ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672
8675 HOUSE LABOR & COMMERCE

To Pete Kott

From Don Hudson DO
Alaska Regional Hosp -

Info I Support House Bill
266 & Strongly Recommend
you Support it -

Thanks

Don Hudson

Fx 333-3262 Home

Roland E. Gower, M.D.
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PRACTICE LIMITED TO GENERAL SURGERY

BY APPOINTMENT ONLY

MEMO

TO: Representative Pete Knott (fax 694-8945)

FROM: Roland E. Gower, M.D., Counselor
Anchorage Medical Society

SUBJ: "Any Willing Provider" legislation

DATE: September 30, 1995

I was unable to attend the meeting this morning concerning "any willing provider" legislation, and wanted to present you my feelings in writing. I feel that this is an important piece of legislation and should be passed this year. It is important in that it protects the independence and autonomy of medical care providers. I think the overwhelming majority of the medical community is cognizant of the need to decrease costs and improve the efficiency in providing medical services. However, a great majority of us do not want to sign contracts and be told how to practice medicine at the direction of an HMO. It seems to me that if a practitioner is willing to offer the same service for the same price as a contract physician, that one should be allowed to do that without being under contract. Obviously, this also protects the patient in allowing them to choose any doctor that they wish who is willing to work for the same fee. I strongly urge you to support this legislation and work toward its passage.

REG:bar

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October 4, 1995

Representative Pete Kott, Chairman
House Labor and Commerce Committee
10928 Eagle River Rd., Suite 141
Eagle River, Alaska 99577

Dear Representative Kott:

This letter is in follow up to Aetna's testimony on House Bill 266 to your Committee on September 27 in Anchorage.

At the close of the hearing, you asked all parties to review Representative Rokeberg's proposed Committee Substitute, which was not made available prior to the hearing. We have reviewed the bill and concluded that the clarifying sections which have been added to the original bill (Sections 2 and 5) do not materially change the impact of Section 1, which is identical to the original version of the bill. If passed, the legislation would still effectively put an end to PPO agreements in Alaska. Aetna continues to oppose the legislation for this reason and urges you to keep HB 266 in the Labor and Commerce Committee.

One point which was made by all of the witnesses in opposition to the bill is that Section 1 would either immediately or over time eliminate any incentive for a hospital or provider to offer a discounted rate. The reason for the elimination of incentive is that the predictability of hospital patient volume which results from a PPO agreement allows a provider to be more efficient. Greater efficiency allows the discounting of linkage of patient volume for "preferred" prices, we believe the economics of any provider agreement related to prices will not be sustainable. Allowing any provider to meet the terms of a PPO agreement would in effect remove predictability of patient volumes and therefore the ability of a provider to manage for efficiency.

A primary reason for high hospital rates is the large unused capacity in hospitals which adds fixed facility and personnel costs even while that capacity is not being fully used. PPO agreements help to keep capacity and personnel costs closer in line with utilization.

The Committee Substitute does now recognize that self-funded employer plans are exempted due to ERISA provisions. What was not discussed at the hearing, however, are the implications of this exemption. It is the larger employer who has the financial circumstances and resources to consider a self-funded arrangement in lieu of a conventionally-insured policy. For these employers, then, any preferred provider arrangements they may have in place or choose to establish will not be impacted by HB 266.

It is instead the small employer desiring a preferred provider arrangement who will effectively be denied that opportunity, since it is not financially feasible for such employers to assume the economic risks and cost unpredictability inherent in self-funded/self-insured arrangements. And it is arguably the small employer who struggles most to provide affordable health insurance for his or her employees and their families and who would benefit most from the collective purchasing power and reduced costs available through insurer-administered preferred provider arrangements.

Preferred provider and other managed care arrangements are a proven vehicle for managing health benefit costs, and they can do so without shifting cost to employees and their families through higher plan deductibles, higher insurance payroll deductions, or the reduction of benefits. Numerous surveys show that employee and patient satisfaction levels are as high as or higher than those for traditional plans. Mature managed care plans integrate the financial aspects of care delivery with an equal focus on clinical quality management, wellness and preventive care promotion, and the screening and evaluation (i.e. "credentialing") of providers based on far more information that is available to the lay person operating in the real world of health care delivery.

As regards the issue of freedom of choice, Aetna and other insurer's preferred provider arrangements allow individuals access to a plan of benefits that provides each consumer the choice to participate in a plan that optimizes cost-effectiveness and minimizes family out-of-pocket costs, while still providing meaningful and significant reimbursement regardless of the health care provider or facility chosen.

Thank you for the opportunity to testify on this most important issue. Please let us know if you need additional information.

Regards,

Steven M. LeBrun

SML/vf

ALASKA STATE LEGISLATURE
House of Representatives

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Representative Norman Rokeberg

JUST THE FAX

Date: 9-15-95

TO: George Dozier

FAX: 694-8945 Telephone 694-8944

FROM: Representative Norman Rokeberg

FAX: (907) 258-2916 Telephone: (907) 258-8191

Number of Pages: 14 (including this page)

Comments: George - This is the "memo" I was trying to track down yesterday. Please call if you have any questions.

Lisa Costello

Have A Nice Day

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

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March 22, 1995

The Honorable Tim Kelly
Chairman, Senate Labor & Commerce Committee
Alaska State Senate
Room 101 State Capitol
Juneau, AK 99801-1182

Dear Senator Kelly:

During and following my testimony before your committee last Thursday, March 16, 1995, you asked for a written response to several questions. As I understand the request, the questions are:

What does AS 21.36.090(d) do?
Is AS 21.36.090(d) a mandate of coverage?
Discuss a generic form of AS 21.36.090(d).
Are Preferred Provider Organizations (PPO's) legal in Alaska?
What does proposed AS 21.36.090(e) do?

The attached discussion attempts to respond to these questions and I hope that it does so clearly. Attached to the discussion paper is an attachment providing the language for selected sections of the hospital or medical service corporation chapter in the Insurance Code. The second attachment is the NAIC Preferred Provider Arrangement Model Act. If this whole thing causes additional questions, I'll be happy to address them. My direct line is 465-2577. Thanks.

Very truly yours,

Donald P. Koch, CIE
Chief of Market Surveillance

Attachments

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08-H11LM

DISCUSSION OF AS 21.36.090(d), (e), and PPO'S

AS 21.36.090(d)

With the introduction of SB 100, there has been considerable discussion centered on the effect of AS 21.36.090(d). This subsection of law is in the section dealing with unfair discrimination issues in life and health insurance. Subsection (d) is focused on group health expense incurred types of policies or indemnity type contracts. The statute states:

> (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 disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by 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.

Certain policies of insurers, any "group disability policy that extends coverage on an expense incurred basis," are impacted, as are contracts of hospital medical service corporations any "group service or indemnity type contract issued by a nonprofit corporation."

What does AS 21.36.090(d) do?

AS 21.36.090(d) is intended to prevent an insurer or a hospital medical service corporation from discriminating against a provider who provides a service or treatment covered by its contract, that is performed within the scope of the occupational license for the providers' profession.

An example would be a policy that provides coverage for treatment of a headache. If treatment of a headache can be performed by a physician, a dentist, an osteopath, or a naturopath, under the occupational license of each of those professions, then the insurer cannot exclude treatment by any one of them. This can and has generated some greater specificity concerning what is covered. Some coverages extend only to procedures in a hospital, such as anesthesia for a surgical procedure performed in a hospital. This obviously excludes some professions who do not have access to a hospital as a provider.

Concern has arisen that expansions of the defined providers under this statute would result in increased costs as the myriad practices drive up costs. There has been no evidence of that occurring and in fact some suggestion that the opposite is true. In past hearings concerning revisions to this statute, there has been testimony presented to the effect that the care or treatment can be provided by some professions at a reduced cost. In any event, insurers have and currently use tools for controlling this concern. The primary of these is the use of indemnification or reimbursement at the usual customary and reasonable charges for a service or treatment. Copayment and deductible features are also utilized. An additional tool is a reasonable review of the medical necessity of a procedure or treatment. Specificity in the contract language as to the extent and limits to coverage is also appropriate. For example, there is a difference between counseling and psychological counselling which the insurer can precisely reflect in its coverage structure without engaging in an unfair discrimination among providers.

The logic given for this statute over the years has been that if the state licenses a provider to perform services or procedures within a stated scope of practice, it has established a policy to allow that profession to practice. It would therefore be inappropriate to allow that profession to be discriminated against by insurers.

DISCUSSION OF AS 21.36.090(d), (e), and PPO'S

Does this statute constitute a mandate of coverage?

The Division of Insurance contends that AS 21.36.090(d) is not a mandate of coverage. It does not tell an insurer that it must provide particular coverages. It merely states that if the coverage is provided, the insurer cannot discriminate against a listed practitioner who can provide the service or treatment within the scope of practice for that profession.

Is the listing of providers in AS 21.36.090(d) the only way to address discrimination?

AS 21.36.090(d) was first enacted in 1966 (Sec. 1 ch 120 SLA 1966) and defined provider as a state licensed physician, dentist, osteopath, optometrist, or chiropractor. It was amended on a number of occasions adding the following professions:

nurse midwife	Sec. 1 ch 80 SLA 1983
advanced nurse practitioner	Sec. 1 ch 56 SLA 1988
naturopath	Sec. 28 ch 2 FSSLA 1987
physical therapist	Sec. 28 ch 2 FSSLA 1987
occupational therapist	Sec. 28 ch 2 FSSLA 1987
psychologist	Sec. 139 ch 67 SLA 1992
psychological associate	Sec. 139 ch 67 SLA 1992
licensed clinical social worker	Sec. 139 ch 67 SLA 1992
certified direct-entry midwife	Sec. 1 ch 51 SLA 1993

SB 100 proposes to add the following professions to the definition of provider in 090(d):

physician assistant
acupuncturist

By defining "provider" in this way, licensed professions not listed in 090(d) effectively can be and are discriminated against. If the argument is accepted that legislative enablement of a particular medical profession constitutes a legislative policy decision to allow that profession to practice and that it is inappropriate to permit discrimination against that profession, then there is another method of achieving discrimination protection. This can be done by revising the existing 090(d) to remove the last sentence which contains the definition and by making minor editorial changes in the first part of the statute as follows:

> (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 disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the person's [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.]

Preferred Provider Organizations

For some time the Division of Insurance has focused on a single statute as the basis for the position that a Preferred Provider Organization (PPO) is not authorized in Alaska. That statute is AS 21.54.020(a).

DISCUSSION OF AS 21.36.090(d), (e), and PPO'S

> AS 21.54.020. DIRECT PAYMENT OF HOSPITAL, MEDICAL SERVICES. (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 disability 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. *(Emphasis added)*

There are several other statutes that, taken collectively, require statutory change before PPO's could operate in Alaska. This does not represent an opposition to the PPO mechanism, merely that the statutes do not currently provide for that mechanism.

How Blue Cross does it

Some of the PPO issue arises from the way that a hospital/medical service corporation, primarily Blue Cross (hereafter "Blue"), operates coupled with the fact that other insurers would like to be able to do those things as well. Blue is authorized under AS 21.87. It delivers health care coverage through the use of two contracts. The first contract is a providers contract in which a medical care provider agrees to provide services and agrees to a level of remuneration from Blue for those services. Blue then sells a second contract to the end recipient of care. This contract is a subscription contract which provides access to the contracts it has entered into with the providers. This contract also provides what is intended to be incidental indemnity coverage so that care may be provided on a non-subscription basis. See AS 21.87.070(3), (4), 120(a)(2), 130(a)(2), 140, 150, and 160 attached to this discussion.

These provisions effectively allow a different benefit to be provided for the subscription basis than for the indemnity basis. Note that AS 21.87.160(b) (2) infers a difference by its use of the phrase "if any."

How an insurer does it

An insurer is defined in AS 21.90.900(24) as an indemnitor in the business of entering into contracts of insurance. Note also the definition of insurance in AS 21.90.900(22).

> AS 21.90.900. DEFINITIONS FOR TITLE. In this title, unless the context requires otherwise,
>
> (22) "insurance" means a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies;
>
> (24) "insurer" includes a person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity;

These definitions do not appear to allow an insurer to enter into subscription contracts of the type contemplated by AS 21.87. An insurer is not an AS 21.87 corporation. An insurer is an AS 21.09 corporation. It must have specific authorization to do the kinds of things a Blue can do. To accomplish this it must seek an authorizing statute.

Discrimination

A more relevant cite is AS 21.36.090(b) & (d), which deals with unfair discrimination.

DISCUSSION OF AS 21.36.090(d), (e), and PPO'S

AS 21.36.090. UNFAIR DISCRIMINATION.

(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 disability insurance or *in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever. (Emphasis added)*

(d) See page 1.

AS 21.36.090(b) impacts only insurers but not Blue because it does not contain the phrase "a group service or indemnity type contract issued by a nonprofit corporation", while AS 21.36.090(d) impacts both. This is important because the limits placed on an insurer for the forms of prohibited discrimination are very broad and would appear to provide a barrier without other statutes. In particular, the phrase "in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever" appears to be a barrier.

Conclusion regarding PPO's

The Division of Insurance believes that an insurer operating a PPO would be in violation of AS 21.36.090(b). The Division is uncomfortable with the notion that a PPO can be operated under current law without specific authorizing language. We do not believe that this was intended by the legislature when it drafted the various statutes cited. A number of states have felt similar constraints and specific statutes have been adopted. The National Association of Insurance Commissioners has prepared a Preferred Provider Arrangements Model Act which is attached to this discussion. For example, PPO's operate in Florida, but Florida has an enabling statute.

What does proposed AS 21.36.090(e) do?

The work draft CS for SB 100(L&C) dated 3/15/95 adds a new subsection (e) to AS 21.36.090 which reads:

(e) Except as otherwise required by law, a person may not unfairly discriminate against a hospital that provides a service covered under a group disability policy that extends coverage on an expense incurred basis or under a group service or indemnity contract issued by a corporation, if the service is within the scope of the hospital's license. In this subsection, "hospital" has the meaning given in AS 18.20.130.

