ALASKA LEGISLATURE 1975

HOUSE and SENATE FINANCE COMMITTEE FILES, 1999 - 2000

126

WHAT ELSE TO LOOK FOR IN 1999

◆ **Higher premiums:** After several years of almost level rates charged to employers and consumers, premiums are headed up. The latest survey, released in January, confirmed HMO premiums are rising 8 percent to 10 percent this year, the largest jump since 1993 (the year of President Clinton's national health reform proposal). At the same time, traditional indemnity health insurance rates also are rising 8 percent, but HMO premiums remain about 20 percent cheaper.

However, copayments and deductibles will become higher and more widespread, as many employers seek ways to continue health benefits for employees without footing the entire bill. Some state regulators may again examine the possibility of capping certain insurance rates.

In the private market, the Midwest Business Group, representing 110 large employers in 11 midwestern states, is "strongly encouraging members to hold the line on premium renewals and to consider tactics such as freezing enrollment in plans where there are large rate increases, raising copayments and deductibles for employees, and warning employees that more drastic changes might be contemplated," according to Larry Soress, the group's vice president.

◆ **Prescription costs:** Most analysts, including the federal Health Care Financing Administration (HCFA), say the main cause of 1999 rate increases is pharmaceutical prices, which are up about 17 percent since last year. Perhaps that's why 24 legislatures say they will look more closely at drug costs, either through regulating formularies and generic substitutes or acknowledging special drug copayments.

◆ **Slow-down of government program enrollment:** After almost a decade of enthusiasm for enrolling Medicaid consumers in managed care, the focus is shifting. There is more emphasis on enforcing the rights of consumers, as well as legislative studies and audits to determine if cost savings are real, and if they can continue. Meanwhile, a push to enroll Medicare recipients in managed care collapsed in a high-visibility dispute between HCFA and managed care organizations about reimbursement rates. HMOs in 29 states announced they were pulling out of the Medicare market, affecting over 450,000 seniors. This dispute may fuel state legislative oversight hearings and investigations, although the resolution remains under federal jurisdiction.

◆ **Direct contracting:** Many large employers and some smaller ones are watching very closely an experiment in Minneapolis-St. Paul. A business consortium has pooled resources to contract directly with doctors and hospitals to provide health care, effectively bypassing HMOs. Policymakers in some other states may conduct their own studies to determine how direct contracting might work in their regions.

◆ **Voluntary improvements:** The American Association of Health Plans is putting its faith in improving quality and in convincing consumers that new regulatory burdens will make things worse, says Karen Ignani, trade association president and corporate executive officer. She expects a "continued evolution" that puts consumers in the driver's seat by giving them more choice of providers and benefits. However, legislators remain skeptical. As Massachusetts Senator Mark Montigny, chair of the Senate Ways and Means Committee and chief sponsor of a 1999 consumer rights bill, notes: "Health care decisions are now driven by third party money managers, obsessed with the bottom line. A comprehensive managed care reform bill will restore the provider-patient relationship and ensure quality health care delivery at reasonable cost. Angry consumers will demand reform in 1999 and we must act with an aggressive bill that puts patients first."

Senator Mark Montigny Massachusetts

◆ **Health vouchers:** Some private sector employers are proposing a simplified voucher system, providing each employee with a standardized monthly payment. This could get employers out of the health decision business in which they have to preselect a limited list of health plans. However, some policymakers question whether the average employee will be able to pick up the remaining costs, especially of family coverage. Expect to see some state interest in either encouraging or further regulating such arrangements.

◆ **Congressional action.** Both parties in Congress and the Clinton administration have said "patient protection" is a top priority for 1999. In the wake of last year's debate over sharply differing bills, key questions are not yet resolved: Will a new federal law replace or preempt existing state laws, especially when the state law is stronger? Will it fully cover other insurance plans that now are outside state regulatory authority?

"The future of state regulation of insurance hangs in the balance of the ongoing debate on regulating managed care," notes Joy Johnson Wilson, director of NCSL's Health Committee.

(Continued from page 15)

the need for emergency hospitalizations."

In fact, says de Montmollin, the most noteworthy thing about the movie scene is that a single waitress in a diner has health insurance for her son at all. "Wow, that's fabulous—fewer than half the women in her situation have any access to coverage," he says.

Rising costs make it harder for businesses and governments alike to provide coverage for the nearly 44 million Americans who remain uninsured. Managed care has been touted as a way to save money that can be used to cover additional people. However, the numbers of uninsured have increased in the past 10 years.

Compared to other insurance, "HMOs generally offer more benefits, including coverage for prescription drugs, and fewer deductibles and copayments," notes William Falk of Towers Perrin, a research firm in Chicago. He expects most employers to stick with HMOs. They are "still an attractive alternative."

But striking a balance between consumer protections and micromanagement remains a challenge.

CONSUMERS NEED HELP

Establishing publicly funded consumer assistance or "ombudsman" programs may be one way to address consumer needs without overregulating managed care plans.

"The public is very confused," says Ron Pollack, executive director of Families USA, a consumer advocacy group. He says the managed care backlash comes from a variety of factors. "I think people clearly do not understand

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— *Health Care Legislation*, 1997 (#6669) and 1998 (#6674) editions.
— *1999 State Health Care Priorities* by the Health Policy Tracking Service (#3029).
— Issue Brief: *Comprehensive Consumer Rights Bills*, by the Health Policy Tracking Service (#0233).
— *Major Health Care Policies: 50 State Profiles*, 1998 (#3027).
— Also check out NCSL's Health Care Web index: www.ncsl.org/programs/health/hc

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today what their choices are, what their rights are and how they can claim those rights. To the extent that we're really going to address the core of people's problems or concerns, we need to provide some specific assistance to consumers."

Pollack says consumer assistance programs would give people information about plans, help them understand their choices and rights, answer questions through free phone access, and help those who want to file an appeal. He also says that such programs can help the managed care plans, employers and regulators. "They can provide a basis for getting quick information about what the problems are that arise as our health care system changes."

"A 'patients bill of rights' should not dictate clinical decisions or redesign health benefits packages," Pollack says. "But such state laws are very important because they help to ensure that patients get the care they need, when they need it. And they give patients and physicians effective tools to fight HMOs' wrongful denials and delays of care," he explains.

THE FUTURE

Evidence points to continued lively and high visibility debate about managed care, including new state laws, renewed congressional debate and more indepth studies of the effect of the recent state laws.

"What will eventually shake out as the health care system in the next century likely will be a muddle of market, policy, regulatory and professionally driven solutions," says Edward O'Neil, director of the Center for the Health Professions at the University of California.

"Such pluralistic approaches are typically the American way of doing things. The best solutions occur when we are clear about our aims and use the various vehicles of market, policy and professions to implement what we desire. But in this case, we do not have the capacity to generate a community or public definition of aim. Until we find a genuine voice for the varied interests in health care, we are likely to continue to suffer the cacophony of competing interests clashing over the $1.1 trillion that is health care in America, and to blame managed care for it all."

4-12-00

Subject: Re: ERISA
Date: Fri, 15 Oct 1999 22:18:52 -0800
From: bob_lohr@dced.state.ak.us (Bob A Lohr)
To: Janet Seitz <Janet_Seitz@legis.state.ak.us>, Bob_Lohr@dced.state.ak.us

The federal Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 et seq (ERISA) comprehensively regulates empoyee pension and welfare plans. An employee welfare plan or welfare benefit plan is defined as one that provides to employees medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability or death. Employer may provide these benefits by purchasing insurance or by self-insuring. Accordingly, any plan that meets this federal definition, whether it is insured or not, is covered by ERISA, except plans for governments, churches, workers' compensation benefits, or an unfunded excess benefit plan.

Under ERISA, uniform procedural standards are established concerining reporting, disclosure, and fiduciary responsibility for welfare and pension plans. ERISA does not regulate the substantive content of welfare-benefit plans. As a result, ERISA contains almost no federal regulation of the terms of benefitplans. On the other hand, ERISA does contain broad preemption provisions to declare that ERISA supersedes any and all state laws insofar as they may now or hereafter related to any employee benefit plan. This preemption provision is substantially qualified by the "insurance saving clause", which states that nothing in ERISA shall be construed to exempt or relieve any person from any law of any state that regulates insurance, except that a employee benefit plan may not be deemed to be an insurance company for the purposes of any state law purporting to regulate insurance companies.

The United States Supreme Court has held that state mandated benefit laws as applied to insurance companies selling insurance to benefit plans are laws that regulate insurance and are, therefore, saved from ERISA preemption. But these same mandated benefit laws are preempted with respect to self-insured benefit plans, because such plans may not be deemed an insurance company for purposes of state law. This means fully insured benefit plans in Alaska must comply with Alaska's mandated benefit laws, but self-insured plans do not.
As stated above, governmental plans are exempt from ERISA and, thus, may be subject to state regulation absent other preemptive federal or state legislation. ERISA defines a governmental plan to include a plan established or maintained for its employees by the U.S. government, by the government of any state or its political subdivision or by any agency or instrumentality of the same. Besides plans of the federal and state governments, school districts, cities, boroughs, municipalities, etc are examples of governmental plans.

With respect to plans for federal government employees, there are federal laws outside of ERISA that govern such plans and the extent of benefits under such plan, such as the Federal Employee Health Benefits Act. Under federal preemption principles, therefore, plans covering federal government employees are generally not subject to state law. With respect to plans for state employees, the Attorney General's office is in the process

of preparing an opinion regarding the application of the insurance code to the state's self-insured health insurance plan, which may also be relevant to any nonfederal governmental plan in this state that is self-insured.

With respect to your question on small employer plans, Alaska law under AS 21.54.500 defines a small employer as one that employed an average of at least two but not more than 50 employees on the business days during the preceding calendar year and that employs at least two employees on the first day of a health benefit plan year. A large group employer means an employer that employed an average of at least 51 employees on the business days during the preceding calendar year and that employed at least two employees on the first day of a health benefit plan year. The requirements for small employer group plans are established under AS 21.56.

Sorry this is so lengthy, but that's federal law for you. If you have any questions, please let me know.

Janet Seitz <Janet_Seitz@legis.state.ak.us> wrote:
>*Bob:*
>
>*Do you have anything that explains ERISA and who is covered and who*
>*isn't? We have been told in the past that governmental plans (state,*
>*local, federal) are not covered and that self-insured plans are not*
>*covered. When I reviewed ERISA, I found reference to government plans*
>*and church plans but not self-insured plans. Also, is there any*
>*minimum number of people in a "small" plan.*
>
>*Thanks*
>
>*Janet*
>*Rep. Rokeberg's Office*
>
>

HB
211

SFIN FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 4/17/00

REPORTED OUT OF SFC 4/15/00

FURTHER:

DATE TURNED IN TO OFFICE: 4/19/00

Finance Committee considered CS FOR HOUSE BILL NO. 211(FIN) am

"An Act relating to regulation of managed care insurance plans; amending Rule 602, Alaska Rules of Appellate Procedure; and providing for an effective date."

and recommends:

[✓] be replaced with S CS CSHB 211 (Fin)
[ ] adopt previous ______ CS ______ (______)
[ ] attached amendment(s)
[ ] adopt Letter of Intent by ______
[ ] further referral to the ______ Committee

CS Forthcoming

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR* ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
[signature]	✓	[signature]	✓		
[signature]	✓	[signature]	✓		
		[signature]			
		[signature]	X		
		[signature]	✓		
Co-Chair: [signature]	✓	Co-Chair:			
Co-Chair:		Co-Chair:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal
DCED	3/7/00	✓	

[ ] APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

REPORTED OUT OF
SFC 4/19/00

No: 1

FISCAL NOTE

Bill Version: CSHB 211(L&C)
(H) Publish Date: 3/8/00

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Revision Date/Time (Note if correction) 03/06/00
Dept. Affected Community & Economic Development
Title An Act relating to liability for providing managed care services, to regulation of managed care insurance plans . . .
BRU Insurance
Component insurance
Sponsor Rokeberg
Requester (H) L&C
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

Sec. 21.07.020, page 7, lines 8-11 require that a managed care entity provide actuarial support to the director upon request for the increased cost of using a non-network provider. It is estimated that fewer than 15 insurers have provider network provisions in their health insurance contracts. Therefore, it is anticipated that no additional resources will be needed to request and review the increased costs of non-network provider use.

Sec. 21.07.060, page13, line 17, requires that the director approve "qualified private standard-setting organizations". It is estimated that there are currently fewer than 5 of these organizations. Therefore, it is anticipated that no additional resources will be needed for the director to certify these "qualified private standard-setting organizations". Also, it is anticipated that no additional resource will be needed to develop regulations, should they be needed, to define related party as provided on page 14, lines 20-22 of this section.

Prepared by: Robert A. Lohr
Phone 269-7900
Division Insurance
Date/Time 3-7-00 9:28 AM
Approved by Commissioner Deborah B. Sedwick
Date 3-7-00
Agency Community & Economic Development

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COMMITTEE COPY

SENATE FINANCE COMMITTEE
Amendment Number: #2
Bill Number: HB 211
Sponsor: [illegible] Date: 4/19/00
Logged In By: Mindy

AMENDMENT

OFFERED IN THE SENATE

TO: CSHB 211 (FIN) AM

Page 7, line 13:

Delete "Medical"

Insert "Notwithstanding AS 21.86.280, medical"

Page 7, line 18, following "gives":

Insert "oral, electronic, or"

Page 7, following line 30:

Insert a new subsection to read:

"(c) Nothing in this section may be construed to prohibit the exchange of medical information between and among health care providers of an applicant or a current or former person covered by a managed care plan for purposes of providing health care services."

SENATE FINANCE COMMITTEE
Amendment Number: #2
Bill Number: HB 211
Sponsor: Torgerson Date: 4/19/00
Logged In By: Mindy

AMENDMENT

OFFERED IN THE SENATE

TO: CSHB 211 (FIN) AM

Page 7, line 13:

Delete "Medical"

Insert "Notwithstanding AS 21.86.280, medical"

Page 7, line 18, following "gives":

Insert "oral, electronic, or"

Page 7, following line 30:

Insert a new subsection to read:

"(c) Nothing in this section may be construed to prohibit the exchange of medical information between and among health care providers of an applicant or a current or former person covered by a managed care plan for purposes of providing health care services."

SENATE FINANCE COMMITTEE

2000 COMMITTEE ACTION

Bill Number	HB 211
Amendment	#2
Motion	
Motion by	Sen Parnell
Objection	
Objection by	
Removed	
Second Objection by	
Committee Member	***Vote***
Senator Al Adams	
Senator Gary Wilken	
Senator Pete Kelly	
Senator Lyda Green	
Senator Randy Phillips	
Senator Dave Donley	
Senator Loren Leman	
Co-Chair Sean Parnell	
Co-Chair John Torgerson	
Tally	
Yea	0
Nay	0
Absent	0
MOTION	No Obj.

