ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672
8932 SENATE LABOR & COMMERCE

MAR 1 1995

RSA Engineering, Inc.
MECHANICAL AND ELECTRICAL CONSULTING ENGINEERS

March 1, 1995

Senator Loren Leman
State Capital
Juneau, Alaska 99801

Dear Senator Leman:

REFERENCE: Senate Bill SB99

I am writing to you to express my opposition to Senate Bill 99, in its entirety. I speak first as an Alaskan resident, second as president of an engineering firm, and third as chairman of the AELS Board (The board has not reviewed this bill, so I am not expressing the opinion of the board) My opposition to the bill is based on the following concerns:

1. Section 1. AS 08.48.221 Seals: The proposed change says that only registered architects, engineers, or land surveyors need to seal their plans. As you know, sealing of plans is required so that the public knows who provided the design, so designers can be held responsible and accountable for their work. Placing a seal on plans therefore causes designers to very carefully review their work to ensure they are doing the best they can to provide a safe, code compliant design or report. This change says to me that if adopted, unlicensed people may prepare plans, specifications, reports, etc., since they do not have to seal their work product, implying also that they do not have to accept responsibility for their work product, since the designer will be unknown. There is *no way* that this provision will enhance public safety; rather it will open the doors to potentially unqualified "designers" or self proclaimed engineers to furnish designs that may very well violate good engineering principles, code, or logical construction.

2. Section 3. AS 08.48.331 Exemptions: Paragraph 10 of this amendment invites all kinds of unqualified people to practice engineering without a license so long as they do it for their company. The trouble is, the resultant building, facility, or project may not (and probably will not) reflect good engineering principles, code compliance, or safe construction. The public or the employees of the company who enter, or otherwise use these facilities, or subsequent purchasers of these facilities, could no longer rely on any assurance that the facility or its subsequent renovations have been designed by competent architects or engineers. Reliance on plan reviews or inspections by OSHA, the State Fire Marshall, or other such regulatory agencies for assurance of proper design would be absurd because:

   - These agencies rely on the competence of the design teams, as evidenced by their seal on the plans. Their plan review is cursory, at best, and certainly does not go into calculation verifications, site conditions, etc.

   - These agencies are not staffed with experts in all the disciplines needed to properly review plans potentially designed by sub-professionals.

- Nobody can build quality into a design after it has been improperly prepared. Construction elements build on one another so improper design can build up to a disaster of a project.

- Only the original designer has access to all the assumptions needed to prepare a proper design. A reviewer (such as a Fire Marshall) relies on the professional competence of the designer (as evidenced by his seal) and on that designer's proper use of assumptions and site conditions.

The specific exclusion of electric utilities is an obvious punitive strike at them because this group worked with the AELS Board to forge a reasonable set of guidelines whereby minimum requirements were called out as to when licensed professionals are needed.

Rather than having the legislature prepare legislation such as this to respond to special interests, I propose that you introduce language that would allow the AELS Board to define specific exemptions based on the relative risk to the public or employees that use the facilities. For example, a majority of the design done by cable TV or telecommunications utilities using voltages less than 120 volts should probably be exempt, provided their designs comply with accepted industry guidelines, applicable codes, and utility right of way agreements. Their *buildings*, however, should be designed by licensed professionals, including power, lighting, civil, and structural systems. The Board, composed of professionals of several disciplines, is closer to the issue of safety and risk to the public than the legislature. For this reason, the AELS Board should be charged with reviewing and evaluating specific industry exemptions regarding the use of licensed architects, engineers, or land surveyors based on protection of the public or employees of these firms.

I would be pleased to testify on this important piece of legislation at your scheduled hearing on March 7. While I understand that the public testimony period begins at 1:30, I will not be available until 2:00, at which time I will call in.

Thank you for considering this important concern. By copy of this letter to interested persons, I urge their response to appropriate legislators, as well.

Very truly yours,

Richard S. Armstrong, P.E.
President

trw
95-224
cc:

Colin Maynard, APDC	(F) 276-7073	Dave Hutchens, ARECA	(F) 561-5547
NCEES, Roger Stricklin	(F) 803-654-6033	Dave Adams, AMC	(F) 272-5993
Mike Massin, CEA	(F) 562-0027	Judy Weske, DCED	(F) 465-2974
Moe Aslam, MLP	(F) 263-5204	AELS Board Members	

Attachment: SB99

FISCAL NOTE

STATE OF ALASKA **BILL NO. SB 99**

1995 LEGISLATIVE SESSION

Revision Date: March 6, 1995 Department: Commerce and Economic Development

Title: An Act relating to the practice of architecture, engineering and land surveying. BRU: Occupational Licensing

Component: Operations

Sponsor: Senate Labor & Commerce

Requestor: Senate Labor & Commerce COMPONENT SERIAL #: 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 95) cost: $ 0.0

POSITIONS

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SB 99 makes several changes to AS 08.48 amending the practice of architecture, engineering, and land surveying, however, new funds are not required to implement these changes.

Prepared by: Jennifer Strickler, Admin. Officer Phone: 465-2144

Division: Occupational Licensing Date: 3/6/95

Approved by Commissioner: William L. Hensley Date: 3/6/95

Agency: Commerce and Economic Development

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For further distribution information, call the Governor's Legislative Office

[redacted]

SENATE LABOR & COMMERCE COMMITTEE AGENDA

TUESDAY, February 28th, 1995
1:30 p.m.
Fahrenkamp Room

1. ***Call Meeting to Order***
2. ***Note time/day/year***
3. ***Note members present***
4. ***Remind Witnesses to Sign In***
5. ***Announce Order of Bills to Be Heard:***

*SB 99 An Act relating to the practice of architecture, engineering, and land surveying.

Josh Fink, Legislative Aide to Tim Kelly

TELECONFERENCE 1. Dick Armstrong, Chairman A/E Board
2. Mike Taurianen
3. Tom Crafford/CIRI
Others to follow

SECOND TO LAST JIM ROWE
LAST TO TESTIFY GRAHAM RALSTAD/Matanuska Tel.

*SB 43 An Act relating to membership on the Board Registration for Architects...

Senator Leman
TELECONFERENCE

*SB 58 Restricting the use of the title 'industrial hygienist' and related titles.

Senator Leman
TELECONFERENCE Erin Tripler
Others to follow

*SB 25 An Act repealing vegetable dealer licensing and regulation.

Senator Donley
TELECONFERENCE Jerry Lucenberger
Clayton Hillhouse

6. ***Adjournment***

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Others to follow

*SB 25 An Act repealing vegetable dealer licensing and regulation.
Senator Donley
TELECONFERENCE Jerry Lucenberger
Clayton Hillhouse

6. ***Adjournment***

Alaska Telephone Association
4341 B Street, Suite 304
Anchorage, AK 99503
(907)563-4000
FAX (907)562-3776

Duane C. Durand
President

James Rowe
Executive Director

March 4, 1995

Honorable Tim Kelly
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Senator Kelly:

RE: SB99

The Alaska Telephone Association recognizes the importance of SB99 to our customers and enthusiastically supports its passage.

The sum of the following list of specific reasons for support is that the public interest will be served by its enactment into law.

- Prior to 1990 utility engineers were exempted from the licensure requirements of the Alaska Board of Architects, Engineers and Land Surveyors by AS 08.48.331(D)(12).
- Most of the local exchange carriers in Alaska, certificated and deemed "fit and able" by the APUC, do not have a professional engineer on staff.
- Alaskan local exchange carriers maintain accepted industry guidelines and standards as endorsed by the National Electrical Safety Code, Bell Operating Company standards, and those that are REA (RUS) borrowers must follow REA (RUS) guidelines.
- There are very few licensed professional engineers in Alaska considered expert in telephone construction.
- Local exchange companies are unaware of any complaints referred to the APUC regarding unsafe or substandard infrastructure construction by local telephone companies.
- Without this exemption the citizens of Alaska will encounter delays in the provision of modern telecommunications infrastructure and in higher costs when service is received.