This section appears to move away from managed care and PPO's. As to insurers, this causes no conflict with the Division's existing view of statute. However the impact on hospital or medical service corporations is substantial. This proposal would entirely restructure the way these corporations must operate and would further require a redrafting of much of AS 21.87. A hospital or medical service corporation is not an insurer. It is a prepaid health care service organization. As noted earlier, under the discussion on PPO's and "How Blue Cross does it," a hospital or medical service corporation delivers health care coverage through the use of two contracts. The first contract is a contract with a hospital or medical service provider in which the provider agrees to provide services and agrees to a level of remuneration for those services. The hospital or medical service corporation then sells a second contract called a subscription contract to the end recipient of care. Thus the subscription contract provides access to the service contracts entered into by the hospital or medical service corporation.

AS 21.87.150 (language appears on page 2 of Attachment #1) governs the hospital service agreement while AS 21.87.160 (language on same page) governs the subscription contract. Rearrangement of these sections would be necessary with imposition of 090(e).

DISCUSSION OF AS 21.36.090(d), (e), and PPO'S

The contractual structure under which a hospital or medical service corporation operates avoids the need for the usual capital and surplus requirements applicable to an insurer. This is because the contract contains provisions that are a financial obligation on the part of the provider. If a noncontract provider or hospital is afforded the same status as a contract provider or hospital without the obligations imposed by the contract, it would follow that there would be no reason for a contract provider or hospital to maintain that contractual relationship and contractual obligation since they would be in the same condition without it. However, with this proposed change, a corporation formed under AS 21.87 would be no different than an insurer, except that it would not have any financial backup. If that occurs, then it would be simpler to repeal AS 21.87 and provide a mechanism for any existing corporation formed under AS 21.87 to become an insurer under AS 21.09.

This subscription contract also provides what is intended to be incidental indemnity coverage so that care may be provided on a non-subscription basis. 090(e) has the potential to increase the incidence of indemnity utilization to the point that a corporation formed under AS 21.87 could no longer operate as intended.

One additional factor that may be relevant to consideration of this provision is AS 21.87.070(3) which states:

> AS 21.87.070 QUALIFICATIONS FOR CERTIFICATE OF AUTHORITY. The director may not issue or permit to exist a certificate of authority to be or act as a service corporation to a corporation which does not fulfill the following qualifications:
>
> (3) if a hospital service corporation, it must have in force at all times while so authorized, service agreements with participant hospitals located in the areas of the subscribers' residences, convenient as to location and sufficient as to capacity and facilities reasonably to furnish the hospital services provided or proposed to be provided by the corporation to its subscribers;

If the reason for consideration of 090(e) is an actual discrimination against a hospital, then a review under AS 21.87.070(3) may be a more appropriate way to proceed before eliminating AS 21.87.

Attachments

Attachment #1

Selected Hospital/Medical Service Corporation Statutes

AS 21.87.070 QUALIFICATIONS FOR CERTIFICATE OF AUTHORITY. The director may not issue or permit to exist a certificate of authority to be or act as a service corporation to a corporation which does not fulfill the following qualifications:

(3) if a hospital service corporation, it must have in force at all times while so authorized, service agreements with participant hospitals located in the areas of the subscribers' residences, convenient as to location and sufficient as to capacity and facilities reasonably to furnish the hospital services provided or proposed to be provided by the corporation to its subscribers;

(4) if a medical service corporation, it must have in force service agreements with participant providers located in the areas of the subscribers' residences convenient as to location and sufficient in numbers and facilities reasonably to furnish the medical and surgical services provided or proposed to be provided by the corporation to its subscribers;

AS 21.87.120 SERVICES AND BENEFITS WHICH MAY BE PROVIDED, MEDICAL SERVICE CORPORATIONS. (a) A medical service corporation shall have the right to provide to its subscribers part or all of the following services and benefits only

(1) medical and surgical services furnished to the subscriber by participant providers;

(2) indemnity in reasonable amount with respect to medical and surgical services furnished to the subscriber by nonparticipant providers, but subject to AS 21.87.070(4);

(3) indemnity in reasonable amount with respect to hospital services furnished the subscriber while under the care and treatment of a participant provider or under the care and treatment of another provider upon referral by a participant provider;

(4) indemnity in reasonable amount with respect to appliances, prosthetics, and similar devices and replacements, and ambulance, x-ray, physiotherapy, and similar services.

(b) This section does not prohibit the corporation from acting as compensated servicing agent as to health care services to be provided by a public agency, or under agreements between other parties not solicited by the corporation.

AS 21.87.130 SERVICES AND BENEFITS WHICH MAY BE PROVIDED, HOSPITAL SERVICE CORPORATIONS. (a) A hospital service corporation shall have the right to provide to its subscribers part or all of the following services and benefits only:

(1) hospital services furnished to the subscriber by participant hospitals;

(2) indemnity in a reasonable amount with respect to hospital services furnished to the subscriber by nonparticipant hospitals, but subject to AS 21.87.070(3);

(3) indemnity in a reasonable amount for other health care services, as defined in AS 21.87.330(1).

(b) This section does not prohibit the corporation from acting as compensated servicing agent as to health care services to be provided by a public agency, or under agreements between other parties not solicited by the corporation.

AS 21.87.140 MEDICAL SERVICE AGREEMENTS. (a) A medical service corporation shall enter into service agreements with providers licensed by the state only.

(b) Each service agreement shall require the participant providers to furnish to subscribers of the service corporation the medical or surgical services, or both, that are, under the subscriber's contract, to be furnished by participant providers. This obligation to furnish the service, as provided for in the subscriber's contract, shall be a direct obligation of the participant providers to the subscribers as well as to the service corporation.

(c) Each service agreement shall further effectively provide in substance that

(1) the participant provider shall be compensated for services rendered to a subscriber in accordance with a schedule of fees contained in the agreement or attached to and made a part of the agreement, and that the participant provider may not request or receive from the service corporation compensation for the services which is not in accord with the schedule;

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant provider withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary of the subscriber's contract, whichever date is the earlier.

(d) The proposed form of the service agreement shall be filed with the director and is subject to the approval of the director under AS 21.87.180.

AS 21.87.150 HOSPITAL SERVICE AGREEMENTS. (a) A hospital service corporation shall enter into service agreements with hospitals approved or licensed by the state only.

(b) Each service agreement shall require the participant hospital to furnish to subscribers of the service corporation the hospital services which are, under the subscriber's contract, to be furnished by participant hospitals; and this obligation to furnish the service, as provided for in the subscriber's contract, shall be a direct obligation of the participant hospitals to the subscribers as well as to the service corporation.

(c) Each service agreement shall further effectively in substance provide that

(1) the participant hospitals shall be compensated for services rendered to a subscriber in accordance with a schedule of charges contained in the agreement or attached to and made a part of the agreement, and that the hospital may not request or receive from the service corporation compensation for the services which is not in accord with the schedule;

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant hospital withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary of the subscriber's contract, whichever date is the earlier.

(d) The service corporation shall terminate the service agreement of a particular participant hospital, in addition to other bases of termination provided for in the agreement, if it is determined that the hospital has knowingly charged or attempted to charge the service corporation for a service not actually rendered, or has knowingly violated a material provision of the service agreement.

(e) The proposed form of a service agreement and of the standard riders and endorsements to it shall be filed with the director and are subject to the approval of the director under AS 21.87.180.

AS 21.87.160 SUBSCRIBER'S CONTRACTS. (a) Each subscriber's contract issued after July 1, 1966, by a service corporation constitutes a direct obligation of the participant providers or participant hospitals of the service corporation to render the medical or hospital services, as the case may be, as agreed to be rendered by the participants in the subscriber's contract.

(b) Each subscriber's contract or certificate shall in adequate detail set out provisions from which can be readily determined

(1) the services to which the subscriber is entitled from participant providers or participant hospitals, as the case may be;

(2) the benefits, if any, to which the subscriber is entitled on an indemnity basis, consistent with AS 21.87.120, 21.87.130 and the other provisions of this chapter;

(3) the periodic subscription charge, rate or fee payable by or to the subscriber; or, if not so expressed and the charge, rate or fee is subject to change, the subscriber's contract shall require that not less than 30 days' written notice of the new charge, rate or fee shall be given to the subscriber or the remitting agent of the subscriber before the change is effective;

Attachment #1

Selected Hospital/Medical Service Corporation Statutes

(4) the date when the respective services and benefits become available to the subscriber, date of expiration of the contract, and the terms, if any, under which the contract may be continued or renewed;

(5) all other terms and conditions of the agreement between the parties consistent with this chapter;

(6) that the subscriber's contract and riders and endorsements thereon or thereto, together with application therefor, if any, signed by the subscriber, and identification issued to the subscriber, constitutes the entire contract between the parties.

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

(d) All exceptions and exclusions in the contract shall be printed and otherwise set out as prominently as the services or benefits to which they apply.

(e) This title may not be construed to prohibit a service corporation from issuing contracts to groups of persons under a master contract. In this event, however, each subscriber covered under the master contract shall be issued an individual certificate which shall set out in adequate detail the provisions itemized in (b) of this section.

(f) All proposed forms of subscriber's contracts shall be filed with the director and are subject to the approval of the director under AS 21.87.180.

Attachment #2

NAIC Preferred Provider Arrangements Model Act

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the Preferred Provider Arrangements Act.

Section 2. Purpose

The purpose of this Act is to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred provider arrangements and the health benefit plans associated with those arrangements.

Drafting Note: 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.

Section 3. Definitions

The following words and phrases when used in this Act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

A. Commissioner - The Insurance Commissioner of the State of _____.

B. Covered Person - Any person on whose behalf the health care insurer is obligated to pay for or provide health care services.

C. Covered Services - Health care services which the health care insurer is obligated to pay for or provide under the Health Benefit Plan.

D. Emergency Care - Covered services delivered to a covered person who has suffered an accidental bodily injury or contracted a medical condition which reasonably requires the beneficiary or insured to seek immediate medical care under circumstances or at locations which reasonably preclude the beneficiary or insured from obtaining needed medical care from a preferred provider.

E. Health Benefit Plan - The health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

F. Health Care Insurer - An insurance company as defined in

Attachment #2

NAIC Preferred Provider Arrangements Model Act

_____, a hospital plan corporation as defined in _____, a health services plan corporation as defined in _____, a health maintenance organization as defined in _____
_____, or a fraternal benefit society as defined in _____.

Drafting Note: This definition may need to be modified to conform to the state's service plan enabling statutes.

G. Health Care Provider - Providers of health care services licensed as required in this State.

H. Health Care Services - Services rendered or products sold by a health care provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

I. Preferred Provider - A health care provider or group of providers who have contracted to provide specified covered services.

J. Preferred Provider Arrangement - A contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this Act.

Section 4. Preferred Provider Arrangements

Notwithstanding any provisions of law to the contrary, any health care insurer may enter into Preferred Provider Arrangements.

A. Such arrangements shall:

(1) Establish the amount and manner of payment to the preferred provider. Such amount and manner of payment may include capitation payments for preferred providers.

(2) Include mechanisms which are designed to minimize the cost of the health benefit plan. These mechanisms may include among others:

(a) The review or control of utilization of health care services.

(b) A procedure for determining whether health care services rendered are medically necessary.

(3) Assure reasonable access to covered services available under the Preferred Provider Arrangement and an adequate number of preferred providers to render those services.

B. Such arrangements shall not unfairly deny health benefits for medically necessary covered services.

C. If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the Insurance Commissioner information describing its activities and a description of the contract or agreement it has entered into with the health care providers. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are exempt from this requirement.

Attachment #2

NAIC Preferred Provider Arrangements Model Act

Drafting Note: Section 4C is an optional section if a state desires to require verification of PPO activity of non-insurance entities.

Section 5. Health Benefit Plans

A. Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber agreements shall contain at least the following provisions:

(1) A provision that if a covered person receives emergency care for services specified in the Preferred Provider Arrangement and cannot reasonably reach a preferred provider that emergency care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(2) A provision which clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of non-preferred providers.

B. If a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

Section 6. Preferred Provider Participation Requirements

Health care insurers may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status, and further provided that selection of preferred providers is primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.

Drafting Notes: Categories of Discrimination - Individual states may wish to add additional protected classes in accordance with state laws or policies.

Quality of Services - The statement of a quality criterion as used in this section is not intended to create any higher standard of care for delivery of services by a preferred provider than is appropriate for other health care providers.

Section 7. General Requirements

Health care insurers complying with this Act shall be subject to and are required to comply with all other applicable laws, rules and regulations of this State.

Section 8. Regulations

The Commissioner may promulgate regulations necessary to the enforcement and administration of this Act.

Attachment #2

NAIC Preferred Provider Arrangements Model Act

Section 9. Severability

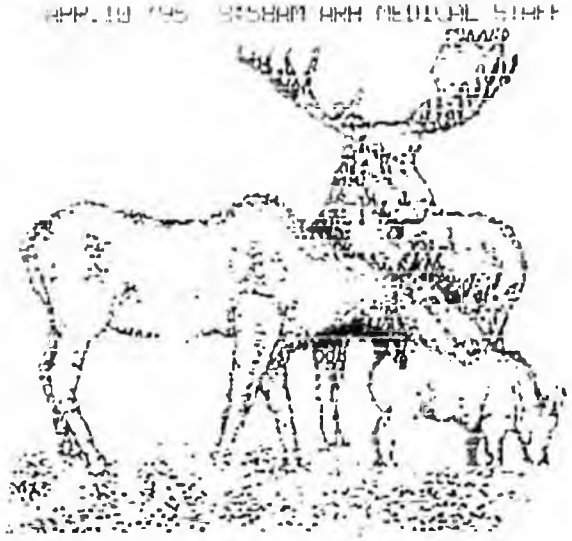
If any provision of this Act is declared invalid or unenforceable by a court of competent jurisdiction, the remaining provisions which are severable from the invalid provisions shall remain in force and effect.

Drafting Note: If a state elects to permit exclusive provider arrangements, the following section should be added to the Act:

Notwithstanding any other provision of this Act, health care insurers may issue policies or subscriber agreements which provide benefits for health care services only if the services have been rendered by a preferred provider, provided the program has met all standards imposed by the Commissioner for availability and adequacy of covered services.

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 19, 652, 713, 716-718 (adopted).