SENATE FINANCE COMMITTEE
Amendment Number: #1
Bill Number: HB 211
Sponsor: Torgerson Date: 4/19/00
Logged In By: Mindy

1-LS0472\X.1
Ford
4/15/00

AMENDMENT

OFFERED IN THE HOUSE
TO: CSHB 211(FIN)

1 Page 7, line 12:
2 Delete "regarding"
3 Insert "that directly identifies"

4 Page 7, line 13, following "plan":
5 Insert "and that relates to the physical or mental health of or the provision of health
6 care to the applicant or to the covered person or former covered person"

7 Page 7, lines 16 - 17:
8 Delete "gives written consent to the disclosure"
9 Insert "consents to the disclosure in writing, electronically, or in another manner that
10 indicates the individual's consent"

11 Page 7, following line 28:
12 Insert a new subsection to read:
13 "(c) Nothing in this section may be construed to prohibit the exchange of
14 medical information between and among managed care entities, providers, and their
15 respective agents for purposes of providing health care services."

16 Page 14, line 19, following "includes":
17 Insert "health care management and"

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

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ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

Sponsor Statement for CSHB 211 (FIN) am

Alaska Patients Bill of Rights

An Act relating to liability for providing managed care services, to regulation of managed care insurance plans, and to patient rights and prohibited practices under health insurance; amending Rule 602(b), Alaska Rules of Appellate Procedure; and providing for an effective date.

Updated: April 17, 2000

Patients need assurance that the quality of their health care will not be compromised as managed care expands. CSHB211 (FIN) am requires managed care entities to provide a reasonable standard of health care. It also establishes requirements for contracts between managed care entities and their health care providers, patients and their group managed care plans, and health care insurers and their insureds, providing patients with the following:

- access to emergency room services
- availability of medical services or adequate referral options
- full disclosure of treatment options
- choice of health care providers, including specialists
- clear descriptions of covered items and services, benefits, procedures, compensation methods, availability (and exclusions) of prescription medications and the availability of translation or interpreter services
- a point-of-service plan option
- follow-through of preapproved payment
- quick utilization review decisions
- opportunity for appeals of utilization review decisions
- added protection from denial, reduction, or termination of payment for health care services

In addition, this legislation gives health care providers the freedom to share all testing and treatment options with their patients, and lets them advocate for their patients without the risk of being penalized or terminated by the managed care entity they contract with. It also prohibits contracts between managed care entities and health care providers from financial incentives for providers to withhold medically necessary services.

HB211 is necessary to ensure continued quality health care in the face of a growing managed care industry. I urge you to support this legislation.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

)7) 465-3867 or 465-2450
AX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 15, 2000

RECEIVED APR

SUBJECT: Sectional Summary of CSHB 211(FIN)

TO: Representative Norman Rokeberg
Attn: Janet

FROM: Michael F. Ford
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Short title for section 2.

Section 2. Imposes certain provisions that must be included in a contract between a health care provider and a managed care entity. Specifies that certain provisions cannot be included in a contract between a health care provider and a managed care entity. Prohibits an indemnification clause in a contract between a provider and a managed care entity. Requires that group managed care plans include certain contract provisions. Imposes certain requirements regarding a covered persons choice of a health care provider, including a non-network option and continuing treatment by a health care provider whose contract is terminated. Specifies that medical and financial information concerning a covered person or applicant is confidential. Establishes an external appeals mechanism for covered persons. Adds a provision regarding religious nonmedical providers.

Section 3. Makes a violation of AS 21.07 an unfair insurance trade practice.

Section 4. Provision that indirectly amends Rule of Appellate Procedure 602(b).

Section 5. Effective date for sec. 21.07.050(s).

Section 6. Effective date.

MFF:glc
00-181.glc

Memorandum Opinion 95-0654

LEGALITY OF PREFERRED PROVIDER ORGANIZATIONS IN ALASKA

April 21, 1995

I. INTRODUCTION

This is in response to your memorandum dated April 13, 1995, by which you requested an opinion on the following question: "Are Preferred Provider Organizations (PPOs) legal in Alaska?" Our conclusion is that they are lawful, although there is no enabling legislation for

II. BACKGROUND

PPOs are a relatively recent development in the health care delivery arena. For much of this century, traditional indemnity insurance, whether through individual or group insurance policies, provided the primary means for health care reimbursement. In the last few decades, due in large part to the trend of disproportionately large increases in health care costs, alternatives to pure indemnity insurance evolved. Many of these alternatives fall under the rubric of managed care and have a primary purpose of cost containment. For instance, in the 1970s, statutory enabling laws for health maintenance organizations (HMOs) were created.[1] Alaska enacted its version of the HMO model law (AS 21.86) in 1990. However, to date there are no licensed HMOs in Alaska.

In the 1980s, PPOs developed as a managed care device.[2] PPOs are a fee-for-service alternative to traditional health insurance. Due to their dramatic growth they soon became a central feature of health care financing and delivery reform.

The PPO, also referred to as a preferred provider arrangement (PPA),[3] involves purchasers managing the cost of health care through contracting with a group of doctors or hospitals ("preferred" or "network" providers). The salient characteristics of the preferred provider arrangement are as follows. In exchange for discounted fees for services, the providers receive a guaranteed supply of patients and a commitment to quick turnaround on claims payments. Providers also typically agree to comply with utilization review procedures intended to reduce inappropriate or unnecessary care. Through a bulk purchase of medical services, purchasers have the advantage of being able to choose providers based on competitive pricing, which is expected to result in

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cost savings. Patients are offered financial incentives such as reduced or eliminated copayments or deductibles if they use designated preferred providers. PPOs are formed by a wide variety of entities — purchasers as well as providers — including insurers, self insurers (employers), unions, physicians, hospitals, HMOs, service corporations, and third party administrators (often owned by insurers).[1]

At a recent hearing before the Senate Labor and Commerce Committee, a representative of the Division of Insurance was asked whether preferred provider organizations (PPOs) are legal in Alaska. The division's response that PPOs are not lawful has created some controversy. The largest group disability[3] insurer in the state (Aetna Life Insurance Co.) has been utilizing PPOs for years based in part on the division's approval of its insurance forms. The Division of Retirement and Benefits also has expressed concern regarding the use of PPOs in the state health plan. As a result, you have referred this question to the Department of Law for a legal opinion.

III. ANALYSIS

PPOs are lawful in Alaska. While there is no enabling legislation for PPOs, no provision of AS 21 on its face prohibits the formation of PPOs or contracting with such entities.

By way of background, and as previously indicated in this memorandum, there is a model law developed by the National Association of Insurance Commissioners (NAIC) entitled the "Preferred Provider Arrangements Act." Currently, over half of the states (29) have adopted some version of the PPO model by legislation, regulation, or bulletin.[6] Alaska has not adopted a version of the model. Whether or not it should have is beyond the scope of this opinion.

It is noteworthy that states have been criticized for passing laws that impede the implementation of PPOs. Even before the creation of the model act, legislation was introduced in Congress in 1983 to prohibit states from restricting the operations of the already emerging PPO mechanism.[7] The existence of PPOs in the absence of enabling legislation is also evidenced by a drafting note for Section 2 of the model (Purpose), which states: "The use of the term 'allowing' in this section is not intended to indicate that health care insurers are acting unlawfully in a state which has not enacted a law allowing Preferred Provider Arrangements."[8]

Although federal law recognizes the PPO mechanism, it does not

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answer the question whether PPOs are legal in Alaska. In a regulation implementing the Medicare program, the Department of Health and Human Services refers to health plans having "premium structure regulated under a State insurance statute or a State enabling statute governing health maintenance organizations or preferred provider organizations." 42 C.F.R. § 1001.952(1)(2). This regulation does not mandate the use of an enabling law for PPOs. The CHAMPUS program, which expressly authorizes federal officials to contract with PPOs, also does not require a state enabling statute. *See* 10 U.S.C. § 1095.

There are no published cases, state or federal, addressing whether PPOs are lawful in the absence of enabling legislation. One case implicitly acknowledges the validity of a state PPO enabling law. In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), the court held that ERISA's savings clause exempted from federal preemption a Virginia enabling law for establishing PPOs. However, there is no federal mandate for an enabling law. Each state may regulate PPOs as it sees fit, in the absence of congressional direction.[3]

Recognizing that there is no Alaska enabling law for PPOs, the Division of Insurance has previously taken the position that certain provisions of the insurance code prohibit the use of PPOs. We find this argument unpersuasive for the following reasons.

AS 21.54.020(a)

One of the provisions the division relies upon is a prohibition applicable to group disability insurers that provides in part: "The [group disability] policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86." AS 21.54.020(a). This law does not prohibit the use of a PPO. To begin with, HMOs, which may contract with a PPO, are exempted. *See id.*; AS 21.86.060(a). In addition, the typical health plan utilizing a PPO gives covered individuals the choice of more than one provider, and often there is an option to use a nonpreferred provider, albeit at higher cost. Only if the covered person is given no choice of provider would this provision be violated.

AS 21.36.090(b)

Another statute relied upon by the division as prohibiting PPOs is AS 21.36.090(b). It provides:

> A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same

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> hazard in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

This provision prohibits only disability (health) insurers from unfairly discriminating against covered individuals. It is part of the Unfair Trade Practices Act (UTPA) in Alaska's insurance code, enacted in 1966 and based upon an NAIC model. Although the legislative history for AS 21.36.090(b) is scant and has no bearing on the PPO issue, the model act is instructive. It was adopted in 1947, well before the emergence of PPOs and the managed care concept.[10] The unfair discrimination provision at AS 21.36.090(b) is substantially the same as the corresponding provision of the model act [Section 4(G)(2)]. The legislative history for Section 4(G)(2) reveals that the primary concerns about unfair discrimination were in the contexts of race, sex, marital status, residence and national origin. More recently, redlining and blackballing underwriting practices have received attention. There is no discussion of PPOs in the legislative history of the model. Indeed, it would be illogical for the NAIC to adopt a PPO model act if PPOs were per se violative of the UTPA. It is true that a PPO could violate AS 21.36.090(b) if its conduct were unfairly discriminatory for any one of a variety of reasons. However, it is additionally possible that there would be no "unfair" discrimination if a PPO treated all individuals of the same class equally as to costs, benefits payable or other contractual terms. In conclusion, AS 21.36.090(b) does not prohibit the establishment of PPOs or contracting with them.

Hospital and Medical Service Corporation (AS 21.87)

Your memorandum also addresses hospital and medical service corporations. *E.g.*, Blue Cross. These entities differ significantly from disability (health) insurers and are not even considered insurers. Unlike traditional insurance companies, which are subject to the provisions of AS 21.09, service corporations are regulated by the provisions of AS 21.87. Service corporations are nonprofit, at least in theory, and pursuant to statute. *See* AS 21.87.070(2). In essence, a service corporation delivers health care coverage through the use of two contracts. In the first one, a service agreement, the service corporation and a participant provider (typically a hospital or physician) agree to exchange health care services for a set fee. *See* AS 21.87.140 — 21.87.150. The second

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contract, called a subscriber contract, is between the service corporation and a recipient of care. *See* AS 21.87.160. It gives the subscriber access to health care services provided by the service contract.

Hospital and medical service corporations have statutory authority to contract with PPOs. *See, e.g.*, AS 21.87.070(3), 21.87.150 (service agreements with participant hospitals authorized); AS 21.87.070(4), 21.87.140 (service agreements with participant providers authorized); AS 21.87.120(a)(2), 21.87.130(a)(2), 21.87.160(b)(1), (2) (indemnity for services by nonparticipant providers and hospitals allowed). These statutes were enacted in 1966, well before the emergence of PPOs. They effectively allow a different benefit to be provided to a subscriber by a participant hospital or participant provider than benefits the subscriber may access on an indemnity basis. Although none of the statutes explicitly reference PPOs, their language is broad enough to allow contracting with PPOs.

Exclusive Provider Arrangements

Finally, your memorandum addresses "exclusive provider arrangements," also referred to as "exclusive provider organizations" or EPOs. These entities are a subspecies of PPOs. As previously indicated, for group disability (health) insurance, AS 21.54.020(a) prohibits the use of an EPO where the covered individual has no choice of provider. Depending on the circumstances, an EPO may also violate provisions of AS 21.36.

IV. CONCLUSION

Unlike most states, Alaska does not have an enabling law for establishing and using PPOs. For the reasons indicated in this memorandum, the Alaska insurance code nonetheless does not prohibit the creation of PPOs.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] *See generally* 42 U.S.C. § 300e *et seq.* (Federal Health Maintenance Organization Act of 1973); Health Maintenance Organization Model Act, Vol. II, NAIC Model Laws, Regulations and Guidelines, pp. 430-1 through 430-31 (adopted 1973).

[2] *See* Gabel, Ermann, Rice & de Lissovoy, *The Emergence and Future of PPOs*, Vol. 11, Journal of Health Politics, Policy and Law, 305 (1986); Preferred Provider Arrangements

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Act, Vol. I, NAIC Model Laws, Regulations and Guidelines, pp. 75-1 through 75-4, (adopted 1987).

[3] A PPO is the group of providers whereas a PPA is the contractual arrangement between that group of providers and purchasers of health care. Your April 13, 1995, memorandum refers to PPOs. For the purpose of this opinion, the PPO and PPA mechanisms are interchangeable.

[4] There are myriad forms of PPOs whose description is beyond the scope of this opinion. *See generally* Combe & Krugman, *Design and Pricing of the PPO and EPO Products*, Practicing Law Institute, Commercial Law and Practice Course Handbook Series, September 25, 1986.

[5] Alaska is in the clear minority of states that uses the term "disability insurance" to refer to what is commonly known as "health insurance." *See* AS 21.12.050 (disability insurance defined); AS 21.54.060 (group disability insurance defined). "Disability insurance" includes "disability income replacement insurance."

[6] *See* Vol. I, *NAIC Model Laws, Regulations and Guidelines*, pp. 75-5 through 75-8 (1993).

[7] *See* Rolph, Ginsburg & Hosek, *The Regulation of Preferred Provider Arrangements*, 6 Health Affairs, 32, 33 (Fall 1987).

[8] *See id.* p. 75-1. *See also* Statement of Commissioner Grode (Pa.), Report of Working Group on Preferred Providers, Vol. I, NAIC Proceedings, at 712 (1987) ("drafting note was added to clarify the possible ambiguity").

[9] *See generally* 15 U.S.C. §§ 1011-12 (McCarran-Ferguson Act delegation of insurance regulatory authority to states).

