non-ERISA plans. There is an open question about the extent of ERISA preemption in this area.

#### **Impact: Health plan costs would increase.**

- Health plans are currently able to negotiate discounted fees from health providers (hospitals, physicians, pharmacies, and other service providers) because they are able to deliver directed patient volume to contracted providers and reduce administrative burden. This results in a mutually beneficial contractual relationship between providers and health plans.
- Health plans include differential payment provisions to encourage participants to use preferred providers who have agreed to negotiated discounts, thus increasing the preferred provider's volume. In order to obtain the most favorable provider discounts, health plans agree to utilize differential payment provisions.
- Small employers have a low elasticity of demand to price increases in health insurance. As the price of offering health insurance increases, employers will drop (or not offer) coverage to their employees. This resulting burden of additional uninsured consumers in the market will have a compounding effect on the price of health care in Alaska.
- Other employers would be forced to either increase costs to their employees or reduce the benefits provided.

#### **Opposition to "Any Willing Provider" provisions**

##### **1) Health plan costs would increase:**

- According to a study by Michael Vita, health care “expenditures are higher when AWP laws are enacted.” Michael G. Vita, “Regulatory Restrictions on Selective Contracting: an Empirical Analysis of “Any-Willing-Provider” Regulations, *Journal of Health Economics* 20 (2001) 955-966.
- In an April 8, 2004 letter to the Attorney General of Rhode Island and Deputy Majority Leader of the Senate of Rhode Island, the Federal Trade Commission commented on Any Willing Provider provisions with respect to pharmacy contracting, “Because any pharmacy would be entitled to contract on the same terms as all other pharmacies, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals. Because all other pharmacies can ‘free ride’ on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus ‘any willing provider’ requirements may substantially reduce competition among pharmacies...Such strategies may actually reduce the options available to consumers without providing any additional consumer benefit.”
- Local provider contracting experience also indicates that any willing provider requirements would increase health plan costs.
  - A recent preferred provider hospital request for proposal (RFP) demonstrated that significantly better discounts were offered when the health plan offered a plan with differential preferred provider (PPO) plan provisions as opposed to a passive PPO arrangement.
  - A recent pharmacy benefits management RFP demonstrated that reducing the pharmacy provider network (selectively contracting) decreased the negotiated rates for pharmacy services
- The National Association of Health Underwriters, in their October 2003 Analysis of State-Level Health Insurance Market Reforms, found that one of the key components to health insurance market stability was the ability of plans to develop appropriate networks and to be able to effectively negotiate discounts with those providers. According to their analysis, “Several states have enacted measures that make it difficult for plans to develop a comprehensive and effective network of providers. For example, a number of states require health plans to accept any willing provider who meets their plan criteria into their networks...Any willing provider mandates may seem like they would benefit consumers, since they allow the greatest number of providers into a plan, but these laws actually have a serious negative consequence. Since any doctor who wishes to participate with a plan can, it makes it much harder for carriers to negotiate any discounts with providers, since there is no financial consequence for non-participation. This leads to higher medical reimbursement costs for all plans in the states, which translates into higher insurance rates for consumers.”

- The Federal Trade Commission (FTC) has taken a strong stand in opposition to any willing provider provisions. The Federal Trade Commission and Department of Justice report, *Improving Health Care: A Dose of Competition*, July 2004, states,
  - “Commission staff has expressed concerns about AWP (Any Willing Provider) and FOC (Freedom of Choice) laws, noting that they could have anticompetitive effects and harm consumers. These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that would likely result from restricted provider networks. They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand. These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans.”
  - “Many provider groups support AWP and FOC legislation. Commission staff observed in its most recent advocacy letter that “several scholars have noted that any willing provider and ‘freedom of choice’ laws are **more likely to appear in states with limited managed care penetration**, and suggested that these provisions are actually intended to preempt competition among providers [provider protection], instead of protecting the interest of patients.” [emphasis added]
  - “When insurers have a credible threat to exclude providers from their networks and channel patients elsewhere, providers have a powerful incentive to bid aggressively. Inclusion in a restricted panel offers the provider the prospect of substantially increased revenue. Without such credible threats, however, providers have less incentive to bid aggressively, and even managed care organizations with large market shares may have less ability to obtain low prices.”
  - The FTC Staff letter to Rhode Island, which was excerpted in the FTC/DOJ report, stated, “Empirical evaluations of any willing provider and ‘freedom of choice’ provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider /freedom of choice laws spent approximately 2% more on healthcare than did states without such policies.”

## 2) Fewer small employers will offer health insurance due to AWP legislation

- The FTC further predicts the number of employees covered by health insurance will drop in the presence of anticompetitive conduct advanced by AWP legislation. The Federal Trade Commission and Department of Justice report, *Improving Health Care: A Dose of Competition*, July 2004, states,

- “When anticompetitive conduct increases prices, it makes it more difficult for many Americans to obtain needed care. Estimates of the price elasticity of health insurance vary, but many small employers do not offer health insurance at all because it is too expensive. When employers offer health insurance, price increases can result in limitations on coverage, employees refusing to sign up for insurance, and employers dropping coverage.”
- According to a study published in the *Journal of Human Resources*, if monthly premiums to firms increased by \$1, the proportion of firms offering health insurance to employees would decrease by almost 2 percentage points. Roger Feldman, et al., “The Effect of Premiums on the Small Firm’s Decision to Offer Health Insurance,” 32 *Journal of Human Resources* 635 (1997).

We believe that in a market like ours with almost no penetration of managed care, AWP legislation will harm consumers through an increase in the price of health care and a decrease in the availability of employer-sponsored health plans.

AMENDMENT \_\_\_\_\_

OFFERED IN THE SENATE HESS COMMITTEE  
FOR SB 299

Page 1, lines 21-22

delete all material

renumber section accordingly.

# Improving Health Care: A Dose of Competition



any mandated benefits.<sup>185</sup> According to several panelists, mandates increase premiums and decrease wages and other benefits employers might otherwise offer.<sup>186</sup>

Other commentators assert that state-imposed mandated benefits disproportionately affect small businesses because they are less able to avoid the costs of such mandates by self-insuring.<sup>187</sup> Although determining the actual cost of an individual mandated benefit can be difficult, the aggregate cost of such mandates appears to account for a substantial percentage of premium cost.<sup>188</sup>

Finally, some commentators have noted the behavioral economic arguments in favor of mandated benefits are theoretical, and not based on empirical evidence

---

<sup>185</sup> Knettel 6/25 at 73-75 (noting that each time a benefit is mandated that mandate "is going to be offset by a benefit reduction of equal or greater cost in some other area"). See also Sloan & Conover, *supra* note 172.

<sup>186</sup> See T. Miller 6/25 at 64 (noting that mandates "can also have offsetting effects in terms of lower wages, decreased employment, reduced generosity of fringe benefits as well"). See also Gitterman 6/25 at 18; T. Miller 6/25 at 57.

<sup>187</sup> As the costs of mandates rise, more firms seek to self-insure to avoid the added expense of state mandates, but some smaller businesses do not have the necessary capital to do so. See Jensen & Morrissey, *supra* note 172, at 10. As stop-loss insurance with low attachment points has made self-insurance available on a broader basis, this problem has become less significant.

<sup>188</sup> See Kanwit 6/25 at 37; Gitterman 6/25 at 15 ("One of the things that you have seen in the 1996 mental health parity debate is the incredible wide range of estimates from each of these different consulting groups. I think the costs were somewhere between zero and 8 percent.").

regarding the performance of the health insurance market.<sup>189</sup> Mandate proponents presented no evidence that consumers demand insufficient health insurance, and there is some evidence that many consumers actually demand excessive health insurance.<sup>190</sup> Mandate proponents presented no evidence that government intervention is likely to improve the efficiency of health insurance benefit design, and there is some evidence to the contrary.<sup>191</sup>

### 3. Any Willing Provider and Freedom of Choice Legislation: A Case Study of Mandates

Any willing provider (AWP) laws require managed care companies to include in their networks any provider that is willing to participate in the plan in accordance with the plan's terms.<sup>192</sup> Freedom of choice (FOC) laws are similar to AWP laws, but are directed at consumers instead of providers.<sup>193</sup> Many states have adopted AWP and/or FOC laws for at least some

---

<sup>189</sup> See generally 6/26 at 6-105; Hyman, *supra* note 177, at 234-36.

<sup>190</sup> The substantial tax subsidy for employment-based health insurance encourages broader and deeper insurance coverage than would otherwise be the case. Pauly 2/26 at 98; Clark Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 69-71 (2002).

<sup>191</sup> See generally Hyman, *supra* note 177.

<sup>192</sup> Michael Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of "Any Willing Provider" Regulations*, 20 J. HEALTH ECON. 955, 956 (2001).

<sup>193</sup> See, e.g., *id.* ("[F]reedom of choice (FOC) laws . . . obligate plans to reimburse for care obtained from a qualified provider even if the provider is not a member of the network")

health care providers.<sup>194</sup>

Commission staff has expressed concerns about AWP and FOC laws, noting that they could have anticompetitive effects and harm consumers.<sup>195</sup> These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that likely would result from restricted provider networks.<sup>196</sup> They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in

---

<sup>194</sup> See, e.g., *id.* ("By one count, 34 states had enacted some form of FOC or AWP law by 1996").

<sup>195</sup> See FTC staff comments on proposed legislation that incorporated any willing provider or "freedom of choice" provisions in the following states: Rhode Island (Letter from Office of Policy Planning et al., to Patrick C. Lynch, Attorney General (Apr. 8, 2004)), at <http://www.ftc.gov/os/2004/04/ribills.pdf>; Massachusetts (Letter from Bureau of Competition, to John C. Bartley, Representative (May 30, 1989)); New Hampshire (Letter from Office of Consumer & Competition Advocacy, to Paul I. Alfano (Mar. 17, 1992)); California (Letter from Office of Consumer & Competition Advocacy, to Patrick Johnston, Senator (June 26, 1992)), at <http://www.ftc.gov/opa/2004/04/04/calpharm.htm>; Montana (Letter from Office of Consumer and Competition Advocacy, to Joseph P. Mazurek, Attorney General (Feb. 4, 1993)); New Jersey (Letter from Office of Consumer and Competition Advocacy, to E. Scott Garrett, Assemblyman (Mar. 29, 1993)); Pennsylvania (Letter from Office of Consumer and Competition Advocacy, to Roger Madigan, Senator (Apr. 19, 1993)); South Carolina (Letter from Office of Consumer and Competition Advocacy, to Thomas C. Alexander, Representative (May 10, 1993)); and Nevada (Letter from Bureau of Competition, to David A. Gates, Commissioner of Insurance (Nov. 5, 1986)).

<sup>196</sup> See, e.g., FTC Staff letter to Rhode Island, *supra* note 195, at 6; Greenberg 6/12 at 68-69.

response to consumer demand.<sup>197</sup> These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans.

As Commission staff explained in its most recent advocacy letter on this issue,

Empirical evaluations of any willing provider and "freedom of choice" provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider/freedom of choice laws spent approximately 2% more on health care than did states without such policies. This finding likely reflects the fact that these laws reduce the ability of insurers to offer less expensive plans with limited provider panels. This interpretation is supported by another study that found that metropolitan areas with a high intensity of any willing provider/freedom of choice regulation had HMO market shares approximately 7% lower than comparable areas without these provisions. "Freedom of choice" provisions reduced HMO market share more than any willing provider laws.<sup>198</sup>

---

<sup>197</sup> See *supra* note 196.

<sup>198</sup> FTC Staff letter to Rhode Island, *supra* note 195. See also Michael A. Morrissey & Robert L. Ohsfeldt, *Do State 'Any Willing Provider' and 'Freedom of Choice' Laws Affect HMO Market Share?*, 40 INQUIRY 362 (2003/2004).

Many provider groups support AWP and FOC legislation.<sup>199</sup> Commission staff observed in its most recent advocacy letter that "several scholars have noted that any willing provider and 'freedom of choice' laws are more likely to appear in states with limited managed care penetration, and suggested that these provisions are actually intended to preempt competition among providers [provider protection], instead of protecting the interest of patients."<sup>200</sup>

#### 4. Potential Responses to the Demand for Mandated Benefits

As the number of mandated benefits has risen, sensitivity to their cost ramifications has increased. The Unfunded Mandates Reform Act discourages Congress from imposing unfunded mandates on other

governmental entities.<sup>201</sup> The states have developed a variety of strategies to weigh the costs of mandated benefits, with varying degrees of success.<sup>202</sup>

There are four basic models for mandatory review processes: (1) use of an independent standing health care commission or legislative advisory commission/interim committee; (2) use of an administrative agency; (3) use of legislative research or fiscal staff; and (4) use of proponent prepared and submitted assessments to the legislative committee.<sup>203</sup> Each model has procedural variations in the review process including how the bills are referred for evaluation and the specific requirements of the impact analysis. Some of the models may be more credible and provide more objective information than others.

*Conclusion.* For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay marginal cost. This task is challenging under the best of circumstances – and

---

<sup>199</sup> See, e.g., Gene A. Blumenreich, *United States Supreme Court upholds "any willing provider" statutes*, 71 AANA J. 259 (Aug. 2003) (Legal Brief of American Ass'n of Nurse Anesthetists), at <http://www.aana.com/legal/legbrfs/2003/pdfs/p259-262.pdf>; American Medical Ass'n, *H-285.984 Any Willing Provider Provisions and Laws* (AMA policy re: "Any Willing Provider" laws, including opposing federal preemption of state AWP laws), at [http://www.ama-assn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policyfiles/HnE/H-285.984.htm](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-285.984.htm) (last visited June 25, 2004); National Community Pharmacists Ass'n, *High Court Upholds State Any Willing Provider Laws* (from AMERICA'S PHARMACIST, May 2003), at [http://www.ncpanet.org/leg\\_gov/notes\\_from\\_capitol\\_hill/2003/may.shtml](http://www.ncpanet.org/leg_gov/notes_from_capitol_hill/2003/may.shtml)

<sup>200</sup> FTC Staff letter to Rhode Island, *supra* note 195. But see Blumenreich, *supra* note 199 (noting that the American Association of Nurse Anesthetists (AANA) supports AWP legislation, arguing that these laws prohibit insurance companies from discriminating against them).

---

<sup>201</sup> CONGRESSIONAL BUDGET OFFICE, CBO'S ACTIVITIES UNDER THE UNFUNDED MANDATES REFORM ACT, 1996-2000 (2001), available at <ftp://ftp.cbo.gov/28xx/doc2843/UMRA-Paper.pdf>. Unfunded Mandates Reform Act (UMRA) of 1995, Pub. L. No. 104-4, 109 Stat. 48. The UMRA requires the Congressional Budget Office (CBO) to prepare an analysis of the direct costs of any mandates and an assessment of whether the bill authorizes or otherwise provides funding to cover the costs of the mandate.

<sup>202</sup> Gitterman & Nordyke, *supra* note 179.

<sup>203</sup> Gitterman 6/25 at 12-13.



JAN 15 2005

LUTIANA SWIGER  
SECRETARY

ENVIRONMENTAL AND PUBLIC PROTECTION CABINET  
OFFICE OF LEGAL SERVICES  
INSURANCE LEGAL DIVISION  
JULIE MIX MCPEAK  
GENERAL COUNSEL  
P. O. BOX 517  
FRANKFORT, KY 40602-0517  
TELEPHONE: 502-564-6032  
TELEFAX: 502-564-1456

January 10, 2005

David Wroten  
Assistant EVP  
Arkansas Medical Society  
P.O. Box 55088  
Little Rock, AR 72215

RE: Cost of Any Willing Provider Legislation

Dear Mr. Wroten:

This letter is in response to your request for information regarding the cost implications of Any Willing Provider ("AWP") legislation in Kentucky. As I stated in a previous e-mail to you, I researched the issue of cost while writing my Merits Brief for the United States Supreme Court and in preparation for oral argument before the Court. I was unable to find conclusive evidence that AWP legislation has increased cost for Kentucky insureds.