FAX TRANSMITTAL SHEET

ALASKA REGIONAL HOSPITAL
2801 Debarr Rd.
P. O. Box 143889
Anchorage, AK 99514-3189

Phone No. (907) 264-1261
Fax No. (907) 264-1414

TO THE ATTENTION OF: Representative Pete Kott - Labor & Commerce Committee Chairperso

COMPANY: House of Representatives PHONE NO. 465-2819

DATE: 04/10/95 TIME: 9:45 am NO. OF PAGES 5

COMMENTS/ REMARKS: Please see the following pages regarding support for House Bill #266. Thank you.

SENT BY:

DEPARTMENT: MEDICAL STAFF OFFICE

IF YOU DO NOT RECEIVE SOME OF THE PAGES, PLEASE CALL US AT: (907) 264-1261

AND ASK FOR Joyce Hodge

Alaska Regional Hospital

April 7, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The Medicine Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 46 physicians present for the vote on this action taken on April 7, 1995 are listed below and on the next page).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

David E Peach MD

David E. Peach, MD
Chairperson, Department of Medicine

DEP/jmh

cc: Labor and Commerce Committee Members
Health & Social Service Committee Members

Department of Medicine Members Present
Mark Agnew, MD
Beth Baker, MD
Ronald Boisen, MD
Jeanne Bonar, MD
William Bowers, MD

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The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Page 2

Department of Medicine Members Present Continued
Keith Brownsberger, MD
Richard Buchanan, MD
Robert Bundtzen, MD
Mary DeMers, DO
Frank Domurat, MD
Wayne Downs, MD
Richard Farleigh, MD
Glenn Ferris, MD
Shirley Fraser, MD
Sheryl Gale, MD
Gregory Gerboth, MD
Thomas Gordon, MD
Shawn Hadley, MD
Hans Hager, MD
David Henry, MD
Charles Herndon, MD
Kris Hirata, MD
Morris Horning, MD
Peter Hulman, MD
Burton Janis, MD
James Julin, MD
Janice Kastella, MD
Jayish Makim, MD
Anne Morris, MD
John Mues, MD
Richard Neubauer, MD
Patrick Nolan, DO
David Peach, MD
Kenneth Pervier, MD
William Ragle, MD
George Rhyneer, MD
Lee Schlosstein, MD
Charles Shannon, MD
Thomas Shreves, MD
Marjorie Smith, MD
Paul Steer, MD
Mary Stewart, MD
Latha Subramanian, MD
James Watson, MD
Dale Webb, MD
Thomas Wood, MD

Alaska Regional Hospital

April 7, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The Pediatric Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 7 physicians present for the vote on this action taken on April 5, 1995 are listed below).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

Jeff I. Brand, MD
Chairperson, Department of Pediatrics

JIB/jmb

cc: Labor and Commerce Committee Members
Health & Social Service Committee Members

Department of Pediatric Members Present

Karl Boll, MD
Jeff Brand, MD
James Briggs, MD
Bruce Chandler, MD
Clinton Lillibridge, MD
Donald Pickering, MD
Daniel Tulip, MD

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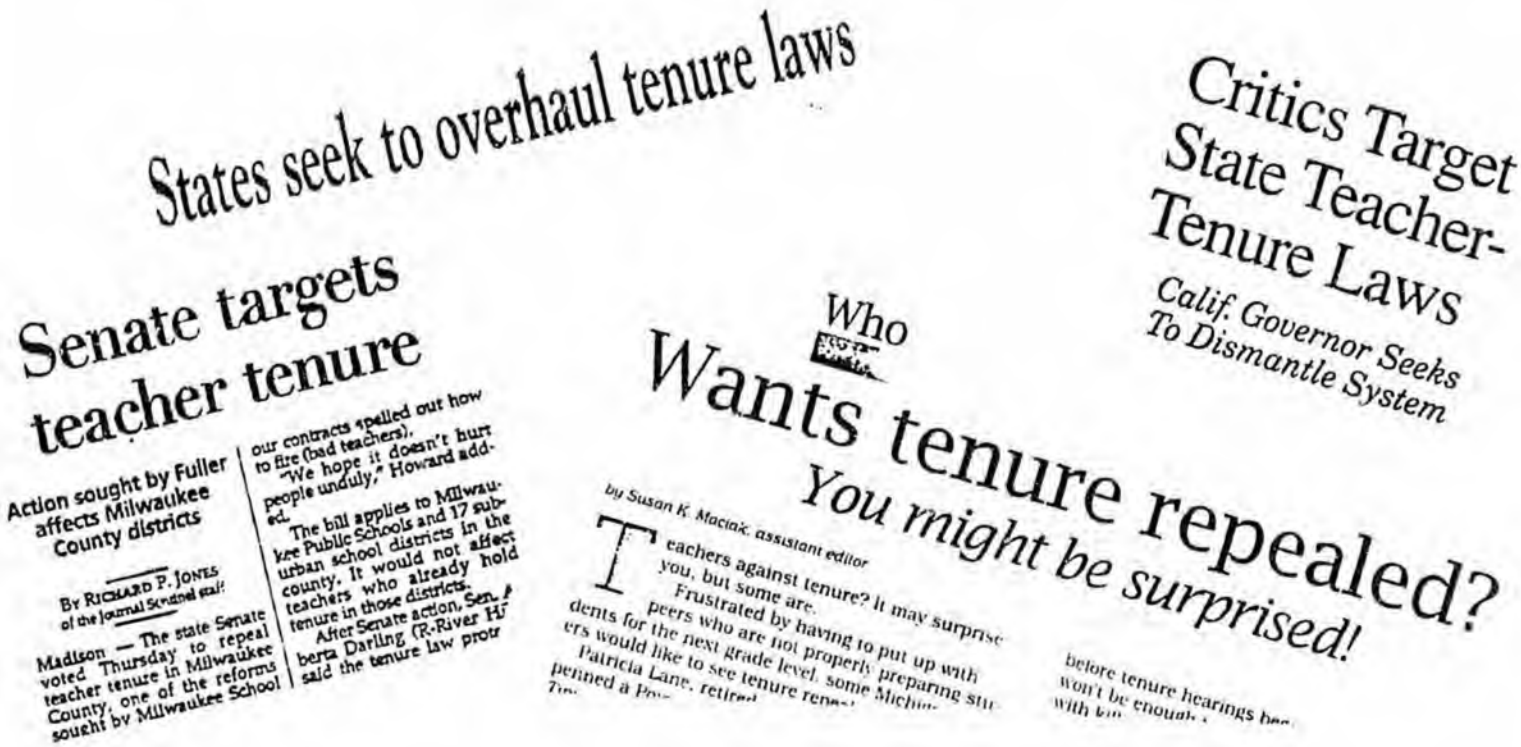
States Weigh Plans To Dismantle All or Part of Tenure Laws



States seek to overhaul tenure laws

Senate targets teacher tenure

Action sought by Fuller affects Milwaukee County districts

By Richard P. Jones of the Journal Sentinel staff

Madison — The state Senate voted Thursday to repeal teacher tenure in Milwaukee County, one of the reforms sought by Milwaukee School

our contracts spelled out how to fire (bad teachers).

"We hope it doesn't hurt people unduly," Howard added.

The bill applies to Milwaukee Public Schools and 17 suburban school districts in the county. It would not affect teachers who already hold tenure in those districts.

After Senate action, Sen. Alberta Darling (R-River Hills) said the tenure law prote

Who Wants tenure repealed? You might be surprised!

by Susan K. Maciak, assistant editor

Teachers against tenure? It may surprise you, but some are.

Frustrated by having to put up with peers who are not properly preparing students for the next grade level, some Michigan educators would like to see tenure repealed. Patricia Lane, retired

before tenure hearings begin. won't be enough with

Critics Target State Teacher-Tenure Laws

Calif. Governor Seeks To Dismantle System

"We want to be able to assure the public that qualifications for classroom instruction are the first consideration for employment and not necessarily seniority."

– Carl Rose, Association of Alaska School Boards

"School districts want to help teachers get the experience, supervision and professional development they need to be successful. Extending tenure acquisition will give districts the time they need to do just that."

– Carl Rose, Association of Alaska School Boards

"Tenure reform, a growing sentiment"

– Education Week, American Education's Newspaper of Record

"I think this has been coming for quite a while."

– Education Commission of the States

"If [teachers] are smart, they'll look at this as an opportunity to elevate the profession. I don't know anyone who's more upset about a bad teacher than a good teacher."

– California Secretary of Child Development and Education

The Trend: Tenure Headlines
"STATES SEEK TO OVERHAUL TENURE LAWS"

• Alaska
Bills seek to extend tenure acquisition, allow for layoff when revenues decline, streamline a costly nonretention process.

• California
Governor's proposal would specifically eliminate tenure. Says the Governor, "Good teachers don't need tenure, [and] our children can't afford a teacher who is just punching the clock." He also proposes to abolish California's entire education code and start over.

• Connecticut
In 1993 the Connecticut legislature tried to amend teacher tenure laws that would have added new causes for dismissing a tenured teacher: The failure to demonstrate performance that promotes student achievement or the failure to take part in activities that enhance professional growth. Members of the legislature's Joint Education Committee are now proposing that Connecticut require five years of service for tenure instead of three.

• New Jersey
Governor has introduced a proposal requiring teachers to undergo periodic recertification to keep their licenses.

• New York
Legislature has already streamlined its procedures for disciplining teachers, but a new bill has been drafted that would require teachers to be licensed every three years and undergo a tenure review every five years.

• Ohio
Governor's proposal would require teachers to teach at least four of the past six years in the same district to achieve a "continuing contract" status. Also proposes a state education licensing board that would evaluate, remediate, and, if performance is judged unsatisfactory, release teachers.

• South Dakota
Governor is introducing legislation that would give school boards more flexibility to nonretain ineffective teachers.

• Texas
Senate Education Committee proposal would make it easier to dismiss teachers: They could be fired after two consecutive unsatisfactory reviews. Governor has praised the bill for encouraging innovation and increasing local control of schools.

• Wisconsin
Senate lawmakers recently passed a bill repealing tenure. Governor supports the bill, and has previously introduced similar bills. The Republican-led legislature is expected to pass the bill into law soon. Other bills would repeal de novo type laws that recently cost the state $200,000 to nonretain two school employees.

STATES THAT HAVE AMENDED TENURE LAWS IN THE PAST FEW YEARS

- **COLORADO** (Repealed tenure)
- **FLORIDA**
- **MASSACHUSETTS**
- **MICHIGAN**
- **NEW YORK**
- **OKLAHOMA**

SOURCE: EDUCATION WEEK, MARCH 1, 1995, WSBA APRIL 18, 1995, EDUCATION COMMISSION OF THE STATES, 1995

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, MT 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] 15 U.S.C. § 41 et seq.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these

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[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). See also Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

[4] See, e.g., Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital of Price George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991); see also American Society of Anesthesiologists, 93 F.T.C. 101 (1979); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. See, e.g., Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

comments have addressed "any willing provider" requirements for health care service contracts.[6]

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action,

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[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

[8] Mont. Code Ann. §33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how providers and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10] In

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[9] Mont. Code Ann. §33-22-1704(3).

[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. See, e.g., J. C. Robinson and C. S. Phibbs, An Evaluation of Medicaid Selective Contracting in California, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study

(continued...)

addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for

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[10](...continued)
concentrated on Medicaid experience; however, further studies based on private health insurance experiences confirm these findings. See, e.g., D. Dranove et al., Is hospital competition wasteful? Rand J. Econ., Summer 1992; see also G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both cost and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without providing any additional consumer benefit.

V. Conclusion.

In summary, we believe that "any willing provider" requirements may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

Michael O. Wise
Acting Director

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662 • FAX (907) 561-2063

APR 2 3 1995

April 26, 1995

Representative Norman Rokeberg
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, AK 99811

Dear Representative Rokeberg:

The Alaska State Medical Association is strongly supportive of House Bill 266, "Any Willing Provider." As you are probably aware, health system reform is not dead. It is happening all the time, primarily in changes created by insurance companies and HMOs. This any willing provider bill restores some balance to these reforms. It allows patients to maintain or establish new relationships with physicians of their choosing as long as that physician is willing to get paid at the preferred provider rate. There is strong support from physicians across the state for this bill. I hope it can be passed this session.

If you have any questions regarding this bill, do not hesitate to contact me.

Sincerely yours,

Donald R. Lehmann, M.D., A.B.F.P.
President, Alaska State Medical Association

DRL:bj

CREED MAMIKUNIAN, M.D.
2401 EAST 42ND AVENUE, SUITE 206
ANCHORAGE, ALASKA 99508
(907) 562-1860 • FAX (907) 562-1865

Otolaryngology
Head and Neck Surgery

Facial Plastic and
Reconstructive Surgery

April 21, 1995

Representative Pete Kott
House of Representatives
Juneau, Alaska 99801

Dear Representative Kott,

I am a solo practitioner who specializes in ear, nose and throat diseases. I have practiced in Anchorage for the past five years. House Bill 266 which is currently before your committee speaks in favor of an open, free market health care system. Passage of this bill would be in the interest of all patients by allowing them the freedom to choose their own physician without being financially penalized for it.

Naturally, in medicine as in any field, there are some practitioners who are better than others. Allowing for the passage of an "any willing provider" bill would allow patients the freedom of choice in choosing a physician who they feel can best take care of them without financial constraints. The open-market system that we currently have allows patients this freedom. I do not think progress in health care should necessarily mean limiting access to be treated by the physician of your choice without incurring additional unnecessary financial burdens.

I strongly urge you to support the passage of HB 266. If I can be of any help to you in any way whatsoever, please let me know.

Sincerely yours,

Creed K. Mamikunian, M.D.

CKM:jaq

MARK E. RICHEY, M.D., OB/GYN
A PROFESSIONAL CORPORATION

PHONE 1-(907) 272-4443
FACSIMILE 1-(907) 272-2262

April 6, 1995

Dear House Member:

I am writing you to [redacted] introduced on 3-17-95. This bill would allow *any willing provider* to provide medical care to patients enrolled in a preferred provider program if that provider was willing to meet the terms and conditions of the patient's particular plan. Passage of this bill would have a number of benefits, but most importantly would improve accessibility to medical services.