[10] *See* Vol. IV, *Model Laws, Regulations and Guidelines*, pp. 880-1 through 880-13 (1993). The NAIC's unfair trade practices model act was one of the initial efforts at developing uniform state legislation in response to the newly enacted McCarran-Ferguson Act. *See* NAIC Proceedings, at 142-43 (1946).

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Memorandum Opinion 96-0291

OPINION ON CHOICE AND PAYMENT OF PROVIDERS UNDER SERVICE CORPORATION BENEFITS

November 3, 1995

I. INTRODUCTION

This is in response to your memorandum dated October 9, 1995,[1] through which you requested answers to the following two questions:

1. Whether patients have the right to receive care from a provider of their choice?

Answer: Yes.

2. Whether providers are entitled to the same fees as those received by providers who enter into contracts with a medical service corporation?

Answer: No.

II. BACKGROUND

The above questions derive from inquiries made to the Alaska Division of Insurance by the Alaska Dental Society (ADS). The attachment accompanying your memorandum indicates ADS' position that the answer to both questions is "yes." Although ADS' inquiries are made in the context of dental care, my analysis and conclusions are applicable to dentists, medical doctors, and all other properly licensed health care providers[2] rendering services within the scope of their occupational licenses. In addition, my analysis for the first question addresses traditional health insurance as well as service corporations, although a primary emphasis is placed on the latter consistent with ADS' letter to you.

It is initially useful to understand the nature of a service corporation. A significant share of group health benefits in this country are provided through "service corporations." These health care financing entities are not traditional fee-for-service insurers, who typically provide for health care through indemnifying an insured after expenses are incurred. In contrast, a service corporation generally facilitates delivery of health care through periodic *pre*payments made by subscribers (recipients of

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care). *See* AS 21.87.010(a). A service corporation may, however, additionally provide subscribers with indemnity benefits. *See id.* AS 21.87.160(b)(2); AS 21.87.190(c).

There are three types of service corporations: (1) a medical service corporation principally provides medical or surgical services to subscribers; (2) a hospital service corporation principally provides hospital services to subscribers; and (3) a medical and hospital service corporation provides a combination of these services to subscribers. *See* AS 21.87.070; AS 21.87.280; and AS 21.87.330(2), (3). For the purpose of this memorandum, the term "service corporation" refers to all three of these entities. In Alaska, there are two authorized service corporations — Blue Cross of Washington & Alaska and Alaska Vision Services, Inc.

Service corporations are characterized by their use of two types of contracts. In the first one, a "service agreement," the corporation and a participant health care provider[4] (typically a hospital or physician) agree to provide health care services for a set fee. *See* AS 21.87.140; AS 21.87.150. A "nonparticipant" provider or hospital, as referenced in AS 21.87, is one that has not entered into a service agreement with the corporation. *See id.* AS 21.87.120(a)(2); AS 21.87.130(a)(2). In the second type of contract, called a "subscriber contract," a subscriber agrees to pay a set amount in exchange for certain health care benefits provided under the service agreement. *See id.* AS 21.87.160; AS 21.87.190. Another important characteristic of service corporations is that, in contrast to insurance companies, service corporations must be organized and operated in good faith as nonprofit entities. *See id.* AS 21.87.020(a); AS 21.87.070(2); AS 21.87.050(a); and AS 21.87.070(2).

Blue Cross and Blue Shield organizations are typically operated as service corporations and are the most well known types of service corporation. Historically, Blue Cross, which pioneered the hospital insurance market nearly 70 years ago, provided for hospital care, and Blue Shield provided for physicians' services (surgical and medical expenses). In 1982 the Blue Cross Association and the National Association of Blue Shield plans merged. The resulting national BlueCross BlueShield Association is currently comprised of 69 separate and locally operated companies called "plans." Blue Cross of Washington & Alaska, an affiliate of a larger holding company, is a member of the association. In the United States, more than 80 percent of hospitals and nearly 70 percent of physicians contract directly with Blue Cross and Blue Shield plans. Together, "Blues" plans in 1994 provided health care benefits for 7.6 million members, ultimately covering over 65 million people —

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roughly one in four Americans. *See BlueCross BlueShield Association 1994 Fact Book*; L. Kertesz, "A blue streak for managed care," *Modern Healthcare*, p. 63 (September 12, 1994). In Alaska, the Blue Cross plan has a large market presence, insuring about 95,000 Alaskans under group and individual policies (subscriber contracts).

There is often confusion about how to categorize a service corporation. The confusion is created in part by the fact that although a service corporation is not a traditional insurer, it is regulated by the state insurance regulatory agency. In Alaska, a traditional indemnity insurer is subject to the provisions of AS 21.09 concerning its authorization and general financial and reporting requirements. In contrast, a service corporation is primarily regulated by provisions of AS 21.87. Regulatory oversight of a service corporation remains similar in many ways to oversight of a traditional insurer by the division of insurance. *See e.g.*, AS 21.87.180 (contract language must be filed with and approved by division); AS 21.87.190 (rates must be filed with division and may not be excessive or unfairly discriminatory); AS 21.87.200 (requirements for adequate reserves); AS 21.87.210 (requirements for surplus fund); AS 21.87.220 (investment requirements); AS 21.87.230 (requirements for books and accounts); AS 21.87.240 (annual statement and fees requirements); AS 12.87.250 (periodic statutory examination); and AS 21.87.260 (taxation). In addition, AS 21.87.340 makes a service corporation subject to numerous other provisions of the insurance code, including most provisions of AS 21.09, so long as the provisions do not conflict with AS 21.87. A service corporation nonetheless is exempted from some important regulatory provisions applicable to traditional insurers. *See, e.g.*, AS 21.87.340 (exemption from Holding Company Act requirements of AS 21.22; and exemption from participation in guaranty association established by AS 21.79).

As further evidence of the confusion regarding how to categorize a service corporation, the entity is expressly prohibited from using a corporate business name including the word "insurance" or other terms descriptive of an insurer or insurer business. *See* AS 21.87.060. And, the U.S. Supreme Court has acknowledged in a case addressing what constitutes "the business of insurance" that Blue Cross as well as some members of Congress do not consider a service corporation's product to be insurance. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 228-29 (1979). Nevertheless, service corporations are commonly referred to as insurers and as engaged in the business of insurance. They are also often included within the rubric "group medical

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expense insurance." *See generally* D. Gregg, *Life and Health Insurance Handbook*, 427 (2d ed. 1964) (chapter entitled: "Group Medical Expense Insurance — Blue Cross and Blue Shield"). It is therefore not uncommon to see service corporations (*e.g.*, Blues) characterized as insurance in some contexts but not as insurance in others.

III. ANALYSIS

A. A patient has the right to receive health care services from the provider of her/his choice.

Your first question focuses on the right of a patient to choose a provider. In the broad context of traditional health insurance, the answer is that a patient (insured) has an unqualified right to seek health care services from the provider of her/his choice. The Alaska insurance code uses the term "disability insurance"[1] to refer to what is commonly known as health insurance. For individual disability insurance policies, the statutory requirement for payment of indemnity to a provider is qualified by the language: "this paragraph does not require that services be provided by a particular hospital or person." *See* AS 21.51.120. Similarly, under AS 21.54.020(a) a group disability policy "may not contain a provision requiring that services be provided by a particular hospital or person," except as applicable to an HMO. The Unfair Trade Practices Act for insurance (AS 21.36) provides additional support for a patient's freedom to choose a provider. AS 21.36.090(b) prohibits a person from unfairly discriminating in a policy or contract of disability insurance. An insurer limiting a patient's ultimate right to use the provider of her/his choice — regardless of provision for payment — violates this provision.

Provisions of AS 21.87, the chapter regulating service corporations, also acknowledge the freedom to choose. As previously addressed, in the typical situation the service corporation enters a contract with "participating" providers. *See* AS 21.87.120(a)(1) (medical and surgical services); AS 21.87.130(a)(1) (hospital services). However, this does not preclude a subscriber from obtaining services of a nonparticipating provider. AS 21.87 expressly authorizes a service corporation to provide indemnification for services provided by nonparticipant providers. *See id.* AS 21.87.120(a)(2) (indemnity for medical and surgical services); AS 21.87.130(a)(2) (indemnity for hospital services).

It is necessary to distinguish that although a service corporation has the right to offer coverage extending payment to a nonparticipant provider, the corporation is not obligated to provide for indemnity of a

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nonparticipant provider. The right to provide a subscriber "indemnity in a reasonable amount" (AS 21.87.120(a)(2) and AS 21.87.130(a)(2)) is not a mandate. The following provisions support this conclusion. AS 21.87.160(b)(2) requires that a subscriber contract must include "the benefits, *if any*, to which the subscriber is entitled on an indemnity basis. . ." (emphasis added). And, it is noteworthy that the minimum service benefits which must be provided through a subscriber contract apply only to participant providers and participant hospitals. *See id.* AS 21.87.170.

As further support of a subscriber's right to choose a provider, a PPO, which allows health care recipients a choice from among a group of providers, is not prohibited by the insurance code. *See generally* 1995 Op. Att'y Gen (Apr. 21; 661-95-0654). A service corporation may contract with a PPO as a participant provider. For service corporation subscribers, this means they can choose to receive health care from among providers who have entered a service agreement, presumably at a lower (negotiated) fee. However, even if a service corporation contracts with a PPO, its subscribers still have the option to use a nonparticipant provider outside the PPO. *See* AS 21.87.120(a)(2); AS 21.87.130(a)(2).

The Unfair Trade Practices Act provides further support for the conclusion that a subscriber may seek treatment from the provider she/he chooses. AS 21.36.090(d) prohibits unfair discrimination in the group context against a provider rendering health care under a service or indemnity type contract issued by a nonprofit corporation (*e.g.*, service corporation).[5] The prohibition applies whether the provider is a participant (having entered a service agreement) or nonparticipant.

And finally, AS 21.87.160(c) provides as follows:

> A [subscriber] contract may not restrict the subscriber's right to free choice of provider or hospital, but must restrict benefits to be provided on a service basis to services rendered by participant providers and participant hospitals.

This provision, which corresponds with AS 21.87.170, reflects that a subscriber has an unqualified right to choose a provider.

B. A nonparticipant provider is not entitled to the same fees as a participant provider in the absence of a contractual provision to the contrary.

While a subscriber has the freedom to use the health care provider of

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her/his choosing, *payment* for services rendered by a nonparticipant provider is subject to terms of the subscriber contract. The insurance code provides that indemnification of a nonparticipant provider must be in a "reasonable amount." *See* AS 21.87.120(a)(2) (medical and surgical services); AS 21.87.130(a)(2) (hospital services). And, as required by statute, the language used by a service corporation in a subscriber contract must be filed with and approved by the division of insurance. *See* AS 21.87.180. This filing requirement applies to contract language providing for indemnification when a subscriber uses a nonparticipant provider.[4] In practice, when the division receives a subscriber contract, it reviews the filing for compliance with applicable provisions of the insurance code, including those of AS 21.87.120(a)(2) and AS 21.87.130(a)(2) requiring that indemnity to nonparticipant providers must be "reasonable" in amount. These provisions do not require that the amount to be indemnified must be equal to the amount paid for a covered benefit under a service agreement. In light of these provisions, AS 21.87 leaves a service corporation discretion to pay a nonparticipant provider less than a participant provider for the same covered service. Payment of different amounts, depending on whether a provider is a participant or nonparticipant, is not *unfair* discrimination. *See* AS 21.36.090(d).

Please do not hesitate to contact me if you have any questions.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] I received your memo on October 25, 1995.

[2] In the context of a service corporation, "provider" is defined as "a physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner." AS 21.87.330(8).

[3] "Participant provider" and "participant hospital" mean a person (or hospital) that has entered into a service agreement with a service corporation. AS 21.87.330(5) and (6). These statutorily defined terms are not synonymous with the concept "preferred provider" as used in the context of a preferred provider organization (PPO).

[4] *See* AS 21.12.050. Disability insurance is not the same as disability income replacement insurance.

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[5] This provision does not apply to individual coverages.

[6] There is an exception from the filing requirement for certain contractual language (*e.g.*, endorsements, forms of unique character). *See* AS 21.57.150(a).

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§ 21.36.080 Boycott, coercion, and intimidation

A person may not enter into an agreement to commit, or by any concerted action commit, an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

History.—§ 1, ch. 120, SLA 1966.

§ 21.36.090 Unfair discrimination

(a) A person may not make or permit unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(b) A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract of health insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

(c) A person may not make or permit arbitrary or unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for a policy or contract of property, casualty, surety, marine, wet marine or transportation insurance, or in the dividends or other benefits payable on the insurance, or in the selection of it, or in any other terms and conditions of the insurance.

Text of subsection (d) effective until January 1, 1999

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a health maintenance organization or a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife.

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the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

History.—§ 1, ch. 120, SLA 1966; § 68, ch. 56, SLA 1996, eff. 9-9-96.

§ 21.54.015 Rate discrimination prohibited

Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

History.—§ 58, ch. 81, SLA 1997, eff. 7-1-97.

§ 21.54.020 Direct payment to health care provider

(a) An insurer may, and upon written request of the covered person shall, within 30 working days after receiving a proof of loss statement, pay indemnities under a group health insurance policy directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86. If the insurer pays indemnities to the covered person after the covered person has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the service, the insurer shall also pay those indemnities to the provider of the service.

(b) A covered person may revoke an election of direct payment of indemnities made under (a) of this section by giving written notice of the revocation to the insurer and to the provider of the services. The written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services. Revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services.

(c) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred to a person who is not the covered person by a qualified domestic relations order. Rights under the qualified domestic relations order do not take effect until the

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period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

History.—§ 1, ch. 120, SLA 1966.

§ 21.51.120 **Payment of claims**

(a) A health insurance policy delivered or issued for delivery must contain the following provisions:

(1) indemnity for loss of life shall be paid according to the beneficiary designation and payment provisions contained in the policy that are effective at the time of payment; if a beneficiary has not been designated, indemnity shall be paid to the estate of the insured; accrued indemnities unpaid at the insured's death shall be paid to either the beneficiary or the estate, at the option of the insurer; all other indemnities shall be paid to the insured;

(2) the insurer may, and upon written request of the insured shall, within 30 working days after receiving a proof of loss statement, pay indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services; an insurer who pays indemnities to an insured, after the insured has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the services, shall also pay indemnities to the provider of the services; this paragraph does not require that services be provided by a particular hospital or person;

(3) a covered person may revoke an election of direct payment of indemnities made under this subsection by giving written notice of the revocation to the insurer and to the provider of the services; the written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services; revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services;

(4) the right of the insured to request payment of indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services or to another person may be transferred to a person who is not the insured by a qualified domestic relations order; rights under the qualified domestic relations order do not take effect until the order is received by the insurer; in this paragraph, "qualified

Revised, 1997

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

February 24, 2000

RECEIVED
FEB 28 2000

Honorable Norm Rokeberg
Chairman, House Labor and Commerce Committee
State of Alaska
House of Representatives
Room 24
Juneau, Alaska 99801-1182

RE: Your Request of an "Executive Summary"

Dear Representative Rokeberg:

At our meeting on 2/22/00 you requested that I provide you with an "executive summary" of the results of the various studies that have been done in regards to the estimated cost implications of the "patient bill of rights" legislation. Attached is a chart done by the AMA. It comes from a publication called "*Economic Impacts of Managed Care Reform*" written by David W. Emmons, PhD and Gregory D. Wozniak, PhD of the AMA's Center for Health Policy Research.