As part of my research, I consulted with our in-house actuary who informed me that he saw no increases in insurers' rate filings attributed to AWP. Although cost was irrelevant to the ERISA preemption argument made by the Kentucky Association of Health Plans, the health plans relied on the cost argument heavily during the six or more years of litigation on the issue. Therefore, I addressed the issue in footnote 7 of the Department's Merits Briefs (previously forwarded to you via e-mail).

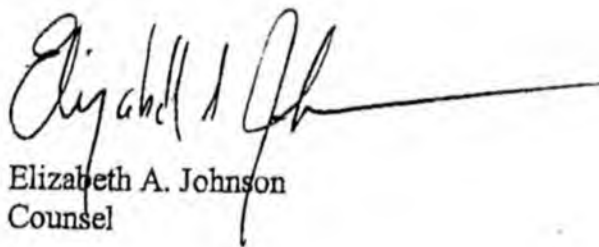
The Robert Wood Johnson Foundation funded a study to determine the effects of Any Willing Provider Laws. The research team made preliminary findings that AWP laws had no affect on managed care plans "or the premiums paid by employers." See attachment 1. A follow-up to the Robert Wood Johnson Foundation study was done on the impact of AWP and Freedom of Choice Laws on HMO Market Share. (See attachment 2). I think it is interesting that Drs. Morrissey and Ohsfeldt question whether certain studies have overestimated the impact of AWP laws. (See pages 19-20, "If these estimates were accurate, one would have expected to see press reports of HMOs leaving

A handwritten signature, possibly "J.M.", written in black ink.

at least some states because of the enactment of the laws."'). This observation is similar to the one made by Justice Ginsburg during oral argument in the KAHP v. Miller case. (Attachment 3, Justice Ginsburg pointing out that these laws have been around for some time). I could not find anything to substantiate the 15% increase in cost referred to by Mr. Eccles in his response to Justice Ginsburg.

In short, I have found no conclusive evidence that Kentucky's AWP laws have affected healthcare costs in this state.

Sincerely,

A handwritten signature in cursive script, appearing to read "Elizabeth A. Johnson", followed by a long horizontal line extending to the right.

Elizabeth A. Johnson  
Counsel

Attachments

DIRECTIVE: 2-2005

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS, ACCIDENT AND HEALTH INSURANCE COMPANIES, ACCIDENT AND HEALTH INSURANCE AGENTS, THE ARKANSAS MEDICAL SOCIETY, THE ARKANSAS HOSPITAL ASSOCIATION, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: ARKANSAS' "ANY WILLING PROVIDER" LAWS

DATE: JULY 15, 2005

The Department issues this Directive to advise all health maintenance organizations ("HMOs") and accident and health insurers conducting business in this state about compliance with Arkansas' Patient Protection Act of 1995 and recent "Any Willing Provider" ("AWP") legislation passed by the Arkansas State Legislature in 2005, in light of a recent decision by the 8th Circuit Court of Appeals ("8th Circuit") on June 29, 2005 in Prudential Insurance Co., et al. v. HMO Partners, Inc., et al., U.S.C.A. No. 04-1465/04-1644 ("Prudential II"). This decision will ultimately apply Arkansas' 1995 AWP Law to insured ERISA ("Employee Retirement Income Security Act") plans and non-ERISA health plans.

In 1995, the Arkansas State Legislature ("Legislature") enacted Acts 505 ("To Ensure Consumer Choice of Health Care Provider") and 1193 ("An Act To Assure The Gatekeeper System Is Preserved And Existing Contracts Are Not Impaired Under The Provisions Of The Patient Protection Act Of 1995"). These two Acts combined are the "The Patient Protection Act of 1995" ("1995 PPA") that required a health care insurer to accept a medical provider in the health insurer's medical network, if the provider agreed to the insurer's terms and conditions. However, before the 1995 PPA became effective, various parties successfully brought suit to prevent the Act's enforcement. Since its inception, the 1995 PPA has been before the courts and has never been enforced.

In 2005, the Legislature passed several new AWP statutes. Act 490 ("Patient Protection Act of 2005") provided a new AWP law designed to become effective only if the courts ultimately hold the 1995 PPA invalid and preempted by ERISA in its entirety. Because the Eighth Circuit recently upheld the 1995 PPA, the 1995 PPA is the law, and Act 490 will not go into effect.

It is the Department's opinion that the remaining AWP legislation passed in the 2005 Legislative Session as Act 491 ("An Act To Provide For Enforcement Of The Patient Protection Act of 2005") and Act 960 ("An Act To Amend The Private Enforcement Provisions Of The Patient

Protection Act Of 1995 And The Patient Protection Act Of 2005") will become effective on August 12, 2005. The Department advises all HMO and accident and health insurers (as defined in Section 5(5) of Act 491 of 2005) to review and be expected to comply with the 1995 PPA, codified in Ark. Code Ann. §23-99-201, *et. seq.*, as amended by Acts 491 and 960 of 2005.

#### Health Benefit Plans Subject To The 1995 PPA As Amended This Legislative Session

In Prudential II, the 8th Circuit explained that the 1995 PPA was a state law saved from preemption by ERISA to the extent that the law "regulated insurance" and was aimed at "entities engaged in insurance" or the "insurance industry." The Court concluded that AWP applied to "non-ERISA health plans" and "insured ERISA plans." However, because "self-funded" ERISA health plans were not "insured," AWP was preempted to the extent it applied to a self-funded ERISA health plan. The Department therefore advises that it intends to apply AWP to all fully-insured health benefit plans: insured by group and individual accident and health policies, health maintenance organization contracts, hospital and medical service contracts, and any other "health benefit plan" defined in Act 491 of 2005.

Generally, health benefit plans that are not subject to AWP include *self-funded* employer plans, even if the health plan hires an insurance company to administer plan benefits or pays for access to a health insurer's provider network.

After reviewing the decision in Prudential II and the 1995 PPA, as amended by Acts 491 and 960 of 2005, the Department describes types of group health benefit plans most common in Arkansas to further clarify the application of AWP to health benefit plans:

1. Insured ERISA plans. These health benefit plans are fully subject to the 1995 PPA, as amended, and provider networks used by them must be AWP-compliant. This is true even if a "non-insurer" (as defined in Section 5(6) of Act 491) provides the plan with a network of medical providers. In other words, with regard to insured plans, the ultimate responsibility for compliance with AWP rests with the health insurer. [Act 491, Section 4(d)(4)].
2. Self-funded ERISA plans. Prudential II holds that self-funded ERISA plans are AWP-exempt, and that the 1995 PPA, as amended, cannot be used to directly or indirectly regulate the operations of self-funded ERISA plans.
3. Self-funded non-ERISA health benefit programs. There exist group health benefit plans which are not subject to the ERISA statutory regime, including but not limited to governmental health benefit plans and church plans. These *non-ERISA* plans are subject to the 1995 PPA unless (1) they are self-funded and (2) contract directly with a "non-insurer" (such as a typical Physician Hospital Organization, Independent Practice Association, or third-party administrator) to provide the plan with a network of medical providers, under Section 4(d)(1) and (2) of Act

491 of 2005. Please note however that if a non-ERISA plan, whether self-funded or insured, arranges with a health insurer to provide the plan with a network of medical providers, the plan is subject to the 1995 PPA as amended. Again, this paragraph applies in the unique circumstances of non-ERISA plans. Most group plans, whether self-funded or insured, are ERISA plans.

4. Arkansas State Employees Health Benefit Plan. It is the Department's position that because the state employee's health plan is a self-funded non-ERISA health plan that has not contracted with a "non-insurer" for a provider network, the health plan is subject to AWP. It is the Department's position that any self-funded governmental or church health benefit plan which has contracted with an insurer to provide the plan with a network of medical providers is a non-ERISA plan subject to AWP, for the reasons explained in paragraph 3. Any insured non-ERISA plan is subject to AWP.

5. Workers' Compensation Health Benefits. After researching the historical definition of a "health benefit plan" in the 1995 PPA, which excepted AWP from applying to workers compensation benefits, and researching the legislative intent behind recent changes to the definition of "health benefit plan," the Department's position is that AWP was not intended to apply to workers' compensation health benefits. Workers' Compensation was excluded from application of AWP in 1995, and the structure and nature of the medical compensation itself derives from liability insurance, rather than health insurance.

#### Health Care Providers Entitled To Any Willing Provider Rights

Medical providers entitled to request AWP access are listed in Act 491 of 2005. AWP access is not restricted to licensed physicians. Other providers are entitled to request AWP access, and these include podiatrists, chiropractors, physical therapists, speech pathologists, audiologists, dentists, optometrists, hospitals, psychologists, licensed professional counselors, respiratory therapists, pharmacists, occupational therapists, long-term care facilities, home health care providers, hospice care providers, licensed ambulatory surgery centers, rural health clinics, licensed certified social workers, licensed psychological examiners, advanced practice nurses, licensed dietitians, community mental health centers or clinics, certified orthotists, prosthetists, licensed durable medical equipment providers, and other medical providers determined by regulations of the Insurance Department. At this time, the Department has not promulgated any rule expanding or modifying the list of medical providers entitled to request AWP access. There is no requirement in the AWP laws to provide coverage of any particular health care service. If the service of a particular class of providers (e.g., chiropractors, dietitians, hospice, etc.) is included in the health benefit plan, then all providers in that same class who qualify for membership are eligible to be part of the plan's network. (Ark. Code Ann. §§ 23-99-204(b) and 205; Act 491, Section 4(c)(1)).

The Department advises health care insurers to pay particular attention to the fact that hospital services are included in AWP in the definition of "health care provider" in Act 491 of 2005; therefore, hospitals that agree to the terms and conditions of the health care plan are entitled to AWP access and rights with health care insurers.

#### Health Care Provider Requests For Network Access

AWP does not describe the mechanics and timing of health care provider requests for network access with the health care insurer. Providers interested in being admitted into a network should contact the insurer or IIMO for an application. The Department advises every IIMO and accident and health insurer to promptly give providers a written application and a description in writing of the application process for each medical provider requesting network access with the health care insurer. In addition, the health care insurer should provide a written description of the health care insurer's terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards. Ark. Code Ann. §23-99-204(3). Act 491 of 2005 requires that the health care insurer "apply such terms and conditions in a nondiscriminatory manner." The Department advises that every health care insurer should follow Ark. Code Ann. §23-99-411 and take no longer than 180 days to process completed applications from medical providers.

#### Restriction On Health Care Provider Discrimination

Arkansas law prohibits health care insurers from imposing any monetary advantage, penalty, or higher copayment under a health benefit plan that would affect a beneficiary's choice of health care providers. Health care insurers should abide by the "non-discrimination" requirements on health care providers in Ark. Code Ann. §23-99-204. AWP prohibits the imposition upon a beneficiary of a health care service any copayment, fee or condition that is not equally imposed on all beneficiaries in the same benefit category, class, or copayment level when the beneficiary is receiving services from a participating health care provider under the health benefit plan. However, the law does not prohibit varying the level of co-payment, fee or condition as between provider types. Also, it is the Department's position that the above requirements only apply to health care providers who have agreed to the terms and conditions of the health benefit plan in Ark. Code Ann. §23-99-204(a)(3).

For questions regarding this Directive, please contact the Legal Division of the Arkansas Insurance Department, 501-371-2820.

(Signed by Julie Benafield Bowman)

(July 15, 2005)

\_\_\_\_\_  
JULIE BENAFIELD BOWMAN  
INSURANCE COMMISSIONER  
STATE OF ARKANSAS

\_\_\_\_\_  
DATE



## **NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS**

### ***Analysis of State-Level Health Insurance Market Reforms***

#### ***October 2003***

The National Association of Health Underwriters (NAHU) is a trade association that represents approximately 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance needs of millions of Americans. As an association of health insurance professionals, NAHU's two top public policy objectives are: (1) reducing the number of uninsured Americans through private-market solutions, and (2) making sure that state-level private health insurance markets are as vibrant and competitive as possible.

NAHU recognizes that state health insurance markets are both extremely diverse and complex. Certainly, market reforms that work well in one state might not work as effectively in another. Furthermore, no one state has what could be termed the perfect health insurance climate. However, the fact remains that some state health insurance markets work much more efficiently than others—more carriers compete in these markets, costs are lower and there are fewer uninsured. This paper will identify some of the key elements of successful health insurance markets, explain why these reforms are important, and give examples of why some state health insurance markets work, and why others have failed.

### **Key Components to Health Insurance Market Stability**

#### ***Ability to Medically Underwrite in the Individual and Small-Group Markets***

One of the most important characteristics of a successful state health insurance market is the ability for health insurers to accurately assess risk for policies sold to both individuals and small businesses. Health insurance is a risk management mechanism and the level of risk varies amongst the insured population. The price of health insurance must reflect these differences in risk, because if everyone paid the same amount for health insurance, only those with the greatest need for expensive medical care would purchase coverage, thereby creating a dysfunctional health insurance market.

The way carriers can accurately assess individual market and small-group risks is through the practice known as medical underwriting. In states that allow for this, each individual applicant or employee is required to complete an individual questionnaire with detailed health information on the employee and all family members to be covered. The underwriter normally uses only information obtained from the application, but sometimes the underwriter will request additional information from an applicant's physician or may telephone the applicant to clarify an item on the application. If an underwriter is unable

to obtain information necessary to accurately determine the risk of a particular applicant, he or she will underwrite more conservatively, meaning that the assumption relative to the missing information will be negative rather than positive. So, for example, if an underwriter sees that a person has a history of high blood pressure that is controlled with medication and has a weight within normal limits, but he or she is unable to determine whether or not the individual smokes and has a normal cholesterol level, the underwriter will assume that the missing information is negative.

All states but nine<sup>1</sup> allow for medical underwriting in the individual market, however, only 37 states<sup>2</sup> allow for medical underwriting in the small-group market. The ability of insurers to accurately assess risk is extremely important, particularly in markets such as the individual and small group markets where the ability to spread risk is limited, and is even more important in states that allow for self-employed individuals to qualify as business groups of one.

The most common type of state small-group rating law<sup>1</sup> allows groups to be rated 25 percent above or 25 percent below an "indexed" rate. The indexed rate is determined by averaging the lowest possible rate and the highest possible rate. Most states that have this type of rating system also have a limit on rate increases due to the health status of the group, which is helpful in stabilizing rates over time. Even with these initial rate fluctuations for a new group, small employer rates in these states tend to be much lower than in states where health status rating is not allowed. A group that is rated correctly up front is much less likely to have a very large increase at renewal, and in order to rate the group correctly, the correct information on the initial application is essential.

The alternative to medical underwriting is community rating or a modified form of this rating mechanism. Certain states employ the community rating mechanism, which requires insurers to charge all individuals who live in the same zip code the same exact premium regardless of their age or health status. So, for example, in a community-rated state, an employer would pay the same amount per month to insure a healthy 27-year old non-smoking male with no health conditions as it would to insure a 55-year old male smoker who is suffering from prostate cancer and a heart condition, simply because the two live in the same zip code.

A variation on this rating mechanism is known as modified community rating. In states that use this mechanism, health plans are allowed to vary the community rate based on limited factors, such as age, gender and/or smoker status. So, for example, in a state that

---

<sup>1</sup> Maine, Massachusetts, New Jersey, New Mexico, New York, North Dakota, Oregon, Vermont and Washington all either require community rating or modified community rating in their individual health insurance markets.