- The results of a 1993 survey conducted and published by the National Council of Examiners for Engineering and Surveying identified the following 26 states that exempt public utility engineers from registration:

Alabama	Indiana	South Carolina
Arizona	Kentucky	South Dakota
California	Massachusetts	Texas
Colorado	Nevada	Utah
Connecticut	New York	Vermont
Delaware	North Carolina	Virginia
Florida	New Mexico	Wisconsin
Georgia	Pennsylvania	
Hawaii	Rhode Island	

I look forward to offering testimony on this issue before the Senate Labor and Commerce Committee next Tuesday.

Very Truly Yours,

James Rowe

TelAlaska, Inc.
2121 Abbott Road Anchorage Alaska 99507 (907) 562 2400 Fax (907) 340 1858

Interior Telephone Co Muklok Telephone Co Eyecom, Inc. Alyeska Cable & Video Telco Properties

February 16, 1995

Honorable Tim Kelly
Senator
Alaska State Legislature
Juneau, AK 99801-1182

Dear Senator Kelly:

I am writing you, to ask for your support in institutionalizing an exemption to AS 08.48.331 (D) (12) for public utility engineers. The loss of this exemption is onerous, burdensome, expensive and could well cause extended delays in a public utilities ability to provide service to the public.

TelAlaska operates two local exchange telephone utilities and a CATV utility in a total of 22 communities throughout the State of Alaska. Fort Yukon to Unalaska, Little Diomede Island to Kodiak Island, as you can see a very dispersed operation. Because of the short construction season, especially near the Arctic Circle, we are forced to run as many as four construction projects simultaneously to complete required work in one year. Construction costs range from $42,000 to $100,000 per mile depending on location and the nature of the project. The requirement to have a consulting certified professional engineer (P.E.) on site at these projects would raise the cost by $1,000 or more per day, per project. Generally, an additional 10% to the cost of construction. The fact that these costs will ultimately be reflected in higher rates for public utility services, should be more than enough to show the public interest in providing the exemption. However, the unavailability of telephone or CATV experienced P.E.'s is much more insidious, because it is this fact, that could well cause the public to go without service.

The fact is that there is almost nothing relating to the design or construction of telephone or CATV facilities within the examinations for a registered professional engineer. These industries use nationally approved and accepted standards. NESC, NEC, RUS Engineering Standards (formerly REA) and the Bell System Practices are all nationally accepted standards.

As this issue has never been a public safety concern where telephone or CATV are concerned, there can be no rational reason in maintaining a standard which is clearly no in the public's interest.

Sincerely,

Jack H Rhyner
President

ACTA

ALASKA CABLE TELEVISION ASSOCIATION

January 28, 1995

The Honorable Tim Kelly
Alaska State Legislature
State Capitol, Room 101
Juneau, AK 99801-1182

Dear Senator Kelly:

The Alaska Cable Television Association ("ACTA") endorses the Alaska Telephone Association's ("ATA") proposed amendment to AS 08.48.331 as submitted.

This amendment restores the exemption of telecommunications organizations from having registered architects, engineers and land surveyors on staff for work that does not involve the offering of services to the general public. Attached is a copy of the proposed amendment for your review.

Cable television ("CATV") plant does not involve the use of electrical elements that present a hazard to the general public. CATV design and construction is subject to the National Electric Safety Code, the National Electric Code and the Occupational Safety and Health Administration. In addition, CATV joint use agreements with other local utilities and municipalities as well as the State Division of Transportation and Public Facilities call for engineering reviews and approvals. Further, any surveying required as a condition of permitting is contracted out to qualified surveying companies.

ACTA, and its member cable television systems believe that the present requirement is unnecessary and only adds to the cost of a project, which is inevitably is passed on to the consumer.

ACTA appreciates your support on this issue, and we are standing by in the event that you or your staff need any additional information. Please do not hesitate to call on us.

Sincerely,

ALASKA CABLE TELEVISION ASSOCIATION

Michael W. Roberge
President

Enclosures

PRIME CABLE

January 26, 1995

The Honorable Senator Tim Kelly
State Capitol, Room 101
Juneau, Alaska 99801-1182

Dear Senator Kelly:

Prime Cable of Alaska would like to add our endorsement for the proposed amendment to AS 08.48.331 (attached) submitted by the Alaska Telephone Association. This amendment restores the exemption of telecommunications organizations from having to have registered architects, engineers and land surveyors on staff for work that does not involve the offering of these services to the public.

Cable Television does not involve the use of electrical elements that present a hazard to the general public. All design and construction work is covered under and must comply with the National Electric Safety Code, National Electric Code, the Occupational Safety and Health Administration as well as individual agreements with our joint use utilities, Municipal Public Works department and the State Division of Transportation and Public Facilities. Joint work involving other utilities or government road projects are submitted to their engineering groups for review and approval. Any surveying required as a condition of a permit is contracted with a land surveying company. Requiring yet another level of official action will only result in unnecessary cost that would be passed on to the consumer.

It is therefore our belief that this exemption is of benefit not only to the telecommunications industry but also the general public. Thanks for your support of this amendment and I am available for further discussions of the matter with you or your staff at 786-9355.