You had asked specifically about the cost of the mandatory point of service option. Please note the projected premium increases range form 0.1% to 0.48%. (The Barents study lists the impact in different terms. The impact is stated such that it would reduce the premium savings realized from a closed-panel option by from 4 to 11 percentage points).

Please let me know if you would like any additional information. (Finally, the Texas Medical Association staff has reported to me that the premium costs have not increased, following the enactment of the Texas Patient Bill of Rights, at any rate different than the rest of the country.)

Thank you for your support on Alaska's Patients Bill of Rights.

Sincerely,

James J. Jordan
Executive Director

cc: ASMA Board of Trustees

JJJ/kms

Freedom of Choice Acts	9%-16% (depending on plan type)					
Elimination of Prior Authorization for Specialty Referrals/Direct Access within Network	9%	0.0%-0.2%	0.2%			
Medical Necessity Determination	4.1%-6.1%[b]					
Continuity of Care		minimal increase				0.2%
Mandatory Point-of-Service Option	4%-11% (among closed panel plans)	0.3%	0.3%		0.48% (assumes plan members incur higher cost sharing out of network)	0.1%
Any Willing Provider		6.6%-8.6%[b]				
Equivalent Reimbursement Rates In and Out of Network		less than 0.5%	5.5%			
Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	1%-3% (among managed care plans)	less than 0.05%	0.5%	less than 1%	0.11%	0.2%
Administrative Requirements			2.0%			
Elimination of Limits on Certain Benefits			5.5%			
Adverse Selection Against Rate Increases	0.1% to 0.5%	4.5%				
Access to Specialists and Standing Referrals to Specialists				0.35% choice of (OBGYNs as primary care providers)	0.02%	0.1%

Exhibit 10 (continued)
Summary Comparison of Managed Care Legislation Costs[a]

Proposals	Barents for AAHP	Muse & Associates for PARC Alliance	Milliman & Robertson for Walmart	Lewin for President's Commission	Price Waterhouse for Kaiser Family Foundation	Coopers & Lybrand for Kaiser Family Foundation	CBO	Mercer
Minimum Stays for Mastectomies					0.01% (48-hour stays)		less than 0.05%	
Expanding Drug Formularies					less than 0.6% (among HMOs)		less than 0.05%	
External Appeals				less than 0.05% (excludes administrative costs)		0.08% (includes administrative costs charged back to plans)	0.3%	
Information Reporting & Disclosure		0.3%-1.3%		0.3%-1.3%		.08%-.4% (under PARCA and CBRR, respectively)	0.3%	

Sources: Barents Group, LLC, *The Effects of Legislation Affecting Managed Care on Health Plan Costs*, (May 1997); Barents Group, LLC, *Impact of Legislation Affecting Managed Care Consumers: 1999- 2003*, (April 1998); Muse & Associates, *The Health Premium Impact of H. R. 1415/S.644, the Patient Access to Responsible Care Act (PARCA)*, (January 1998); Milliman & Robertson, Inc., *Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA)*, (November 1997); The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals*, (November 1997); Price Waterhouse, *The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals in California*, (November 1997); Coopers & Lybrand, LLP, *Estimated Costs of Selected Consumer Protection Proposals*, (April 1998); Congressional Budget Office, *Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998*, (July 1998); and William M. Mercer, Inc. and the American Medical Association, *Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation* (August 1998).

a/ Estimates of increased costs or reductions in savings rather than premium increases have been specified.
b/ Figures from Barents (1998), all other figures in the column are from Barents (1997).

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Barents Gr Consumers April 1998.
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Chassin, M Geographi of Three P Associatio
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American Medical Association
Physicians dedicated to the health of America

Economic Impacts of Managed Care Reform

Center for Health Policy Research

Economic Impacts of Managed Care Reform

David W. Emmons, PhD
Gregory D. Wozniak, PhD

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Executive Summary

This report reviews nine studies of the impact of managed care reform legislation on health insurance premiums and managed care cost savings. A table at the end of the report presents a summary of the various published cost estimates of managed care reform legislation.

The studies examined are:

- a 1997 Milliman and Robertson study of the impact of eight provisions in PARCA on health insurance premiums — the composite effect of these provisions on premium increases is estimated to be 23%, and the "estimate range" of the premium impact ranges from 7% to 39%;

- a 1998 Muse & Associates study of the effects of the PARCA legislation on health insurance premiums — the enactment of PARCA is estimated to increase national premiums between 0.7% and 2.6%;

- a 1997 Lewin Group study of the costs and benefits of the information disclosure and external appeals provisions of the proposed Consumer Bill of Rights and Responsibilities — the information reporting and disclosure provisions are estimated to increase premiums between 0.3% and 1.3%, the external appeals provision is estimated to increase premiums no more than 0.05%;

- a 1997 Price Waterhouse assessment of the impact of expanded insurer liability, direct access to obstetric and gynecologic services, and lengths of stay for mastectomy patients — the impact on premiums of these provisions is fairly minimal, ranging from less than 0.1% to 1.3%;

- a 1997 Barents Group analysis of the impact of seven types of legislation or legislative elements affecting the cost saving from managed care; the analysis is general in nature rather than being carried out with respect to a specific legislative proposal — the estimated reduction in managed care savings relative to fee-for-service varies between 1 and 11 percentage points across the provisions;

- a 1998 Barents Group study of the potential cost of increasing plan exposure to malpractice liability, deeming utilization review to be the practice of medicine, prohibiting health plans from determining medical necessity and requiring plans to accept any willing provider — these types of legislation are estimated to increase managed care plans' costs by 2.2% to 8.6%;

- a 1998 Coopers & Lybrand analysis of the provisions in CBRR and PARCA dealing with information disclosure, access to emergency services, direct access to specialists, external appeals, a required point-of-service option for HMOs, and expanded health plan liability for medical decision making. Coopers & Lybrand present aggregate impact figures (excluding the effects of the expansion in plan liability proposed in PARCA) of 0.61% of premiums for the reforms in CBRR and 0.77% of premiums for the reforms contained in PARCA;

- a Congressional Budget Office analysis of the patient protection standards set out in the PBR — the provisions in the bill are estimated to increase premiums by 4% when all of the bill's provisions are fully phased in; and

- a William M. Mercer study of the cost impact of managed care accountability legislation — after considering a broad range of impact scenarios, premiums are estimated to increase between 0.1% to 1.8%.

Differences in the impact estimates between the studies are heavily dependent upon the interpretation of reform provisions and assumptions as to the extent of savings from managed care. The two studies prepared by the Barents Group for the American Association of Health Plans and the study prepared for Wal-Mart by Milliman & Robertson depict patient protection as very costly. Underlying these analyses, however, are extreme characterizations of proposed protections and exaggerated notions of cost savings.

Review of the estimates prepared by the Lewin Group, Muse & Associates, Price Waterhouse, Coopers & Lybrand, the Congressional Budget Office, and William M. Mercer all suggest that the effect of reasonable patient protection provisions on health insurance premiums is negligible. The Lewin results suggest that the additional costs of what are thought by many to be the most expensive patient protections are on the order of pennies per insured person per month.

The two most recent studies in this literature focused on the cost of expanding managed care plans' liability. The CBO estimated that expanding legal liability for ERISA plans would raise premiums among employer-sponsored plans by 1.2%. The CBO estimate may overstate the actual impact as it fails to account for the ability of managed care organizations to insure against liability claims at significantly reduced rates relative to providers. The estimate is consistent, however, with the range derived by William M. Mercer in an actuarial analysis of the impact of a model managed care accountability law. Mercer concluded that holding plans liable for damages to enrollees would add 0.1% to 1.8% to managed care organization premiums. If ERISA construction were narrow under the law, cost increases were predicted to be in the range of 0.5% to 1.8% of premiums.

Concerns about any cost increases associated with reform include potential losses of insurance coverage and reductions in the number of employed individuals. Several parties have inappropriately generalized an estimate of the impact of other reform legislation to suggest that a 1% increase in health insurance premiums is associated with a loss of insurance coverage for 200,000 individuals. The 1998 Barents study claims that each 1% increase in managed care plans' costs would result in a potential loss of insurance coverage for about 315,000 individuals. Neither of these estimates can be substantiated.

ALASKA STATE LEGISLATURE
House of Representatives

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Representative Norman Rokeberg

LETTERS OF SUPPORT
March 20, 2000

Attached is a list of letters of support received by Rep. Norman Rokeberg concerning HB 211.

LastName	FirstName	Organization
		Alaska Physicians and Surgeons
		Alaska State Medical Association
Alexander, MD	David G.	David G. Alexander, MD
Anschuetz, MD, FACC	Richard A.	Alaska Heart Institute
Arita, MD	Adam A.	Adam A. Artia, MD
Armstrong, MD, FACR	Michael B.	Michael B. Armstrong, MD
Baker, MD	Beth	Internal Medicine Associates
Baldauf, MD, FACC	James A.	Alaska Heart Institute
Barnett, MD	Mark R.	
Beacham, MD	Sherman	Sherman Beacham, MD
Bell, MD	Owen R.	Owen R. Bell, MD, Wendy Thon, ANP, RN-C, Martha Linden, CNM, MSN, PC
Bergeson, M.D.	Marvin E.	Tanana Valley Clinic
Bruce	Doug	Provide Alaska Medical Center
Buchanan, MD	Richard	Internal Medicine Associates
(cannot read signature)	Robert	Opthalmic Associates
Cates, MD	J C	J C Cates, MD
Cates, MD	Vern	Vern A Cates, MD
Chen, MD	Barbara M.	Barbara M. Chen
Child, DO	Gary	Medical Park Family Care, Inc.
Coalwell, MD	Timothy	Medical Park Family Care, Inc.
DeKeyser, MD	John	John B. Dekeyser, MD, PC
DeMers, DO, MPH	Mary P.	Mary P. DeMers, DO, MPH
Endres, MD	Donald R.	Geneva Woods Ear, Nose &
Farah, MD	Richard F.	
Farleigh, M.D.	Richard M.	Richard M. Farleigh, MD, PC
Ferris, MD	Glenn A.	Alaska Spine Institute

LastName	FirstName	Organization
Fortson, MD	Jayne	Jayne Fortson, MD
Gerboth, MD	Gregory	Internal Medicine Associates
Gordon, M.D.	Thomas	Alaska Neurological Consultants, LLC
Gordon, M.D.	Thomas	Alaska Neurological Consultants, LLC
Gower, MD	Roland E.	Roland E. Gower, MD
Hadley, MD	Shawn	Alaska Rehabilitation Medicine, Inc.
Hayams, D.O., FACOS	Stephen	Stephan P. Hayms, D.O., LLC
Hummer, MD	Milton T.	Milton T. Hummer, MD
Janis, MD	Burton	Burton Janis, MD
Jayich, Ph.D., MD	Steven	Pathology Associates
Jones, MD	F. Leland	Medical Park Family Care, Inc.
Koval, MD	Janice	Internal Medicine Associates
Krauss, MD	Seth L.	Alaska Heart Institute, LLC
Ladyman, MD	George H.	Health South
LastName	FirstName	Organization
Lawrason, MD	Peter	Fairbanks Clinic
LePique, MD, FACOG	Marcelyn	Marcelyn LePique, M.D.
Lipke, MD,	Robert W.	Robert W. Lipke, MD, APC
Makin, MD	Harbir	Harbir S. Makin, MD
Manuel, MD	Michael D.	Michael F. Manuel, MD
Mason, DO	Bret L.	Orthopaedic Trauma Care
Mayer, MD, FACC, FACP	William P.	American College of Cardiology
McCormic, MD	John J.	Health South
McCray, MD	William	Internal Medicine Associates
McGuire, MD	David A.	David A. McGuire, MD
Mues, MD	John C.	John C. Mues, MD, FACP

LastName	FirstName	Organization
Neubauer, MD, FACP	Richard	Richard L. Neubauer, MD, FACP
Nolan, DO	Patrick M.	Patrick M. Nolan, DO, Inc.
Norman, MD	Michael C.	Michael C. Norman, MD
Nyboer, MD		Dr. Nyboer and Associates
Peach, MD	David	Internal Medicine Associates
Peters, MD	Richard	Richard A. Peters, MD
Richey, MD	Mark E.	Mark E. Richey, MD, PC
Roberts, PA-C	John R.	Orthopaedic Trauma Care
Sahagun, MD	Geronimo	Internal Medicine Associates
Schultes, MD	Glenn	Medical Park Family Care, Inc.
Schultz, DO	John	John Schultz, DO
Senter, MD	Thomas P.	Thomas P. Senter, MD
Smith, MD	Jack Arlyn	Jack Arlyn Smith, MD
Steiner, MD	Griff C.	Griffith C. Steiner, MD
Tamai, MD	Jim	Tanana Valley Clinic
Taylor, MD	R. Randy	Medical Park Family Care, Inc.
Weale, PT	Mary	Alaska Physicial Therapy Association, Inc.
White, MD	R. Matison	Medical Park Family Care, Inc.
Wilder, MD	Norman J.	Norman J. Wilder, MD
Williams, MD	J. David	Geneva Woods Ear, Nose & Throat Associates, Inc.
Worrell, MD	Paul	Paul M. Worrell, MD

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Nation & World : Sunday, March 12, 2000

So far, Texans happy with patient-rights law

by Jim Brunner
Seattle Times Olympia bureau

FORT WORTH, Texas - This week, Gov. Gary Locke is expected to sign a Patient Bill of Rights that will make Washington the fourth state to give its citizens the right to sue health plans for denying medical care.

In passing the legislation, Washington lawmakers from both parties largely ignored the warnings of the health-insurance and managed-care lobby, which predicted the law would encourage a flood of lawsuits, cause a big leap in health-care costs and price thousands out of health-insurance coverage.