Please support this measure.

Sincerely,

Mark Richey

Mark Richey

1200 AIRPORT HEIGHTS, SUITE 205 ANCHORAGE, ALASKA 99508

Alaska Regional Hospital

April 17, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The Family Practice Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 18 physicians present for the vote on this action taken on April 12, 1995 are listed below and on the next page).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

Gary L. Child, DO
Chairperson, Department of Family Practice

GLC/jmh

cc: Labor and Commerce Committee Members
Health & Social Service Committee Members

Department of Family Practice Members Present
Robert Bosveld, MD
Sheila Burke, MD
Gary Child, DO
Ronald Christensen, MD
T. Layne Crowe, MD

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Department of Family Practice Members Present Continued
Elizabeth deSchweinitz, MD
Ilona Farr, MD
Maryann Foland, MD
Lynn Hornbein, MD
Winfield S. Kiester, DO
Katherine Kolb, MD
Jerry Little, MD
Ernest Meinhardt, MD
Kenneth Moll, MD
Glenn Schultes, MD
John J. Smith, MD
Douglas C. Smith, MD
Tryon Wieland, MD

HUMAN AFFAIRS ALASKA

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(907) 562-0794

Statement for Legislative Testimony

I'm Marilyn Patterson, and I am employed by Human Affairs of Alaska. Human Affairs has been an Alaskan business since 1979, when our owner, Darryl Logan, pioneered the concept of Employee Assistance Programs in Alaska. We provide employees an employer prepaid benefit for confidential, face to face mental health counseling from skilled mental health clinicians. This preventive approach to helping employees get back on track by resolving personal and work related problems early on helps maintain worker productivity and other job performance indicators, as well as reduce potential costs for medical and surgical claims down the road.

Human Affairs also began providing Managed Behavioral Health Care Programs in Alaska in 1989. We are the largest provider of Employee Assistance programs in the state, and a leading provider of MBHC.

We currently serve over 200 companies and organizations statewide, with more than 50,000 employees and 120,000 covered members with our programs. We have offices in Fairbanks, Juneau, and Wasilla in addition to Anchorage.

Our company is strongly opposed to House bill 266, or any other amendment or legislation that would potentially restrict our ability to offer managed mental health care plans to our customers, now and in the future. It would be bad for our company, bad for our customers, and we believe, bad public policy.

Many of our customers are interested in providing a mental health benefit to employees, but managing this benefit helps to both contain costs for the company while providing a valuable benefit to the employee. We use a Preferred Provider Network of physicians, therapists, and treatment facilities that meet our clinical standards, and we contract with providers who share our brief therapy, problem/resolution behavioral management philosophy, assuring compliance with the health plan's requirements.

We are able to negotiate favorable financial arrangements with providers in return for supplying increased patient volume. These savings are passed on to our customers in lower costs, and to the employee in lower costs and in an enhanced employee benefit.

Having Preferred Provider Networks makes it possible for us to monitor provider performance and on-going quality assurance and utilization management programs more efficiently. It also helps to minimize our administrative overhead in monitoring treatment patterns, maintaining electronic connectivity, conducting provider education, and monitoring patient satisfaction with a smaller, selected number of providers.

We believe strongly that HB 266 clearly discourages competition among providers of health care. Requiring that programs be open to all providers wishing to participate on the same terms reduces the portion of our business that each preferred provider can expect to obtain, making it less advantageous for these providers to enter agreements with us at discounted prices. Also, since any provider would be entitled to contract on the same terms as other providers gives little incentive for providers to compete in developing attractive, innovative, and cost-containing proposals. Because this would make it possible for all other providers to "free ride" on a successful proposal formulation, providers would likely be unwilling to bear the costs of developing a proposal. There would simply be no reason or motivation for them to be competitive.

I understand that the Federal Trade Commission staff, in response to requests from officials in other states considering legislation that requires managed care plans to contract with any health care provider willing to meet the health plans terms and conditions, have issued opinion letters stating that this type of legislation discourages competition among providers of health care, and may promote increased costs.

It is our experience at Human Affairs that competition is a powerful and necessary tool in controlling costs. Managed mental health care will only work in a competitive environment, containing costs by integrating financing and delivery of healthcare.

In conclusion, HB 266 is anti-competitive, will promote increased costs, and provides no benefit for our company or customers, or the thousands of employees we serve across the state who benefit from our contracts with preferred providers. This bill would be extremely detrimental to many Alaskans, and we ask that it not be passed out of committee in any form.

Thank you for the opportunity to testify on this issue.

NATIONAL GOVERNORS' ASSOCIATION

News Release

FOR IMMEDIATE RELEASE
July 21, 1994 (102-94)
Contact: Rae Young Bond, 202-624-5898

Governors' policy affirms managed care to control costs

Washington, D.C.—A policy passed by the National Governors' Association (NGA) on Tuesday was described today by new NGA Chair Howard Dean of Vermont as "an affirmation of managed care as a means of controlling health-care costs."

The policy put the association on record in opposition to overly restrictive "any willing provider" legislation on the federal or state level. Such legislation would require managed-care networks to accept all providers regardless of the need for their services.

South Carolina Gov. Carroll A. Campbell Jr., who turned his chairman's gavel over to Gov. Dean Tuesday, presided over the midmorning policy session at NGA's annual summer meeting in Boston. The governors approved the policy just before President Clinton made a major address on health care.

Gov. Campbell said: "It's essential that government not stand in the way of the development of networks of health care by forcing inappropriate restrictions on them."

Gov. Dean said: "This type of legislation has a devastating effect on our ability to manage cost and quality. And this means patients pay more for health care."

Such bills have been turning up in states across the country. Governors have vetoed them in Colorado, Vermont, and Massachusetts.

-30-

NATIONAL GOVERNORS' ASSOCIATION
Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1572
Telephone (202) 624-5300

EC-9. MANAGED CARE AND HEALTH CARE REFORM

9.1 Preamble

As the nation moves to comprehensively reform its health care system, states are again at the forefront of change. A number of states have aggressively moved to reduce health care inflation, expand access for the working poor, and bring greater accountability to the system. Managed care has played an integral role in the efforts of many states to reform their health care systems and is an important part of national health care reform.

9.2 Any Willing Provider Legislation

So-called "any willing provider" legislation has appeared in a number of state legislatures recently and is usually framed as a patient choice issue. Such legislation may undermine state health care reform efforts and could roll back our significant state-by-state progress in this area.

Generally, the legislation requires that any health care provider who agrees to meet the terms and conditions of a health plan be allowed to participate in that plan. This type of legislation is problematic because it has the potential to undermine the efforts of managed care organizations to control costs and limit the size of networks in order to achieve maximum efficiency. The result may be decreased patient volume to managed care organizations, crippling their ability to control utilization of health care services. This type of legislation can have devastating effects on current managed care delivery systems by:

- destroying the gatekeeper concept essential to managed care, severely curtailing managed care organizations' ability to control health care costs and the quality of their provider networks;
- significantly increasing managed care organizations' administrative and claims costs;
- preventing managed care organizations from achieving significant provider discounts in exchange for patient volume;
- undercutting the administrative efficiencies of managed care;
- actually reducing consumer choice by limiting the patient's choice to indemnity plans; and
- impeding efforts to improve health care quality through contracting standards and information exchanges that can lead to better outcomes and higher quality care for patients.

9.3 Conclusion

"Any willing provider" laws arise from good motives—the desire to preserve existing patient-provider relations and to safeguard patients' access to care or choice of provider from arbitrary decisions by health plans to exclude or drop providers from their networks. These are legitimate goals that need to be addressed through vehicles that do not threaten the cost, quality, and access advantages that well-designed managed care delivery systems can provide.

The Governors do not support, at either the state or federal level, overly restrictive "any willing provider" laws. We remain committed to retaining the state flexibility that managed care delivery systems provide to us as we move to reform our health care system.

Time limited (effective July 1994-July 1996).
Adopted July 1994.

Municipality of Anchorage

P.O. Box 196650
Anchorage, Alaska 99519-6650
Telephone: (907) 343-4431
Fax: (907) 343-4991

Rick Mystrom, Mayor

OFFICE OF THE MAYOR

April 25, 1995

Representative Pete Kott
Alaska State Capitol
Juneau, Alaska 99801

Dear Representative Kott:

Preferred provider organizations (PPO's) play a key role in the Municipality of Anchorage's ability to manage health care costs for our employees. House Bill 266, "An Act relating to preferred provider agreements offered by hospital or medical service corporations" would effectively eliminate PPO's. I oppose its passage.

The Municipality uses several different PPO arrangements to help contain the costs of our health care programs. They allow us to reduce our costs yet maintain benefit coverage levels for our employees. We plan to expand these arrangements in the future to further control the costs of our health care program. In our current negotiations, several of the bargaining units have agreed to enter into PPO arrangements. We expect to save $1,066,000 annually through the use of PPO's for these unions. This is in addition to savings of approximately $1,008,000 gained from PPO programs already in place.

If this legislation is enacted, it would have a severe financial impact on the Municipality. The savings projected would evaporate and financial concessions agreed to would be difficult, if not impossible, to fund without a serious negative impact on Municipal services. Such legislation would seriously limit the ability to control the costs of our health plan without actually eliminating benefit coverage.

I urge you to reject this legislation and any other type of "any willing provider" legislation that hampers an employer's ability to effectively manage the cost of health insurance coverage for its employees.

Sincerely,

Rick Mystrom
Mayor

Attachment D
Special Committee on Health Care Reform
7/1/94

NAIC

Hall of the States
444 N. Capitol Street, N.W., Suite 309
Washington, D.C. 20001-1512
202-624-7790

FAX 202-624-8579 Washington Counsel
FAX 202-624-8460 Financial Analysis

National
Association
of Insurance
Commissioners

August 10, 1994

Via Hand Delivery

The Honorable George J. Mitchell
U.S. Senate
Washington, DC 20510

Dear Senator Mitchell:

In an effort to promote basic consumer protections, the National Association of Insurance Commissioners' Special Committee on Health Care Reform (the "NAIC Committee")[1] has recently sent two letters to you and your fellow Congressional leaders setting forth several recommendations relating to self-funded plans and community-rating (the last correspondence, dated July 27, 1994, is enclosed for your convenience). This letter expands upon the recommendations in our prior correspondence.

Solvency Requirements for Self-Funded Plans

In July, the NAIC Committee recommended that the self-funding threshold for employers be set at a group size of 500 or more employees. The NAIC Committee recommends further that minimum solvency requirements be established for all employer-sponsored self-funded plans that provide health care coverage. Under any federal health care reform proposal, the NAIC Committee believes that states should be charged with implementing these solvency standards.

Over the years, states have gained experience in developing and enforcing solvency standards in connection with the regulation of various types of health coverages. For example, states actively supervise the financial condition of insurance companies, Blue Cross/Blue Shield plans, health maintenance organizations, preferred provider organizations, workers' compensation carriers, and disability insurers, among others. Traditionally, states have used a myriad of solvency tools to protect consumers from the potential harm of health plan insolvencies, including: minimum deposit and reserve requirements; capital and surplus or risk-based capital requirements; financial reviews and audits; reinsurance or stop/loss provisions; hold/harmless requirements; and/or guaranty funds.

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1 As you know, the National Association of Insurance Commissioners (NAIC), founded in 1871, is the nation's oldest association of state public officials, composed of the chief insurance regulators in the fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands.

Capitation and Self-Funding

The NAIC Committee reaffirms the belief that when self-funded employers reimburse their employee health care costs through capitated payment arrangements or through other transfers of financial risk to providers, provider groups, or other outside entities, these arrangements are subject to state regulation.

Ability to Community-Rate

In July, the NAIC Committee recommended that all health insurance policies offered to groups with fewer than 500 employees be community-rated. In part, this position reflects the NAIC Committee's concern that the community-rated pool should be as large as possible to maximize the spreading of the cost of insurance coverage among various population groupings. To this end, the NAIC Committee now also recommends that all policies sold to individuals including both the standard benefits package and supplemental coverage be community rated in the same manner as group coverage.

Furthermore, the NAIC Committee believes that health plans should have the option to community-rate policies sold to employers with 500 or more employees. In conjunction with this recommendation, it is imperative that precautions be taken, either through minimum participation requirements or special assessments, to ensure that large employers do not take unfair advantage of the community-rated market. Also, safeguards should be implemented to ensure the fair marketing of health care coverages, including community-rated policies, by health plans.

Pooling the Community-Rated Products

The NAIC Committee also recommends that the medical cost component of the premiums for individual and group policies, including both the standard benefits package and supplemental coverage, be incorporated into the same community-rated pool for each health plan. With regard to the technical aspects of pooling the medical costs, some flexibility may be needed to accommodate the various types of supplemental coverages as they are pooled. The NAIC Committee recommends further that health plan administrative or overhead costs (e.g., salaries, rents, taxes and commissions) as a portion of the premium should be clearly identifiable and should not be included in the community-rated pool, in order to encourage competition and efficiency among health plans. Furthermore, states should be permitted to establish appropriate regulatory standards for the administrative and overhead costs so that they do not become a device used by health plans to circumvent the community-rating requirements.

Supplemental Coverage

The NAIC Committee recommends that coverage supplemental to the standard benefit package be community-rated as referenced above. The NAIC Committee supports the requirement of health plans offering these supplemental policies on a guaranteed issue basis and opposes the offering of supplemental coverage that in any way duplicates coverage provided in the standard benefits plan (such as dread disease coverage).

Any Willing Provider Provisions

The NAIC Committee believes that "any willing provider" provisions compromise the ability of managed care organizations to offer quality and cost-effective care. This type of provision may force managed care organizations to accept any provider that is willing to meet the terms and conditions of the health plan. Consumers would not be well-served if health plans have to accept less qualified providers in their provider networks and if the ability of health plans to negotiate volume discounts is reduced as the number of participating providers in the networks increase. Moreover, state insurance regulators do not believe that the adoption of an "any willing provider" requirement is the proper means to ensure appropriate consumer access to providers or consumer choice of providers.

The NAIC members continue to look forward to working with Congress on the technical insurance-related details of federal reform measures to help ensure its proper direction and successful implementation. We would be happy to answer any questions and provide you with any additional background information upon request. If you have any questions, please contact Garry Carneal or Nicole Tapay in the NAIC's Washington, D.C. office at (202) 624-7790.