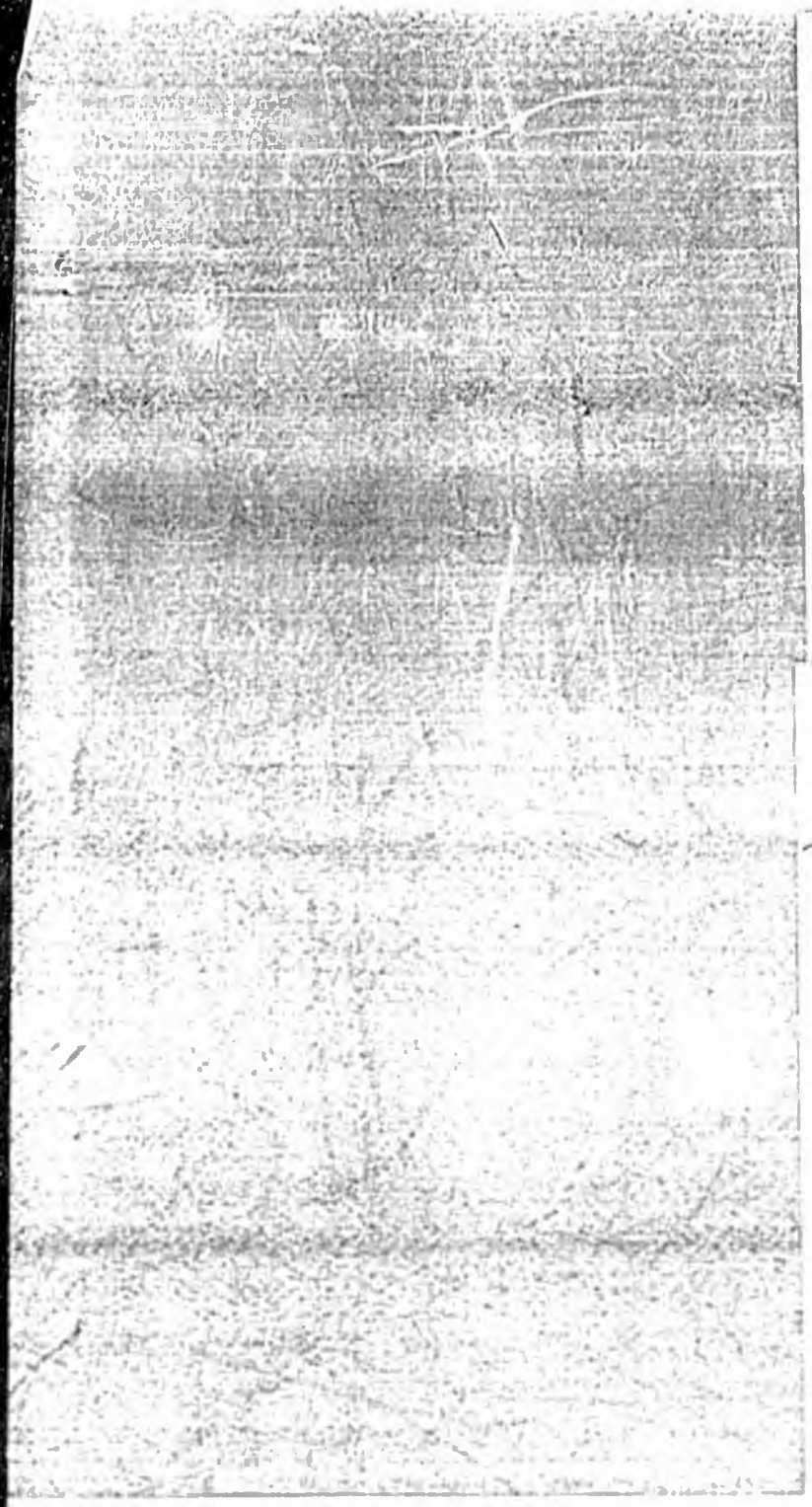
Sincerely,

Gary S. Haynes
V.P. of Operations

Attachments

SB

100



Rachel

Gates would
(marital therapist)

like to talk

- Judith Frost

Wants to testify on
this Bill.

03/23/95 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150

13:14:47 PARTICIPANT LIST (ALL PARTICIPANTS) BY.FBX

TCN:50441 SCHEDULED FOR:03/23/95 13:30 TO 15:30 FOR:FBX

PUBLIC HEARING SENATE LABOR & COMMERCE

LOCATION:FAIRBANKS

SEAT# MR DENNIS BROWN TESTIFY

Alaska State Legislature

Senator Tim Kelly, Chair
Senator John Torgerson, Vice Chair
Senator Mike Miller
Senator Jim Duncan
Senator Judy Salo

SENATE LABOR AND COMMERCE COMMITTEE

STATE CAPITOL, SUITE 101
JUNEAU, ALASKA 99801-1182
PHONE: (907) 465-3822
FAX: (907) 465-3756

716 W. 4TH, SUITE 400
ANCHORAGE, AK 99501-2133
PHONE: (907) 258-8180
FAX: (907) 258-4524

Sponsor Statement
SB 100

"An Act relating to unfair discrimination against a physician assistant or acupuncturist under a group health insurance policy."

SB 100 was introduced at the request of several groups of acupuncturists and the Alaska Academy of Physicians Assistants. SB 100 amends AS 21.36.090(d) to include physicians assistants and acupuncturists in the definition of "provider."

SB 100 would prohibit a person from practicing or permitting unfair discrimination against a physician assistant or acupuncturist who provides a service covered under a group disability policy that extends coverage on an expense incurred basis if the rendered service is within the scope of the physician assistant's or acupuncturist's occupational license. **SB 100 does not mandate insurance coverage for services rendered by physician assistants and acupuncturists.** Simply put, SB 100 would require insurance companies who elect to cover the services of acupuncturists or physician assistants to treat these practicioners each equally. For example, if an insurance policy covers treatment by an acupuncturist, then the insurance company is bound to pay for similar services rendered by different acupuncturists.

SB 100 mandates parity amongst acupuncturists and amongst physicians assistants. Insurance companies covering these types of procedures must treat physician assistants and acupuncturists equal amongst themselves for services rendered within the scope of their respective occupational licenses.

FAMILY MEDICINE OF ALASKA, Inc.
1261 Seward Meridian, Suite A
Wasilla, Alaska 99654
Telephone: (907) 376-1218

March 3, 1995

Honorable Lyda Green, State Senator
Chairperson Rees Committee/L&C

Dear Senator:

I am in favor of S.B. #100 relating to unfair discrimination of Physician's Assistants and Accupuncturists.

Section 1 AS 21-16-090 (d) I am greatly in favor of passage of this amendment.

Sincerely,

M.E. Kirkpatrick PA-C

MEK/pl

4411 Abby Way
Juneau, AK 99801
February 16, 1995

Dear Senator Tim Kelley,

I'm writing to let you know that I support the insurance coverage of acupuncture treatment. Presently insurance companies discriminate against acupuncturists, the only state licensed health care professionals so discriminated against.

Please make sure that the legislators and appropriate officials are aware of my support for amending AS 21.36.090, Unfair Discrimination.

I have found acupuncture effective, and more thorough, in its healing results than any other medical treatment. I have used acupuncture as a treatment mode since 1973. Sometimes the cost was prohibitive because insurance didn't cover it, so sometimes I delayed treatment---but still, in the end acupuncture, not allopathic medicine was what supported my recovery. I can understand it not being covered by insurance in the 1970's, but in the 90's, going into the next century, it has certainly been proven to be effective.

When regular doctors could do nothing for my 12 year old daughter's headaches and her menstrual cramps, several treatments of acupuncture healed both. When I was exhausted by hypoglycemia, doctors told me I would just have to get used to it, and that my test results weren't that bad anyway. They said they could do nothing to help me. Acupuncture had me feeling energetic and strong within about 6-8 treatments. In 1978 I had fibroids in one breast, with a lump that was quite painful in one area. The typical Western method of treatment didn't sound good to me. After several months of acupuncture treatments the lump was gone, the breasts were free of the fibroids. Whenever I've felt the beginnings of a flu hitting me, I have sought acupuncture and have never had to suffer the same devastating symptoms as those around me have. In being treated by an acupuncturist I am treated with more care and depth than I've experienced elsewhere. I'm never greeted with a quick prescription for antibiotics (which happens with Western medical doctors even before they have determined there's an infection), or a quick prescription for anything. Acupuncture is safer in that there aren't any sensitivity or allergic reactions, or any other deleterious side effects.

Please support the amendment to AS 21.36.090, Unfair Discrimination.

Thank you. I am sincerely yours,

Patricia Hartzell

GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION, INC.
P.O. BOX 10004 / KANSAS CITY, MISSOURI 64171-0004 / 816-753-1200
(CLAIM INQUIRIES - 816-257-5000)

August 16, 1994

APA REIMBURSEMENT ISSUES

Healy Clinic
248 Parks Hwy
Usibellispur Rd.
Healy, AK 99743-0062

Re:

Dear Sir or Madam:

This is in response to your inquiry regarding our denial of services provided by John Winklmann, P.A.

As stated in the 1994 brochure, covered providers are: "A licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers who may render services without the supervision of an M.D. but for which the Plan provides benefits include a chiropractor, nurse midwife, nurse anesthetist, dentist, optometrist, qualified clinical social worker, qualified clinical psychologist, podiatrist, speech, physical and occupational therapist, nurse practitioner/clinical specialist and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification. Within States designated as medically underserved areas, any licensed medical practitioner is covered. For 1994, the States designated as medically underserved are: Alabama, Louisiana, Mississippi New Mexico, North Dakota, South Carolina, South Dakota, West Virginia and Wyoming."

According to the information submitted, John Winklmann has a degree in Physic' a Assistant which does not fall within the guidelines of a covered provider. The services rendered by John Winklmann were correctly denied.