Here in Texas, which in 1997 became the first state to give people the right to sue their health plans, the criticisms sound familiar. The insurance lobby fought tooth and nail against that law, using arguments identical to those now being leveled against the Patient Bill of Rights in Olympia.

But in the Lone Star State, those doomsday predictions haven't come to pass.

"They were saying it was going to be awful, that the apocalypse was going to visit us all," said George Parker Young, a Fort Worth attorney who took on the managed-care industry in several lawsuits before the new law. "It hasn't happened."

Only a few lawsuits - estimates are between five and 10 - have been filed in three years under the Texas reforms. The insurance industry acknowledges that the law has so far not driven up health-care costs.

And doctors, patients and lawyers in Texas say the statute,

while not perfect, has given them more leverage to demand treatment from their health plans.

Some early doubters have come around, most notably Texas Gov. George W. Bush - who allowed the measure to become law without signing it because of concerns about its impact on health-care costs. On the presidential campaign trail, Bush now touts the measure as evidence of his record as a "reformer with results" and says he would favor similar legislation on the national level.

But critics of the Texas law warn that its true impacts are yet to be felt.

"Those who draw a conclusion that the flood of lawsuits didn't happen are premature," said Jerry Patterson, executive director of the Texas Association of Health Plans.

The Texas law is being challenged in a federal appeals court, which will decide whether the law is superseded by federal law that prohibits such lawsuits. If the Texas law is upheld, Patterson predicted that there could be many more lawsuits. He said attorneys have been holding seminars around the state to teach lawyers how to sue HMOs successfully.

Costs will rise, agencies warn

In Washington, some state agencies issued warnings about the potential costs of the state's Patient Bill of Rights as it sailed to Locke's desk with broad bipartisan support. Early estimates are that the measure could add $34 million to health-insurance costs for state employees - a daunting price tag in the post-Initiative-695 era of shrinking tax revenues.

Some analysts say that medical costs could balloon, either because of multimillion-dollar lawsuit awards against health plans, or if the plans feel pressured to approve unnecessary medical treatments as a precaution against lawsuits.

According to industry studies, every 1 percent increase in health-care costs means 8,400 Washington residents lose coverage, either because they or their employers can't afford it, said Karen Merrikin. The director of health policy development for Group Health Cooperative of Puget Sound, she testified before state lawmakers in January. Merrikin said the industry predicts that Washington's Patient Bill of Rights could boost insurance costs by 2 to 8 percent.

But in Olympia and across the nation, worries about costs are being trumped by high-profile stories of how **managed-care** plans have interfered with the doctor-patient relationship.

When health-care costs skyrocketed in the 1980s, many employers turned to **managed care** to control costs. HMOs and other forms of **managed care** encouraged prudence and careful oversight by refusing to pay doctors for performing what the plans considered unnecessary tests or procedures.

But those strategies produced horror stories about patients who claimed they were denied coverage for lifesaving treatments. **Managed-care** reform has become a huge national issue, with Congress now negotiating over a national patient bill of rights and presidential front-runners Bush and Vice President Al Gore both pledging their support.

The role of independent review

Under Texas' new patient bill of rights law, the lawsuits filed so far allege that penny pinching by managed-care outfits has interfered with sound medical judgments, with disastrous results.

In one case, a 66-year-old woman with a cancerous tumor in her jaw claims she was unable to get a referral from her doctor - the doctor she also worked for - to begin chemotherapy with an oncologist. The doctor was allegedly reluctant to refer patients to specialists because of an HMO plan, later ruled illegal, that put more money in the pockets of physicians who were stingy with referrals.

She eventually got the chemotherapy. But the woman, who is terminally ill, claims the delay blocked her chance at recovery.

In another case, a 68-year-old man with a history of depression killed himself just one day after being discharged from a hospital where he had been admitted after an earlier suicide attempt. His family sued, claiming the hospital prematurely discharged him because of HMO regulations discouraging long hospital stays.

In both of those cases, the lawsuits come too late to save the patients involved. That's why insurers, lawyers and doctors agree the most important part of the Texas law is that it gives people the right to an independent review of HMO decisions.

"That's been the ticket, that's been the most important part," said Dr. Paul Handel, a Houston urologist.

The reviews, similar to those which would be allowed by Washington's Patient Bill of Rights, are conducted by three independent review organizations certified by the Texas Department of Insurance. Doctors review cases where insurers

deny coverage as medically unnecessary.

The results of the reviews have been almost evenly split.

As of January, 791 complaints had been fielded by the independent review organizations. In 365 cases, the insurers' refusal to authorize a treatment was upheld. In 374 cases, their decisions were overturned. In 52 cases, their decisions were partially overturned.

For Jackie Burros, a Fort Worth woman fighting breast cancer, an independent review allowed her to win treatment for lymphedema - a painful swelling of the limbs caused by the removal of her lymph nodes during treatment for the cancer.

Burros is a serene woman who maintains a cheerful outlook despite a five-year battle with breast cancer and two mastectomies. A sign in her bathroom says, "Good morning, this is God. I will be handling all your problems today."

But that optimism didn't come so easily last year. After an exhausting regimen of chemotherapy, Burros said her HMO refused to authorize the lymphedema treatment her doctor insisted was necessary.

Burros' condition is treatable with specialized massage and tight-fitting fabric sleeves that keep the lymph fluid from building up in her arms. Her insurer, Harris Methodist, had approved the treatment in 1995 following Burros' initial diagnosis. But Harris denied the treatment last year when Burros and her doctor sought it again.

In February, the independent review organization ruled that Burros' lymphedema treatment was medically necessary, overturning Harris' denial.

"Thank God," said Burros.

Threat of lawsuit is powerful

Sometimes just the threat of an independent review or a lawsuit is enough to persuade reluctant HMOs to authorize medical care.

Cynthia Vance, a Fort Worth mother of three, fought successfully to get her HMO to pay for nursing care for her 19-month-old son, Jordan, who was born nearly four months premature.

Jordan suffers from underdeveloped lungs and a windpipe so narrow he would suffocate if not for the tube in his neck. He is

fed through another tube attached to his belly.

All of these conditions are normal for premature babies, says Dr. John Pfaff, a pediatric pulmonologist who treated the boy. With proper care, Jordan will probably grow up to be a healthy, normal child, Pfaff said.

In fact, he could have been sent home from the hospital several weeks earlier if his insurer had not resisted paying for in-home nursing care. Without that care, Pfaff said, he refused to let Jordan be discharged, even though the insurer was threatening to stop paying for his care.

"There's no doubt in my mind the child's life would have been imperiled," Pfaff said.

After months of wrangling and a call to Young, the Fort Worth attorney, Vance got the HMO to pay. Vance is convinced the law gave her the leverage she needed.

Handel, the Houston urologist, said the law hasn't erased all his concerns about managed care but it has provided more tools to people like Vance.

"There have been fewer problems. That is a sense across the state," Handel said. "To my thinking there really has not been a downside."

Jim Brunner: 360-236-8266.

EARN GOOD MONEY.

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Office of the Governor

Date: March 15, 2000
FOR IMMEDIATE RELEASE
Contact: Governor's Communications Office, 360-902-4136

Locke signs 'Patient's Bill of Rights' legislation

TACOMA - Gov. Gary Locke today took a giant step in helping people get the care they need from managed health care providers.

Locke signed into law what has been called a "patient's bill of rights" that strikes a balance between providing quality health care and containing rising health-care costs. The legislation will make sure consumers can get information to make informed decisions when they purchase health care and hold accountable their health care plans.

"It's just unacceptable that medical treatment can be delayed because HMOs and insurance companies question a doctor's diagnosis," Locke said. "People need to be able to make decisions about their health care with their doctors, not insurance companies, accountants or auditors."

Sen. Lorraine Wojahn, prime sponsor of the bill, echoed the governor's comments.

"I am calling the patient's bill of rights a 'people bill,'" she said. "A life can sometimes hang in the balance while an insurance company decides whether or not to pay. Without the protection of this bill, people could be forced to suffer needlessly or, yes, even die."

The legislation provides several basic rights:

- A fast and impartial grievance process to resolve health care disputes.
- A timely external and independent medical review of health care disputes.
- The right to sue managed care plans if patients believe their managed care system has harmed them through negligence.
- The right to get access to information about health care plans.
- Protection from unnecessary invasions of health care privacy.
- A health plan medical doctor who is a licensed doctor.

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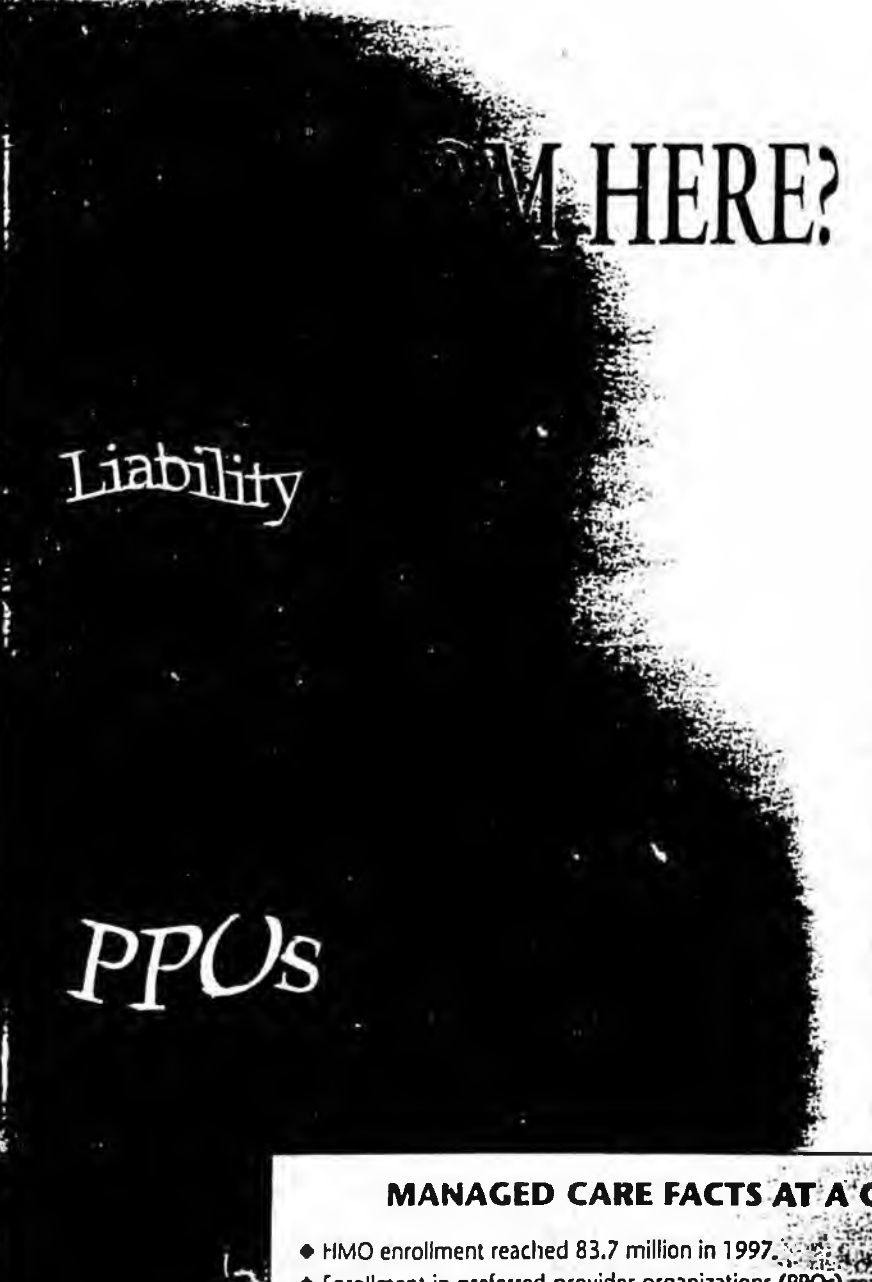

In 10 years, managed care has changed the landscape of American health care, saving money, simplifying paperwork and engendering lots of new legislation — but all the problems haven't been solved.

By Richard Cauchi

When Helen Hunt's character in the movie "As Good as it Gets" blasted her managed care plan for not giving her asthmatic son the help he needed, audiences cheered.

Is dissatisfaction with managed care organizations as widespread as headlines lead us to believe? Or are we in danger of "over-managing" managed care, defeating its purpose with micro-oversight of health care decisions?

Certainly the 1998 congressional debate about patient protection legislation caught the public's ear. Meanwhile, the real action has been in state legislatures. Between 1994 and 1998, 39 states approved "patient protection acts" or "comprehensive consumer bills of rights" affecting managed care. Eleven of those were adopted in 1998. The remaining 11 states have considered similar legislation.

Much legislative activity is driven by consumer complaints. For example, legislators heard about women being released from hospitals less than 24 hours after delivering babies because managed care plans wouldn't pay for longer stays. Under this so-called "drive-through delivery" practice, most women and babies did fine, but some had serious problems. In the first year after this issue made headlines, 27 states enacted laws requiring coverage for longer stays, typically 48 hours.

In Colorado, a personal story came from a mother who also happened to be a legislator and chair of a legislative health committee. During a 1998 managed care hearing, she told of her daughter, "Marcia," who was diagnosed with uterine cancer at age 30. Marcia's older sister also had the disease at a young age, resulting in a hysterectomy several years previously. With Marcia's diagnosis and family history, her doctor recommended a full hysterectomy. But her health maintenance organization (HMO) said "no, it would pay only for a partial procedure," and continue to monitor her condition.

MANAGED CARE FACTS AT A GLANCE

- HMO enrollment reached 83.7 million in 1997.
- Enrollment in preferred provider organizations (PPOs) reached 89[illegible] million in 1997.
- Insurance companies own 60.4 percent of PPOs.
- Fifteen of the top 25 HMO plans are nonprofits.
- There were 757 licensed HMOs and 1,035 PPOs operating in the United States in 1997.
- Managed care enrolled 46.7 percent of the Medicaid population [illegible] 1997 (14.6 million people).
- HMOs enrolled 14.9 percent of the Medicare population in 1997 (5.6 million people).
- After actually decreasing 1.3 percent in 1997 (from $434 to $429 for family coverage), health maintenance organizations' (HMOs) average [illegible] ums are rising to an estimated $460 in 1999.

Richard Cauchi covers health insurance for NCSL at the Denver office. NCSL staff Molly Stauffer, Marla Rothouse and Joy Johnson Wilson contributed material used in this article.