Thank you for your consideration of these recommendations.

Sincerely,

David J. Walsh
President, NAIC
Director, Alaska Division of Insurance

Enclosure

cc: Members of Congress

Does Managed Care Really Save Money?

By David S. Hilzenrath
Washington Post Staff Writer

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

When Shelby A. Fowler had the same operation at the same hospital less than three months later, the hospital was paid only $10,987.

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

The hospital said it made a profit of $12,481 on Turner but lost $7,160 on Fowler because the deal it made with Fowler's HMO amounted to a below-cost discount. Georgetown lost $6.2 million during its past fiscal year on inpatients covered by HMOs and other managed care plans that received discounts, the hospital says.

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

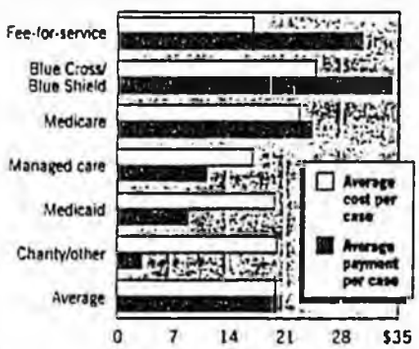
SHIFTING THE COSTS

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

CORONARY BYPASS OPERATIONS

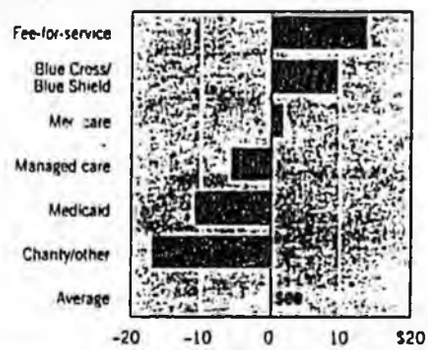
The hospital's cost per procedure was similar for each group, but actual payments varied widely...

IN THOUSANDS OF DOLLARS



...so its average profit per case was far greater for patients with traditional insurance coverage

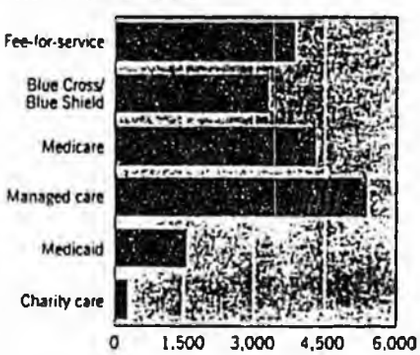
AVERAGE PROFIT PER CASE, IN THOUSANDS OF DOLLARS



ALL INPATIENT BUSINESS

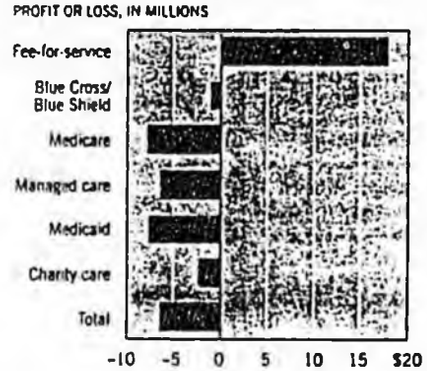
While only a minority of patients had traditional fee-for-service coverage...

1993 INPATIENT ADMISSIONS



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

PROFIT OR LOSS, IN MILLIONS



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

THE WASHINGTON POST

PRIVATE INSURANCE COMPANIES have long complained about cost-shifting, by which they mean the extra charges they pay to make up for the money hospitals lose treating uninsured patients and those covered by government insurance programs for the elderly, poor and disabled.

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

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

"You can't give everyone a discount," as health economist Harold S. Luft of the University of California at San Francisco, puts it.

The pursuit of discount prices works only as long as hospitals can compensate by cutting costs, lowering profits or raising somebody else's charges, industry analysts and executives say. And hospitals are running out of potential somebody elses, because HMOs and other types of managed care are rapidly expanding their share of people covered by private insurance.

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

- As HMOs and other plans that benefit from discounts grow, people already enrolled in those plans could find their insurance costs rising in relation to other people's premiums, because they could be forced to assume costs now shifted to others.
- For the same reason, a new national health care system designed to save money by steering people into large purchasing groups, such as the systems proposed by President Clinton and many lawmakers, could experience an element of diminishing returns.

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

Advocates of HMOs, which coordinate patients' care through medical gatekeepers, discounts can lead to lasting s ings for all patients because th drive hospitals to operate m efficiently.

They say HMOs also save other ways, such as by empha ing preventive medicine, contr ling patients' access to expens medical specialists, cutting do on unnecessary surgery, red ing hospital stays, and by urgi the use of more cost-effecti treatments.

"There is a tremendous pot tial savings from quality mana ment and emphasis on preve tion," says Karen Ignani, pre dent of Group Health Associati of America Inc., an HMO lobby.

However, a recent study by t Healthcare Leadership Council, health care industry group th supports managed care, fou that those medical manageme techniques account for only abo a fifth of the savings that the mo popular form of HMO offers ov typical fee-for-service insurance.

The remaining 78.9 percent the network-style HMOs' savin result from discounts from do tors and hospitals, according the study, prepared by th research firm Lewin-VHI Inc. ar based on internal data from Aetn Health Businesses.

Many health care network known as preferred provide organizations rely almost entire on discounts for their cost adva tage.

GEORGETOWN, A LARG teaching hospital, knows all to well what discounts do in the ne world of cost-shifting.

Georgetown finished its mos recent fiscal year, which ende June 30, $4.8 million in the re even though it made a profit o $17.9 million on inpatients wh had fee-for-service insurance That profit was erased by the $6.2 million the hospital los on managed care inpatients, combined with millions of dol lars of losses on Medicare, Medicaid, Blue Cross/Blu Shield and charity care inpatients.

Although the hospital made an average profit of $4,68 each time it admitted a fee-for-service patient, it lost an aver age of $1,159 each time it admitted a managed care patient the hospital says.

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

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

For example, among 232 Georgetown patients undergoing the coronary bypass operation without cardiac catheteriza-

Section 15. Prohibited State Action. No bill of attainder or ex post facto law shall be passed. No law impairing the obligation of contracts, and no law making any irrevocable grant of special privileges or immunities shall be passed. No conviction shall work corruption of blood or forfeiture of estate.

Rep [illegible]

I [illegible] [illegible] [illegible] supporting
Bill [illegible] — Any Willing Provider.

A bill already exists
that applies to [illegible] etc.
Blue Cross should have
similar legislation and not
escape because it is a
"corporation."
A medical service

Respectfully Submitted

[illegible] MD
4/08/95

Info. Health Care Reform

Position Regarding
Any Willing Provider Laws

Sisters of Providence, Alaska

The Sisters of Providence oppose introduction of Any Willing Provider laws into the current health care environment. Our reason is simple:

The system can't work two ways at once.

- The Any willing Provider concept **destroys the spirit of competition** in the current health care setting.
- It becomes **unnecessary** in a **reformed health care setting**.

Discounts are Based on Volume.

Payers (insurance, employers groups) negotiate with providers (health facilities, professionals) for discounted fees in exchange for volume given.

If "any willing provider" is allowed to enter the picture offering the same discounts, volume is dispersed. Without offsetting volume, discounts are difficult or impossible to sustain. Before long, all discounts disappear. (Basic rules of business and competition.)

We would argue differently if health reform & universal coverage initiated.

If we had health reform and universal coverage however, the picture could/should change.
These **negotiated** discounts and **involuntary discounts** imposed by government payers (Medicaid, Medicare, VA and Champus, etc.) contribute to the cost shifting cycle.

In a **new health care system, reduced volume** will **mean lower cost.** We believe that if a comprehensive Alaskan health reform bill offering universal coverage was passed, cost shifting would stop. Under the reform proposals which we have supported, everyone takes on a fair share of their responsibility. Focus on prevention and early intervention on medical problems will mean less time in the hospital (less volume and less expense to the Alaska Health Plan).

With offsetting advantages of no "bad debt" and simplified paperwork, providers would be able to charge all their patients the same price*. The "vicious circle" of passing on costs to someone else becomes a "cooperative circle" instead.

*The "market-based" aspect of the proposed market based single payer system allows providers to set their own fees so Hospital A can charge more or less than Hospital B. Hospital A just can't charge a State employee one price, a "self-paying" individual or a Medicare recipient another price. Consumers may make their selections based on cost, quality, accessibility, etc.

RICHARD A. ANSCHUETZ, M.D., F.A.C.C.
CARDIOVASCULAR DISEASES
A Professional Corporation
3340 Providence Drive, Suite 357
Anchorage, Alaska 99508-4627
Telephone: (907) 561-0066 FAX: (907) 563-9386

April 4, 1995

Representative Pete Kott
Alaska State Legislature
State Capitol, Room 432
Juneau, AK 99801-1182

Dear Rep. Kott:

I would like to make a brief commentary in support of House Bill 266 (Any Willing Provider).

I know that you have received many conflicting messages of support and opposition to this legislation.

As a cardiovascular specialist practicing in Anchorage, I feel that passage of the Any Willing Provider Bill is a very important step.

Alaska is a small enough state and the medical community is small enough that, should any one "insurance" entity or hospital choose to exclude certain physicians, this could represent a significant negative impact on a medical practice. As long as a physician can meet the "medical" standard created by a payer, and is willing to perform services at the contract price, he shoı ld be allowed to participate. An equally important aspect is the protection of due process such that a payer cannot arbitrarily exclude a practitioner from a plan without appropriate due process.

All of the physicians with whom I have discussed this issue are in support of Any Willing Provider legislation. The only entities that seem to be opposed are those that are or want to become provider/payers.

Please consider continuing a patient's right to choose his physician, and a physician's right to continue to practice his profession in your deliberations on this bill. I hope that you will come to the conclusion that support of the Any Willing Provider Bill is very important.

Thank you for your interest in this matter. Please feel free to contact me at any time.

Sincerely,

Richard A. Anschuetz MD

Richard A. Anschuetz, MD
Fellow, American College of Cardiology

RAA/sl

Alaska Regional Hospital

April 10, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The Pathology/Radiology Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 4 physicians present for the vote on this action taken on April 10, 1995 are listed below).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

Steven Jayich, MD
Chairperson, Department of Pathology/Radiology

SJ/jmh

cc: Labor and Commerce Committee Members
Health & Social Service Committee Members

Department of Pathology/Radiology Members Present

Geoffrey Hastings, MD
Julee Holayter, MD
Steven Jayich, MD
Lester Lewis, MD

2801 DeBarr Road
P.O. Box 143889
Anchorage, AK 99514-3889
907-276-1131 Fax 907-264-1143

Head & Neck Surgery
Trauma & Maxillofacial Surgery

ALASKA FAMILY ENT

DAVID S. KILLEBREW, M.D.

Otologic Surgery
Facial Plastic and Reconstructive Surgery

April 4, 1995

Dear Representative:

PLEASE SUPPORT HB 266 - ANY WILLING PROVIDER AMENDMENT

This useful legislation will help to control future medical care cost.

Dave Killebrew MD

David S. Killebrew, M.D.
1200 Airport Hts. #200
Anchorage, AK 99508
(907)264-1016

Alaska Regional Hospital

April 7, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The OB/GYN Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 9 physicians present for the vote on this action taken on April 6, 1995 are listed below).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

John B. DeKeyser, MD
Chairperson, Department of OB/GYN

JBD/jmh

cc: Labor and Commerce Committee Members
Health & Social Service Committee Members

Department of OB/GYN Members Present

Donna Chester, MD
Wynd Counts, MD
John DeKeyser, MD
John Erkmann, MD
Melanie McCleave, MD
Mark Richey, MD
Sherrie Richey, MD
George Stransky, MD
Robert Thompson, MD

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907-276-1131 Fax 907-264-1143

RICHARD A. ANSCHUETZ, M.D., F.A.C.C.
CARDIOVASCULAR DISEASES
A Professional Corporation
3340 Providence Drive, Suite 357
Anchorage, Alaska 99508-4627
Telephone: (907) 561-0066 FAX: (907) 563-9386

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State Capitol, Room 432
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Sincerely,

Richard A. Anschuetz MD

Richard A. Anschuetz, MD
Fellow, American College of Cardiology

RAA/sl

"Any Willing Provider" Legislation

Summary Comments

"Any willing provider" laws add costs to the health care system.

- A health plan's ability to control costs is in part a function of its ability to limit its selection of providers (Ref. Atkinson & Company: "The Cost Impact of 'Any Willing Provider' Legislation").
- Plans can negotiate favorable discounts with providers in return for patient volume. Physicians in the plan's system generate hospital referrals, which incentivizes the hospital to offer competitive pricing to the plan to retain business.
- Consumers can benefit from lower premiums when plans are able to contain claims costs by obtaining favorable pricing from providers.
- A health plan's contracting should not have to maintain providers that have surplus capacity (e.g. a hospital with a low census).
- If plans have to accept any willing provider, the administrative costs of plans monitoring and managing providers rises.

"Any willing provider" laws threaten quality of health care delivery.

- Delivering all care within a single delivery system offers continuity of care to consumers.
- A delivery system that encompasses specialty, hospital-based ancillary and hospital services facilitates the process of continuous quality improvement and quality monitoring. A referral system that integrates care depends on the plan's ability to contract selectively.
- BCWA's plans are to focus on accreditation by the National Committee on Quality Assurance. Without selective contracting, our efforts to meet the NCQA criteria are compromised.
- With unlimited provider networks, plans lose their ability to monitor quality efficiently and effectively.

"Any willing provider" laws can have a negative impact on consumers.

- Consumers do not benefit if plans that already have adequate provider networks are forced to contract with additional providers. The costs of contracting with unneeded providers result in higher premiums.
- Plans no longer have the right to choose the best and most efficient providers to serve their customers.
- Selective contracting enables plans to demonstrate that high quality care can be provided for lower cost to the benefit of the consumer.

"Any willing provider" laws are anti-competitive.