<sup>2</sup> Arizona, Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Jersey, New Mexico, Oregon, Vermont and Washington all allow for either modified community rating or community rating in their group markets. However, Colorado will begin to allow for rate flexibility in the small group market in 2004.

<sup>3</sup> Fourteen states allow for small-group rate bands of +/- 25 percent. The other remaining 23 states either allow for rate bands that range from 10-55 percent, or allow for medical underwriting without rate bands in the small-group market.

allows modified community rating with variations for age, an insurer could charge more for the 55-year old male smoker with cancer and a heart condition than for the 27-year old healthy male. However, the insurer would have to use the same rate when calculating premiums for the healthy 27-year old male as it would for a male co-worker who is the same age but suffers from juvenile diabetes. Also, it is important to note that state-level modified community rating laws vary greatly. Some allow for many adjustment factors, but many allow for just a limited few, such as gender, age and family composition only. Modified community rating has a severely negative impact on health insurance rates in all states that employ the mechanism, but the more limited the rate adjustment factors, the more severe the problem.

NAHU has observed that in all states with the community rating and modified community rating mechanisms, younger healthier individuals and workers are penalized since carriers cannot account accurately for these healthy risks. This leads to much higher overall health insurance rates than in the states that allow for the use of medical underwriting in the individual and small-group markets. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which in turn limits consumer choice, reduces competition and leads to overall price increases.

### *Appropriate Group Size Definitions*

How states define and divide their health insurance markets also has a strong impact on market stability. State health insurance markets are generally divided into three categories—the individual, small-group and large-group markets. Individual markets serve people who for some reason do not have access to employer-sponsored health insurance coverage. In almost every state, the small-group health insurance market serves employer groups with less than 50 employees. The majority of states define an employer group as at least two individuals, but 14 states allow for self-employed individuals to be considered a business group of one. Large-groups are typically defined as employer groups that have more than 50 employees.

In studying state-level health insurance markets nationally, NAHU has found that the most successful states define their group markets as follows—small-groups as 2 to 50 employees, and large-groups as 51 employees and above. The states that allow for business groups of one typically have much higher overall small-group rates for a variety of reasons. First of all, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health insurance be guaranteed issue for all employer groups. This is a requirement that only three of the 14 states place on their individual market carriers<sup>4</sup>. Guaranteed issue in the individual market and for groups of one has historically been a problem, because in a group of one, there is absolutely no means for an insurer to

---

<sup>4</sup> The three states that allow for business groups of one and mandate that all insurers in the individual market guarantee issue coverage to all individuals are Maine, New York and Vermont. In three other states, Hawaii, Michigan and Massachusetts, Blue Cross/Blue Shield currently serves as the guaranteed issue carrier of last resort for the individual market.

spread risk. If an insurer has to cover all individuals who make up groups of one regardless of any medical conditions, then the insurer is forced to assume that each of these one-person groups is a medical risk, and rate all small-group products accordingly. In addition, in the nine states (Colorado, Connecticut, Delaware, Florida, Hawaii, Maryland, Michigan, Mississippi and North Carolina) that permit medical underwriting in the individual market, the laws create a perverse incentive for individuals with serious medical conditions to try and "game" the system and attempt to obtain guaranteed issue group coverage as a business group of one, even if they do not operate legitimate businesses. This is known as "adverse selection," which inevitably leads to higher rates for all individuals in the small-group market.

### ***High-Risk Health Insurance Pools***

NAHU has found that another key component to health insurance market stability in a state is the existence of a well-functioning, appropriately funded, health insurance high-risk pool for medically uninsurable and HIPAA-eligible individuals. High-risk health insurance pools have been created in 32 states<sup>5</sup> in order to provide affordable and quality private health insurance options for individuals with catastrophic medical conditions who do not have access to the group insurance market. The vast majority of these states also use these pools as an alternative mechanism to the guaranteed group-to-individual health insurance portability provisions required by HIPAA.

Risk-pool consumers are often self-employed individuals, early retirees or employees of small businesses that do not offer benefits. They generally have very serious preexisting medical conditions, such as cancer, diabetes, or another chronic illness that would cause them to be turned down if they applied for traditional private-market individual insurance. For most people who buy coverage in these pools, the risk-pool is an intermediate coverage solution. The average amount of time an individual spends in a risk-pool is 30 months, since many individuals eventually obtain group coverage or qualify for Medicare or another government-sponsored health insurance program.

High-risk health insurance pools help stabilize insurance markets, because they allow insurers to segment the severely unhealthy people seeking individual coverage, but still offer these individuals access to private market coverage. Consumers that need to purchase coverage in the high-risk-pool have access to comprehensive private-market coverage options that might not otherwise be available to them. These individuals pay higher rates than other individual market consumers, but these rates are capped, generally at about 125-200 percent of the average individual market rate. This arrangement benefits both consumers and insurers. Consumers are provided with a very important safety net, and insurers are provided with a predictable means of accounting for uninsurable risks. This allows individual market carriers to keep rates much lower for all

---

<sup>5</sup> The states that have created health insurance high-risk pools are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

traditional consumers, and since state laws cap risk-pool participant premiums based on the average individual market rate, the high-risk consumers also significantly benefit from these lower rates. Furthermore, small-group health insurance carriers and consumers also greatly benefit from stable high risk-pools, since the availability of a risk-pool in a state significantly decreases the risk that a person with a serious medical condition will try and "game" the system and obtain guaranteed issue group coverage. This, in turn, helps keep small-group rates in the state much lower.

In addition to the existence of a high-risk health insurance pool, stable funding for the pool is crucial. State risk-pool rates are capped, and because the individuals that utilize the pool often have the highest possible loss ratios, premiums alone would never be sufficient to satisfy claims. Therefore, the 32 states that have created high-risk pools to serve their individual health insurance markets have also established additional funding mechanisms to offset pool losses. State funding sources for high-risk pools range from legislative appropriations, to tobacco settlement funds, to hospital use surcharges. The most common funding source is some type of assessment levied on health insurance carriers in the state. While NAHU favors a specific type of carrier assessments for offsetting risk-pool losses, our organization has found that the most important item necessary in creating a successful risk-pool is selecting a stable funding source.

Examples of states that have had problems with pool funding instability in the past include California, Florida, Illinois, and Louisiana. All of these states have had to either limit enrollment, implement waiting lists, reduce services and/or close their pools, in order to deal with funding shortfalls. In addition, due to the current status of many state budgets, states that use funding mechanisms like appropriations, tobacco settlement revenues and assessments with premium tax credit offsets, such as Utah, Kentucky and Arkansas, respectively, have indicated that they are likely to encounter funding troubles in the future.

### *File and Use vs. File and Approve*

NAHU has also found that state regulations regarding the filing of health insurance rates also have an important impact on market stability, especially in the individual and small-group markets. In most states, insurers are permitted to simply file their rates with the state insurance departments and then immediately be able to "use" them. However, in some states, insurers are required to submit their rates to the state department of insurance for approval prior to use. This can be problematic, especially in the individual market, where rates are more volatile, due to the inability of health insurance carriers to spread risk. Rate increases in "file and approve" states tend to be higher than in "file and use" states because carriers have to build in reserve funds for every rate increase request, to compensate for the possibility of future rate change denials. In addition, "file and approve" requirements can hinder carriers from bringing new insurance products into the market in a timely basis, which also hurts consumers, since it can limit choice in health products.

## *Limits on Mandated Benefit Laws*

Another important component of a stable state health insurance market is a limited number of health insurance mandated benefit requirements. In recent years, the number of mandated benefit laws, or laws that place requirements on the content of private health benefit plan contracts, have increased significantly. Mandate laws range from statutes that require health plans to cover services by particular types of providers (e.g., chiropractors, optometrists), requirements to cover specific diagnostic or treatment services (e.g., mammography, infertility) or laws to extend certain benefits to certain populations (e.g., continuation coverage of employees or health plan liability). While individual mandates are often very popular since they are intended to provide specific populations with greater access to particular services, there is a cumulative price tag associated with ensuring such access. The sheer volume of mandated benefit laws being passed in the states has caused health insurance premiums to rise substantially. Research shows that there are now over 1000 benefit mandates in existence, and various studies indicate that they have caused health insurance premiums to increase as much as 25 percent<sup>6</sup>. Therefore, an increase in the number of mandates that are imposed leads to more people being priced out of health insurance, further swelling the ranks of the uninsured. A large number of health insurance mandates hits the small-group and individual health insurance markets particularly hard, since larger employer groups are more likely to self-insure, thus exempting them from state-level mandated benefit laws, as provided by the federal Employee Income Retirement Security Act of 1974 (ERISA).

Certain states, like Maryland (57 state mandated benefit requirements) and Connecticut (49 state mandated benefit requirements)<sup>7</sup>, lead the pack when it comes to mandates. However, in recent years, many states have taken action to curb state-level mandated benefit requirements, as one way to keep health insurance costs under control. States have taken various approaches to this task. Virginia, for example, with 47, has a very high number of mandated benefit requirements. However, six of those mandated benefit requirements, including some of the more expensive mandates, like morbid obesity treatment and bone marrow transplants, are mandatory offer laws.<sup>8</sup> This means that employers and individuals only have to be given the option of choosing policies that include those benefits. This can substantially reduce costs for employers and individuals, since they do not have to select the benefits that do not meet their individual needs. Twenty-five states<sup>9</sup> have requirements that all mandated benefit proposals go through some type of cost-evaluation before enactment. However, in only five of those states, Maryland, Pennsylvania, South Carolina, Virginia and Washington, are those cost review impact studies mandatory and completed on a regular basis. Finally, a few states, like

---

<sup>6</sup> Source: Jensen, G. and Morrissey, M. "Mandated Benefits Laws and Employer-Sponsored Health Insurance." Health Insurance Association of America, January, 1999.

<sup>7</sup> Source: Blue Cross Blue Shield Association. "State Legislative Health Care and Insurance Issues; 2001 Survey of Plans." January 2001.

<sup>8</sup> Ibid.

<sup>9</sup> Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin are the states with mandated benefit evaluation laws.

Louisiana, North Carolina and Oregon, have passed legislation in recent years limiting the number new mandates that can be enacted, due to the impact those mandates have on health insurance costs in the states.

### *Appropriate Regulation of Managed Care Carriers*

While the problem of appropriate regulation of managed care carriers has only arisen in a few states, it can be a very serious impediment to market stability. The vast majority of states make the appropriate distinction in their laws between health maintenance organizations (HMOs) other types of managed care health insurance products, such as preferred provider organization (PPOs). HMOs exercise a great deal of control over the health care treatment of their policyholders, while PPOs typically do not strictly control the medical treatment of policyholders. However in a few states, like Rhode Island, all managed care insurance companies, including both PPOs and HMOs, are considered "health insurance issuers" without any regard to the particular products they offer in the marketplace. The result is that all of the operations of the insurance company, including non-HMO products, become subject to the requirements of the state's HMO law.

Unlike HMOs, PPOs simply make decisions concerning the reimbursement of health care expenses of policyholders based upon the insurance contract. Additionally, PPOs do not use a gatekeeper or require referrals from a primary care physician in order to see a specialist. However, in states where PPOs are subject to all HMO requirements, these plans can be forced to implement very expensive and unnecessary reforms, such as hiring a full-time medical director. NAHU has found that placing additional regulation on entities that only finance health care services creates additional financial burdens on these companies without any benefit to consumers. The result has been massive carrier withdrawal from these states. For example, Rhode Island is down to one individual market insurer, two small-group insurers, and four large-group insurers.

### *Ability of Plans to Develop Appropriate Networks*

Another important characteristic of a successful state health insurance market is the ability of health insurance plans to be able to develop strong networks of providers, and to be able to effectively negotiate discounts with those providers. This is critical for both health insurance plans and health insurance consumers, since plans need to be able to negotiate with a wide range of quality providers in order to both attract customers and to keep costs low, and consumers benefit from having a wide range of doctors from which to choose.

Several states have enacted measures that make it difficult for plans to develop a comprehensive and effective network of providers. For example, a number of states require health plans to accept any willing provider who meets their plan criteria into their networks. The vast majority of these states limit these measures, so that they, for example, only apply to pharmacies. However, Idaho and Kentucky extend these requirements to all providers. Any willing provider mandates may seem like they would benefit consumers, since they allow the greatest number of providers into a plan, but

these laws actually have a serious negative consequence. Since any doctor who wishes to participate with a plan can, it makes it much harder for carriers to negotiate any discounts with providers, since there is no financial consequence for non-participation. This leads to higher medical reimbursement costs for all plans in the states, which translates into higher insurance rates for consumers.

Another way states can limit a health plan's ability to negotiate with providers is through the passage of an antitrust exemption for physicians in a state. Currently, when doctors and other healthcare providers negotiate their contracts for services rendered with health benefit plans, they must abide by state and federal antitrust laws that prohibit them from engaging in collective bargaining. However, legislation has been passed in Alaska, New Jersey and Texas that gives physicians and other health care professionals immunity from those antitrust laws and allows them to bargain collectively according to the same rules that apply to organized labor groups who are governed by the federal National Labor Relations Act.

Competition keeps healthcare costs down in the private sector, as well as in the Medicare and Medicaid programs, and these antitrust laws help eliminate competition amongst healthcare professionals by permitting them to engage in price-fixing, boycotts and market allocation agreements that would otherwise be illegal under the antitrust laws. Advocates for these measures have claimed that they are necessary to help providers protect consumers, but that is not really the case. Antitrust waivers are needed to enable providers to collectively discuss health plans issues involving legitimate quality-of-care concerns or bring such issues to the attention of the public. The 1996 Department of Justice/Federal Trade Commission guidelines state that such discussions are permitted under the current antitrust laws as long as they do not involve boycotts or other collective activity that could limit the choices available to consumers. The reality is that these measures are simply a means for providers to band together to negotiate higher fees, which only hurts health plan consumers by increasing health insurance rates.

### *Allow For the Widespread Availability of Different Plan Choices*

Perhaps the most important element of a successful state health insurance market is the availability of a wide variety of plan options for consumers to choose from. Competition lowers prices, and with many competitively priced plan options out there, less people will go uninsured. States can help ensure that individuals have a wide array of plan options by implementing laws that allow for the introduction of innovative products in their markets, such as medical saving accounts. But the most important thing a state can do to ensure a greater degree of consumer choice is to make sure that the state maintains a regulatory and legislative environment that encourages many health insurance carriers to actively market products in the state.

Accurately tracking the number of health insurance carriers actively marketing in a state can be problematic, since HIPAA requires a five-year ban on reentry for all carriers that officially withdrawal from a state health insurance market. As a result, many carriers get around this requirement by simply limiting their marketing efforts, or by only servicing

current policyholders. As such, state insurance department records of the number of health insurance carriers in a state are not always precise.

However, NAHU has found a high degree of correlation between the states that do not always follow the criteria listed in this paper for successful health insurance markets and states where health insurance producers report a high rate of insurance carrier exodus. Furthermore, in these states we also have seen evidence of higher rates, and higher number of uninsured individuals. As such, NAHU strongly recommends that states allow for the use of medical underwriting in the small-group and individual markets, prohibit business groups of one, create high-risk pools, allow rates to be filed and then immediately used, limit the number of mandated benefit requirements, regulate PPO plans appropriately, and allow for the development of effective plan networks. This will keep health insurance rates down, the level of competition high, and the number of uninsured as low as possible.