Our brochure also states if the member does not agree with this benefit determination, the member is entitled to a review of the claim by the Office of Personnel Management. The brochure provides specific

instructions on claim appeal.

If you have any questions, please contact our office.

Aetna

4300 B Street Suite 205
Anchorage, AK 99503-2781
907-561-0011

November 9, 1994

Karolyn Bowyer
1679 Taroka Drive
Fairbanks, AK 99709

Plan Sponsor: University of Alaska
Employee : R. T. Bowyer
SSN : 561-70-1088
Dependent : Jeffrey

Dear Karolyn:

We are writing in response to your request for written notification of the denial on Jeffrey's claim, date of service September 12, 1994, in the amount of $132 dollars.

These expenses are not covered because this provider, M. Weber, P.A., is not recognized under the plan definition of a physician.

The charges in question are being billed directly by M. Weber, P.A., and a physician assistant billing on his own behalf is not covered.

Sincerely,

Sandra Kent

Sandra Kent
Anchorage Member Services
Aetna Life Insurance Company

1487C

Fax Transmittal Memo 7672

To Mike Weber — From Cheryl Kilgore — 11/30/94

Company — Company

Location — Location — Date Change

Fax # 451-9480 — Telephone # 454-7687 — Fax # 451-2948 — Telephone # 451-2940

Comments Here is the section of the benefits booklet that Aetna quoted to me.

Original [ ] Destroy [ ] Return [ ] Call for pickup

regardless of your physical condition. If you have received more than $5,000 of covered medical benefits, your full maximum may be restored when you submit proof of good health satisfactory to the health carrier.

This provision will not provide benefits for covered expenses incurred before the date the maximum is restored.

Pre-existing Conditions Limitation

Pre-existing conditions are conditions, including pregnancy, for which you received diagnosis, tests or treatment (including taking medication) during the three consecutive months before the most recent day you became covered under this plan.

Only the first $1,000 of covered medical expenses are paid by the Medical Plan for pre-existing conditions. However, once you have been covered for 12 consecutive months, this limitation is cancelled.

Physician's Services

The State's Medical Plan pays for covered medical treatment and surgery performed by a qualified physician.

A physician is a person licensed to practice medicine and surgery (M.D.), osteopathy and surgery (D.O.), or dentistry (D.D.S. or D.M.D.). Also, the physician may be a psychologist; occupational therapist; physical therapist; a licensed clinical social worker (L.C.S.W.); audiologist; optometrist; midwife; naturopath; ophthalmologist; chiropractor; podiatrist (D.P.M.); or a Christian Science Practitioner authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts. Also included in the definition of physician is a nurse practitioner, psychological associate, or a practitioner with a master's degree in psychology or social work if supervised by a psychologist, medical doctor or licensed clinical social worker. All providers must be licensed by the state in which they practice and practicing within the scope of such license.

AETNA Health Plans
P.O. Box 21645
Seattle, WA 98111

JACK -
I have a total of 5 of these mixed UAF/State employees

January 11, 1995

Orthopaedic Triage of Fairbanks
1919 Lathrop St., #202
Fairbanks, AK 99701

re: R. Boutang
State of Alaska SSN: 468-40-3118

Dear Mr. Weber:

We have reviewed your letter of November 28, 1994, regarding the treatment that you performed for Robert Boutang.

Based on the information provided, we will not be able to pay benefits for your claims. Our reason for this determination is based on your credentials. The State of Alaska Group Medical Plan does not consider a physician's assistant a payable provider.

In order to receive reimbursement for your services you would need to be employed by a medical doctor, and the payment would then be made to that doctor under his tax indentification number.

We are sorry our determination could not be more favorable. If you have any other questions, please contact this office at the address shown above or call 1-800-426-3211.

Sincerely,

JWilliams

Joanna Williams
Customer Service Representative
Seattle Claim Department
Aetna Life Insurance Company

cc: R. Boutang

Alaska State Legislature

STATE CAPITOL, SUITE 101
JUNEAU, ALASKA 99801-1182
PHONE (907) 465-3822
FAX (907) 465-3756

716 W. 4TH, SUITE 400
ANCHORAGE, AK 99501-2133
PHONE (907) 258-8180
FAX (907) 258-4524

SENATE LABOR AND COMMERCE COMMITTEE

Sponsor Statement
SB 100
"An Act relating to unfair discrimination against a physician assistant or acupuncturist under a group health insurance policy."

SB 100 was introduced at the request of several groups of acupuncturists and physicians assistants. SB 100 amends AS 21.36.090(d) to include physicians assistants and acupuncturists in the definition of a health care "provider."

SB 100 would prohibit a person from practicing or permitting unfair discrimination against a physician assistant or acupuncturist who provides a service covered under a group disability policy that extends coverage on an expense incurred basis if the rendered service is within the scope of the physician assistant's or acupuncturist's occupational license. Therefore, SB 100 would mandate insurance coverage of services performed by physician assistants and acupuncturists so long as such services are within the scope of their occupational licenses.

Currently, services performed by acupuncturists and physician assistants are not covered by insurance. SB 100 would remedy this problem by amending the statute to include acupuncturists and physicians assistants in the definition of "providers" for which insurance coverage is made mandatory. However, the service provided must be within the scope of the acupuncturist's or physician assistant's occupational license in order to be covered.

SENATE LABOR & COMMERCE COMMITTEE AGENDA

Thursday, March 23, 1995
1:30 p.m.
Fahrenkamp Room

1. *Call Meeting to Order*

2. *Note time/day/year*

3. *Note members present*

4. *Remind Witnesses to Sign In*

5. *Announce Order of Bills to Be Heard:*

(2) **SB 100 "Relating to unfair discrimination against a physicians assistant or acupuncturist under a group health insurance policy."**

(1) **SB 104 "An Act relating to joint insurance arrangements."**

1. Mary Jackson-- Torgerson's Aide

HOLD OVER (CS HAS NOT BEEN FINISHED)

SB 95 "An Act requiring offers of automobile insurance to include coverage for uninsured or underinsured motor vehicles with policy limits for coverage equal to coverage voluntarily purchased."

6. *Adjournment*

9-LS0788\F
Ford
3/22/95

CS FOR SENATE BILL NO. 100(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE LABOR AND COMMERCE COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to services covered under a group health insurance policy that are provided by a physician assistant or acupuncturist."

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

* Section 1. AS 21.36.090(d) is amended to read:

(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, <u>physician assistant, acupuncturist,</u> 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.

9-LS0788\C
Ford
3/15/95

CS FOR SENATE BILL NO. 100(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE LABOR AND COMMERCE COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to services covered under a group health insurance policy that are provided by a physician assistant, acupuncturist, or hospital."

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

*** Section 1.** AS 21.36.090(d) is amended to read:

(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, <u>physician assistant, acupuncturist,</u> 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.

* **Sec. 2.** AS 21.36.090 is amended by adding a new subsection to read:

(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.

151 Farmington Avenue
Hartford, CT 06156 - 9080

Joseph J. Kempf, Jr.
Supervising Attorney
Law and Regulatory Affairs, YFF1
(203) 275-3151
Fax: (203) 275-4020

March 28, 1994

Saundra L. Woodward, CPIW, AIC
Consumer Service Specialist
Alaska Department of Commerce and Economic Development
Division of Insurance
800 East Dimond Blvd., Suite 560
Anchorage, Alaska 99515

RE: STATE OF ALASKA EMPLOYEE BENEFIT PLAN
COMPLAINANT: CATHY BIGGERSTAFF, M.S.
YOUR LETTER DATED MARCH 3, 1994

Dear Ms. Woodward:

Enclosed is our response to Ms. Biggerstaff. We believe that it addressees all of the concerns expressed in your March 2 letter.