- Hospitals and professional providers no longer have the incentive to compete for patient volume by agreeing to accept deeper discounts.
- Supporters of "any willing provider" provisions are seeking a guaranteed source of business at the consumer's expense.
- Consumer demand is a sufficient incentive for competing health plans to develop attractive provider networks.

Many organizations and regulatory agencies do not support "any willing provider" laws.

- The National Governors' Association has issued a policy statement in opposition to "any willing provider" laws.
- The National Association of Insurance Commissioners is opposed to "any willing provider" laws.
- The Federal Trade Commission has stated that "any willing provider" laws are anti-competitive and would result in reduced consumer choice.

Alaska Regional Hospital

April 18, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The Surgery Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 22 physicians present for the vote on this action taken on April 18, 1995 are listed below and on the next page).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

James E. O'Malley, MD
Chairperson, Department of Surgery

JEO/jmh

cc: Labor and Commerce Committee Members
Health & Social Service Committee Members

Department of Surgery Members Present
David Anderson, MD
Robert Briller, MD
John Broda, MD
Won P. Chung, MD
Donald Dippe, MD

2801 DeBarr Road
P.O. Box 143889
Anchorage, AK 99514-3189
907-276-1131 Fax 907-264-1143

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson

Department of Surgery Members Present Continued
Steven Floerchinger, MD
John Godersky, MD
Roland Gower, MD
William Hammel, MD
Thomas Harrison, MD
Herbert Kloss, MD
Oliver Korshin, MD
Stephen Kulin, MD
Creed Mamikunian, MD
Michael Manuel, MD
James O'Malley, MD
William Pease, MD
Robert Risica, MD
James Scully, MD
George Siegfried, MD
Kevin Tomera, MD
Charles Tschopp, MD

Alaska Regional Hospital

April 19, 1995

The Honorable Pete Kott
House of Representatives
Labor and Commerce Committee Chairperson
Juneau, Alaska 99801

Dear Mr. Kott:

The Emergency Medicine Department of the Medical Staff at Alaska Regional Hospital has unanimously endorsed House Bill #266, "An act relating to preferred provider agreements offered by hospital or medical service corporations". We urge passage of House Bill #266 out of committee and passage of the bill by the legislature. (Those 4 physicians present for the vote on this action taken on April 19, 1995 are listed below).

As physicians we are concerned when patients are prevented from seeing the physician and using the hospital of their choice or are financially penalized for doing so. We support this bill as a way of continuing to assure consumer freedom of choice of hospital and other providers.

Thank you for your consideration of this important health care issue and for passing the bill out of your committee.

Sincerely,

Donald Hudson, DO
Acting Chairperson, Department of Emergency Medicine

DH/jmh

cc: Labor and Commerce Committee Members
Health, Education & Social Services Committee Members

Department of Emergency Medicine Members Present

Peter Hackett, MD
Donald Hudson, DO
Keith Winkle, MD
Ken Zafren, MD

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Info. Health Care Reform

Position Regarding
Any Willing Provider Laws

Sisters of Providence, Alaska

The Sisters of Providence oppose introduction of Any Willing Provider laws into the current health care environment. Our reason is simple:

The system can't work two ways at once.

- The Any willing Provider concept **destroys the spirit of competition** in the current health care setting.
- It becomes **unnecessary** in a **reformed health care setting.**

Discounts are Based on Volume.

Payers (insurance, employers groups) negotiate with providers (health facilities, professionals) for discounted fees in exchange for volume given.

If "any willing provider" is allowed to enter the picture offering the same discounts, volume is dispersed. Without offsetting volume, discounts are difficult or impossible to sustain. Before long, all discounts disappear. (Basic rules of business and competition.)

We would argue differently if health reform & universal coverage initiated.

If we had health reform and universal coverage however, the picture could/should change.
These **negotiated** discounts and **involuntary discounts** imposed by government payers (Medicaid, Medicare, VA and Champus, etc.) contribute to the cost shifting cycle.

In a **new health care system, reduced volume** will **mean lower cost.** We believe that if a comprehensive Alaskan health reform bill offering universal coverage was passed, cost shifting would stop. Under the reform proposals which we have supported, everyone takes on a fair share of their responsibility. Focus on prevention and early intervention on medical problems will mean less time in the hospital (less volume and less expense to the Alaska Health Plan).

With offsetting advantages of no "bad debt" and simplified paperwork, providers would be able to charge all their patients the same price*. The "vicious circle" of passing on costs to someone else becomes a "cooperative circle" instead.

*The "market-based" aspect of the proposed market based single payer system allows providers to set their own fees so Hospital A can charge more or less than Hospital B. Hospital A just can't charge a State employee one price, a "self-paying" individual or a Medicare recipient another price. Consumers may make their selections based on cost, quality, accessibility, etc.

Providence | Health System

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P.O. BOX 196604
ANCHORAGE, ALASKA
99519-6604

Tel 907 562-2211

Providence Health System
Position Points Regarding
Any Willing Provider Legislation

Overview

The proposed legislative language in HB266 to create an "Any Willing Provider" provision and thus replace Preferred Provider contracting in Alaska raises several key issues:

1. **Without preferred provider programs, there will be no "volume discounts".**
2. **This legislation will increase costs–particularly in Anchorage (the only community where there are competing hospitals).**
3. **This legislation will take away the ability of purchasers (primarily employers) to determine where they purchase services.**
4. **Why legislate to protect one specific institution that already has a healthy profit margin?**

Responding to the first two issues . . .

1. No "volume discounts" and 2. Increased costs

We reiterate our testimony before this committee last spring . . .

- The **Preferred Provider concept has been key in reducing the spiraling costs** of health care in Alaska. Competition has led to volume discounts for employers and insurance companies without lowering the quality of health care.

- **If "any willing provider" is allowed to offer the same discounts, volume is dispersed and the discounts are impossible to sustain. The ultimate result will be increased health care costs,** a fact readily admitted by Alaska Regional Hospital who has requested this bill. *(See Attachment A: What the increase would be for current Providence contracts.)*

- **Preferred Provider contracts** have been sought by employers **because they allow organizations to better manage their health care costs. In fact, over 97,000 Alaskans–now part of Preferred Provider contracts–would be negatively affected by this bill.** Any Willing Provider legislation means Alaska would not be able to have managed care or HMOs, which have proven very effective in controlling cost of care in

other states. (Note: Managed care is being strongly promoted at the Federal level as an approach to the impending Medicare crisis.)

Issue 3: This legislation takes away the ability of purchasers (usually employers) to determine where they purchase services for their employees.

- We believe that as the major purchasers of health care, employers should continue to be able to select the health plan of their choice to offer as an employee benefit.

- Under current plans, employees retain their freedom to choose health care providers and may seek service from other than those listed as Preferred Providers. When exercising this choice however, the employee must be willing to pay the difference in deductibles to go outside the plan. (The trade-off--which has always been in effect--is that by accepting an employer's health care benefit dollars, the employee also agrees to some limitation in "purchasing" choices.)

- Some physicians support Any Willing Provider, and raise the issue of patient choice of physician. We believe Lower 48 experience indicates benefits to managed care subscribers (convenience, access, satisfaction in less out-of-pocket expense) generally offsets concerns regarding some limitations in choice of physician.

Issue 4. Why legislate to protect the institution that is already the most profitable hospital in the state?

Not-for-Profit vs For-Profit. Tax issue.

Small Provider vs Large Provider/Opportunity to Compete

- For-Profit providers maintain that because they must pay taxes they cannot compete with Not-For Profit hospitals who do not pay taxes.

Providence Alaska Medical Center maintains that **For-Profit hospitals have deliberately chosen to be in business to make a profit, waiving the traditional tax-exempt** status of hospitals. The state's only for-profit hospital, Alaska Regional reported a profit of $8 million in 1994, even after paying taxes. According to submissions to the State's Medicaid Raid Advisory Commission, their net income per ("adjusted") day is **94% higher than Providence's .** *(See Attachments B1 and B2)*

- The designation "Not *for* profit" indicates that while an institution such as Providence needs to have annual net revenue exceed expenses--make a "profit"--in order to remain viable, all our revenues may only be reinvested into the organization or used for charity care and community health needs.

- The large player in this issue is not Providence Alaska Medical Center; it is Alaska Regional Hospital which is owned by Columbia/HCA Healthcare Corporation, the largest health care corporation in the world.

- Alaska Regional has not been locked out of the market and does in fact, have a number of Preferred Provider Agreements *(see Attachment C)* and they had the Aetna contract previously.

- We believe Providence's commitment to control costs (while still maintaining quality) has resulted in our success in obtaining contracts. (*See Attachment D: Cost comparisons for State of Alaska employees as reported by Aetna, their insurance provider. Average cost per day at Providence $1,920, $2,927 at Regional.)*

- If Providence charged what Alaska Regional charges per adjusted patient day, we would have net operating income of $52,317,516 as opposed to our current $7,966,671. *(See Attachment E: This demonstrates the complete difference in charges applications between hospitals.).*

ATTACHMENT A

IF ANY WILLING PROVIDER PASSES
NEGOTIATED CONTRACTS WILL END
AND PROVIDENCE PRICES WILL INCREASE IMMEDIATELY
DUE TO NO KNOWN VOLUMES IMPACTING THE FOLLOWING:

EFFECT ON:		
BLUE CROSS (75,000 lives)	$	4,000,000
AETNA (13,000 lives)		2,418,000
ETHIX		420,000
SOUND HEALTH		2,115,000
FIRST CHOICE		540,000
TOTAL INCREASE IN INSURANCE COSTS (these groups)	$	9,493,000

EFFECT ON EMPLOYER THRU DIRECT CONTRACTS

BRITISH PETROLEUM	$	152,000
ALYESKA PIPELINE		130,000
CARRS		65,000
TEAMSTERS		1,100,000
TOTAL INCREASE IN HEALTHCARE COSTS (these groups)	$	10,940,000

ATTACHMENT B1

1994 ACTUAL	PROV	ARH
OPERATING INCOME	7,966,671	8,094,372
NET INCOME	11,724,377	8,514,342
INPATIENT REVENUE	151,339,046	98,540,019
OUTPATIENT REVENUE	61,307,973	47,205,391
TOTAL REVENUE	212,647,019	145,745,410
PATIENT DAYS	67,743	24,047
AVERAGE DAILY CENSUS	186	66
MEDICARE DAYS	17,551	5,709
MEDICAID DAYS	12,694	4,540
OCCUPANCY	54	28
DISCHARGES	14,026	5,204
MEDICARE	2,388	849
MEDICAID	3,076	1,047
MED/MCAID PERCENTAGE DAYS	45%	43%
MED/MCAID PERCENTAGE DISCHARGES	39%	36%
ADJUSTED PATIENT DAYS	95,186	35,567
ADJUSTED DISCHARGES	19,708	7,697
AVERAGE DAILY ADJUSTED PATIENT DAYS	261	97

ATTACHMENT B2

	Providence	Alaska Regional	% DIFFERENCE
OPERATING INCOME PER ADJUSTED (ADJ) DAY	84	228	172%
NET INCOME PER ADJ DAY	123	239	94%
AVERAGE REVENUE PER ADJ PATIENT DAY	2,234	4,098	83%
COST TO CHARGE RATIO	0.65	0.38	-42%
PERCENTAGE OF PATIENTS PAYING FULL CHARGES	25%	25%	

ATTACHMENT C

ALASKA REGIONAL HOSPITAL'S PREFERRED PROVIDER AGREEMENTS NOW IN FORCE

AFFORDABLE HEALTHCARE	$	1,000,000
CIGNA		
WALMART		
VETERANS ADMINISTRATION		
INDIAN HEALTH SERVICE		
NEW YORK LIFE		27,000
ASI FLEX	$	140,000

Significant Findings
1994

State Of Alaska

ATTACHMENT D

Top Ten Hospital Providers

Provider Name	Location	Inpatient Benefits	Outpatient Benefits	Total Benefits	Percent to All Hospitals	Admits	Bed Days	Avg Cost Per Day*
Providence Hospital	Anchorage	$2,501,406	$1,424,271	$3,925,677	16.6%	337	1,657	$1,920
Alaska Regional Hospital	Anchorage	$1,574,493	$1,066,199	$2,640,692	11.2%	157	666	$2,927
Bartlett Memorial Hospital	Juneau	$1,110,392	$1,663,101	$2,773,493	11.7%	365	938	$1,406
Fairbanks Memorial Hospital	Fairbanks	$736,506	$754,203	$1,490,709	6.3%	148	471	$1,924
Swedish Hospital Med-Ctr.	Seattle	$506,696	$227,389	$734,085	3.1%	49	315	$1,892
University of Washington	Seattle	$459,747	$221,987	$681,734	2.9%	30	255	$2,098
Childrens Hospital and Med. Ctr.	Seattle	$439,735	$205,003	$644,738	2.7%	13	161	$3,079
Valley Hospital Association	Anchorage	$347,590	$288,104	$635,694	2.7%	43	140	$2,945
Charter North Hospital	Anchorage	$323,990	$14,534	$338,524	1.4%	35	430	$1,249
Virginia Mason Hospital	Seattle	$195,742	$226,090	$421,832	1.8%	20	104	$2,215
TOTAL		$8,196,297	$6,090,881	$14,287,178	60.5%			
Percent To Total Hospital Benefits		54.8%	70.3%	60.5%				

- The facilities shown above are the top ten hospitals ranked by the total benefits payable during 1994
- The differences seen in the average cost per day is significantly influenced by case mix, i.e., the severity of illnesses and intensity of services rendered.
- The high number of pregnancy/childbirth confinements and costly treatments at the top four hospitals influence high average cost per day.