## Examples of State Markets That Work

### *Virginia*

The Commonwealth of Virginia is one of the more attractive environments for health insurance carriers to do business in the United States, for several reasons. First of all, in Virginia, health insurance carriers are able to fully underwrite both individuals and small employer groups based on medical history. Furthermore, the definition of a small employer for the purposes of obtaining health insurance is one that employs between two and 50 individuals, and the state maintains tight controls to ensure that qualifying businesses are legitimate and actually employ at least two people.

Virginia does not have a high-risk health insurance pool for medically uninsurable people in the individual market, but Anthem Blue Cross/Blue Shield, the largest health insurance carrier, serves as the carrier of last resort for people with catastrophic health conditions, in exchange for tax advantages from the Commonwealth. As such, Anthem essentially functions as a private high-risk pool, and all of the state's other individual market carriers derive similar benefits from Anthem's actions as they would if Virginia had a traditional high-risk pool in place. Furthermore, Virginia's small-group market benefits from the individual market stability, just as it would if a risk-pool were in existence. As a result, for the size of the state, there are a large number of carriers competing in the market place, rates are relatively low for individuals and businesses, and only 12 percent of the state's population goes without health insurance, compared with the 14.7 percent national average.<sup>10</sup>

This is not to say that Virginia's health insurance market is entirely problem-free. Health insurance rates in Virginia have climbed in recent years, just as they have nationwide. The difference is, though, that cost increases in Virginia can primarily be attributed to overall rising medical costs, instead of rising medical costs combined with regulatory

---

<sup>10</sup> Source: U.S. Census Bureau. *Health Insurance Coverage: 2002*. "Table 4. Percentage of People Without Health Insurance Coverage for the Entire Year by State (Three-Year Average): 2000 to 2002."

costs and lack of competition, as is the case in many states. Also, the number of mandated benefit laws in Virginia remains very high, but as explained earlier in this paper, a number of the most expensive mandates are "mandatory offer" requirements, as opposed to "mandatory inclusion," and the state has one of the few effective mandate evaluation boards operating in the country.

### ***Illinois***

Another state with a very stable health insurance market is Illinois. Carriers in Illinois are not subject to any rating restrictions in the individual market, and in the small-employer market, carriers can medically underwrite their products as long as they stay within rate bands of plus or minus 25 percent. The small-group health insurance market serves employers with between 2-50 employees, and the state has a moderate number of health insurance mandated benefit requirements, with 32 mandates currently on the books. Perhaps the most important facet of Illinois' market stability is the regulatory climate it provides to health insurance plans in the state. Illinois not only allows for the "file and use" of health insurance rates, but the state has also been cited by several major insurance carriers as providing one of the friendliest regulatory environments to carriers in the country, which helps make plans want to do business in the state. As a result, the market is extremely competitive, and consumers in Illinois benefit from the correspondingly low health insurance rates.

One area where Illinois could stand some improvement concerns its high-risk health insurance pool. The pool has been serving high-risk people in the individual market since 1989, and is in many ways extremely effective. However, Illinois splits the way it funds losses incurred by its risk-pool. Losses for traditionally medically uninsurable individuals are funded by direct appropriations from the state, whereas losses for HIPAA-eligible individuals who enter the pool exercising their guarantee-issue rights are funded by assessments on health insurance carriers in the state. As a result, the HIPAA-eligible portion of the pool has always had a stable source of funding, but the medically uninsurable portion of the pool has faced periodic challenges. In order to meet funding restrictions, Illinois has had to impose a cap on enrollment for medically uninsurable people, and this has sometimes caused the state to have to implement a waiting list for pool coverage. NAHU feels that the medically uninsurable component of the risk pool in Illinois would greatly benefit from a more stable funding source, and it is our hope that the recent availability of federal funding for state high-risk pools will help spur a legislative change in the state to create a more stable funding base for this segment of the pool.

## **Examples of State Markets That Are In Trouble**

### ***Rhode Island***

The private health insurance market in Rhode Island is on the verge of collapse. In 2001 and 2002, the state witnessed a number of carriers leave both the individual and small-group health insurance markets. According to the state Department of Business Regulation's Division of Insurance, currently, only one carrier is actively marketing policies in the individual market and one carrier is merely servicing existing

policyholders. In the small-group market, two carriers are actively marketing policies, and for large-groups, there are four carrier options available. In NAHU's view, several factors have contributed to this state's carrier exodus.

First of all, the state does not make a regulatory distinction between HMOs and PPOs. As such, all carriers who operate PPO plans and serve more than 1,000 policyholders in the individual market and more than 10,000 policyholders in the small-group market are required to follow all of the same very stringent and expensive regulatory requirements of an HMO plan. Since PPO plans, due to their structural differences, are generally much less expensive than HMO plans to operate, this regulatory environment has made it cost-prohibitive for most carriers to offer PPO products in the state. Those that do offer PPO products are faced with a perverse disincentive to grow their customer base beyond 1,000 lives in the individual market and beyond 10,000 lives in the small-group market, as doing so would significantly increase costs beyond the profitability level.

Some other problems in the state include the lack of a permanent option for medically uninsurable individuals in the individual market, and a "file and approve" requirement for all health insurance rates. Currently, Blue Cross and Blue Shield of Rhode Island, which is the only carrier actively marketing an individual product in the state, voluntarily offers guaranteed issue coverage to people seeking coverage in the individual market, regardless of health condition. However, the individual product this carrier offers has limited major medical benefits, and high-risk individuals can exceed the maximum benefit in rather short order. As a result, many Rhode Island residents with catastrophic medical conditions who do not have access to group coverage are currently uninsured, and have no legitimate options for obtaining private coverage. Rhode Island's "file and approve" requirement for health insurance rates has also been cited by several health insurance carriers as an impediment to doing business in the state, since the requirement restricts carriers ability to adjust rates based on economic and market changes, and it can also hinder the ability of carriers to bring new products to market in a timely fashion.

Finally, legislation that was enacted several years ago and is slated to go into effect in 2005 may make it difficult to attract new health insurance carriers to the state. The state currently defines a small-employer group as 2-50 employees. However, beginning in October of 2005, the definition of a small group for the purposes of health insurance will be changed so that business groups of one will be eligible for guaranteed issue group health insurance. When combined with the competitive hurdles that already exist for health insurance carriers in this state, these forthcoming reforms have prevented any new health insurance carriers from entering this market since the carrier exodus began in 2001.

### ***Florida***

The private health insurance market in Florida has been on the decline for some time. And while a variety of factors have contributed to this decline, the most significant factor, in NAHU's view, is the state's lack of a mechanism for providing coverage to medically uninsurable people in the individual market. Florida technically has a high-risk health insurance pool in existence, but the pool has been closed to new applicants for the past

eleven years due to funding woes. Since there is no adequately functioning risk-pool, the state requires that all individual carriers guarantee issue coverage to individuals exercising their HIPAA group-to-individual portability rights, at great expense. For people seeking private individual market health insurance coverage who are not HIPAA-eligible and are declined for coverage due to health conditions, there are no legitimate options available.

This lack of a high-risk pool has caused serious repercussions in the state's individual market, as well as in the small-group market. No means of covering individuals with serious medical conditions other than the group market would be problematic in any state, but it is particularly troubling in Florida, where the warm climate attracts a huge number of early retirees. Early retirees frequently do not have access to group medical insurance benefits, and they are also disproportionately likely to have one or more medical conditions that would hinder their ability to qualify for traditional medically-underwritten individual health insurance.

Since carriers are forced to take HIPAA-eligibles on a guaranteed issue basis, participating in the Florida health insurance market is particularly expensive. Many carriers attempt to make up for large HIPAA-eligible losses by imposing particularly strict medical underwriting criteria on the rest of the individual market. Many other carriers deemed it too expensive to write traditional individual insurance in the state, and instead until recently operated in the market in a limited fashion under the state's out-of-state-group law. This peculiarity in Florida state law was changed during the 2003 legislative session, but it had allowed non-domiciled carriers to sell products in the state under limited regulation by the state Department of Financial Services. This loop-hole had allowed the state's individual market to stay relatively competitive under adverse market conditions, but it also led to some carrier abuses like the use of re-underwriting in the individual market, as well as in a proliferation of sham health plans being marketed in the state. While NAHU feels that a level playing field is essential for a competitive health insurance market, and that closing this loophole was necessary for appropriate market regulation, its existence did help mask the state's individual market problems. Now that it is closed, it remains to be seen how the state's individual market will react.

The Florida small group market is, in many ways, in even worse shape. Florida allows for the sale of guaranteed issue group coverage to one-life groups. And since there is no functioning risk-pool many people with serious medical problems who can't obtain individual coverage seek to obtain coverage through the individual market by claiming to be self-employed. The result has been the creation of hundreds of thousands of one-life groups in Florida over the past few years, and the high loss-ratios associated with these groups have caused rates for the entire small-group market to skyrocket.

To further complicate the problem, Florida does not allow for true medical underwriting in their small-group market. Instead, Florida utilizes the modified community rating mechanism. Reforms enacted in 2000 enabled insurers to use health status on a very limited basis as one of the factors allowed in determining rates, but this is not the same as allowing complete medical underwriting, and thus has not had the desired effect on rates.

During the 2002 legislative session, a measure was passed that allows one-life groups to be segmented from the rest of the small-group market and rated separately, but it remains to be seen what impact, if any this will have on overall small-group rates.

## **Examples of States on the Rebound**

### ***New Hampshire***

In 1995, the New Hampshire health insurance market was relatively healthy and competitive, with 34 carriers offering health insurance products. However, reforms enacted in the 1990s eliminated the use of medical underwriting in the state and required that individual market health insurance products, as well as group health insurance products, be offered on a guaranteed issue basis. Furthermore, for many years New Hampshire was the only state in the nation that defined a small employer for the purpose of providing health insurance as an entity that employs between 1-100 individuals. As a result, the state's health insurance market began to rapidly deteriorate and costs began to rise, so that by 2000, the state was down to five carriers offering health insurance products, with two of those carriers dominating 90 percent of the small-employer market.

During the 2001 legislative session, members of the New Hampshire Association of Health Underwriters worked with legislators, health insurance carriers, business groups and other insurance agent trade associations on reform measures to repair the state's private health insurance market. This effort was largely successful, and legislation was passed that eliminated the guaranteed issue requirement for individual market health insurance, allowed for the use of medical underwriting, and created a high-risk health insurance pool, amongst other changes. Based on these legislative changes, one very large insurance carrier immediately agreed to re-enter the New Hampshire individual and small group markets, and subsequently, since the risk-pool has become operational, several other carriers have begun to market new products in New Hampshire, and costs are already beginning to drop.

During the 2003 legislative session, the New Hampshire Association of Health Underwriters and many coalition partners tackled the state's small group health insurance market laws and again they were very successful in getting market-friendly changes passed into law. The legislation passed in the spring of 2003 changed the size of a small employer group in New Hampshire for health insurance purposes from 1-100 employees to 2-50 employees, bringing New Hampshire in line with national standards. Furthermore, the new legislation eliminated modified community rating in the state's small group market and allows health insurance carriers to medically underwrite groups by plus or minus 25 percent, as recommended by the NAIC's model small group reform legislation. The new law also allows carriers to vary rates according age by a 4 to 1 margin (meaning that the highest rate adjusted for age can be no more than four times greater than the lowest rate charged). Furthermore, it allows rate variations for industry and group size of 20 percent, as well as a variation for geography of 15 percent. Since these changes were just enacted at the end of the 2003 legislative session, it is to soon to tell what their direct impact on the New Hampshire health insurance may be. However, health insurance industry groups were actively supportive of the changes in the law, and

have indicated that these changes were just what was needed to make their member carriers interested in returning to New Hampshire's small group health insurance marketplace.

### **Colorado**

For almost 10 years, the Colorado small-group health insurance experienced an exodus of carriers, and in NAHU's view the problem could be traced primarily to two significant factors—the use of modified community rating for products sold in that market, and the existence of one-life employer groups. Carriers in Colorado only were allowed to adjust rates based on the limited factors of age, geographic location and family composition. As such, carriers in this market had no means of underwriting products based on health status, which caused rates in the state to skyrocket.

Furthermore, the Colorado small-group market is plagued by adverse selection. This is due in part to the fact that the state allows business groups of one to purchase guaranteed issue group coverage. The volume of claims associated with one-life groups is significantly higher than with larger groups where there is more spreading of risk. Furthermore, one-life groups in Colorado tend to purchase coverage on an episodic basis, with the average contract length being only nine months. Other factors contributing to adverse selection in the small-employer market are ironically the state's competitive individual market and unique state laws that make it relatively easy for even very small healthy groups to self-fund, and therefore qualify for exemption from state mandates as rating laws, as provided by ERISA.

The end result of all of these problems is that in 1994, before rate reforms were instituted in Colorado, 83 carriers marketed health insurance in the state. Currently, the small-group health insurance market in the state is actively served by only 12 carriers, with only four carriers actively marketing coverage in the vast rural portions of the state.

However, at the end of the 2003 legislative session, Colorado lawmakers took an important step towards improving their state's small group health insurance market. Legislation was enacted that, among other things, allows health insurers to vary small group market rates based on health status, smoking status, claims experience and industry classification. Beginning September 1, 2003 small-group premiums may be discounted below the indexed rate by up to 15 percent based on those criteria, and effective September 30, 2004, the rates may vary by up to 10 percent above the index rate and 25 percent below it based on the criteria. The reform measure does not address the problem of one-life groups in the state, but it will allow small group carriers to more accurately assess risk and price products more appropriately. So far, no new carriers have reentered the Colorado small-group health insurance market, but several have expressed an interest in doing so by September 30, 2004, when the rating legislation goes into complete effect.

### **Conclusion**

As a professional association of benefit specialists, NAHU members occupy a unique role in the health insurance marketplace. On a daily basis, our membership works with both individual and corporate health insurance consumers to help provide them with the

type of coverage that best serves their individual needs. As such, NAHU members have an excellent understanding of what kinds of health insurance markets best serve consumers effectively. And after years of researching state health insurance markets nationally, NAHU has found time and time again that states that create perverse incentives for individuals to forgo health insurance coverage while driving up the cost of insurance for those who maintain it through anti-market "reforms" like guaranteed issue, mandates or community rating, have only exacerbated the growing problem of the uninsured. Conversely, states that have implemented market-friendly measures, such as high-risk pools, "file and use" laws, and measures that do not hinder the development of extensive health plan networks, have higher degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured. NAHU urges all states to implement the market-friendly reforms discussed in this paper, and we look forward to working with state and federal-level policymakers to ensure that our goals of reducing the number of uninsured and ensuring vibrant and competitive health insurance markets in all states are achieved.

**NOTE: This document is the exclusive property of the National Association of Health Underwriters. It was prepared as an information resource for NAHU members, state and federal policymakers and other interested parties. It is not to be duplicated, copied or taken out of context. Any omission or inclusion of incorrect data is unintentional. If you have any questions about the information presented in this document, please contact Jessica Fulginiti Waltman, NAHU Director of State Government Affairs at either (703) 276-3817 or [jwaltman@nahu.org](mailto:jwaltman@nahu.org).**

Summary of Testimony  
Senate Health, Education and Social Services Committee  
February 22, 2006  
Opposition to SB299

Colleen Savoie  
Vice President  
Willis of Alaska

I provide consulting services to a wide variety of health plans, including smaller insured plans and large self-funded entities. We oppose the any willing provider (AWP) legislation in SB299. In the interest of time, I want to address several of the issues brought up earlier.