Your letter also requested a copy of the applicable coverage language, and evidence as to whether the state of Alaska self-insures the mental health portion of its employee benefits plan. We are in the process of accumulating the information that you requested. We did not, however, want to delay responding to Ms. Biggerstaff. The requested information will be forwarded to you as soon as it is available.

If you should have any further questions, please do not hesitate to contact me.

Sincerely,

Joseph J. Kempf, Jr.
Supervising Attorney

FaxSav

To: Steve Brown From: Joe Kempf

(206) 467-2087

151 Farmington Avenue
Hartford, CT 06156 - 8060

Joseph J. Kempf, Jr.
Supervising Attorney
Law and Regulatory Affairs, YPF1
(203) 275-3151
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March 28, 1994

Via Airborne Express

Cathy Biggerstaff, M.S
Licensed Psychological Associate
2550 Denali Street, Suite 1606
Anchorage, Alaska 99503

Dear Ms. Piggerstaff:

This is in response to your complaint to the Alaska Department of Commerce and Economic Development. Your letter was forwarded to us from the Department by letter dated March 3, 1994.

According to Saundra L. Woodward, Consumer Service Specialist, you are concerned that Aetna Life Insurance Company ("Aetna") may be operating a Preferred Provider Organization ("PPO") in violation of Alaska law. We believe that this interpretation is not supported by applicable law.

Aetna participates in a number of employer-sponsored, self-insured employee welfare benefit plans. These plans are pre-empted from state insurance laws and regulations by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Therefore, the provisions of the insurance code cited in Ms. Woodward's letter dated March 3, 1994, are pre-empted and do not apply to self-insured plans.

We agree, however, that the provisions cited in that letter do apply to insured arrangements. However, those provisions do not prohibit PPOs.

Ms. Woodward's letter cites Section 21.36.090(d). This section prohibits an insurer from practicing or permitting "unfair discrimination" against providers who perform services covered under a group disability policy. Aetna does not unfairly discriminate against providers by operating a PPO in Alaska. We believe PPOs are permitted in all states, including Alaska. In fact, Aetna filed with the Department its policy and certificate pages to permit PPOs in its insured products. Aetna's first submission, dated May 15, 1985, was received by the Department on May 22, 1985. A second PPO filing was dated November 22, 1985, and stamped received by the Department on November 29, 1985. At no time has Aetna received notice that either of these approved filings have been questioned.

We read Section 21.36.090 (d) as prohibiting insurers from unfairly reimbursing the provider types specified in the statute for covered services rendered by those providers. For example, we believe that too great a benefit differential between the benefits payable to a preferred and a non-preferred provider would constitute "unfair discrimination." Under Aetna's standard PPO plans the benefit differential between preferred and non-preferred providers does not exceed 30%. In addition, preferred providers are reimbursed on a negotiated charge (which is generally lower than reasonable and customary), while non-preferred providers are reimbursed based on reasonable and customary charges. Aetna believes that a 30% benefit differential is not unfair. In comparison, Florida permits benefit differentials of up to 50%. (See Florida Insurance Code Section 627.6471(4)(e)).

March 28, 1994
Cathy Biggerstaff, M.S.

Aetna's PPOs always reimburse recognized providers for covered services. The benefit differential does not result in unfair discrimination. As additional protection to insureds, and to recognize Aetna's obligations under the statute, the plans contain an additional benefit feature that reimburses providers who perform covered services, when providers of that type are not in the network. All such providers are reimbursed at the same coinsurance percentage that would have applied had there been no PPO, usually 80%.

The second section cited, Section 21.54.020(a), also does not prohibit PPOs. The statute provides that the policy "may not contain a provision requiring that services be provided by a particular hospital or person...." (emphasis added). Aetna's PPO does not require that services be provided by a particular hospital or person.

PPO members are permitted to choose any preferred provider, or any non-preferred provider, whenever services are required. Covered services are reimbursed by the health plan. A member electing to utilize a preferred provider is permitted to pick any provider on the preferred provider panel. Members are also permitted to elect coverage from any recognized provider who is not on the panel. The member is not required to use any particular provider or hospital under either the preferred or non-preferred benefit. In addition, the benefit differential is not sufficient to amount to requiring that the member use only preferred providers. A reasonable financial incentive does not constitute a mandate that services be provided by a particular provider.

For all of the reasons discussed above, Alaska law does not prohibit PPOs. We do not believe that the statutes cited, or the intent of the Alaska legislature, was to prohibit the operation of PPOs.

We hope that this issue has been addressed to your satisfaction.

Sincerely,

Joseph J. Kempf, Jr.
Supervising Attorney

cc: Saundra L. Woodward, CPIW, AIC
Consumer Service Specialist
Department of Commerce and Economic Development
Division of Insurance
800 East Dimond Blvd.
Anchorage, Alaska 99515

Any Willing Provider Legislation

How does Any Willing Provider legislation affect managed care plans?	• Any Willing Provider legislation requires managed care plans to contract with any health care provider willing to meet the health plan's terms and conditions as to qualification and contracting. • Any Willing Provider legislation may be written to apply to physicians, hospitals, allied health professionals, and/or pharmacies.	• A managed care plan would have to contract with any health care provider regardless of whether it had the capacity to absorb additional providers. This would result in larger, less efficient networks, increasing administrative costs by 34% and claims costs by 8.8%, according to a study done by the Wyatt Company, an independent employee benefits consultant.
Why should health plans be allowed to limit the number of its contracted providers?	• Permits health plans to have networks sized suitably in relation to the number of enrollees, with an appropriate mix of primary care physicians and specialists. This creates competition among providers to join health plans, resulting in reduced costs and improved services for consumers. • Enables health plans to select only the highest quality physicians. Once such a network is established, it enables the retention of high quality physicians, since they prefer to work with other highly reputed professionals. • Permits health plans to negotiate favorable financial arrangements with providers in return for supplying increased patient volume. These savings are passed on to the consumer in lower costs.	• Permits managed care plans to select providers who share their medical management philosophy, assuring compliance with the health plan's requirements. • Allows health plans to monitor provider performance and on-going quality assurance and utilization management programs more efficiently. It is easier to monitor treatment patterns, conduct provider education, and monitor patient satisfaction with a smaller number of providers. • Allows health plans to minimize their administrative overhead by only credentialling as many providers as they need, and only training, profiling, supporting, and maintaining electronic connectivity with a limited number of providers.
Are Any Willing Provider laws anti-competitive?	• The Federal Trade Commission staff, in response to requests from officials in states considering such laws, have issued opinion letters stating that this type of legislation discourages competition among providers of health care.	• FTC staff have also stated that in their view Any Willing Provider laws may promote increased costs and limit consumer choices of health plans without providing any substantial benefit.
Aetna opposes Any Willing Provider requirements	• Any Willing Provider legislation is anti-competitive, and competition is a powerful tool in controlling costs. • Any Willing Provider [illegible] provider [illegible] for the need for their [illegible]	• Managed care works in a competitive environment, controlling health care costs by integrating the financing and delivery of health care.

[illegible]

GOVERNORS ASSOCIATION

Chair

Tommy G. Thompson
Governor of Wisconsin
Vice Chair

Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1512
Telephone (202) 624-5300

Original also sent to
Republican Leader Robert Michel

August 1, 1994

The Honorable Richard Gephardt
Majority Leader, U.S. House of Representatives
U.S. Capitol, H-148
Washington, D.C. 20515-6502

Dear Congressman Gephardt:

As Congress begins its final deliberations, we are writing to reaffirm the Governors' commitment to national health care reform this year and offer some additional perspectives on aspects of the debate. As a framework, we believe that some national uniformity with state flexibility especially in service delivery systems makes practical sense and is good public policy. We remain committed to bi-partisan solutions that result in meaningful health care cost containment while affording universal access to care and believe that labels and political positioning in this debate are very much less important than meeting the health care challenge that continues to face both states and the federal government.