* *Based on billed inpatient Charges (not shown in aggregate)*

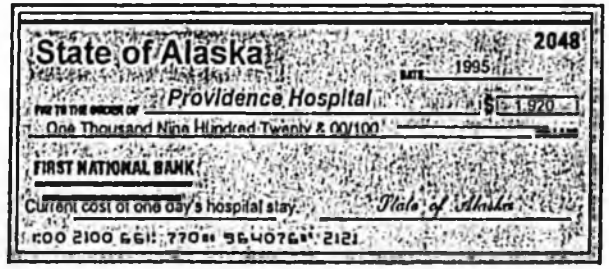
ATTACHMENT E

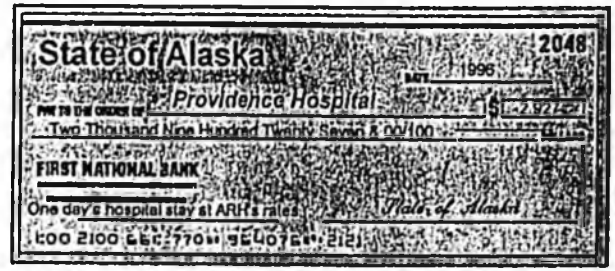
ASSUMING ARH RATES USED AT PROVIDENCE
PROVIDENCE NET INCOME

REVENUE PER ADJ PATIENT DAY ARH	4,098
REVENUE PER ADJ PATIENT DAY PROV	2,234
DIFFERENCE	1,864
ADJUSTED PATIENT DAYS	95,186
CHARGE BASED PAYOR PERCENTAGE	25%
CHARGE BASED VOLUME	23,797
INCREASE IN NET INCOME WITH ARH RATES	44,350,845
PROVIDENCE ACTUAL NET OP INCOME	7,966,671
NET OPERATING INCOME WITH ARH RATES	52,317,516
PERCENT INCREASE IN NET OP INCOME ARH RATE	557%

	PROVIDENCE	PROV ARH'S RATES	ARH
NET INCOME	7,966,671	52,317,516	8,514,342.00
		557%	

STATE OF ALASKA EMPLOYEES	PROVIDENCE	ARH	% DIFF
AVERAGE COST PER DAY	1,920	2,927	-0.52





HUMAN AFFAIRS ALASKA

4300 B Street
Suite 202
Anchorage, AK 99503
(907) 562-0794

part of the Aetna Health Plans family

April 20, 1995

Alaska State Legislature
House Labor and Commerce
Committee Members
State Capitol
Juneau, Alaska 99801

Dear Legislators:

I would like to voice my strong objection to HB 266 being moved out of the House Labor and Commerce committee in any form.

I founded Human Affairs in Anchorage in 1979, and we have been providing Employee Assistance Programs (EAPs) to businesses and organizations across the state since then. We are the largest provider of EAPs in Alaska, and the leading provider of Managed Mental Health Care (MBHC) in the state. We have offices in Anchorage, Fairbanks, Juneau, and Wasilla.

Our EAPs provide employees an employer prepaid benefit for confidential, face to face mental health counseling from Masters level or above professionals that are particularly skilled in the problem/solution brief therapy model of counseling. The philosophy behind EAPs is that helping employees deal with work related or personal problems early on helps employers and employees by enhancing workplace productivity.

We have also been providing Managed Mental Health Care to Alaskan employers since 1989. Some of our customers include the Municipality of Anchorage, the State of Alaska, the Alaska Railroad, and Alyeska Pipeline. Under our MBHC contract with the State of Alaska, we have brought the net mental health cost per employee down from $582 per employee prior to inception of our program in 1993, to $220 per employee in 1994. This represents a savings to the State of Alaska of over $5 million dollars in claims costs since we started managing the mental health benefit.

These savings are possible partly because of the monitoring, case management, and utilization review that we do, and also because we use a preferred provider network of physicians, therapists, and treatment facilities that meet our high quality clinical standards, and with whom we have negotiated discounted rates.

HB 266, allowing any willing provider or hospital to participate on the same terms as our preferred providers, gives no incentive to a hospital or medical service corporation to offer discounted rates to us, and virtually wipes out competition.

In addition, regarding the statement in the bill...."A subscribers contract containing a preferred provider program must provide for payment for a service provided by a non preferred provider"...we believe that in the employer group context, all covered individuals under a preferred provider contract are treated the same. If they go to a preferred provider, they receive preferred or enhanced benefits. If they go to a non network provider, they get non-preferred benefits. There is no discrimination between covered individuals of the same class. The distinction is between what provider is used, not who uses the provider, and all covered individuals have the same ability to receive preferred benefits.

Human Affairs represents thousands of workers and covered dependents in communities all across the state who are able to receive a high quality benefit under their employers plan because of our ability to negotiate discounted rates with out preferred providers. Our customers want Managed Mental Health Care because they are able to provide a desirable mental health benefit, but at the same time, contain costs. It is a win/win for employer and employees alike.

This legislation, while only written to apply to Blue Cross at the moment, could easily be expanded to cover Human Affairs, as was the case in a recently proposed amendment to SB 100. If applied to us, this legislation would eliminate our ability to offer managed mental health care programs to our customers, including making favorable financial arrangements with providers, and creating effective provider monitoring and quality assurance. It is fundamentally anti-competitive, and bad public policy.

I urge you to vote it down. I would welcome the opportunity for me or my staff to discuss this critical issue with you, and would be available at any time to do so. I can be reached on my direct line at (907) 273-9207.

With best regards,

Darryl R. Logan
Area Director

ORTHO TRAUMA

Bret L. Mason, D.O.
Orthopaedic Surgery
Fellowship Trained Traumatology
(907) 562-5589

SEPTEMBER 27,1995

RE: ANY WILLING PROVIDER LEGISLATION HEARING

DEAR MR. KNOTT'S,

I WOULD LIKE TO VOICE MY OPINION IN SUPPORT FOR, "ANY WILLING PROVIDER" LEGISLATION. PLEASE HELP US GET THIS IMPORTANT BILL PASSED.

SINCERELY,

BRET MASON D.O.

4048 Laurel St.
Suite 306
Anchorage, AK 99508

Complex Fractures
Posttraumatic Reconstruction
Pelvis & Acetabulum

DONALD W. DIPPÉ, M.D.

A PROFESSIONAL CORPORATION
DIPLOMATE
AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES AND SURGERY OF THE EYE

SUITE 25
2841 DeBARR ROAD
ANCHORAGE, ALASKA 99508

TELEPHONE
(907) 264-1405
FAX (907) 264-1404

REP PETE KOTT

PLEASE SUPPORT

HOUSE BILL No 266

Thank You,

Donald W. Dippé

MICHAEL D. MANUEL, M.D.
PLASTIC & RECONSTRUCTIVE SURGERY
CERTIFIED BY AMERICAN BOARD OF PLASTIC SURGERY
PROVIDENCE MEDICAL OFFICE BUILDING • SUITE 160 • 3340 PROVIDENCE DRIVE • ANCHORAGE, ALASKA 99508
TELEPHONE (907) 562-2002 • FACSIMILE (907) 562-7629

April 21, 1995

Representative Kott
Re: House Bill No. 266

Dear Representative Kott,

As a representative of the Anchorage Medical Society and a member of the House of Delegates of the Alaska State Medical Association, I would like to make you aware of a vote outcome at a recent medical society meeting. The members of the Anchorage Medical Society voted without opposition to support House Bill 266. I trust that the support of the society will be considered strongly in the hearings and eventual vote on this important piece of legislature.

Sincerely,

Michael D. Manuel, M.D.

MICHAEL D. MANUEL, M.D.
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April 20, 1995

Representative Kott
Re: House Bill No. 266

Dear Representative Kott,

I write in support of House Bill 266 regarding the preferred provider agreements offered by hospital or medical service corporations and being in essence, an "any willing provider" bill.

As a Plastic and Reconstructive Surgeon, two of my main areas of interest are children with cleft lip and palate or other congenital abnormalities as well as post-mastectomy breast reconstruction. As I am sure you are aware, often times these patients require years of intervention for correction of congenital abnormalities and postop cancer surveillance. Assurance of patient choice in the ability to continue with their existing physician or the opportunity to seek the physician of their choice to treat and follow their condition is essential. Although HB 266 has often times been portrayed as being a fight between two hospitals in the Anchorage area (Providence Hospital opposed to the bill and Alaska Regional Hospital supporting the bill) this is an extremely small and insignificant issue. I believe that this bill more accurately represents the preservation of a patients right to choose his or her own physician as well as to allow a physician to practice independently and not within the confines of a hospital or medical service corporation. Failure to insure patients selection will lead to limitations in the number and quality of physicians available to treat most, if not all, medical conditions and will distract from the excellent medical care available in this state. A passage of House Bill No. 266 will not in anyway inhibit the medical service organizations from offering lower cost care to those who need it and this is indeed an admirable goal. It would however insure patient choice to be treated by the physician of their choosing and to enable the continuation of long term established patient/physician relationships.

I trust you will take this matter seriously and would appreciate your support in passage of this Bill.

I will be available to answer any questions regarding this.

Sincerely,

Michael D. Manuel, M.D.

Member
AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS INC

HOUSE BILL NO. 266

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE BY REQUEST

Introduced: 1/17/95
Referred: Labor and Commerce, Health, Education and Social Services, Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act relating to preferred provider agreements offered by hospital or medical service corporations."

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

* Section 1. AS 21.87 is amended by adding a new section to read:

Sec. 21.87.135. PREFERRED PROVIDER PROGRAMS. A hospital or medical service corporation may offer a preferred provider service agreement to a provider or hospital licensed in this state. A provider or hospital willing to meet the terms and conditions of the preferred provider service agreement may not be excluded from treatment as a preferred provider. A subscriber's contract containing a preferred provider program must provide for payment for a service provided by a nonpreferred provider or hospital.

New Text Underlined [DELETED TEXT BRACKETED]

Anchorage Medical Society
3701 E. Tudor Rd, Ste 208 ■ Anchorage, AK 99507 ■ (907)562-1567 ■(907) 561-7464 fax

DATE: April 21, 1995

TO: House Labor & Commerce Committee

RE: HB 266

The Anchorage Medical Society supports the amendment to Section 1. AS 21.87 regarding Preferred Provider programs.

PATIENT PROTECTION ACT COALITION

POST OFFICE BOX 250213 • LITTLE ROCK, ARKANSAS 72225-0213

January 24, 1995

FOR IMMEDIATE RELEASE

CONTACT:
Senator Bill Gwatney, Arkansas State Senate 682-2902
Lynn Zeno or David Wroten, Arkansas Medical Society 224-8967
Stacy Pittman, Legislative Consultant 664-6445

PATIENT CHOICE ADDRESSED IN PROPOSED LEGISLATION

LITTLE ROCK - Arkansans who belong to managed care plans, such as HMOs, might have more choice in selecting their health care providers if the Legislature passes a bill introduced today by Senator Bill Gwatney of Jacksonville.

The Patient Protection Act would guarantee that every company that writes insurance policies in Arkansas must give every qualified health care provider the opportunity to participate in their health care plans, if they can agree to comply with the managed care operating criteria. Those criteria include fee schedules, quality standards and utilization review requirements determined by the health insurance company.

Gwatney said the proposed legislation will offer Arkansans the freedom to choose their physician, hospital, pharmacist and other health care providers while also protecting the fundamental components of managed care.

"When the American public demanded affordable health care services, insurance companies responded by creating managed care organizations," said Gwatney. "But in their effort to control costs, many insurance companies are sacrificing quality health care by severely limiting the patient's choice of health care providers."

At the present time, insurance companies who write policies in Arkansas do not allow all qualified providers, willing and able to meet the

-continued-

managed care criteria, to participate in their health care plans. However, Gwatney feels confident his legislation will pass, just as it has in other states across the country.

"Fourteen other states have provided patients with their medical freedom to choose without intervention from the government or health insurance companies," Gwatney said. "And they've provided this freedom while also protecting and preserving managed care's goal of containing health care costs. It's a perfect match for everyone -- patients, health care providers, and insurance companies."

Gwatney has already attracted seven co-sponsors for the bill among his Senate colleagues.

Members of a coalition who are supporting Gwatney's bill point out that rural communities experience greater consequences when their local doctors and hospitals are not allowed to negotiate and participate in managed care plans.

Lynn Zeno of the Arkansas Medical Society said that many insurance companies are jeopardizing the viability and economy of rural communities by excluding physicians and hospitals from treating patients in their communities.

"With the increase in managed care plans, it's not unusual for patients in rural communities to be forced to seek medical services outside the county, miles away from home," said Zeno. "These communities, which are being arbitrarily excluded, will see access to health care services deteriorate and will then find it difficult to attract new industries to the area."

"We all know that public education, recreation and health care services are critical to attracting new industry to our communities," said Zeno.

The Patient Protection Act is supported by several state organizations including the Arkansas Medical Society, the Arkansas Pharmacists Association, the Arkansas Hospital Association, the Arkansas State Dental Association and the Area Agencies on Aging.

-30-

PATIENT PROTECTION ACT COALITION

A Health Care Problem in Arkansas

Insurance companies have established an exclusive and arbitrary selection process fo selecting physicians, hospitals and other health care providers who can participate in the HMO/Managed Care Plans.

Managed Care Plans are not equally open to all qualified health care providers who are willin to meet the rules and requirements of the plan. This results in a disruption of the currer provider-patient relationship. Arkansans are losing the ability to maintain relationships wit their physicians, pharmacists, their local hospitals and other health care providers.

Access to health care services is jeopardized when we begin excluding quality physician hospitals and other health care providers from treating their existing patients or attractin new patients.

Rural communities experience greater consequences when their local doctors and hospital are not allowed to participate in managed care plans. As a result, residents of smaller com munities are forced to drive long distances to seek medical attention and prescription dru services.

Insurance companies are jeopardizing the viability and economy of rural communities b excluding physicians and hospitals from participating in their plans. Rural communities wi see access to health care services deteriorate and find it difficult to attract new industries int their area. Public education, recreation and health care are critical to attracting new indus tries.

The Solution

The Patient Protection Act of 1995

The Patient Protection Act of 1995 is supported by the Area Agencies on Aging • Arkansas Medical Society • Arkansas Pharmacists Association • Arkansas Hospital Association • Arkansas State Dental Association • Arkansas Speech-Language-Hearing Association • Arkansas Osteopathic Medical Association • Arkansas Occupational Therapy Association • Arkansas Podiatric Medical Association • Arkansas Physical Therapy Association • Arkansas Chiropractic Association • Arkansas Optometric Association • Arkansas Counseling Association • Arkansas Ophthalmological Society • Arkansas Psychological Association • Arkansas Association of Ambulatory Surgery Centers

The Patient Protection Act of 1995

The Managed Care Industry Will Tell You:

The Truth Is:

[illegible] Protection Act will kill managed [illegible] health care coverage [illegible] unaffordable for [illegible]

Managed Care [illegible] ing in fourteen [illegible] already in place. Some states have [illegible] ing provider laws for [illegible] not been detrimental to the cost effective opera- tions of the managed care networks. The Patient Protection Act does not tamper with the "gatekeeper" concept of managed care, it does not require insurance plans to cover specified health care services, nor does it affect workers' compen- sation laws.