- Health plans in Alaska and across the country are struggling with the cost of providing benefits to their employees. **In response to rising costs, employers are forced to make tough choices: reduce benefits, increase employee contribution rates or cost share, or eliminate benefits altogether.**
- One effective method health plans use to help control costs without reducing benefits is to negotiate preferred provider (PPO) agreements with hospitals, physicians, pharmacies and other health care providers.
- Limited PPO networks are successful because:
  - The provider is willing to substantially discount fees, in order to increase their patient volume.
  - The health plan agrees to provide a financial incentive for participants to use the preferred providers.
  - By establishing a mutually beneficial relationship with a network of providers, the providers & health plan work together to positively impact patient service and quality
- **Without the ability to contract with preferred providers and control the provider network, costs will increase.**
  - A study published by Michael Vita in the Journal of Health Economics in 2001 found that health expenditures are higher when AWP laws are enacted.
  - We have first-hand experience with preferred provider negotiations. For example, we participated in a competitive bid process for Anchorage hospital services. Both hospitals were willing to give significant discounts, as long as the plan agreed to contract with one facility and implement financial incentives to use their hospital. They would not offer these significant discounts without this "steerage."
- We are not alone in our opposition to AWP legislation.
  - The National Association of Health Underwriters stated in their 2003 Analysis of State-Level Health Insurance Market Reforms that one of the key components to health insurance market stability was the ability of health plans to develop appropriate networks. They identified **AWP legislation as a threat to market stability.**

- The Federal Trade Commission opposes AWP legislation
  - FTC and Dept of Justice Report, Improving Health Care: A Dose of Competition, July 2004, speaks to this problem. I encourage you to review their report
    - They noted that **AWP laws have anticompetitive effects:**
      - Make it less likely to be able to obtain provider discounts
      - Restrict the ability of health insurers or health plans to structure offerings with varying levels of choice – Would actually reduce options available
    - Recognized the cost impact of AWP laws – and how that affects the consumer: premium increases leading to employers forced to make tough choices about limiting or dropping coverage for employees
    - Suggested that **AWP or Freedom of Choice laws are intended to reduce competition between providers, rather than to protect the interests of patients.**

In addition, I questioned why there is no fiscal note for this bill. The State of Alaska Select Benefits plan, which provides benefits to active employees, recently implemented a PPO arrangement with Providence Hospital which includes "steerage" provisions. They projected a significant cost savings for this change. If the ability to control the network is eliminated, the State's plan would no longer enjoy this cost savings. Why is that not disclosed as a fiscal note?

Thank you for your time.



ELSEVIER

Journal of Health Economics 20 (2001) 955–966

JOURNAL OF  
HEALTH  
ECONOMICS

www.elsevier.com/locate/econbase

## Regulatory restrictions on selective contracting: an empirical analysis of “any-willing-provider” regulations

Michael G. Vita\*

*Bureau of Economics, United States Federal Trade Commission, 600 Pennsylvania Avenue,  
NW, Washington, DC 20580, USA*

Received 1 November 2000; accepted 1 June 2001

---

### Abstract

“Any-willing-provider” (AWP) laws compel managed care plans to accept any provider willing to accept the plan’s terms and conditions, potentially undermining managed care’s ability to constrain spending. However, AWP laws potentially respond to inefficient risk-selection by providers of managed care. With risk selection, observed reductions in expenditures in the managed care sector may be offset by increases in the fee-for-service (FFS) sector, with no net decrease. This paper uses panel data on state expenditures to compare per capita spending levels in states with and without AWP laws. The results indicate that expenditures are higher when AWP laws are enacted. Published by Elsevier Science B.V.

*JEL classification:* H1; K2; L0

*Keywords:* Managed care; Regulation; Fee-for-service

---

### 1. Introduction

Managed care health insurance plans have grown substantially over the past two decades, to the point where most privately insured Americans now subscribe to such plans.<sup>1</sup> Although the term ‘managed care’ masks substantial heterogeneity in the nature of the contractual arrangements among providers, subscribers, and insurers, managed care plans as

---

\* Tel.: +1-202-326-3493; fax: +1-202-326-2625.

E-mail address: mvita@ftc.gov (M.G. Vita).

<sup>1</sup> According to the American Association of Health Plans 1999 Fact Sheet, HMO enrollment grew from 34.7 million in 1990 to 78.8 million in 1998. For PPOs, the comparable figures are 38.1 and 89.1 million. This represents about 88% of all privately insured Americans (Census, <http://www.census.gov/hhes/hi/thins/hlthin98/hi98d.html>).

conventionally defined almost always provide enrollees with some financial incentive to obtain health care services from a limited panel of providers.

Notwithstanding, the rapid growth of selective contracting, this practice appears to have proven unpopular with at least some subscribers (who would prefer fewer restrictions on provider choice) and some providers (who suffer financially when they are not included in managed care provider networks). This discontent has precipitated the enactment of regulations that would limit the ability of insurers to contract selectively. Enacted in numerous states, and proposed in many more, these laws fall into two related categories: "any-willing-provider" (AWP) laws, which compel managed care plans to accept into their networks any qualified provider who is willing to accept the plan's terms and conditions; and 'freedom of choice' (FOC) laws, which obligate plans to reimburse for care obtained from a qualified provider even if the provider is not a member of the network.<sup>2</sup> By one count, 34 states had enacted some form of FOC or AWP law by 1996.<sup>3</sup>

Holding constant managed cares' market share, it is seemingly self-evident that AWP/FOC laws must increase health expenditures, since they appear to undermine a principal instrument by which managed care entities constrain health care spending, and more generally, because they constrain presumptively beneficial voluntary contracting among providers, subscribers, and insurers. It is possible, however, to rationalize AWP/FOC laws as a welfare-improving response to inefficient risk-selection by managed care insurers, a phenomenon that, if uncorrected, could actually increase expenditures in the fee-for-service (FFS) sector.

There currently is little empirical evidence on the effects of AWP and FOC regulations.<sup>4</sup> In this note, I attempt to assess the impact of AWP/FOC laws on annual state-level health care expenditures data, a task that is complicated by the possible endogeneity of the managed care penetration level. I find some evidence that highly restrictive AWP laws are associated with higher health care expenditure levels. Some caution is warranted in interpreting these results, however, as I also find some evidence indicating that managed care penetration levels and expenditure levels are determined simultaneously.

## 2. Restrictions on managed care: background

The conventional explanation for the replacement of traditional FFS health insurance plans by managed care institutions is well known, and thus, does not require extensive discussion.<sup>5</sup> The traditional FFS (or indemnity) policy reimbursed providers retrospectively on the basis of incurred expenditures, thereby, inducing moral hazard, i.e. physicians prescribe, and consumers purchase, medical services that would not have been purchased were consumers expected to bear the full cost of the treatment. By integrating the health insurance and health care production functions, and linking physician compensation to the

<sup>2</sup> There are also 'direct access laws', which guarantee that managed care subscribers can seek care directly from specialists without a referral from a primary care provider, without losing benefits. Although 11 states now have such laws, they are all of very recent vintage (i.e. 1994 and 1995).

<sup>3</sup> Ohsfeldt et al. (1998, appendix).

<sup>4</sup> A recent review article found that the only evidence on the impact of AWP laws comes from a handful of studies conducted by consulting firms on behalf of large managed care organizations. See Hellinger (1995).

<sup>5</sup> A more thorough analysis is provided in Cutler and Zeckhauser (2000).

Health Maintenance Organization's (HMO) financial performance, this moral hazard can be attenuated, thereby, reducing the plan's per capita expenditures.<sup>6</sup>

If HMOs, PPOs, and other managed care organizations successfully address the moral hazard problems inherent in traditional FFS plans, they not only will induce efficient choices by their own providers and subscribers, but potentially in FFS plans as well. This is because of the simple logic of market competition: the loss of market share and profits to managed care entities may compel traditional FFS plans to offer subscribers (or their employers) comparable premium reductions. This will be especially true in market settings where competition among incumbent FFS plans was sufficiently imperfect to allow them to earn rents. Thus, an increase in managed care market share might be expected to lead to (per capita) expenditure (and, therefore, premium) reductions in both the managed care and FFS sectors. Baker and Corts (1996, 1999) call this the 'market discipline' effect.

Although most analyses of managed care have focused on its ability to (efficiently) constrain expenditures through mitigation of moral hazard, several recent contributions have focused on a less desirable consequence, which Baker and Corts term the 'market segmentation' effect. This effect derives from the susceptibility of insurance markets to adverse selection—consumers who expect to be in relatively poor health will tend to prefer health care plans offering generous benefits, while the relatively healthy will have less demand for broad coverage. Since insurers cannot easily identify the riskiness of prospective enrollees *ex ante* and charge them different premiums to reflect this risk, they might attempt to charge a premium reflecting average risk. But this premium structure would tend to disproportionately attract unhealthy consumers into the generous plan, necessitating further premium increases.<sup>7</sup>

The existence of unobservable heterogeneous risks gives insurers an incentive to identify high risk enrollees, and to price the policy to reflect this risk (when such pricing is possible), and to discourage enrollment when it is not.<sup>8</sup> Some observers (Newhouse, 1996) have suggested that selectively contracting only with those providers who choose to treat a relatively healthy patient mix is one means by which insurers accomplish the latter. It is this behavior that provides an efficiency rationale for AWP laws. If selective contracting is primarily a mechanism by which insurers undertake privately profitable, but socially inefficient risk selection, policies that restrict their ability to contract selectively might reduce this efficiency loss.

If this selection phenomenon is empirically important, the efficiency gains frequently attributed to managed care are overstated. Premium and expenditure reductions in the managed care sector would be offset, at least partially, by increases in the FFS sector. A number of studies have examined the impact of managed care on conventional FFS expenditures and premiums. The evidence does not clearly favor either of the two competing

<sup>6</sup> In addition to the cost and expenditure reductions obtained through attenuation of subscriber and provider moral hazard, the selective contracting aspect of managed care creates efficiencies because the lower administrative and monitoring costs associated with a smaller provider network. Administrative expenses account for approximately 15% of insurance premiums (Cutler and Zeckhauser, 2000, p. 590). The ability to reduce these expenses substantially, therefore, may also constitute a non-trivial source of economic efficiency from limited provider panels.

<sup>7</sup> This can create what Cutler and Zeckhauser (2000, p. 616) term an adverse selection 'death spiral'. This phenomenon arises when there is no equilibrium in which the most generous plan survives.

<sup>8</sup> See Feldman and Dowd (2000) for a general discussion.

hypotheses. Some studies (e.g. Cutler and Sheiner, 1998; Gaskin and Hadley, 1997; Baker, 1997; Zwanziger and Melnick, 1988) found that increases in managed care market shares led to reductions in FFS expenditure levels and/or rates of growth, a result consistent with the 'market discipline' effect. Other studies, however (e.g. Baker and Corts, 1996, 1999; Feldman et al., 1993; McLaughlin, 1987), found that managed care market share growth can lead to higher FFS premiums, a finding consistent with the 'market segmentation' hypothesis.

### 3. Empirically testing the impact of AWP and FOC regulations

#### 3.1. Model specification

In this section, I assess the effects of AWP and FOC laws on various measures of health expenditures.<sup>9</sup> The basic test of the impact of AWP laws proposed here exploits state-level information on per capita health care expenditures provided by the Health Care Financing Administration (HCFA). HCFA has constructed annual estimates (for 1980-1998) of total health care spending in each state.<sup>10</sup> These expenditure estimates are disaggregated further by expenditure category (e.g. hospital care, physician care). The empirical specification used here is an adaptation of the framework used in Cutler and Sheiner (1998) and Baker (1997). In those papers, various measures of per capita expenditures are regressed on a measure of managed care market share and a set of control variables. I employ a similar specification, modifying it to include variables indicating the presence of AWP/FOC regulations:

$$e_{it} = \alpha_0 + \beta_1 \times \text{HMOSHARE} + \beta_2 \times \text{AWP} + \sum_{i=1}^N \gamma_i \times \text{STATE}_i + \delta \times \text{TREND} + \varphi' X_{it} + \varepsilon_{it} \quad (1)$$

where  $e_{it}$  equals real per capita health care expenditures (or some individual component of total expenditures, such as hospital expenditures) in state  $i$  and year  $t$ ; HMOSHARE is the HMO market share (estimates of PPO enrollment are not available);<sup>11</sup> AWP is a dummy

<sup>9</sup> There is a paucity of empirical information on the effects of these regulations. These studies are Lewin-VHI (1995); Wyatt (1991); Atkinson (1994). The Atkinson study is an update of the Wyatt study. The Atkinson and Wyatt studies are simulation studies based on proprietary models of managed care providers. The Lewin-VHI study is a regression analysis which estimates the impact of AWP laws on HMO market share, and the impact of HMO market share on per capita health care expenditures.

<sup>10</sup> The expenditure data are described in Levit et al. (1995). A possible drawback associated with the HCFA state expenditure data is that they are based on revenue received by providers, rather than benefits received by residents (Basu et al., 1995). To the extent there is substantial border crossing by consumers of health care, per capita expenditures calculated on 'revenues received' and 'benefits received' bases could differ. HCFA carried out border crossing adjustments for 1991, which appear to have a relatively minor impact on estimated per capita expenditures on physician services and inpatient hospital services (about 1.80 and 0.98%, respectively). For the purposes of this paper, I assume that the 1991 adjustment factors apply to other years as well, and I adjust the data accordingly.

<sup>11</sup> This variable was obtained from InterStudy, which estimates (as of July of each year) HMO enrollment. These estimates have been used in most other studies of managed care, such as Cutler and Sheiner (1998) and Gaskin and Hadley (1997).

variable indicating the presence or absence of an AWP law;  $STATE_i$  are state dummy variables;<sup>12</sup>  $TREND$  is a linear time trend; and  $X_{it}$  is a vector of other control variables related to health care expenditures (e.g. age, race, income, education).

In the basic specification presented above, the effect of AWP laws is captured by the coefficient on a single dummy variable. This representation is too simplistic, as it fails to capture the heterogeneity observed in actual AWP laws. Marsteller et al. (1997, p. 1135) note that none of the existing quantitative studies differentiates among existing AWP or FOC laws in terms of the strength of the restriction. As they note, this is a potentially a serious drawback, since an AWP/FOC law 'can either greatly interfere with regular plan operations or have little effect in practice' (Marsteller et al., 1997, p. 1140). Restrictions on selective contracting can vary across a number of dimensions. First, some laws apply to some classes of health plans (e.g. PPOs) but not others (e.g. HMOs).<sup>13</sup> Second, some laws make it extremely difficult to terminate providers, while in others termination is easy. Third, some laws affect virtually all providers, while others apply to only certain specific categories of providers.<sup>14</sup>

To reflect this heterogeneity in the strength of AWP restrictions, I adopt a classification scheme derived from the descriptive information contained in Marsteller et al. (1997). Marsteller et al. (1997) rank existing AWP/FOC laws ('weak'; 'weak-to-medium'; 'medium-to-strong'; 'strong'), according to three criteria: (1) entities regulated (e.g. all health plans, or just some small subset); (2) range of providers covered and (3) stringency (e.g. do deselected providers have a grievance procedure?).<sup>15</sup> From this classification scheme, I create two measures of AWP strength: 'weak/moderate', equal to 1 if the regulation falls into the 'weak', 'weak-to-medium', or 'medium-to-strong' categories; and 'strong', equal to 1 if the regulation is classified as 'strong'.