We call to your attention two issues that were discussed by Governors last month at our annual meeting in Boston. The first addresses the Medicare Part C proposal of the leadership bill and the second addresses "any willing provider" legislation. Governors oppose an expansion of the Medicare program to include a new Part C as the primary mechanism for expanding access for health care. We believe that America's health care system must remain responsive to market conditions and should operate only with selective regulation by both the federal and state governments. Medicare, a government run price controlled system, does not meet that goal. Moreover, expanding the use of Medicare reimbursement rates to major additional portions of the health care system would have disruptive, if not disastrous, effects on the health care delivery system. The Medicare program is also highly bureaucratic and unresponsive to local needs and has been ineffective at controlling overall costs. We urge you to consider a state-based model for expanding low-income coverage.

Our second concern is with the so-called "any willing provider" legislation. Consistent with our support of market-based approaches, we adopted a new policy in Boston that puts us squarely opposed to overly restrictive any willing provider laws at either the state or federal levels. While we agree that individual providers and patients must have protections in this new competitive health environment, health care networks must also be allowed to make the hard decisions necessary to control costs. If these networks are denied the tools they need to operate effectively, prices cannot be controlled. Government can then only blame itself for failing to meet the goal that all Americans value most – affordable, quality health care. Again we urge you to take great care in including any such provisions in your final bill.

GOVERNORS ASSOCIATION

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ASSOCIATION

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.

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 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 these 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

Special Committee on Health Care Reform
7/1/94

NAIC

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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 [illegible] 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

What Are "Any Willing Provider" Laws?

Any Willing Provider (AWP) laws apply to any and all health care networks including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Simply put, AWP bills mandate that certain types of health care providers--like physicians, hospitals, or pharmacies—must have the opportunity to enter health networks, even if the networks already have enough such providers or have no real need of this particular type of provider.

Many different versions of AWP legislation exist. Some AWP bills have been signed into law, and many more have been proposed in state legislatures across the country.

What Is Wrong with "Any Willing Provider" Laws?

AWP laws interfere with the ability of health plans to contract selectively with providers. They drive up costs and erode coverage. The end result is a marked decrease in the network's value to consumers.

Network health plans achieve success by negotiating with providers. They offer providers an assured sustainable and predictable volume of patients in exchange; the plans obtain lower fees and more services. If any willing provider can join the network, providers no longer need to compete with one another in effect, their incentive to negotiate with plans on prices and services is taken away by government mandate.

More Red Tape

AWP laws allow the government to dictate the terms and conditions under which health networks select providers. They add more government red tape to health care.

Who Are the Losers?

Consumers lose two ways as costs rise, plans can no longer pass on savings, and the number and types of services covered may shrink.

Small businesses will be especially hard hit by AWP. Almost two-thirds of insured Americans get their health coverage at the workplace—and more than half of America's business is small business.

In the small group market, prices for insurance depend on projected utilization of services, the type of plan chosen, and the projected costs. With AWP mandates driving up the cost of services, premiums will rise.

Prices Go Up

A network that opens its doors to "any willing provider" can no longer assure the same volume of patients to providers. Without "economies of scale" and a predictable number of patients, doctors and hospitals lose incentive to negotiate, and networks lose their ability to provide care at a discounted rate.

Further, a network accepting "any willing provider" will experience an increase in the costs of administering the network. As the costs to health networks rise, so will premiums. (One recent study projects HMO premiums under AWP to go up by $128 for a family and $58 for an individual per year.) With higher premiums, the small business owner may find "him-self or herself unable to find affordable coverage.

Fewer Health Plans

The ever-increasing cost of providing care may force some insurers to leave the market, cutting down on the number of health plans that employers have to offer their workers. And as the difference between network care and indemnity coverage lessens, businesses shopping for employee coverage will have fewer and fewer options from which to choose. Network plans will become more cumbersome to administer.

Less Coverage

As the price of care increases, coverage will shrink. Prevention and health education and outpatient and ambulatory care may diminish in favor of crisis intervention—and acute in-hospital care.

A Lower Standard of Care?

The services sold by doctors, hospitals, pharmacies, and other practitioners are especially important to the public, and health plans want to make sure these services meet certain standards and are appropriate for their patients. To best serve its customers, then, a health plan must establish its own selection standards (and timetable) and decide on the optimal number and specialties of providers.

Some proposed legislation not only places constraints on how and when to select providers but also impedes the plan's ability to monitor, and even dismiss, providers. Procedural requirements make it more difficult and time-consuming both to select the best providers and to remove substandard or unethical providers—thereby imperiling treatment and care of patients. AWP laws don't protect consumers, they protect doctors.

If health plans cannot tailor their choice of providers to their patients' needs, and if they are forced to accept—and retain—providers they normally would exclude, quality of care will necessarily suffer.

Should Government Tell Business Who to Hire?

AWP laws restrict the right to contract freely with suppliers and employees in so doing, AWP laws open the door to further government intrusion into fundamental rights. AWP laws thus not only confine health plans but also threaten other business owners. For those health networks that actually hire staff or use selected providers, AWP cuts into the ability to hire and fire freely. (Government doesn't tell doctors what nurses or medical technicians to hire into their practices!)

AWP laws set a bad precedent: all businesses must have the freedom and flexibility to select suppliers and employees whose skills and services best meet their customers' needs.

☆ Consequences of AWP

With soaring premiums, less comprehensive benefits, and fewer plans from which to choose, ever more people and businesses will forego coverage altogether or will make painful employment decisions that will curtail business growth or mobility. Employees will lose coverage, exacerbating the downward turn in the number of privately insured individuals and straining state resources.

☆ Who's Pushing This Legislation?

The American Medical Association (AMA) and medical, dental, and pharmacy societies are lobbying for such laws, which guarantee employment and protect incomes and profits—at least in the short run.

☆ Do All Providers Support AWP?

No. Many providers, including the American Hospital Association, question the wisdom of AWP legislation. As more doctors and hospitals form their own networks or create group practices (which can then contract with health networks), they are recognizing the costs and inefficiencies of contracting with every provider in a community.

Some providers realize that in the long run AWP laws will undermine the incentives for physicians to participate in health networks, thus destroying their economic viability. In short, AWP threatens to eliminate network care, and some providers do not want that to happen.

☆ Who's Opposing AWP?

Health plans, business owners, and consumer groups oppose AWP. In addition, the National Governors Association has gone on record against AWP mandates, and many governors have vetoed such legislation.

Federal Trade Commission analyses of AWP have raised antitrust concerns. FTC staff have noted that AWP laws promote higher prices and tend to unnecessarily restrict consumer choice in prepaid health care programs without providing any substantial public benefit. The leadership of the National Association of Insurance Commissioners also has spoken out against AWP.

Under **Any Willing Provider** laws, government steps in and diminishes the ability of health networks to offer consumers value for their premium dollars. This is contrary to sound public policy and sensible business practices.

Public policy must protect and enhance the diversity of health coverage models and products that now exists and that may be developed in the future. The consumer and purchaser marketplace will then let its preferences be known. To maintain quality, business prosperity, consumer choice, and value, it is critical that network health plans remain a competitive option for employers and employees.