[illegible] to [illegible]

Patient volume [illegible] quality health [illegible] health care providers [illegible] managed care organizations to reduce access to health care. A bigger threat to patients is insurance companies trying to limit needed medical care.

[illegible]

Health care providers [illegible] for patients by providing [illegible] service. Patient volume [illegible] competitive and [illegible] insurance companies [illegible] fees. They [illegible] the insurance carrier.

[illegible]

If administrative [illegible] these costs would be [illegible] reduced reimbursement [illegible]

PATIENT PROTECTION ACT OF 1995

The number one concern regarding health system reform is the patient's fear of losin the ability to choose their personal health care provider. The "Patient Protection Act of 199 will significantly enhance patient choice through any-willing provider provisions.

By affording health care providers greater opportunities to participate in health care plans, this Act will:

- give patients greater access to a variety of qualified health care providers.
- foster patient choice by prohibiting health care plans from excluding qualified providers who are willing to accept traditional managed care operating criteria. These criteria could include adherence to fee schedules, quality standards and utilization review requirements.
- strike an appropriate balance between the needs of health care plans to establish management criteria and the patient's freedom to choose their health care provider.

WHAT THE PATIENT PROTECTION ACT WILL DO:

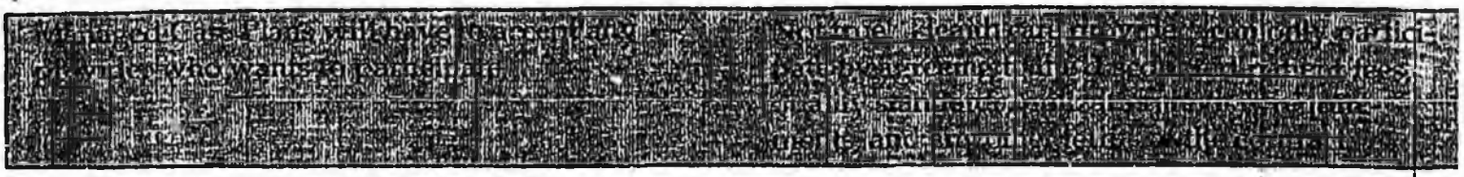
- **It will** prohibit insurance companies from excluding qualified providers who want to accept the managed care participation requirements.
- **It will** enhance your choice of health care providers.
- **It will** protect patients from economic penalties.
- **It will** assure patients in rural communities greater access to quality health care providers in their communities – like doctors, hospitals, dentists and local pharmacists.

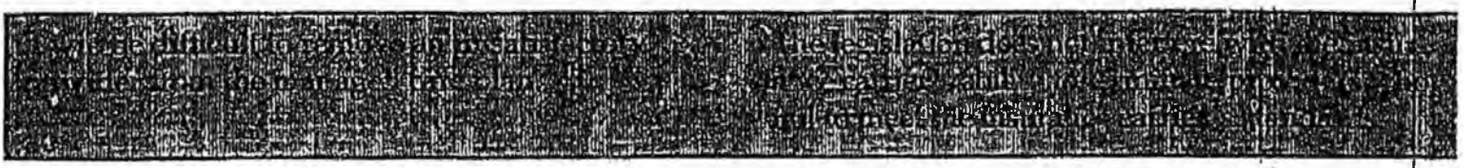
WHAT THE PATIENT PROTECTION ACT WILL NOT DO:

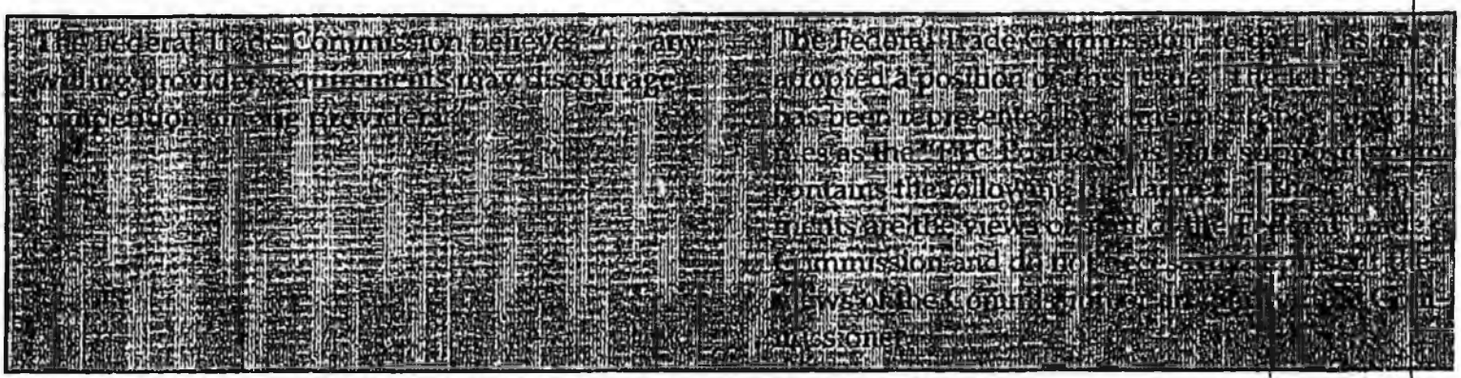
- **It will not** prohibit managed care concepts, like the primary care physician or the "gatekeeper" concept.
- **It will not** require an insurer to cover any specific health care service.
- **It will not** interfere with an insurance company's ability to utilize traditional managed care concepts including patient fee schedules, quality standards and utilization review requirements.
- **It will not** affect workers' compensation reform.

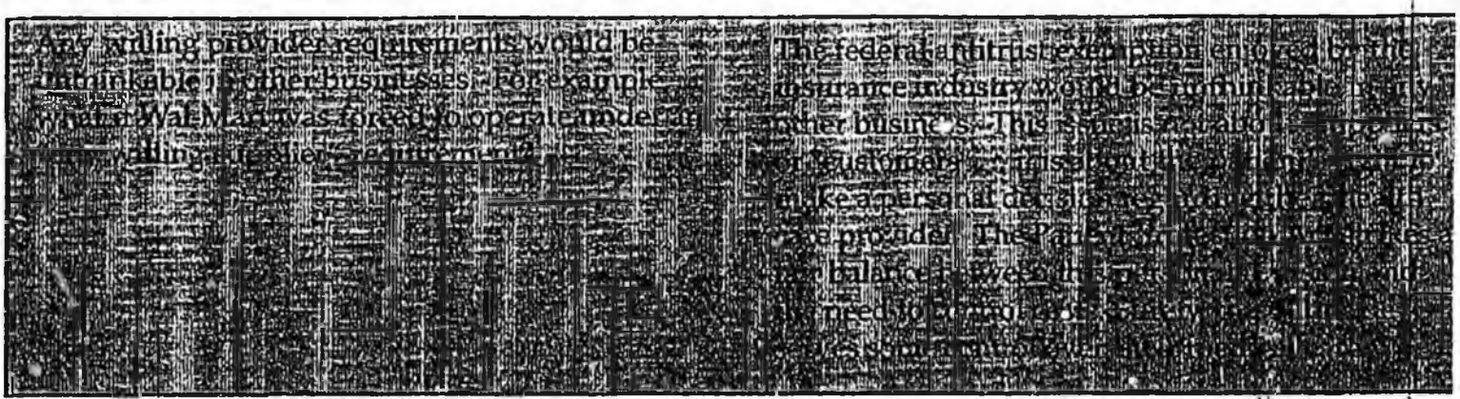
VOTE FOR ARKANSAS' PATIENTS.

VOTE FOR THE PATIENT PROTECTION ACT









The Patient Protection Act Coalition is supported by the Arkansas State Dental Association • • Arkansas Medical Society • Arkansas Hospital Association • Arkansas Pharmacists Association • Arkansas Chiropractic Association • Arkansas Physical Therapy Association • • Arkansas Osteopathic Medical Association • Arkansas Occupational Therapy Association • • Arkansas Counseling Association • Arkansas Podiatric Medical Association • • Arkansas Speech-Language-Hearing Association • Arkansas Optometric Association • • Arkansas Psychological Association • Arkansas Opthalmological Society •

Professional
Infusion
Pharmacy, Inc.

September 25, 1995

Legislature of the State of Alaska
House Labor and Commerce Committee
HB266

Dear Committee Members:

I would like to offer my support of House Bill (HB266), which addresses preferred provider programs. I strongly support allowing any health care provider willing to meet the terms and conditions of the preferred provider service agreement to participate and provide service. I feel this type of legislation is essential to the State of Alaska and it's residents.

The major problems relating to health care in the State of Alaska, both in terms of quality and cost, have to do with accessibility and availability. Alaska has a small population base, spread out over a large geographic area, with few health care providers. Many "larger" towns, such as Bethel and Dutch Harbor, don't even have a physician, retail pharmacy or hospital. Transportation costs, to access health care, are a significant component of health care costs in Alaska. If exclusive, preferred provider programs are allowed to exist in our state, they will only decrease further the number of health care providers and increase the cost to access health care.

I have recently witnessed the implementation of a restrictive preferred provider program. A medical service corporation decided to limit the number of home infusion providers in their network for both the states of Alaska and Washington. Before the new contract, there were six home infusion providers in the State of Alaska, four in Anchorage, one in Soldotna and one in Juneau. Now, three providers remain in the network as preferred providers, all based in Anchorage. Even if the providers in Juneau and Soldotna are willing to accept the proposed reimbursement rate, they are being excluded from participating. Is this good for Alaska? Do we want to discourage health care providers from setting up practice in any community other than Anchorage?

The cost of health care will not be increased by allowing open participation in preferred provider programs. A business will either accept or not accept a proposed rate. If the rate becomes too low for them to do business, they will drop out of the network. By allowing open participation, you are allowing competition and the free market place to work.

The quality of health care in Alaska will be severely affected if exclusive preferred provider programs are allowed to operate in our state. What health care is available in areas outside of Anchorage will decrease or become extinct. People in areas outside of Anchorage will delay seeking medical attention and in an emergency they will have no one in town to turn to. If a patient is unhappy with the quality of his care, he'll be restricted from changing providers. Multiple providers, patient choice and competition are what keep quality up.

725 Northway Drive Anchorage, Alaska 99508
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As to choice, a person will have none. Even in Anchorage we only have two hospitals. If you restrict it even by one, you have in essence, eliminated any inkling of choice. People in areas outside of Anchorage, will have a "choice" to come to Anchorage and be seen at the preferred provider hospital, doctor's office or what not. Which brings up the question of who's going to pay for these increased transportation and accommodation expenses?

HMO's and restrictive preferred provider programs may work in dense, highly populated areas of the United States, where you have a large number of hospitals, primary care physicians and specialists; but they won't work in Alaska. We need more providers, not less. We need more accessibility, not less. Health care providers willing to meet the terms and conditions of a preferred provider service agreement, need to be allowed to participate and provide service.

Sincerely,

Karen Marcey

Karen Marcey RPh/VP

TESTIMONY ON HOUSE BILL 266

BEFORE THE

ALASKA HOUSE LABOR AND COMMERCE COMMITTEE

April 24, 1995

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a trade association of the nation's leading commercial health insurance companies which provide health insurance for approximately 55 million Americans.

HIAA opposes House Bill 266, which ostensibly would allow a hospital or medical service corporation to offer a preferred provider service agreement to a provider or hospital licensed in Alaska.

At this time Alaska does not have a statute directly authorizing the operation of PPOs ("preferred provider organizations") in the state. There is a model PPO act drafted by the National Association of Insurance Commissioners ("NAIC"), which has not been adopted in Alaska, but HB 266 would not serve the same purpose as a true PPO act.

HB 266 is nothing more than a badly disguised "any willing provider" mandate, the consequence of which in the long run would be to increase the costs and reduce the efficiencies of managed care.

An integral part of managed care is the provider network. When a managed care plan such as a PPO enters into a

contract with a particular provider -- whether a hospital, a physician, or some ancillary provider -- it seeks to accomplish several purposes.

One is to establish a long term relationship with the provider that enhances the plan's market attractivness and its ability to provide access to quality health care.

A second purpose of the plan is to establish a method of reimbursement with the provider that improves the plan's ability to manage its health care costs effectively.

Managed care plans attract providers by guaranteeing access to a specified pool of enrollees. If all providers in a community are required to be included in a plan -- as the second sentence in HB 266 would require -- there is no economic incentive for any provider to enter into an alternative delivery or reimbursement system.

"Any willing provider" laws erode savings since, as the costs to a plan increase, savings can no longer be passed along to consumers, and the value of the plan for consumers is lost.

"Any willing provider" legislation also hurts consumers by hindering the ability of health insurers and HMOs or PPOs to construct delivery systems that can guarantee specified standards of care to meet the needs of their members. To serve its enrolled population efficiently, a health plan must be allowed to establish its own credentialing standards and to decide on the optimal number (and specialty) of providers to be included.

HIAA believes that managed care systems should be able to limit their networks of providers and to alter reimbursement systems to reward efficient providers in their network. Insurers should be free to negotiate reimbursement schedules with providers to contain health care expenditures.

HIAA is opposed to legislation that would restrict the ability of an insurer or other entity to contract with providers, and which would require the insurer to accept ANY provider in a particular service agreement.

Buyers of insurance plans -- and not state government -- should dictate what services and which provider groups should be covered.

The Federal Trade Commission has determined that "any willing provider" mandates are anti-consumer and "may discourage competition among providers, in turn raising prices for consumers and unnecessarily restricting consumer choice in prepaid health care programs, without providing any substantial public benefit."

In addition, the National Governors' Association has gone on record as opposing "any willing provider" mandates at both the state and federal levels. They believe these laws can undermine the access, cost containment, and quality assurance benefits provided by effective managed care organizations.

We urge the committee to reject HB 266.