A second issue involves the endogeneity of the managed care share and AWP variables. Basic reasoning suggests that managed care penetration is unlikely to be exogenous with respect to expenditure levels; the greatest opportunities for managed care growth are likely to arise when utilization levels are relatively high, a conjecture that has found empirical support in several earlier studies.<sup>16</sup> Similarly, AWP laws might be more likely to be enacted where

<sup>12</sup> Including the state dummies may help control for some of the simultaneity between managed care share and expenditures, as it has been hypothesized (Cutler and Sheiner, 1998) that HMO growth during the 1980s and 1990s was greatest in states with the highest initial levels of per capita spending. The effects of any such cross-sectional differences will be captured in the coefficients on the state dummy variables.

<sup>13</sup> It is important to note that no AWP or FOC law applies to self-insured employee benefit plan because the Employment Retirement Security Act of 1974 (ERISA) prevents states from regulating any employee health plan. Additionally, the Health Maintenance Organization Act of 1973 (HMO Act) also preempts certain categories of laws that would restrict the growth of HMOs (Marsteller et al., 1997, p. 1145).

<sup>14</sup> Arkansas's AWP law, for example, applies to a very large class of providers (including physicians, hospitals, osteopaths, podiatrists, pharmacists, long-term care facilities, among many others) and all types of insurance networks (except of course those that are exempted by ERISA), and provides grievance procedures for deselected providers (Marsteller et al., 1997, p. 1140). A much weaker plan is Utah's, which appears to allow plans to impose limitations based on 'reasonable' selection criteria, which include 'substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles' (Marsteller et al., 1997, p. 1141).

<sup>15</sup> For a more detailed discussion, see Marsteller et al. (1997), Table 2.

<sup>16</sup> See, e.g. Welch (1994) and Porell and Wallack (1990).

growth in HMO share has had a substantial impact on provider welfare. This suggests that expenditures, HMO share, and presence of AWP laws might be determined simultaneously. If so, ordinary least squares estimates of Eq. (1) will yield biased and inconsistent parameter estimates. The standard approach to addressing this would be to employ instrumental variables; however, it is highly questionable whether suitable instruments are available here.<sup>17</sup> Rather than attempting to justify the use of invalid instruments, I attempt instead to assess through indirect means whether endogeneity of these variables is likely to be a problem here.

The empirical implementation of Eq. (1) also includes a number of other exogenous determinants of health care expenditures found in previous studies (e.g. McLaughlin, 1987; Baker, 1997; Baker and Corts, 1999) to vary systematically with health care expenditures. These include: percentage of the population aged 65 and up; population growth rate; percentage of the population black; percentage of the population with bachelor's degrees or better; the unemployment rate; real per capita income; the HCFA wage index; and the percentages of total employment in the following categories: government, agriculture, construction, manufacturing, transportation and public utilities, retail trade, and wholesale trade.

### 3.2. Parameter estimates

The parameters of Eq. (1) are estimated using state-level annual data for the 1983-1997 period using a generalized least squares procedure that corrects for first order autocorrelation.<sup>18</sup> Table 2 presents a series of regression results, corresponding to three different dependent variables, all calculated on a per capita basis: real total health care expenditures; real total physician services expenditures; and real total hospital care expenditures.<sup>19</sup> I estimate first a model (see Table 2, panel (A), columns (1)-(3)) in which expenditures are a simple additive function of the controls (see Table 1 for a complete list), HMO share, the two AWP regulatory dummy variables, state fixed effects, and a single linear time trend.<sup>20</sup> The coefficients from this model specification suggest that while one cannot reject the null hypothesis that 'weak' or 'moderate' (WEAK) AWP laws have no effect on health care expenditure levels, 'strong' (STRONG) laws are associated with substantially higher total spending levels (see column (1)), a result that is significant at the  $p = 0.05$  level. Both the hospital (column (2)) and the physician (column (3)) components of total spending are also substantially higher in the presence of 'strong' AWP laws, although only the former result is significant ( $p = 0.10$ ) at conventional levels of significance.

<sup>17</sup> A few recent studies (Baker, 1997; Baker and Corts, 1999) of the relationship between managed care penetration and expenditures have attempted to develop instruments for managed care penetration, but the plausibility of these instruments is dubious. And as Bound et al. (1995) have shown, estimates derived using poor instruments may perform worse than OLS.

<sup>18</sup> The estimation procedure assumes a common autocorrelation coefficient across states.

<sup>19</sup> As Cutler and Sheiner (1998, p. 79) found, managed care might shift expenditures from one category to another (e.g. procedures might be shifted from hospitals to physicians' offices).

<sup>20</sup> For brevity, I show only the coefficients on the AWP and HMO variables. The full set of coefficient estimates is available upon request.

Table 1  
Descriptive statistics

	Description	Mean	Minimum	Maximum
WEAK	State has weak AWP/FOC law	0.06	0	1
STRONG	State has strong AWP/FOC law	0.048	0	1
HMO SHARE	HMO penetration rate	10.68	0	49.33
P <sub>health</sub>	Per capita total health expenditure	2917.03	1528.06	4616.94
P <sub>hosp</sub>	Per capita hospital expenditure	1211.81	660.15	1814.14
P <sub>cmd</sub>	Per capita MD expenditure	809.03	337.75	1310.46
P <sub>crx</sub>	Per capita Rx expenditure	115.74	49.48	239.17
Black (%)	Proportion population black	9.6	0.24	36.38
65%+	Proportion population 65+	12.29	2.91	18.56
BA <sub>degree</sub> (%)	Proportion population BA degree	20.84	11.1	33.5
Govt <sub>employee</sub> (%)	Proportion workforce government	17.58	0	31.31
Agric <sub>employee</sub> (%)	Proportion workforce agriculture	1.03	0	6.60
Const <sub>employee</sub> (%)	Proportion workforce construction	4.75	0	9.71
Manu <sub>employee</sub> (%)	Proportion workforce manufacturing	16.99	3.1	32.91
Trans <sub>employee</sub> (%)	Proportion workforce transportation/ public utility	5.23	2.37	9.4
Ret <sub>employee</sub> (%)	Proportion workforce retail trade	18.61	3.6	22.9
Ws <sub>employee</sub> (%)	Proportion workforce wholesale trade	5.43	3.2	11.52
Unemploy <sub>rate</sub>	Unemployment rate	6.21	2.2	18
Income	Real per capita income	22032.53	13629.16	36827.5
Wage <sub>index</sub>	HCFA wage index	8608.92	6577	14878
Growth	Population growth rate	0.009	-0.79	0.09
Density	Population density	165.87	0.86	1085.62

Columns (4)-(6) of Table 2, panel (A), relax the assumption of a single linear time trend, and instead allow for state-specific time trends.<sup>21</sup> The resulting coefficient estimates continue to indicate that 'strong' AWP laws are associated with increased levels of total health spending, although the magnitude of this effect (US\$ 38 versus 52), and its significance level ( $p = 0.10$ ), are smaller compared to the results obtained with a common trend. The bigger changes occur in the hospital and physician expenditure equations (columns (5) and (6)). Here, the coefficient on STRONG in the hospital equation falls substantially (from US\$ 25-14), as does its significance level (from  $p = 0.09-0.31$ ). By contrast, the coefficient on STRONG in the physician services equation increases considerably (from US\$ 17-23), and is now statistically significant ( $p = 0.08$ ). This result is consistent with anecdotal evidence that the principal constituency for AWP laws are physicians, not hospital owners.<sup>22</sup> When AWP laws are enacted, the results in column (6) suggests the primary beneficiaries may be high cost physicians who are admitted into what otherwise would be lower cost physician networks.

The estimates in Table 2, panel (A) also suggest, consistent with earlier research (Cutler and Sheiner, 1998; Baker, 1997), that HMO share growth is associated with

<sup>21</sup> We reject the null hypothesis of a common trend at the  $p < 0.001$  significance level.

<sup>22</sup> See, e.g. 'Florida Effort Would Let More Doctors Into Managed Care'. Business Insurance, 23 September 1996, p. 30.

Table 2  
Per capita expenditure equations and annual data, 1983-1997 (*t*-statistics in parentheses)<sup>a</sup>

	Total health expenditures <sup>b</sup> (1)	Hospital expenditures <sup>b</sup> (2)	Physician expenditures <sup>b</sup> (3)	Total health expenditures <sup>c</sup> (4)	Hospital expenditures <sup>c</sup> (5)	Physician expenditures <sup>c</sup> (6)
<b>(A) Includes HMO share</b>						
WEAK	2.68 (0.19)	5.98 (0.74)	-7.77 (-1.06)	-14.19 (1.22)	-7.13 (-0.96)	-9.82 (-1.42)
STRONG	52.39* (2.07)	24.80* (1.70)	16.93 (1.29)	38.62 <sup>+</sup> (1.79)	14.18 (1.02)	22.81 <sup>+</sup> (1.77)
HMO SHARE	-3.80** (-4.23)	-3.18** (-6.14)	-0.83 (-1.78)	-4.51** (-5.91)	-3.31** (-6.84)	-1.35** (-2.97)
<b>(B) Excludes HMO share</b>						
WEAK	5.12 (-0.36)	7.74 (0.94)	-7.11 (-0.97)	-10.79 (-0.94)	-4.43 (-0.60)	-9.09 (-1.31)
STRONG	49.73* (1.96)	22.14 (1.49)	16.59 (1.26)	32.57 (1.54)	9.88 (-0.72)	21.11 <sup>+</sup> (1.64)

<sup>a</sup> Parameters estimated with GLS procedure assuming common autocorrelation coefficient across panels. Sample size:  $N = 50$ ,  $T = 15$ . Other control variables: black (%); 65+ (%); BA\_degree (%); government\_employee (%); agric\_employee (%); const\_employee (%); manu\_employee (%); trans\_employee (%); ret\_employee (%); ws\_employee (%); unemploy\_rate; income; wage\_index; growth; density.

<sup>b</sup> Includes state fixed effects and common time trend.

<sup>c</sup> Includes state fixed effects and state-level time trends.

<sup>+</sup> Significant at  $p < 0.10$ .

\* Significant at  $p < 0.05$ .

\*\* Significant at  $p < 0.01$ .

economically and statistically significant reductions in total health care expenditures.<sup>23</sup> These estimates are generated under the maintained hypothesis that managed care share is exogenous, notwithstanding the possible invalidity of this assumption. For example, as Cutler and Sheiner (1998) argue, it is plausible that managed care growth rates were highest in those states where initial expenditure levels were highest. Indeed, similar arguments could be made about AWP regulations—for example, it is plausible that the presence of these laws might be determined in part by a state's recent experiences with health care expenditures.

The natural approach to addressing possible endogeneity problems would be to use instrumental variables, provided suitable instruments could be found.<sup>24</sup> It is difficult, however, to conceive of variables that plausibly are determinants of HMO membership or AWP laws, but not health care spending behavior.<sup>25</sup> Because of this difficulty in obtaining defensible instruments, it is important to attempt to assess the severity of any simultaneity bias through some alternative means.

As a first pass at this, I simply re-estimate Eq. (1) using the original additive specification (i.e. the specification used in Table 2, panel (A)), but omitting the managed care share variable. These estimates are presented in Table 2, panel (B). As in panel (A), these regressions are estimated with both a common trend and with state-specific trends. Comparing the results contained in panel (B) with those in panel (A), one sees that although the omission of the managed care variable reduces slightly both the economic and statistical significance of the estimated coefficients on STRONG, the basic effect is fairly robust to this change in specification. In particular, the coefficient on STRONG is positive in both physician expenditure regressions; it is statistically significant ( $p = 0.10$ ) in the regression with state-level time trends.

An alternative approach is provided by Gruber and Hanratty (1995) and Friedberg (1998). Here, I create dummy variables set equal to 1 in the year preceding enactment of a 'weak' or 'strong' AWP law. If the direction of causation in the AWP-expenditure relationship is from the former to the latter, then the coefficient on the lead variable should equal zero. If high levels of expenditures prompt the enactment of AWP laws, then the lead term coefficient should be positive. I also include in this equation a lead term for HMOSHARE. If, as seems possible, high expenditure current levels lead to high (future) managed care penetration, we

<sup>23</sup> Although previous research appears to have established that managed care is associated with lower health care expenditures, not all of these studies are clear about the mechanism by which these reductions are achieved. As noted by Cutler and Sheiner (1998, pp. 82–83), managed care programs can curtail expenditures either through 'one-time' reductions—for example, reductions in the fees paid to physicians, or reductions in hospital lengths-of-stay—or through 'ongoing' reductions—related, for example, to the rate at which new medical care technologies are adopted (see Baker and Phibbs, 2000; Baker, 2000). Conceivably, the success of managed care in states such as California reflects 'one-time' reductions that cannot be sustained. If so, presumably this would imply that any attenuation of managed care's ability to reduce expenditures brought about by AWP policies is also of a one-time nature. To differentiate between these possibilities, I estimate a version of Eq. (1) in which the dependent variables are defined as the annual growth rate of real per capita expenditures (i.e.  $\log(\epsilon_{it}/\epsilon_{it-1})$ ). The resulting parameter estimates (available upon request) suggest that the expenditure-increasing effects of strong AWP laws may be of a one-time nature, although it must be noted that most of these 'strong' laws are of a fairly recent vintage, and there may be insufficient data points to accurately estimate any effects the laws might have on expenditure trends.

<sup>24</sup> See, e.g. Baker and Corts (1999) for such an attempt.

<sup>25</sup> As Bound et al. (1995) show, using poor instruments can be a worse estimation strategy than using no instruments.

Table 3  
Per capita expenditure equations and annual data, 1983-1996 with lead terms for AWP laws and HMO share (*t*-statistics in parentheses)<sup>a</sup>

	Total health expenditures <sup>b</sup> (1)	Hospital expenditures <sup>b</sup> (2)	Physician expenditures <sup>b</sup> (3)	Total health expenditures <sup>c</sup> (4)	Hospital expenditures <sup>c</sup> (5)	Physician expenditures <sup>c</sup> (6)
WEAK	15.33 (0.81)	14.55 (1.36)	-10.20 (-1.01)	-11.10 (-0.68)	-1.09 (-0.11)	-12.62 (-1.27)
WEAK(+1)	14.72 (1.05)	9.62 (1.21)	-0.96 (-0.13)	2.45 (-0.20)	3.05 (0.42)	-3.23 (-0.45)
STRONG	51.45 (1.57)	33.32 <sup>†</sup> (1.80)	4.94 (0.28)	36.04 (1.20)	13.19 (0.73)	20.25 (1.11)
STRONG(+1)	2.01 (0.08)	9.33 (0.67)	-10.40 (-0.78)	-8.38 (-0.38)	-0.68 (-0.05)	-6.40 (-0.48)
HMOSHARE	-3.64** (-3.49)	-2.96** (-4.99)	-0.82 (-1.45)	-4.79** (-5.33)	-2.92** (-5.40)	-1.84** (-3.37)
HMOSHARE(+1)	-3.18** (-3.49)	-2.54** (-4.90)	-1.08* (-2.18)	-4.41** (-5.57)	-2.97** (-6.24)	-1.81** (-3.77)

<sup>a</sup> Parameters estimated with GLS procedure assuming common autocorrelation coefficient across panels. Sample size:  $N = 50$ ,  $T = 14$ . Other control variables: black (%); 65+ (%); BA.degree (%); government\_employee (%); agric\_employee (%); const\_employee (%); manu\_employee (%); trans\_employee (%); ret\_employee (%); ws\_employee (%); unemploy\_rate; income; wage\_index; growth; density.

<sup>b</sup> Includes state fixed effects and common time trend.

<sup>c</sup> Includes state fixed effects and state-level time trends.

<sup>†</sup> Significant at  $p < 0.10$ .

\* Significant at  $p < 0.05$ .

\*\* Significant at  $p < 0.01$ .

would expect to find that future HMO shares would be positively correlated with current expenditures.