Coalition for Health Insurance Choices
Major funding by the
Health Insurance Association of America
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Washington, DC 20036-9998

"ANY WILLING PROVIDER" MANDATES

☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆

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April 4, 1995

Marianne Burke, Director
Department of Commerce and Economic Development
Division of Insurance
P.O. Box 110805
Juneau, Alaska 99811

RE: Preferred Provider Arrangements

Dear Director Burke:

This letter provides comments and analysis relative to the discussion paper recently drafted by your department staff concerning managed care insurance arrangements in Alaska. An Aetna Health Plans attorney in our Law and Regulatory Affairs Department was the primary reviewer and is available for follow-up discussions or clarification. Satisfactory resolution of this issue is of significant concern to Aetna, to our employer plan sponsors, and to our enrolled state, municipal, and private-sector plan members. Currently tens of thousands of Alaska residents are insured under one or more type of preferred provider arrangement offered by Aetna Health Plans in conformance with our previously-approved managed care form filings.

The following are our comments, following the order of commentary in the DOI document titled "Discussion of AS 21.36.090(d), (e), and PPO's."

Discussion of AS 21.36.090(d), (Pages 1-2 of the paper)

This discussion concerns discrimination between type of licensed providers. In our opinion, nothing contained in this section supports the prohibition against benefit differentials. Benefit differentials apply only on the basis of whether a provider has contracted for network participation. Strictly speaking, the type of licensure has nothing to do with whether a provider is preferred or nonpreferred. The only thing that matters is whether the provider has signed a provider contract with Aetna.

For example, if an individual receives treatment of a back injury, and the treatment is covered and within the scope of the license of the provider that rendered the treatment, then it does not matter whether the provider is an MD or a chiropractor. If the provider is a network provider, the benefits are paid at preferred. If the provider is not in the network, the benefits are paid at nonpreferred, regardless if the provider is an MD, chiro or whatever.

The discussion paper consistently refers to AK 21.36.090(d) as prohibiting all discrimination, which is inaccurate. What is prohibited is UNFAIR discrimination, and we believe there is a difference. Under the state's interpretation, you must treat all providers of covered services exactly the same. Unfair discrimination infers that some distinctions, differences or "discriminations" are allowed, but must be made or be structured on a fair basis.

Discussion of PPOs, (Pages 2 - 4)

The discussion paper first starts out by saying that the state DOI had traditionally focused on a single statute for its position that PPOs are not authorized in Alaska. This is a statute that allows direct payment of benefits to providers It contains a prohibition against policies requiring that services be provided by a particular provider.

Aetna's PPO policies do not require that covered services be provided by a particular provider in order for the service to be reimbursed Our PPO policies reimburse all medically necessary, covered services rendered within the scope of a provider's license, regardless of whether a network provider utilized. While the rate of reimbursement may differ, it is a reasonable differential and does not rise to the level of denying access to non-network providers.

Aetna would tend to agree that this language prohibits insured exclusive provider arrangements, where no benefits are paid unless the covered individual uses a network provider. However, under a PPO plan design, individuals are free to choose any provider for the provision of covered services. Alaska Statute 21.54.020 does not support the position that an insured PPO is not authorized under state law. None of the other states which have enacted "direct pay" provisions has taken the position that such a provision prohibits insured PPOs. Aetna has, however, consistently taken the position that direct pay laws may prohibit insured EPOs.

The commentary then describes how the statutes under the service corporation statutes authorize Blue Cross to enter into provider contracts with providers and subscription contracts with employers. Subscriber contracts are contracts under which the entity agrees to provide or provide access to covered services to an employer on the basis of a period, prepaid basis.

The author opines that the insurance definitions do not allow an insurer to enter into subscription contracts of the type contemplated by the med/surg service corporation statutes. In fact, Aetna would agree that, as an insurer, it isn't authorized to issue an subscription contract. What Aetna is doing is issuing a insurance contract, not a subscription contract. We are not agreeing to provide care or access to care, but are instead agreeing to indemnify for care received.

The fact that the service corporation laws allow service corporations to offer prepaid health plans which contain a network component, should not be interpreted as prohibiting insurance companies from issuing insurance contracts which contain benefit differentials which incent the use of network providers Nothing in the service corporation laws state that only service corporations may enter into contracts with providers. These laws merely allow service corporations to do so

Likewise, nothing in the insurance statutes prohibits insurance companies from

entering into contracts with providers, nor is there any prohibition against issuing an health insurance policy (which is NOT a prepaid subscriber contract) containing reasonable benefit differentials. While it is true that there is no affirmative authorization given in the statutes to engage in these activities, the lack thereof should not be interpreted as a prohibition against them, especially where an insurer filed for and received insurance department approval prior to issuing these types of insurance contracts.

The state says that a number of states have felt constraints against allowing PPOs without specific authorizing statutory language. We know of only one state that took this position, New Jersey. However, N.J. made this position clear to carriers and did not approve insured PPO filings, unlike Alaska. (NJ recently adopted regulations that do permit PPOs.)

However, of the 16 states that currently do not have PPO laws, NOT ONE has taken the position that insured PPOs are prohibited. Aetna has insurance department approval in all of these states to offer insured PPOs.

Discrimination

Alaska cites Alaska Statute 21.36.090 (b) & (d) and states that an insurer that operates a PPO would be in violation of this statute.

Section 21.36.090 (b) basically states that an insurer can not, for individuals of the same class, and essentially the same risk, unfairly discriminate in the amount of premium, policy fees, rates charged for a policy, or in the benefits payable or any other terms and condition of the contract.

First, we believe this statute is designed to protect the covered individual (not a provider). Second, in the employer group context, all covered individual's under a PPO contract are treated the same. If they go to a network provider, they receive preferred benefits. If they go to a non-network provider, they get nonpreferred 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 to same ability to receive preferred benefits.

Finally, the state refers to Section 21.36.090 (d), which states that an insurer may not unfairly discriminate against a person who provides a covered service if the service is within the scope of the provider's occupational license. The PPO benefit differential does not unfairly discriminate between providers. While Aetna agrees that too great a benefit differential may constutute unfair discrimination, we believe that benefit differentials of between 20% and 30% are not inherently unfair.

In support of this approach, we offer the example of Missouri, which, like Alaska, has not enacted specific PPO legislation. Missouri has an even more specific unfair discrimination provision than Alaska. Unlike Alaska, Missouri specifically states that an insurer can not unfairly discriminate between

individuals in any manner, including not permitting insureds "full freedom of choice in the selection of" certain licensed providers (physicians, chiropractors, etc.).

However, Missouri has not interpreted this language to prohibit benefit differentials. Instead, the Missouri DOI took the position that benefit differentials were permitted, stating that "managed care incentives to utilize panel providers...continue to be acceptable when contract provisions and benefits provided are not unfairly discriminatory. (Provisions are considered unfairly discriminatory if they serve to penalize the member for using a non network provider. The MO DOI has approved a 100/70 plan for use on an insured basis in Missouri.)

Again, it appears that no other state has relied on its unfair discrimination statutes to prohibit PPOs.

To summarize, none of the states that currently lack specific statutory authorization for PPOs have taken the position that insured PPOs are prohibited. In addition, the statutes cited in the state's discussion do not appear to support Alaska's arguments that PPOs offered by insurers amount to per se unfair discrimination

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Since the Alaska Department of Insurance has already approved several managed care/PPO style benefit plan designs--in 1985, 1989, 1990, 1991, and 1992--Aetna is distressed that assertions are now being made that such plans are not permitted on an insured basis under Alaska law. Preferred provider arrangements and managed care plan provisions have proven their value as a means of providing cost-effective care while promoting the quality of care. Both Aetna and the insurance plan sponsors we service are concerned about any statutory interpretations that would disrupt or adversely impact current and future cost management programs, products and initiatives. The serious impact of the proposed statutory interpretation would be to increase health insurance rates for most of our customers and to create an unlevel playing field of competition in Alaska between insurers and hospital/medical service corporations such as Blue Cross

Thank you for interest in this matter, and please contact me or Reed Stoops if we can provide you with additional information.