SELECTED STATE LAWS ON MANAGED CARE / HMOs

STATE	Comprehensive consumer law (year)	Ban on financial incentives	Ban on gag clauses	Direct Access to ob/gyn	Continuity of Care	HMO Medical Director	Emergency Prudent layperson	Insurer Liability	Independent Review
Alabama	-			■		■			
Alaska	1998	■	■	**					
Arizona	-		■				*		■
Arkansas	1997		■	■**	■	■	■		
California	1994, '95	■	■	■	■	■	*		exp
Colorado	1997		■	■	■		■		■
Connecticut	1997		■	■**			■	hh	■
Delaware	Regulations	■	■	■	■	■	■		■
Florida	1997	■	■	■**	■	■	*		■
Georgia	1996	■	■	■**			■		
Hawaii	1998		■				■		■
Idaho	1997	■	■	■			■	hh	
Illinois	-			■					
Indiana	1998		■	■	■	■	■		
Iowa	Voluntary		■				■		
Kansas	1997	■	■		■		■		
Kentucky	1998		■	**		■	■		
Louisiana	1997	■	■	■			■	hh	
Maine	1996		■	■**			■	hh	
Maryland	1995	■	■	■	■	■	■	hh	■
Massachusetts	-		■						
Michigan	-		■				■		■
Minnesota	1997	■	■	■	■		■		
Mississippi	1995			■					
Missouri	1997	■	■	■	■	■	■	hh	■
Montana	1997	■	■	■**		■			
Nebraska	1998	■	■	■			■		
Nevada	1997	■	■	■		■	■		
New Hampshire	1997		■	■				hh	
New Jersey	1997	■	■	■	■	■			■
New Mexico	1998	■	■	■			*		■
New York	1996		■	■	■		■	hh	■
North Carolina	Regulations		■	■			■		■
North Dakota	-		■					hh	
Ohio	1997	■	■			■	■		exp
Oklahoma	1997		■			■			
Oregon	1997		■	■			■	hh	
Pennsylvania	1998	■	■	■	■		■		■
Rhode Island	1996	■	■	■		■		hh	■
South Carolina	1998		■	■	■		■	hh	
South Dakota	-								
Tennessee	1998		■	■	■			hh	■
Texas	1997	■	■	■	■	■	■	■hh	■
Utah	-		■	■					
Vermont	1996	■	■	■	■	■	■	hh	■
Virginia	1995, '98		■	■	■		■	hh	■
Washington	1996		■	■			■		
West Virginia	-	■	■	■			■		
Wisconsin	1998		■		■	■	■		
Wyoming	-		■						
Dist. of Columbia	1998		■	■	■		*		■
Puerto Rico	-								
TOTAL	39	22	46	37	20	18	31	1	22

** Alaska and Kentucky have direct access only to chiropractors; Maine covers ob/gyn and chiropractors; Arkansas also covers optometrists; Colorado, Connecticut, and Montana also cover advance practice nurses or midwives and Florida and Georgia also cover dermatologists.

Source: Health Policy Tracking Service, National Conference of State Legislatures.

* State has adopted a variation of the prudent layperson standard

hh = ban on health plan "hold harmless" clauses, which shift all liability to doctor or health facility

exp = applies to experimental treatments

Note: In some cases, state provisions are contained in regulations or administrative code.

SOME STANDARD FEATURES

After five years of state actions some clear trends have emerged for managed care. At least 20 states have enacted laws with these requirements:

◆ **Any willing provider:** In response to complaints that consumers want to use a local drug store, 22 states require that managed care organizations allow any pharmacy to be a provider to their enrollees; several states also include doctors or other providers.

◆ **Bans on gag clauses:** Forty-six states have laws prohibiting any agreement that limits doctors' ability to inform patients of treatment options, especially if some choices may cost the insurer more. A 1997 federal law now bans gag clauses for Medicaid and Medicare managed care.

◆ **Bans on financial incentives:** Twenty-two states prohibit a managed care plan from rewarding doctors for performing a less costly procedure or prescribing a less costly drug.

◆ **Direct access to women's health specialists:** Thirty-six states and the District of Columbia now allow women to see an obstetrician or gynecologist without first getting permission or a referral from a primary care provider.

◆ **Hospital stay after childbirth:** Forty-three states require reimbursement for (typically) at least a 48-hour maternity stay. A federal law requiring coverage for a 48-hour stay took effect in January 1998.

◆ **Independent review of denials:** Twenty-one states and the District of Columbia now require an independent panel to evaluate the validity of denied care. Once opposed as too costly by the managed care industry, this idea now is embraced as a "reasonable" alternative to court suits. In Texas, an HMO association actually urged a federal judge to retain that state's external appeals process. Aetna, the nation's largest managed care company, has announced it will voluntarily allow such appeals for enrollees in 30 states, as of June 30, 1999. In addition, all 50 states require some form of internal appeal for denials of care.

◆ **Prudent layperson standard for emergencies:** Thirty-one state laws specify automatic coverage for emergency medical conditions "of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy."

◆ **Financial standards and licensing:** All 50 states provide for structural regulation of managed care organizations, usually requiring a "certificate of authority" to operate, financial solvency standards, periodic reporting and filing of operational plans.

"I believe the HMO made its decision based on financial considerations and not on what was best for Marcia," asserts her influential mother. She believes legislators play an important oversight role to protect consumers.

Another issue making headlines concerns access to emergency services under managed care plans. When 2-year-old Michael Silver cracked his head open on Thanksgiving eve several years ago, his parents rushed him to the nearest emergency room, five minutes away. The child received three layers of stitches from a plastic surgeon, but the family's HMO refused to pay the $560 bill because Michael's case didn't constitute an "emergency" under the plan. Nor had his parents contacted the HMO for prior permission to take him to a facility outside the network.

"My son was gushing blood. I was scared to death, and my hands were holding his wound shut," reports Michael's mother. "It certainly was an emergency in my mind, and it never occurred to me to take him the 40-minute drive to our HMO's closest emergency center or to call them up. Getting my baby immediate help was all that was on my mind."

In response to similar cases, more than 30 states have implemented "prudent layperson" standards to make getting emergency care easier. Such laws require plans to cover emergency care if a "prudent layperson" believes that immediate treatment is needed.

Personal stories such as Marcia's, Michael's and others made managed care a top constituent issue for many state legislators in the 1990s. With lives, livelihoods and votes at stake, states acted decisively. Among the 50 states, nearly 900 laws passed that affect managed care, according to NCSL's Health Policy Tracking Service (HPTS).

PRO-CONSUMER LEGISLATION

State laws addressing these issues have not followed any single model act, although insurance regulators, physicians and consumer advocates have circulated several such examples. In fact not all were high visibility packages. Many of the 900 state laws addressed particular issues reported by consumers negotiating the managed care system, such as gaining access to a specialist, being fully informed of medical options, getting coverage for emergency room services, obtaining 48-hour hospital coverage following birth for maternity cases, receiving adequate hospital coverage for mastectomies, appealing a denial of coverage for a specific service or procedure, or even just knowing what is covered.

Along the way, legislatures also have addressed structural and financial issues not as visible to the individual enrollee. These include: requiring consumer "report cards," requiring all HMO medical directors to be licensed MDs, allowing more providers to join health plans, requiring advance notice when terminating doctors and other providers and requiring prompt payment for doctors or specialists.

Many of these recent laws expand state authority or mandate additional action or services. However, at the same time, the legislative sponsors generally made it clear that they did not intend to restrict enrollment or hurt the growth of managed care plans. In fact, some would say the pro-consumer regulations may well make HMOs more acceptable and ultimately more popular.

With all these laws in effect, has managed care finally been "managed?" For 1999, many legislators would answer, "No way!" An HPTS survey of legislators active in health issues conducted in December indicates that managed care in general is still a priority in all 50 states and D.C. "

Others worry, however, that overregulation of managed care plans may defeat their very purpose. While the horror stories make the headlines, the reality is that managed care has become a way of life for most Americans. At last count, more than 160 million people were enrolled in some form of managed care. These plans appear to serve the needs of many enrollees, especially those with few

INNOVATIVE AND CONTROVERSIAL IDEAS

As the managed care debate evolves in the media and on the floor of state legislatures, new (some might say far-reaching) provisions have been enacted by selected states:

◆ **The right to sue your HMO:** Texas is the first state to enact an "insurer liability" provision that holds health maintenance organizations liable for health treatment decisions. Missouri used another approach by repealing an earlier law prohibiting the "corporate practice of medicine." Health plans decry right to sue provisions and say they will prompt premium increases of up to 10 percent; in addition federal law limits the reach of states' authority. However, 31 states reported that this is a legislative issue for 1999.

◆ **Report cards:** In an effort to assist consumers in choosing a plan, 11 states now require publication of an evaluation booklet, commonly called a "report card." In Vermont, for example, the public report card will measure how well plans are complying with about 60 selected state laws and regulations. "Ultimately it will be a great tool for consumers," noted William Little of Kaiser Permanente, Vermont's largest HMO.

◆ **Specialists as primary doctor:** For people with a single chronic health problem, the usual procedure of calling a primary care provider first can be frustrating and unproductive. In 1998, Indiana, Kentucky, New Mexico and Pennsylvania joined New Jersey, New York and Texas in allowing an enrollee to select a specialist (such as a neurologist, a mental health provider or a cancer specialist) to be their main provider.

◆ **Medical director requirements:** Some managed care organizations' chief officers have business degrees rather than medical credentials. In the past two years, 18 states have established specific qualifications and responsibilities for HMO medical directors; most require a current in-state medical license. Several states make such directors "responsible for treatment policies...of the carrier," which means they could be legally liable for actions of their staff.

◆ **Consumer assistance/ombudsman programs:** Over a dozen states established ombudsman programs for Medicaid managed care. Now California, Maine and Vermont have launched such publicly funded advocacy programs for private market enrollees, and other states are looking closely at these examples.

major health problems. And they do so with fewer complaints than most people believe.

Some legislators are looking for a middle ground. "Yes, I believe some regulation is necessary, but we don't want to drive HMOs out of business," says Representative Gregg Underheim, chair of the Wisconsin Assembly Health Committee. He adds, "Some HMOs behave very appropriately. Clearly there are some bad actors in the HMO industry and they are making the environment more difficult for those who have operated ethically and efficiently."

Representative Gregg Underheim Wisconsin

"It was really the private employer who caused the rapid growth of managed care over the last decade," says John Iglehart, founding editor of *Health Affairs*, a leading national journal. "It wasn't really until the private sector came along with the private employer's contribution and decided that rather than put it into indemnity insurance, which was uncontrolled at that point, they would move into managed care.

"So we should remember that the conflict and the commotion really isn't a consequence of governmental action . . . governments we all like to kick around; it really was a result of private decision making," he says.

MANAGED CARE HERE TO STAY

Agree or disagree, policymakers recognize that managed care is here to stay. The business community accepts the analysis of health leaders such as Stanford University's Dr. Alain Enthoven that managed care has the best chance of increasing access, improving quality and moderating the rate of increase in health care costs.

For private employers and governments alike, the biggest HMO success story is cost savings.

"The role of managed care is to attack unnecessary and inappropriate costs," says Stephen de Montmollin, vice president of AVMed Health Plan of Florida, a managed care plan. "Double digit inflation caused millions to lose access to affordable health care insurance," he emphasizes. "In 1988, the average per employee cost for medical benefits in the United States shot up 18.6 percent; in 1989, another 16.7 percent; in 1990, up 17.1 percent; in '91 up 12.1 percent. With managed care, these figures have been reduced dramatically, with increases below 2 percent for 1998. In 1997, premiums actually decreased by 1.3 percent."

Citing several national and local polls, de Montmollin also says that most Americans, including those enrolled in managed care plans, are satisfied with their health care coverage. He also warns that burdensome regulations will result in higher costs, and that the alternative to a managed care system often is "uncoordinated care. Don't put the entire managed care system at risk in the absence of conclusive evidence that there is some systemic problem."

A SYSTEMIC PROBLEM?

Others believe there is a systemic problem. "The U.S. health care system is in chaos," asserts Ted Lewers, a vice chair of the American Medical Association's executive committee. "A lot of the satisfaction statistics that you've seen are from people who probably have not used the health care system—who have not had any chance to know whether it works or doesn't work.

"For example, if you look at mental health care, only 7 percent of Americans use those benefits. So if you look at your satisfaction questionnaire, you'd say you're satisfied with your mental health coverage, even if you haven't used it," he points out.

Many people aren't aware of the innovative things HMOs do, de Montmollin counters. Commenting on the Helen Hunt character and her asthmatic son, he says, "The irony is that many HMOs have been pioneers in putting together comprehensive asthma programs that help children control their symptoms and reduce

continued on page [illegible]

WHAT ELSE TO LOOK FOR IN 1999

◆ **Higher premiums:** After several years of almost level rates charged to employers and consumers, premiums are headed up. The latest survey, released in January, confirmed HMO premiums are rising 8 percent to 10 percent this year, the largest jump since 1993 (the year of President Clinton's national health reform proposal). At the same time, traditional indemnity health insurance rates also are rising 8 percent, but HMO premiums remain about 20 percent cheaper.

However, copayments and deductibles will become higher and more widespread, as many employers seek ways to continue health benefits for employees without footing the entire bill. Some state regulators may again examine the possibility of capping certain insurance rates.

In the private market, the Midwest Business Group, representing 110 large employers in 11 midwestern states, is "strongly encouraging members to hold the line on premium renewals and to consider tactics such as freezing enrollment in plans where there are large rate increases, raising copayments and deductibles for employees, and warning employees that more drastic changes might be contemplated," according to Larry Boress, the group's vice president.

◆ **Prescription costs:** Most analysts, including the federal Health Care Financing Administration (HCFA), say the main cause of 1999 rate increases is pharmaceutical prices, which are up about 17 percent since last year. Perhaps that's why 24 legislatures say they will look more closely at drug costs, either through regulating formularies and generic substitutes or acknowledging special drug copayments.

◆ **Slow-down of government program enrollment:** After almost a decade of enthusiasm for enrolling Medicaid consumers in managed care, the focus is shifting. There is more emphasis on enforcing the rights of consumers, as well as legislative studies and audits to determine if cost savings are real, and if they can continue. Meanwhile, a push to enroll Medicare recipients in managed care collapsed in a high-visibility dispute between HCFA and managed care organizations about reimbursement rates. HMOs in 29 states announced they were pulling out of the Medicare market, affecting over 450,000 seniors. This dispute may fuel state legislative oversight hearings and investigations, although the resolution remains under federal jurisdiction.

◆ **Direct contracting:** Many large employers and some smaller ones are watching very closely an experiment in Minneapolis-St. Paul. A business consortium has pooled resources to contract directly with doctors and hospitals to provide health care, effectively bypassing HMOs. Policymakers in some other states may conduct their own studies to determine how direct contracting might work in their regions.