The results from this specification are shown in Table 3. They provide little evidence of AWP law endogeneity—in none of the equations are the coefficients on the lead term of an AWP variable statistically different from zero. The same is not true of the lead value of HMOSHARE, however; its coefficient tends to be large (in absolute value) and significantly different from zero, a finding consistent with the possibility that HMOSHARE is endogenous. The signs of these coefficients are inconsistent, however, with the theory that high current expenditures lead to high future managed care shares—in three of the four equations we find a negative (and statistically significant!) coefficient on the future HMO share variable.

#### 4. Conclusion

Previous research on the relationship between managed care penetration and expenditure levels has yielded mixed evidence on the extent to which this growth will result in market segmentation or market discipline. None of this research has taken into account the impact of regulations that attenuate the ability of managed care entities to contract selectively with providers. In this paper, I have done so explicitly, controlling not only for the presence or absence of such regulations, but also the 'strength' of such constraints. This paper's basic finding—that HMO growth reduces health care expenditures, and that AWP laws attenuate this effect—is broadly consistent with earlier research on managed care. The economic magnitude of the AWP effect is robust across the various empirical specifications, and is statistically significant in most. Perhaps most interesting is the indication that AWP laws may have had a larger impact on physician expenditures than on hospital expenditures. Previous research into the relationship between managed care and the individual components of health expenditures found that managed care reduced hospital expenditures, but may have actually increased physician expenditures. By contrast, my results suggest that managed care has reduced both the hospital and physician components of health care spending, and that a principal effect of AWP laws is to mitigate this latter effect. This is an interesting possibility that invites further research.

#### Acknowledgements

Assistant Director for Antitrust. The opinions expressed here are the author's, not those of the Federal Trade Commission or any individual Commissioner. I thank Denis Breen, Jonathan Gruber, Paul Pautler, and an anonymous referee for helpful comments. Remaining errors are mine.

#### References

- Atkinson and Co., 1994. The Cost Impact of "Any-Willing-Provider" Legislation.
- Baker, L., Phibbs, C., 2000. Managed care, technology adoption, and health care: the adoption of neonatal intensive care. NBER Working Paper No. 7883.

- Baker, L., 2000. Managed care and technology adoption in health care: evidence from magnetic resonance imaging. NBER Working Paper No. 8020.
- Baker, L., 1997. The effect of HMOs on fee-for-service health care expenditures: evidence from medicare. *Journal of Health Economics* 16, 453–481.
- Baker, L., Corts, K., 1996. HMO penetration and the cost of health care: market discipline or market segmentation. *American Economic Review* 86, 389–394.
- Baker, L., Corts, K., 1999. The effects of HMO's on conventional health insurance premiums: theory and evidence. Manuscript.
- Basu, J., Lazenby, H., Levit, K., 1995. Medicare spending by state: the border-crossing adjustment. *Health Care Financing Review* 17, 219–241.
- Bound, J., Jaeger, D., B. . . R., 1995. Problems with instrumental variables estimation when the correlation between the instruments and the endogenous explanatory variable is weak. *Journal of the American Statistical Association* 90, 443–450.
- Cutler, D., Sheiner, L., 1998. Managed care and the growth of medical expenditures. In: Garber, A. (Ed.), *Frontiers in Health Policy Research*, Vol. 1. NBER, New York, pp. 77–115.
- Cutler, D., Zeckhauser, R., 2000. The anatomy of health insurance. In: Culyer, A., Newhouse, J. (Eds.), *Handbook of Health Economics*, North Holland, Amsterdam.
- Feldman, R., et al., 1993. The effect of HMOs on premiums in employment-based health plans. *Health Services Research* 27, 779–811.
- Feldman, R., Dowd, B., 2000. Risk segmentation: goal or problem? *Journal of Health Economics* 19, 499–512.
- Friedberg, L., 1998. Did unilateral divorce raise divorce rates? *American Economic Review* 88, 608–627.
- Gaskin, D., Halley, J., 1997. The impact of HMO penetration on the rate of hospital cost inflation, 1985–1993. *Inquiry* 34, 205–216.
- Gruber, J., Hanratty, M., 1995. The labor market effects of introducing national health insurance: evidence from Canada. *Journal of Business and Economic Statistics* 13, 163–173.
- Hellinger, F., 1995. "Any-willing-provider" and freedom of choice laws: an economic assessment. *Health Affairs* 14, 297–302.
- Levit, K., et al., 1995. State health expenditure accounts: building blocks for state health spending analysis. *Health Care Financing Review* 17, 201–230.
- Lewin-VHI, Inc., 1995. The cost of legislative restrictions on contracting practices: the cost to governments, employers, and families.
- Marsteller, J., et al., 1997. The resurgence of selective contracting restrictions. *Journal of Health Politics, Policy and Law* 22, 1133–1189.
- McLaughlin, C., 1987. HMO growth and hospital expenses and use: a simultaneous equation approach. *Health Services Research* 22, 183–205.
- Ohsfeldt, R., et al., 1998. The spread of state any willing provider laws. *Health Services Research* 33, 1537–1562.
- Newhouse, J., 1996. Reimbursing health plans and health providers: selection versus efficiency in production. *Journal of Economic Literature* 34, 1236–1263.
- Porell, F., Wallack, S., 1990. Medicare risk contracting: determinants of market entry. *Health Care Financing Review* 12, 75–85.
- Welch, W., 1994. HMO market share and its effect on local medicare costs. In: Luft, H. (Ed.), *HMOs and the Elderly*, pp. 231–249.
- Wyatt Company, 1991. A cost analysis of state legislative mandates on six managed health care practices.
- Zwanziger, J., Melnick, G., 1988. The effects of hospital competition and the medicare PPS program on hospital cost behavior in California. *Journal of Health Economics* 7, 301–320.

**Jason Hooley**


---

**From:** Dr William Pfeifer [family@ptialaska.net]  
**Sent:** Sunday, March 05, 2006 1:43 PM  
**To:** Brian Hove; Sen. Ralph Seekins; Goeff Bullock  
**Cc:** Jason Hooley; Sen. Fred Dyson; Sen. Gary Wilken; Sheila Peterson; Sen. Lyda Green; Ivy Frye; Sen. Donny Olson; Sen. Kim Elton; Alaska Chiropractic Society - Debbie Ryan; Kurt Hediger (ACS President); Robert Wheeler, Jr (ACS Secretary); Clark Davis (AK Board of Examiners); Jeff Logan; Jamie Mulligan (ACA legal); Tom Daly  
**Subject:** SB 299 - Justice Scalia - Regulating insurance redefinition  
**Attachments:** Law Watch 582292\_1.pdf; SYLLABUS OF THE COURT - Supreme Court Upholds AWP for ERISA -Kentucky.doc

Attached you will find two documents with my highlights. One is a Newsletter from Foley and Lardner discussing the results of the case of **Kentucky Assn. of Health Plans, Inc. v. Miller**, decided April 2, 2003, in the United States Supreme Court. The Court upheld two Kentucky statutes that prohibit health insurers from discriminating against providers who are willing to meet the insurers' terms and conditions for panel participation. The second document is the "Syllabus of the Court" whose decision was written by Justice Scalia for the unanimous decision in this case. Exerpts below come from this document, for your reference.

This case is the basis for SB 299 that the Alaska Chiropractic Society (ACS) has raised questions and concerns about. I have provided these two documents so that you can see that the definitions have changed as result of the decision and clarification made during the Kentucky case. The resulting decision and redefinition now allows states to provide stronger language than those which were in place and tried in the Kentucky case at the time.

**I understand from the Alaska Physicians and Surgeons lobbyist that their concern is that if it is a bill about doctors per se that a court challenge against the bill by the insurance companies will occur. They reiterate that the bill needs to be about "Regulating Insurance."**

**It appears the Alaska Physicians and Surgeons are looking only at a narrow strict re-creation of the Kentucky case and a model of the Arkansas Bill so as to avoid court challenge. It is clear in the attached documents that Justice Scalia's written decision of the court allows for other language so long as it meets two points.**

**Justice Scalia and the Court conclude that:**

**[43]"Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a "law . . . which regulates insurance" under §1144(b)(2)(A), it must satisfy two requirements. First, "a state law must be specifically directed toward entities engaged in insurance. See Pilot Life, supra, at 50, UNUM, supra, at 368; Rush Prudential, supra, at 366. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky's law satisfies each of these requirements."**

**In addition Justice Scalia says that:**

**[48]"our test requires only that the state law substantially affect the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk."**

[37]"We have never held that state laws must alter or control the actual terms of insurance policies to be deemed "laws . . . which regulat[e] insurance" under §1144(b)(2)(A); it suffices that they substantially affect the risk pooling arrangement between insurer and insured. By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds in a manner similar to the mandated-benefit laws we upheld in Metropolitan Life, the notice-prejudice rule we sustained in UNUM,<sup>3</sup> and the independent-review provisions we approved in Rush Prudential. No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer."

[46] ). ERISA's savings clause does not require that a state law regulate "insurance companies" or even "the business of insurance" to be saved from pre-emption; it need only be a "law . . . which regulates insurance," *ibid.* (emphasis added), and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan.

**Justice Scalia's redefinition allows for more extensive language change than what is being presented in SB 299. We will continue communication with the sponsor of the bill and all committee members to strengthen this AWP bill. We believe our prior comments regarding the Bill are just and can be addressed under the guidelines presented by Justice Scalia in the court decision and is in the best interest of the patient.**

**I understand that SB 299 may have been sent back to legislative legal to address the hospital and facilities issue we raised. At this point I don't know what else is being considered and have not seen a new version of the bill. This bill should be kept in committee and redrafted in legal to assure true non-discrimination against any type of provider. In fact it should be addressed in terms of covered conditions regardless of provider.**

**The insurance company can decide what conditions they choose to cover but if a condition is covered there should be no discrimination against providers providing it. Any willing provider with the scope of practice and who is appropriately licensed by the state should be able to agree to the terms of participation. There should also be no discrimination in terms of payment for same services since this could, or would, likely be part of the agreement that any willing provider would have to consider when deciding to be a participant or not.**

**Therefore Page 1 line 12, 13 and page 2 line 1 of the existing bill need to be struck where it states:**

**"This subsection does not affect different reimbursements to different types of health care providers, nor does it affect coverage for the service of a particular type of health care provider."**

**I am also aware that the exception to Workers compensation referenced in SB 299 is**

due to the fact that ERISA cannot be applied to Workers compensation. Since that is already in Federal law it seems unnecessary to have it stated in this Bill. Therefore ACS would still support striking this language since it appears unnecessary. If you have not received our original comments let me know and I can forward them to you.

**The Alaska Chiropractic Society asks that SB 299 be sent to Legislative legal with the explicit intent and instructions to strengthen the anti-discrimination language of the bill so that it protects all types of providers and will also meet Justice Scalia's definitions and two requirements he laid out in the Kentucky court decision.**

**Please call me if you need clarification or have opinions to the contrary from legislative legal.**

Thank You for your consideration,

**Dr Bill Pfeifer  
ACS Vice President  
ACS Legislative Chairman**

**William D. Pfeifer DC  
2901 Baranof Ave  
Ketchikan, AK 99901**

**Wk 907-225-9090  
Hm 907-247-2267**

**[family@ptialaska.net](mailto:family@ptialaska.net)**

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: SB 299  
 ( ) Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): 3/13/06 8:56 a.m. Dept. Affected: Administration  
 Title An Act prohibiting unfair discrimination against a health provider willing to meet health insurer's terms.. RDU Centralized Administrative Services  
 Component Group Health Insurance  
 Sponsor Senator Seekins  
 Requester (S) HES Component No. 2152

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

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	*	*	*	*	*	*
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	*	*	*	*	*	*

<b>CAPITAL EXPENDITURES</b>						
-----------------------------	--	--	--	--	--	--

<b>CHANGE IN REVENUES ( )</b>						
-------------------------------	--	--	--	--	--	--

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1017 Group Ben	*	*	*	*	*	*
<b>TOTAL</b>	*	*	*	*	*	*

Estimate of any current year (FY2006) cost: 0.0  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)  
 This bill would prevent unfair discrimination against a health care provider who is willing to meet a health insurer's terms and conditions for participation in the insurer's plan, policy, or contract for health care services and amends the definition of 'provider' as it relates to authorized collective negotiations by physicians affecting rights of providers under health benefit plans.  
  
 Group Health Insurance is submitting an interminate fiscal note based on the legislation.

Prepared by: Melanie Millhorn, Director Phone 465-4408  
 Division Group Health Insurance Date/Time 3/13/06 12:42 PM  
 Approved by: Mike Tibbles, Deputy Commissioner Date 3/13/2006  
 Agency Department of Administration

24-LS1474VF

Bailey

3/3/06

**SPONSOR SUBSTITUTE FOR SENATE BILL NO. 299**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-FOURTH LEGISLATURE - SECOND SESSION**

**BY SENATOR SEEKINS**

**Introduced:**

**Referred:**

**A BILL**

**FOR AN ACT ENTITLED**

1 "An Act relating to preventing unfair discrimination against a health care provider who  
 2 is willing to meet a health insurer's terms and conditions for participation in the  
 3 insurer's plan, policy, or contract for health care services; amending the definition of  
 4 'provider' as it relates to authorized collective negotiations by physicians affecting the  
 5 rights of providers under health benefit plans; and providing for an effective date."

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 \* **Section 1.** AS 21.36.090(d) is repealed and reenacted to read:

8 (d) A health insurer may not discriminate against a health care provider who is  
 9 located in the geographic coverage area of a health benefit plan if the health care  
 10 provider is willing to meet the terms and conditions for participation established by the  
 11 health insurer. This subsection applies to a health benefit plan that affects the rights of  
 12 an Alaska insured. This subsection does not affect different reimbursements to  
 13 different types of health care providers, nor does it affect coverage for the service of a

1 particular type of health care provider. In this subsection,

2 (1) "health benefit plan"

3 (A) means a health insurance policy or certificate, health  
4 maintenance organization contract, hospital or medical service corporation  
5 contract or certificate, self-insurance plan, plan provided by a multiple  
6 employer welfare arrangement, or group health insurance policy to the extent  
7 permitted by 29 U.S.C. 1001 - 1461 (Employee Retirement Income Security  
8 Act);

9 (B) does not include insurance under AS 23.30 (Alaska  
10 Workers' Compensation Act);

11 (2) "health care provider" means a state licensed, certified, or  
12 otherwise authorized

13 (A) physician;

14 (B) podiatrist;

15 (C) chiropractor;

16 (L, physical therapist;

17 (E) speech language pathologist;

18 (F) audiologist;

19 (G) dentist;

20 (H) optometrist;

21 (I) psychologist;

22 (J) counselor;

23 (K) marital and family therapist;

24 (L) pharmacist;

25 (M) occupational therapist;

26 (N) long-term care facility;

27 (O) ambulatory surgery center;

28 (P) rural health clinic;

29 (Q) social worker;

30 (R) advanced nurse practitioner;

31 (S) dietitian or nutritionist; or

1 (T) community mental health center or clinic;

2 (3) "health insurer" means an entity that is authorized by the state to  
3 offer or provide health benefit plans, policies, subscriber contracts, or similar contracts  
4 that indemnify or compensate health care providers for providing health care services.

5 \* Sec. 2. AS 23.50.020(o)(2) is amended to read:

6 (2) "provider" means a state licensed physician, physician assistant,  
7 dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse  
8 practitioner, naturopath, physical therapist, occupational therapist, marital and  
9 family therapist, psychologist, psychological associate, licensed clinical social  
10 worker, or certified direct-entry midwife [HAS THE MEANING GIVEN IN  
11 AS 21.36.090(d)].