◆ **Voluntary improvements:** The American Association of Health Plans is putting its faith in improving quality and in convincing consumers that new regulatory burdens will make things worse, says Karen Ignani, trade association president and corporate executive officer. She expects a "continued evolution" that puts consumers in the driver's seat by giving them more choice of providers and benefits. However, legislators remain skeptical. As Massachusetts Senator Mark Montigny, chair of the Senate Ways and Means Committee and chief sponsor of a 1999 consumer rights bill, notes: "Health care decisions are now driven by third party money managers, obsessed with the bottom line. A comprehensive managed care reform bill will restore the provider-patient relationship and ensure quality health care delivery at reasonable cost. Angry consumers will demand reform in 1999 and we must act with an aggressive bill that puts patients first."

Senator Mark Montigny Massachusetts

◆ **Health vouchers:** Some private sector employers are proposing a simplified voucher system, providing each employee with a standardized monthly payment. This could get employers out of the health decision business in which they have to preselect a limited list of health plans. However, some policymakers question whether the average employee will be able to pick up the remaining costs, especially of family coverage. Expect to see some state interest in either encouraging or further regulating such arrangements.

◆ **Congressional action.** Both parties in Congress and the Clinton administration have said "patient protection" is a top priority for 1999. In the wake of last year's debate over sharply differing bills, key questions are not yet resolved: Will a new federal law replace or preempt existing state laws, especially when the state law is stronger? Will it fully cover other insurance plans that now are outside state regulatory authority?

"The future of state regulation of insurance hangs in the balance of the ongoing debate on regulating managed care," notes Joy Johnson Wilson, director of NCSL's Health Committee.

(Continued from page 18)

the need for emergency hospitalizations."

In fact, says de Montmollin, the most noteworthy thing about the movie scene is that a single waitress in a diner has health insurance for her son at all. "Wow, that's fabulous—fewer than half the women in her situation have any access to coverage," he says.

Rising costs make it harder for businesses and governments alike to provide coverage for the nearly 44 million Americans who remain uninsured. Managed care has been touted as a way to save money that can be used to cover additional people. However, the numbers of uninsured have increased in the past 10 years.

Compared to other insurance, "HMOs generally offer more benefits, including coverage for prescription drugs, and fewer deductibles and copayments," notes William Falk of Towers Perrin, a research firm in Chicago. He expects most employers to stick with HMOs. They are "still an attractive alternative."

But striking a balance between consumer protections and micromanagement remains a challenge.

CONSUMERS NEED HELP

Establishing publicly funded consumer assistance or "ombudsman" programs may be one way to address consumer needs without overregulating managed care plans.

"The public is very confused," says Ron Pollack, executive director of Families USA, a consumer advocacy group. He says the managed care backlash comes from a variety of factors. "I think people clearly do not understand

Come to Jacksonville for the Assembly on State Issues (ASI) Spring Meeting

April 9-11, 1999
Omni Jacksonville and Jacksonville Hilton & Towers

The ASI Spring Meeting is your Capitol-to-Capitol Connection. Through this forum, both legislators and staff come together to discuss issues and ideas. With eight standing committees and a task force, ASI members address many topics:

- children, families and health
- communications and information policy
- criminal justice
- economic and cultural development
- education
- fiscal, oversight and intergovernmental affairs
- legislative effectiveness
- science, energy and environmental resources
- redistricting

You do not need to be a committee member to attend this meeting. Everyone is welcome.

For more information, contact Vicky Rodriguez at 303/830-2200 ext. 113 or e-mail Vicky.Rodriguez@NCSL.org.

FOR MORE MANAGED CARE INFORMATION, ORDER THESE NCSL REPORTS:

— *Health Care Legislation*, 1997 (#6669) and 1998 (#6674) editions.
— *1999 State Health Care Priorities* by the Health Policy Tracking Service (#3029).
— Issue Brief: *Comprehensive Consumer Rights Bills*, by the Health Policy Tracking Service (#0233).
— *Major Health Care Policies: 50 State Profiles*, 1998 (#3027).
— Also check out NCSL's Health Care Web index: www.ncsl.org/programs/health/hc

For NCSL publications call the Marketing Department at (303) 830-2054. The Health Policy Tracking Service material is also available from Jeff Strandberg in NCSL's Washington, D.C., office: (202) 624-8695.

today what their choices are, what their rights are and how they can claim those rights. To the extent that we're really going to address the core of people's problems or concerns, we need to provide some specific assistance to consumers."

Pollack says consumer assistance programs would give people information about plans, help them understand their choices and rights, answer questions through free phone access, and help those who want to file an appeal. He also says that such programs can help the managed care plans, employers and regulators. "They can provide a basis for getting quick information about what the problems are that arise as our health care system changes.

"A 'patients bill of rights' should not dictate clinical decisions or redesign health benefits packages," Pollack says. "But such state laws are very important because they help to ensure that patients get the care they need, when they need it. And they give patients and physicians effective tools to fight HMOs' wrongful denials and delays of care," he explains.

THE FUTURE

Evidence points to continued lively and high visibility debate about managed care, including new state laws, renewed congressional debate and more indepth studies of the effect of the recent state laws.

"What will eventually shake out as the health care system in the next century likely will be a muddle of market, policy, regulatory and professionally driven solutions," says Edward O'Neil, director of the Center for the Health Professions at the University of California.

"Such pluralistic approaches are typically the American way of doing things. The best solutions occur when we are clear about our aims and use the various vehicles of market, policy and professions to implement what we desire. But in this case, we do not have the capacity to generate a community or public definition of aim. Until we find a genuine voice for the varied interests in health care, we are likely to continue to suffer the cacophony of competing interests clashing over the $ 1.1 trillion that is health care in America, and to blame managed care for it all."

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Brady Building
1031 W. 4th Avenue, Suite 400
P.O. Box 107502 • Anchorage, AK 99510-7502

13 April, 2000

Representative Eldon Mulder
Co-Chair, House Finance Committee
State Capitol, Room 507
Juneau, AK 99801-1182

Representative Gene Therriault
Co-Chair, House Finance Committee
State Capitol, Room 511
Juneau, AK 99801-1182

Re: HB211

Dear Representatives Mulder and Therriault,

This morning we had a lengthy and fruitful conversation with Representative Rokeberg regarding HB211. In the absence of any other changes, if an exemption for self-insured plans is incorporated into the bill, any definition of "medical necessity" is eliminated, and pending resolution of one other contract issue that Representative Rokeberg agreed to research, we can recommend HB211 to our customers.

Thank you for your consideration.

Sincerely,

Ed Burgan
Senior Vice President

cc: Representative Rokeberg
Associated General Contractors of Alaska
Mechanical Contractors of Anchorage
Mechanical Contractors of Fairbanks
Steel Erectors Associations
National Electrical Contractors
Alaska Hotel and Motel Association
Members of the Labor and Commerce and Judiciary Committees
Alaska State AFL-CIO
Alaska Electrical Health & Welfare Fund
Alaska UFCW Trust
Alaska Teamsters Welfare Trust
All Labor Organizations Sponsoring Health & Welfare Plans
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Alaska State Medical Association

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

April 12, 2000

Honorable Gene Therriault
Co-chair, House Finance Committee
House of Representatives
State Capital, Room 511
Juneau, Alaska 99811-1182

RECEIVED
APR 1 2 2000

RE: CS HB 211—Alaska's Patients' Bill of Rights

Dear Representative Therriault:

CS HB 211 (version "W".) contains some significant protections for Alaska's patients. However, the job is not yet completed. Two major issues remain—managed care entity accountability ("liability issue") and the issue pertaining to the definition of "medical necessity" with its impact on the external appeal mechanism and with liability.

Given the short time remaining in this session and the complexity of the above two issues; ASMA feels that those two issues cannot receive the amount of attention warranted for the Legislature to make a reasoned policy decision. ASMA also is very aware that Congressional action is expected on the "National" Patient's Bill of Rights (with such action possibly having an impact on what may or may not be adopted in Alaska). Therefore, it is ASMA's intent to come back to the Legislature early in the next session with separate legislation pertaining to those issues. Although, ASMA feels that the ERISA pre-emption of the various states regulating "quality of care" issues has been significantly narrowed through recent court decisions, it is expected that the "National" Patient's Bill of Rights will directly address that issue.

So, therefore, ASMA supports CS HB 211 version "W", as on balance it provides important patient protections, but the issues of "liability" and "medical necessity" still need to be addressed by the Legislature in the next session.

Thank-you for all the work you, and your committee, have done on this important legislation.

Sincerely,

BY: Peter Lawrason, MD, President
FOR: The Alaska State Medical Association

kms

Alaska Physicians & Surgeons, Inc.
4120 Laurel Street, Suite 206
Anchorage, Alaska 99508
Phone: 561-7705 Fax: 561-7704
E-mail: akphys@alaska.net

RECEIVED
APR 12 2000

April 12, 2000

The Honorable Gene Therriault
Alaska State House of Representatives
Room 511, State Capitol Building
Juneau, Alaska 99811

Dear Representative Therriault:

Alaska Physicians & Surgeons supports version W. of House Bill 211. However, we have concerns about supporting a bill that does not have a definition of "medical necessity" nor contains a section regarding civil liability of managed care entities.

By supporting this version of HB211, we are not waiving our commitment to enact into law these two provisions. Given that there are only a few weeks of session left, we will pursue enacting these sections in separate legislation next year.

We look forward to working with you in the future to resolve the important issues left out of HB211.

Sincerely,

Michael Haugen, JD, MBA
Executive Director
Alaska Physicians & Surgeons

Jack C. McRae
Senior Vice President

P.O. Box 327
Seattle, Washington 98111-0327

April 14, 2000

The Honorable Norman Rokeberg
Chair, House Labor & Commerce Committee
State Capitol, Room 24
Juneau, AK 99801-1182

BY FAX: 907/465-2040 (1 page)

Dear Chairman Rokeberg:

I want to take this opportunity to thank you for the hours of time you have devoted to the goal of passing a Patients' Bill of Rights. Your tenacity on this issue brought together the diverse parties that hammered out the present HB 211.

Blue Cross Blue Shield of Alaska supports version W of HB 211 with some minor changes, which we have discussed with your staff. I do not see that these changes would in any substantive way detract from the goals of HB 211.

We are looking forward to working with you as HB 211 goes to the Senate, and if we can be of assistance, please don't hesitate to contact us.

Sincerely,

Jack C. McRae
Senior Vice President

Subject: **Re: ERISA**
Date: Fri, 15 Oct 1999 22:18:52 -0800
From: bob_lohr@dced.state.ak.us (Bob A Lohr)
To: Janet Seitz <Janet_Seitz@legis.state.ak.us>, Bob_Lohr@dced.state.ak.us

The federal Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 et seq (ERISA) comprehensively regulates empoyee pension and welfare plans. An employee welfare plan or welfare benefit plan is defined as one that provides to employees medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability or death. Employer may provide these benefits by purchasing insurance or by self-insuring. Accordingly, any plan that meets this federal definition, whether it is insured or not, is covered by ERISA, except plans for governments, churches, workers' compensation benefits, or an unfunded excess benefit plan.

Under ERISA, uniform procedural standards are established concerining reporting, disclosure, and fiduciary responsibility for welfare and pension plans. ERISA does not regulate the substantive content of welfare-benefit plans. As a result, ERISA contains almost no federal regulation of the terms of benefitplans. On the other hand, ERISA does contain broad preemption provisions to declare that ERISA supersedes any and all state laws insofar as they may now or hereafter related to any employee benefit plan. This preemption provision is substantially qualified by the "insurance saving clause", which states that nothing in ERISA shall be construed to exempt or relieve any person from any law of any state that regulates insurance, except that a employee benefit plan may not be deemed to be an insurance company for the purposes of any state law purporting to regulate insurance companies.

The United States Supreme Court has held that state mandated benefit laws as applied to insurance companies selling insurance to benefit plans are laws that regulate insurance and are, therefore, saved from ERISA preemption. But these same mandated benefit laws are preempted with respect to self-insured benefit plans, because such plans may not be deemed an insurance company for purposes of state law. This means fully insured benefit plans in Alaska must comply with Alaska's mandated benefit laws, but self-insured plans do not.
As stated above, governmental plans are exempt from ERISA and, thus, may be subject to state regulation absent other preemptive federal or state legislation. ERISA defines a governmental plan to include a plan established or maintained for its employees by the U.S. government, by the government of any state or its political subdivision or by any agency or instrumentality of the same. Besides plans of the federal and state governments, school districts, cities, boroughs, municipalities, etc are examples of governmental plans.

With respect to plans for federal government employees, there are federal laws outside of ERISA that govern such plans and the extent of benefits under such plan, such as the Federal Employee Health Benefits Act. Under federal preemption principles, therefore, plans covering federal government employees are generally not subject to state law. With respect to plans for state employees, the Attorney General's office is in the process

of preparing an opinion regarding the application of the insurance code to the state's self-insured health insurance plan, which may also be relevant to any nonfederal governmental plan in this state that is self-insured.

With respect to your question on small employer plans, Alaska law under AS 21.54.500 defines a small employer as one that employed an average of at least two but not more than 50 employees on the business days during the preceding calendar year and that employs at least two employees on the first day of a health benefit plan year. A large group employer means an employer that employed an average of at least 51 employees on the business days during the preceding calendar year and that employed at least two employees on the first day of a health benefit plan year. The requirements for small employer group plans are established under AS 21.56.

Sorry this is so lengthy, but that's federal law for you. If you have any questions, please let me know.

Janet Seitz <Janet_Seitz@legis.state.ak.us> wrote:
>*Bob:*
>
>*Do you have anything that explains ERISA and who is covered and who*
>*isn't? We have been told in the past that governmental plans (state,*
>*local, federal) are not covered and that self-insured plans are not*
>*covered. When I reviewed ERISA, I found reference to government plans*
>*and church plans but not self-insured plans. Also, is there any*
>*minimum number of people in a "small" plan.*
>
>*Thanks*
>
>*Janet*
>*Rep. Rokeberg's Office*
>
>

FOR IMMEDIATE RELEASE

Contact: Clara Kinner
(425) 670-5799
(425) 670-5575 fax

Blue Cross Blue Shield of Alaska Introduces Independent Review Program

ANCHORAGE, April 11, 2000—Effective March 31, all Blue Cross Blue Shield of Alaska health plan members have access to a binding independent review program. This service assures members of a fast and neutral review by independent medical experts should they ever disagree with a coverage decision.

"We're not waiting until the Federal Patients' Bill of Rights is passed into law. And while we're working closely with Representative Norman Rokeberg (R - Anchorage), sponsor of the Alaska Patients Bill of Rights, we want our members to have access to independent review services immediately," said Jeff Davis, Executive Director and Vice President of Blue Cross Blue Shield of Alaska. "We will contract with three independent review organizations that will review our cases on a rotating basis."