12 \* Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

**Beech  Street**  
**C O R P O R A T I O N**

25000 Commercetown Drive  
Lake Forest, Ca. 92630-8855  
949-639-5841  
FAX: 949-458-4978  
[Frank.Krumpal@beechstreet.com](mailto:Frank.Krumpal@beechstreet.com)

March 13, 2007

The Honorable Senator Dyson

FAX: 907-465-4587

Re: Alaska Senate Bill 299 - Any Willing Provider Provisions

Dear Senator Dyson:

Beech Street, a national preferred provider organization, which has a network of hospitals, physicians, and ancillaries throughout the State of Alaska would like to express its opposition to Alaska Senate Bill 299 – Any Willing Provider.

SB299 would impact the ability of health plans to obtain favorable negotiated discounts for health care services. This legislation would open up the health plan's provider network to all providers and thus we would not be able to channel patients to the providers desired by our customers and who have met our credentialing criteria. Providers who come into the network due to Senate 299 are those who would not render favorable discounts to Beech Street and our members in Alaska. Healthcare costs for the citizens of Alaska would increase.

Any willing provider mandates may seem like they would benefit consumers since they allow the greatest number of providers into a plan but these laws actually have a serious negative consequence. Since any doctor who wishes to participate with a plan can, it makes it much harder for carriers to negotiate any discounts with providers, since there is no financial consequence for non-participation. This leads to higher medical reimbursement costs for all plans in the state, which translates into higher insurance rates for consumers."

Health plans are currently able to negotiate discounted fees from health providers (hospitals, physicians, pharmacies, and other service providers) because they are able to

deliver directed patient volume to contracted providers and reduce administrative burden. This results in a mutually beneficial contractual relationship between providers and health plans.

Small employers have a low elasticity of demand to price increases in health insurance. As the price of offering health insurance increases, employers will drop (or not offer) coverage to their employees. This resulting burden of additional uninsured consumers in the market will have a compounding effect on the price of health care in Alaska.

A recent preferred provider hospital request for proposal (RFP) demonstrated that significantly better discounts were offered when the health plan offered a plan with differential preferred provider (PPO) plan provisions as opposed to a passive PPO arrangement.

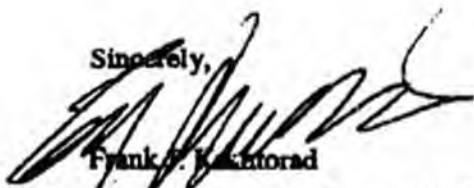
The Federal Trade Commission (FTC) has taken a strong stand in opposition to any willing provider provisions. The Federal Trade Commission and Department of Justice report, *Improving Health Care: A Dose of Competition*, July 2004, states: "Commission staff has expressed concerns about AWP (Any Willing Provider) and FOC (Freedom of Choice) laws, noting that they could have anticompetitive effects and harm consumers. These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that would likely result from restricted provider networks. They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand. These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans."

Beech Street had experience with the Any Willing Provider Legislation in the State of Virginia. CAPP CARE, the organization prior to the merger with Beech Street, was required to go to District Court in the State of Virginia. A physician had sued CAPP CARE since she was excluded from the CAPP CARE Network. The District Judge ruled that CAPP CARE had the right to run its business as it saw fit. The Company had the right to exclude physicians and providers that it deem unfit for its network. The District Judge overruled the Any Willing Provider Legislation here.

The Alaska Market has almost no penetration of managed care. Physician Charges are substantially higher in Alaska than any other state. AWP legislation will harm consumers even more through an increase in the price of health care and a decrease in the availability of employer-sponsored health plans.

We would appreciate your vote against Any Willing Provider Legislation.

Sincerely,



Frank S. Kantorad

Director, National Contracting Programs



March 13, 2006

The Honorable Senator Fred Dyson  
Chair, Senate Health, Education and Social Services Committee  
Alaska State Capitol, Rm. 121  
Juneau, AK 99801

Re: Senate Bill 299 – Oppose

Dear Senator Dyson:

On behalf of Aetna, I am writing to express our opposition to Senate Bill 299, relating to a proposed any-willing-provider statute for health insurers. Senate Bill 299 would mandate insurers offer contracts with any health care providers willing to meet the insurer's reimbursement rates and credentialing requirements – even if additional providers are needed at the time and regardless of quality measurements the insurer may use to designate the most qualified and efficient providers in the community.

Moreover, this bill would limit the ability of insurers to seek favorable reimbursement rates with some providers in exchange for increased patient volume. Simply put, if all providers have the same guaranteed access and payment rates, competition among providers is discouraged. As a result, individuals and employers will likely experience higher costs.

Today, consumers have the choice to see just about any provider they want. They may have higher co-insurance amounts if seeking services from a non-contracted provider, but they do have a choice. Products that utilize networks are designed because employers are asking for lower premiums – this is one way an insurer can control costs. Aetna would not want to see this option diminished to the point it would not serve that purpose.

Finally, the legislation would be detrimental to consumers because it would increase costs, reduce choice of products in the market place, and restrict the ability of insurers to promote the highest quality care available. For these reasons, Aetna respectfully requests your opposition to Senate Bill 299. Should you have any questions, please do not hesitate to contact me directly at (916) 817-6869, or you can contact our retained lobbyist, Reed Stoops, at (907) 463-3223.

Thank you for your time and consideration.

Sincerely,

A handwritten signature in cursive script that reads "Kris Frank".

Kris Frank   
State Government Relations, West Region

SB 299

Testimony of Rosemarie Kalamarides, Administrator for the Alaska Teamster Health Plan

Thank you for the opportunity to testify against Senate Bill 299.

The premise under which this legislation is being introduced and argued is that individuals buy their own health care. This is not true.

Out of over \$5 billion spent in Alaska last year, only about 5% was paid on individual policies. The average cost per employee is higher in Alaska than in the rest of the U.S. However, workers pay a smaller share here. Health care spending was almost \$8,000 per Alaskan in 2005. Spending is increasing approximately 9% per year.

Most health care is funded by employers for their employees. This legislation impacts Alaskan employers directly and negatively. It will increase the already huge share of their budgets that health care costs represent. It also impacts their employees directly and negatively. As health care costs continue to increase, employers shift the increase to their employees.

What happens then when "any willing provider" legislation is passed? Employers have no ability to negotiate group discounts with providers. Employers can only negotiate discounts if they can guarantee volume. With this legislation, they cannot guarantee volume and costs, therefore, increase. These increases are then passed on to their employees. Employees' out of pocket expenses increase; in some cases to 100%, as many employers are simply dropping health care, leaving employees to fend for themselves.

This type of legislation has been popular in states where the reaction to rising health care costs was managed care. There is virtually no managed care in Alaska. Therefore, the usual scare tactics that are being used to by the proponents of this bill are a smoke screen. This legislation is intended to increase the income of doctors, nothing more.

According to a recent ISER study, medical and surgical procedures in Alaska are 18% higher than elsewhere in the U.S. Doctors are paid well here. They don't have to content with managed care, there are no HMOs here. **THERE ARE NO HMOs HERE!**

Some doctors resist signing into networks because they don't want to negotiate lower rates, even for volume. That is their choice. Attempting to regulate their industry through anti-competitve legislation is stepping into the past. If we still lived in an economy that heavily regulated industries, like back in the 60's and 70's, then this legislation might make sense. But it is anachronistic and serves to protect the income of physicians...physicians who are already well paid.

This legislation serves to burden employers even more and make it more difficult for them to provide health care to their employees.

This legislation impacts my employer's ability to address quality care. By working with smaller groups of hand-picked physicians, my employer is able to provide me direct access to excellent care.

My health plan recently introduced a Disease Management Program which works directly with our employees on improving health. With the aid of a personal health coach, the program guides the employee to better health by helping them increase their physical activity, develop healthy eating habits and stop smoking. This legislation would increase the cost of the disease management program by allowing any company to provide these services to our employees.

If I were paying for my own health care costs, I would feel strongly that I should have the choice to pick any doctor regardless of price; after all, I would be paying the bill. If I were paying for my own health care, this legislation even if passed would have no impact on me.


But I'm not paying for my health care. Just like the vast majority of Alaskans, my employer is paying the bill and I leave it to my employer to negotiate the best networks they can find to keep my and my coworkers health care costs low so that next year, perhaps the increase in the wage package can go into my retirement or my pocket, instead of my health care. I certainly do not want to give my raise next year to my doctor.

If I were paying my own health care, I would shop around and find the right doctor at the right price. Fortunately, my employer does that for me.

As legislators, under the ruse of this legislation, you would actually be taking choice away from your constituents. The choice to put money into retirement or into wage increases. This legislation only serves to increase health care costs as it shifts money from workers' pockets to doctors' pockets.

I understand that doctors tend to be big campaign contributors, but your duty is to your constituents, all of them, not just a select few.

Please do not pass this piece of legislation out of committee.

  
3-13-06

Jack C. McRae  
Senior Vice President

March 23, 2006

Senator Fred Dyson, Chair  
Senate Health, Education & Social Services Committee  
Alaska State Legislature  
State Capitol, Room 121  
Juneau, Alaska 99801-1182

RE: Senate Bill 299

Dear Senator Dyson,

I am writing on behalf of Premera Blue Cross Blue Shield of Alaska in opposition to Senate Bill 299, typically called an "any willing provider" measure. My comments relate specifically to the draft Sponsor Substitute (version "F").

In short, SB 299

- is based on false assumptions,
- fails to recognize the significant value of health insurers' provider networks, and
- does nothing to address rapidly escalating health care costs in Alaska.

#### False assumptions

Proponents of SB 299 argue that insurers exclude providers from their networks, thereby causing disruption of services to consumers. Frequently cited examples involve the situation where a consumer's personal physician is not on the provider network serving their employer's health insurance plan. The implication is that the insurer has not allowed the physician to participate. In fact, the reality is just the opposite.

Premera Blue Cross Blue Shield of Alaska has been contracting with Alaska providers for approximately 20 years. In those years of experience we have found that consumers most frequently are disadvantaged, not because insurers exclude providers, but instead because providers refuse to contract with insurers. Typically, instead of switching providers, a consumer will stay with his or her provider of choice but be forced to pay significant "balance billing" charges billed by the provider who refuses to contract with the consumer's health insurer.

Most states where "any willing provider" bills have been introduced are characterized by a strong market presence of health maintenance organizations (HMOs). Historically HMOs have sought to control costs by restricting payment for insurance benefits to a

relatively small, carefully selected panel of providers. Proponents of SB 299 have invoked the specter of HMOs in Alaska practicing exclusionary tactics that will disrupt services to consumers. That is a bogus argument that blatantly ignores the realities of the Alaska market and the legislative framework in which it operates.

To my knowledge, virtually no HMOs or true "managed care" plans exist in Alaska. Because of persistent and ultimately successful efforts by some in the medical community, the legislature effectively outlawed HMOs with the passage of SB 197 in 1998.<sup>1</sup> That measure requires any HMO to offer every enrollee the option of receiving services from out-of-network providers. Further, the "Patient Bill of Rights" enacted in 2000 (HB 211) requires that any insurer offering a closed-network plan also offer a non-network option to enrollees.<sup>2</sup> These measures assure that people covered by health insurance plans will not be "forced" to change providers when their plan changes, in spite of what SB 299 advocates are attempting to lead legislators to believe.

I urge you not to be misled by the arguments of SB 299 proponents. The problems they bring forward are extremely rare in Alaska, if they exist at all. SB 299 is simply an outmoded "HMO-backlash" law copied from the lower 48 states. It has no relevance for today's Alaska market.

#### The Value of Provider Networks

A broad and robust provider network is arguably the greatest value a health insurer can bring to an Alaska consumer. Basically, the insurer and provider agree that the provider will accept the insurer's allowed amount as payment in full for a given service, and the consumer will be "held harmless" or not charged for any difference between the provider's actual charge for the service and the amount allowed by the insurer. Frequently these "balance billing" amounts can be significant, in the hundreds or even thousands of dollars, depending on the service provided.

Contrary to the arguments of SB 299 proponents, Premera Blue Cross Blue Shield of Alaska customers are not forced to choose between lower costs and choice of provider. Our enrollees currently have a wide choice of providers in all categories, and our networks are open to any provider listed in version "F" of SB 299.<sup>3</sup>

---

<sup>1</sup> AS 21.xx.xxx

<sup>2</sup> AS 21.07.030(a)

<sup>3</sup> Page 2, lines 13-31 through page 3, line 1.

Premiera Blue Cross Blue Shield of Alaska quantified the value of our provider network in the context of the recent award to administer health benefits for Alaska state employees. In our proposal for that business, we stated that our provider network would save \$45 million for persons covered under the state's plan. That number represents both a huge monetary value for the state as a purchaser and peace of mind and financial protection for consumers enrolled in the plan.

### Health Care Costs – the Real Problem

The value of provider networks illustrates the key role that health insurance plays in mitigating trends of ever-increasing health care costs. Cost is a nationwide problem, but one that is particularly serious in Alaska.

A recent study by the Institute of Social and Economic Research at the University of Alaska<sup>4</sup> offers striking illustrations of the gravity of this problem and its consequences for Alaska consumers. The authors note that medical costs average 25% higher in Alaska compared to the rest of the country, with variations depending on the type of service.<sup>5</sup>

Figures that compare costs for doctor office visits are even more striking. In Alaska the average cost in 2001 was \$79, compared to a U.S. average of \$61, or 30% higher in Alaska compared to the rest of the U.S.<sup>6</sup>

Patients seeing doctors who refuse to join health insurers' networks feel a direct impact of higher Alaska costs. The authors of the study estimate that individual Alaska consumers pay approximately \$1 billion of the total annual Alaska health care bill. The authors attribute \$431 million of that \$1 billion to out-of-pocket costs. For consumers who have health insurance, those costs include not only deductibles and coinsurance required by the plan but also "balance bills" from out-of-network providers who refuse to contract with the health insurer.

For consumers, a contracted provider network represents financial peace of mind. For providers who bill significantly higher than amounts allowed by the insurer, the network contract represents substantial loss of revenue. For these providers, SB 299 does nothing to help their patients. The real problem for Alaska consumers is that health care costs start higher and are increasing faster than in the rest of the country, and it costs 30% more to go to the doctor than anywhere else in the United States.

---

<sup>4</sup> Mark Foster and Scott Goldsmith, Alaska's \$5 Billion Health Care Bill – Who's Paying? Understanding Alaska Research Summary No. 6, Institute of Social and Economic Research, University of Alaska Anchorage, March 2006.

<sup>5</sup> Foster and Goldsmith, page 7.

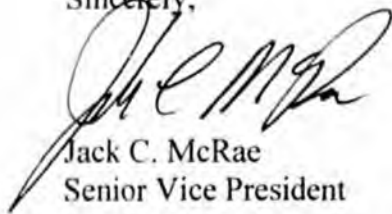
<sup>6</sup> S. as preceding note.

March 23, 2006

In closing, allow me to reiterate: SB 299 is ill-advised, unneeded legislation that does nothing to ease the \$1 billion health care price tag borne by today's Alaska consumers. Based on false assumptions, it undermines insurers' provider networks while doing nothing to address rapidly escalating health care costs in Alaska.

Premera Blue Cross Blue Shield of Alaska greatly appreciates the opportunity to offer these comments. If you have questions about our concerns, please do not hesitate to contact me.

Sincerely,



Jack C. McRae  
Senior Vice President  
Premera Blue Cross Blue Shield of Alaska

CC: Jerry Reinwand  
Phyllis Kilgore, Legislative Chair, AAHU