Blue Cross Blue Shield of Alaska contracts cover virtually all services ordered by physicians and other practitioners. A small percentage of claims are denied, and when they are, it is almost always because the service is not covered by the member's contract. An even smaller percentage of claims are denied because the services are not considered medically necessary, or are considered within the medical profession as experimental or investigational procedures.

"In the rare cases where these disputes arise, independent review offers an additional measure of patient protection," explained Eric Wall, M.D., Regional Medical Director for Blue Cross Blue Shield of Alaska. "We hope it gives peace of mind to our members, knowing that should they ever disagree with a coverage decision, this independent option is available."

Under the new program, members have access to this binding independent review once they have completed Blue Cross Blue Shield of Alaska's internal appeal process. Independent review organizations provide neutral medical experts who have an "arms-length" relationship with Blue Cross Blue Shield of Alaska and have no conflicts of interest. Blue Cross Blue Shield of Alaska pays the cost of the review and agrees in advance to honor the reviewer's decision. This newest protection is just one example of the many ways Blue Cross Blue Shield of Alaska aggressively advocates for its members' rights.

"Our goal is to provide our members with peace of mind about their health care," said Davis. "This is another step toward that goal."

Blue Cross Blue Shield of Alaska is part of Premera Blue Cross which provides quality health care coverage to more than one million people in Alaska, Washington, and Oregon. Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

# # # #

Teleconference Update Summary

Main Menu
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System Access

TCN: 10809

Summary Data

TC Date:	April 19, 2000	Moderator:	
Time:	9:00 AM TO 11:00 AM	Toll Free Number:	800 368 8772
Status:	In-Progress	Dial-up Number:	
Sponsor:	SFIN: FINANCE	Personal Number:	907 258 8772
Chairs:	Parnell Torgerson	Testimony Allowed:	Yes
		Time Limit:	5 minutes
Purpose:	PUB	Backup Material:	No
Contact:	Darwin 4652138	Meeting ID:	7346

Public Remarks:

Internal Comments: Other sites may add.

Agenda

Bill Number	Bill Subject
SB 308	MARINE PASSENGER VESSELS
HB 133	VOTER APPROVAL OF SERVICE AREA CHANGES
HB 211	HEALTH CARE INSURANCE
HB 304	CLEAN WATER FUND/DRINKING WATER FUND

LIO Sites

Chair	Name	Room
	ANCHORAGE	
x	JUNEAU	CAP532
	MATSU	

VTS Sites

Chair	Code	Name	Location	LIO

Off-net Sites

Chair	Code	Name	Location	Phone
	OF1	Bill Green hb133	Anchorage	907-343-4357
	OF2	Dan Heincy hb211		916-791-3750

Participants

Name	Type	Bill

John Hanson - Vancouver BC

HB
214

HFIN

FILE

(11)

HOUSE COMMITTEE REPORT

Date Referred to Committee: May 3, 1999

FURTHER REFERRALS:

Date of Committee Action: 5\4\99

The FINANCE Committee considered:

HB 214

HOUSE BILL NO. 214

PRISON LITIGATION

"An Act relating to litigation involving correctional facilities; and amending Rules 59(f), 60(b), 62, and 65, Alaska Rules of Civil Procedure."

recommends it be replaced with the following committee substitute CSHB 214 (Jud)

[X] the same title
[ ] a new title

[ ] additional referral to ____________ Committee
[ ] attached amendment(s)

ADOPTS: ____________ Letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal note(s) ____________

[ ] zero fiscal note(s) ____________

APPROVES PREVIOUS: (Dept/Date)

[X] fiscal note(s) DOC (indeterminat 5\3\99

[ ] zero fiscal note(s) ____________

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
[signature] Therriault	X			
[signature] Mulder	X			
[signature] Kohring	X			
[signature] Davies		X		
[signature] Grussendorf	X			
[signature] Moses	X			
[signature] Davis			X	
[signature] Williams	X			
[signature] Foster	X			

CHAIR'S SIGNATURE [signature] [signature]

CO-

No: 1

FISCAL NOTE

Bill Version: CSHB 214(JUD)
(H) Publish Date: 5/3/99

STATE OF ALASKA
1999 LEGISLATIVE SESSION

Revision Date/Time (Note if correction)
Dept. Affected: Department of Corrections
Title: An Act relating to litigation involving correctional facilities; and amending rules 59(f), 60(b), 62, and 65, Alaska..
BRU: Administration and Operations
Component: All
Sponsor: Representative Mulder
Requester: House Judiciary Committee
Component Serial No. #0694

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	****	****	****	****	****	****
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	****	****	****	****	****	****

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

The Dept. of Corrections is submitting an indeterminate fiscal note for this legislation because the Department is unable to ascertain its economic impact. Under the terms of this bill, the Department will be able to seek closure of the Cleary class action lawsuit one year following the effective date of the legislation. It is unknown, however, whether the court will act favorably on the Department's motion. Furthermore, even if it is assumed that the court does act favorably on the motion, the Department cannot readily determine the fiscal impact of such a ruling. On the "savings" side, the Department is currently paying for a court-appointed compliance monitor in the *Cleary* lawsuit. Presumably, these costs will no longer be incurred following termination of the lawsuit. Though not anticipated, it is possible that new litagation could be filed requiring comparable monitoring.

Prepared by: Bruce Richards — Phone: 465-3307
Division: Commissioner's Office — Date/Time: 4/29/99 8:48 AM
Approved by: Comm. Margaret M. Pugh (signed: Margaret M. Pugh) — Date: 4/29/99
Agency: Department of Corrections

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SPONSOR STATEMENT
HOUSE BILL 214
"Prisoner Litigation Reform Act"
REPRESENTATIVE ELDON MULDER

Modeled after successful federal legislation, HB 214 provides that court decisions effecting Alaska's prison system be as direct and unobtrusive as possible to the overall operations of the prison system. Currently, as seen with the Cleary case, judicial judgements are allowed to make broad sweeping requirements of the entire system in order to solve specifically identified, non-systemic problems within the Department of Corrections.

House Bill 214 requires any court orders or consent decrees be limited in scope to include only the specific problems or issues contained in the original complaint. It would also requires the court to take into consideration the overall effect of its decisions on the management and fiscal impact on the department.

The States constitution clearly states that the Legislature has the exclusive right to appropriate. Recent court orders and consent decrees requiring certain levels of funding or services is in direct conflict with the Legislature's exclusive appropriation powers.

The far reaching effects of recent court orders and consent decrees have also been in conflict with the Administrative branch's requirement to manage the State facilities and carry out the several constitutional goals of prison administration.

While the legislature recognizes the Judiciary's ability to ensure the constitutional rights of Alaska's prison population, it also recognizes that there is a constitutional separation of powers and duties that allows the State to effectively carry out its duties. House Bill 214 will accomplish this goal.

HB
217

HFIN FILE

(11)

. .OUSE COMMITTEE REPC .T

Date Referred to Committee: April 29, 1999

FURTHER REFERRALS:

Date of Committee Action: 5/4/99

The FINANCE Committee considered: HB 217

HOUSE BILL NO. 217 FISHERY COOPERATIVE CONTRACTS

"An Act relating to obligations and payments to the state under fishery cooperative contracts; and providing for an effective date."

recommends it be replaced with the following committee substitute ______ [ ] the same title [ ] a new title

[ ] additional referral to ______ Committee

[ ] attached amendment(s)

ADOPTS: ______ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[X] fiscal note(s) DOR

[ ] zero fiscal note(s) ______

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) ______

[ ] zero fiscal note(s) ______

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
[signature] Therriault	X			
[signature] Mulder	X			
[signature] Kohring			X	
[signature] Davies	X			
[signature] Grussendorf	X			
[signature] Moses	X			
[signature] Williams	X			
[signature] Foster	X			

CHAIR'S SIGNATURE [signature] [signature]

Therriault Mulder

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 217

Revision Date/Time (Note if correction)

Title: Fishery Cooperative Contracts

Sponsor: (H) FIN

Requester: (H) FIN

Dept. Affected: Revenue

BRU: Revenue Operations

Component: Income and Excise Audit

Component Serial No. 113

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES** (increase)	256.2-512.5	256.2-512.5	256.2-512.5	256.2-512.5	256.2-512.5	256.2-512.5

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year (FY99) cost: 0.0

POSITIONS	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Full-time						
Part-time						
Temporary						

ANALYSIS:

** The estimated revenue increase is due to provisions of the American Fisheries Act. The bill provides for how these payments will be remitted to the State. Because there is no precise data on the amount of BSAI pollock that is landed outside of the State, we have provided a range instead of a point estimate. Please see attached for further analysis.

Prepared by: Brett Fried, Economist — Phone: 465.3C?2

Division: Income and Excise Audit — Date/Time: April 30, 1999

Approved by Commissioner: Wilson L. Condon — Date: April 30, 1999

Agency: Department of Revenue

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SECTIONAL ANALYSIS BY THE DEPARTMENT OF REVENUE OF HB 217 – FISHERY COOPERTIVE CONTRACTS

SECTION ANALYSIS

Section 1 amends AS 43.77 by adding AS 43.77.015 to categorize payments made to the state under federal fishery cooperative contracts. Pursuant to recently enacted federal law, the American Fisheries Act, cooperatives are required to execute contracts with its members who must agree to make payments to Alaska for pollock harvested in the Alaska pollock fishery that is not landed in Alaska. The payments are to be equal to the amount that would have been due had the product been landed in Alaska and subject to the Landing Tax. The bill provides that these payments are to be deposited by the department in the separate account maintained in the general fund for landing taxes, and treated as tax revenue collected for revenue sharing purposes. This allows for the payments to be shared with municipalities in the routine manner upon appropriation.

The amount of the obligation imposed by contract is treated as if it were a tax for purposes of AS 43.77.020. This imposes the obligation upon the cooperative members to file necessary state "as if" Landing Tax returns and to remit the proper payment. However, the payments are not taxes for other intents, such as for assessment, interest, penalty, and collection purposes.

Section 2 provides that the bill has an immediate effective date.

OPERATION EXPENSES

The Department of Revenue does not anticipate increases in cost due to the provisions of this bill.

REVENUES

The American Fisheries Act changed the structure of the Bering Sea and Aleutian Islands (BSAI) pollock fishery. Catcher processors fishing in the BSAI have signed a fishery cooperative contract that was authorized by the American Fisheries Act. Consequently, they must also make payments to the State for any BSAI pollock harvested in the pollock fishery but not landed in the State. Prior to passage of the American Fisheries Act this pollock was not subject to Alaska fish taxes.

In order to estimated the amount of pounds of pollock harvested in the BSAI but not landed in the State, we compared historical Department of Revenue BSAI pollock data to National Pacific Management council data. DOR pounds of pollock were 16% to 18% less than those identified by the National Pacific Marine Council. Although these differences could be due to different factors (including how unprocessed pounds are calculated), we used this historical information to estimate two scenarios: (1) pollock landed outside the State accounts for 10% of total pollock landed and (2) pollock landed outside the State

accounts for 20% of pollock landed. Using these two scenarios the amount of new revenue coming into the State as a result of the American Fisheries Act would be from $256,000 to $512,000. There is, however, no method for adjusting these historically based numbers to reflect the new reality of the cooperative fishery. The pace of fishing has been altered by the fact that the catcher processors no longer compete with each other to maximize their share of the pollock. This could result in changes to the amount of pollock landed in Alaska. Additionally if motherships sign a fishery cooperative contract then payments should increase.

Alaska Department of Revenue

Income and Excise Audit Division

Fishery Cooperative Contracts
HB 217
April 30, 1999

Assumptions	1999
Total Allowable Catch in the BSAI for pollock in metric tons	992,000
Metric Tons to Pounds conversion factor	2,205
Total Allowable Catch in the BSAI for 1999 in pounds	2,187,360,000
CDQ Allocation (10% of TAC)	218,736,000
Total Non-CDQ allowable catch	1,968,624,000
Bering Sea Catcher-Proc. Percent Discards Pollock 1998	2.5%
Percentage of CDQ to Catcher Processors	85.0%
Percentage to Motherships	10.0%
Percentage to Catcher Processors	40.0%
Percentage to Inshore Processors	50.0%
Price Pollock per pound	0.09
Tax rate	3.0%
Scenario 1: Last Load Percentage	10.0%
Scenario 2: Last Load Percentage	20.0%

BSAI POLLOCK "LAST LOAD" - ANNUAL REVENUE FY 2000-FY2005				
Pounds of Pollock	Value (@ $.09/lb.)	Tax Revenue (@ 3% tax rate)	Last Load Scenario 1	Last Load Scenaric 2
949,040,820	$85,413,674	$2,562,410	$256,241	$512,482

Sources: North Pacific Fishery Management Council, National Marine Fisheries Service and Department of Revenue Fishery Resource Landing Tax and Fisheries Business Tax Returns.

SPONSOR STATEMENT / SECTIONAL ANALYSIS

HB 217 - Obligations & Payments To The State Under Fishery Cooperative Contracts

House Bill 217 grants specific statutory authority to the Department Of Revenue, necessary to collect payments in lieu of taxes which are required under the American Fisheries Act of 1998.

The AFA provided for payments in lieu of commercial fishery landing taxes, as part of fishing cooperative contracts for the at-sea pollock fishery. Once nine factory trawlers were removed from the fishery, remaining vessels were allowed to form these cooperatives in order to fish on a more flexible schedule, and with more attention to safety and by-catch restrictions.

Senator Ted Stevens and others recognized that the use of coops could have unintended impacts upon the state and its coastal communities. Among these was the potential loss of landing tax revenues due to the possible shift in landing sites of fish product to Seattle and other ports.

To avoid the loss of landing tax revenue, the following section was included in the AFA of 1998:

> "Any contract filed under subsection (a) shall include a contract clause under which parties to the contract agree to make payments to the State of Alaska for any pollock harvested in the directed pollock fishery which is not landed in the State of Alaska, in the amounts which would otherwise accrue had the pollack been landed in the State of Alaska subject to any landing taxes established under Alaska law."

House Bill 217 continues the landing tax unchanged, with the State of Alaska collecting the revenues, but would additionally assure that payments in lieu of taxes are processed as intended in current state law.

Section 1 (a): Adds a new section to AS 43.77 which provides the authority for the state to deposit the collected payments in lieu of landing taxes into a new account for that purpose.

(b): Provides that the payment-in-lieu-of-taxes obligation in the cooperative fishing contract should be treated as a fishery landing tax obligation for collection as tax revenue.

Section 2: Immediate effective date.

HB 217 / Rp. Carl E. Moses (staff: tim benintendi)
CEM/tb