Regards,

Steve LeBrun

copies Robert Stalnaker, Director, Division of Retirement & Benefits
Jim Hickey, Market Vice-President, Aetna Health Plans, Seattle

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:

Re: SB 100

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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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 counseling 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).

> 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

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;

(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.

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

_____, 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 Arrangen ent - 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.

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.

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).

Municipality of Anchorage

OFFICE OF THE MAYOR

P.O. Box 196650
Anchorage, Alaska 99519-6650
Telephone: (907) 343-4431
Fax: (907) 343-4791

Rick Mystrom, Mayor

March 22, 1995

Senator Tim Kelly
Alaska State Capitol
Juneau, Alaska 99801

Dear Senator Kelly:

It has been brought to our attention that SB 100 has been amended to ban discriminating against hospitals if services rendered are within the scope of the hospital's license. The stated intent of this amendment is to prohibit selective preferred provider organizations (PPOs).

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

Blue Cross of Washington and Alaska | HealthPlus | NCAS | State Sponsored Plan

January 10, 1995

Michael T. Weber, PAC
Orthopedic Triage of Fairbanks
2458 Green Acres Drive
Fairbanks, AK 99712

Dear Mike:

Before the holidays you had inquired as to how the University of Alaska's contract would treat services rendered by a physician assistant. As you know, the contract does allow coverage for physician assistants. The following details reimbursement:

- Services billed by physician assistants for care provided in remote areas will be paid as long as they are within the scope of the physician assistant's license. This payment will be made if the billing comes under the physician assistant's name and tax I.D. number.

- Services rendered by physician assistants that are not in remote areas must be billed by the attending physician who supervised those services.

- Surgical services provided by a physician's assistant are only payable during major surgery for which such services are medically necessary as determined by Blue Cross, and only when the attending primary surgeon bills for the P.A.'s services. When all of these coverages criteria are met, the services rendered by a P.A. are calculated at ten percent of the primary surgeon's allowable charge, not to exceed the P.A.'s billed charge

Please give me a call if you have questions.

Sincerely,

Barbara B. Russell, CLU
Sales Executive

BBR/gt

cc: Mike Humphrey

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. [illegible]

Revision Date:
Title: Physician Assistants' Services
Sponsor: [illegible]
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations

COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL EXPENDITURES	0	0	0	0	0	0
CHANGE IN REVENUES	0	0	0	0	0	0
FUND SOURCE						
1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

Estimate of current year (FY 94) cost: $ 0

POSITIONS	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Jean Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: [illegible]

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development
Date: 1/19/94

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Rev 11/93

COMMERCE & ECONOMIC DEVELOPMENT - INSURANCE - ZERO FISCAL NOTE

MetLife SUMMARY STATEMENT OF BENEFITS

P.O. BOX 5091
ROLLING MEADOWS IL 60008

SEND INQUIRIES TO ABOVE ADDRESS
OR CALL (800) 323-5520

PROVIDER NAME: RICHARD J BURGER MD
PROVIDER I.D. #: 920089715
DATE OF STATEMENT: FEB 14, 1995
GROUP #: 0038800

SEARS GROUP MEDICAL PLAN

Employee Name Employee I.D. # Claim #	Patient's Name Patient Acct # Provider If Assgn or Drg #	Date(s) of Service	CPT Code OR Service	Total Expenses	Expenses Excluded	Notes (see over)	Copay-Deduct Amount	Benefit Paid
[illegible] 801308078I-0B	CLARKE 101837	01/12/95	17100	101.00	101.00	28B		
			TOTALS	101.00	101.00			.00
					PATIENT RESPONSIBILITY****		>	101.00
801308078I-0B	CLARKE 101837	01/12/95	36415	.00	.00	18B		.00
			TOTALS	.00				
801308078I-0B	CLARKE 101837	01/12/95	80018	39.30	39.30	28B		
			TOTALS	39.30	39.30			.00
					PATIENT RESPONSIBILITY****		>	39.30

PLEASE SEE BACK FOR INFORMATION ABOUT ELECTRONIC CLAIM SUBMISSION.

PAGE TOTAL .00
GRAND TOTAL .00

* PAYMENT AMOUNT IS REDUCED BY COINSURANCE AMOUNTS, OTHER INSURANCE BENEFITS, MEDICARE BENEFITS, AND/OR BENEFITS PAID TO EMPLOYEE
# = WITHHOLD AMOUNT

SEE REVERSE SIDE FOR INSTRUCTIONS, NOTES, AND INFORMATION REGARDING THE CLAIM SUBMISSION PROCESS

LB4451 Rev 893

SEARS GROUP MEDICAL PLAN - 0038800
METROPOLITAN LIFE INS. CO.
P.O. BOX 5091
ROLLING MEADOWS IL 60008

RICHARD J BURGER MD
2009 COWLES ST
FAIRBANKS AK 99701

METLIFE PROVIDES FASTER, MORE EFFICIENT CLAIM PROCESSING FOR ELECTRONICALLY SUBMITTED CLAIMS.THERFORE WE ENCOURAGE YOU TO SUBMIT CLAIMS ELECTRONICALLY THROUGH NEIC. FOR CLAIMS THAT MUST BE SUBMITTED ON PAPER, THE USE OF SCANNABLE CLAIM FORMS FACILITATES MORE EFFICIENT CLAIM PROCESSING.

188 - The charges for services performed on this date have been combined and benefits have been determined based on the primary procedure.

288 - This provider of service is not considered eligible under your group medical plan. Therefore, this expense is being declined according to the plan provisions.

NOTE:

THE GROUP-NO, CLAIM-NO AND PATIENT'S NAME SHOULD BE FURNISHED WHEN REFERENCING A PARTICULAR CLAIM. IF THERE IS A NEED TO RETURN A PAYMENT ON A SPECIFIC CLAIM, A PERSONAL CHECK IN THE AMOUNT OF THAT PAYMENT SHOULD ACCOMPANY YOUR INQUIRY. TO EXPEDITE FUTURE CLAIMS, PLEASE ALWAYS PROVIDE THE INSURED'S NAME, SOCIAL SECURITY NUMBER, EMPLOYER NAME, GROUP NUMBER AND PATIENT NAME.

PROVIDER ADDRESS:

THIS CLAIM WAS PROCESSED IN ACCORDANCE WITH THE TERMS OF YOUR EMPLOYEE BENEFIT PLAN.

IN THE EVENT A CLAIM HAS BEEN DENIED, IN WHOLE OR IN PART, YOU CAN REQUEST A REVIEW OF YOUR CLAIM. THIS REQUEST FOR REVIEW SHOULD BE SENT TO GROUP CLAIMS REVIEW AT THE ADDRESS OF THE METROPOLITAN OFFICE WHICH PROCESSED THE CLAIM, WITHIN 60 DAYS AFTER YOU RECEIVE NOTICE OF DENIAL OF THE CLAIM. WHEN REQUESTING A REVIEW, PLEASE STATE THE REASON YOU BELIEVE THE CLAIM WAS IMPROPERLY DENIED AND SUBMIT ANY DATA, QUESTIONS OR COMMENTS YOU DEEM APPROPRIATE.

ALL INFORMATION WILL BE EVALUATED AND YOU WILL BE INFORMED OF THE DECISION IN A TIMELY MANNER.

LBN881 NY 0194

Richard J. Burger, M.D.
2009 Cowles St.
Fairbanks, Alaska 99701

Phone: 907-452-6610 Fax: 907-452-5754

Date Mar. 17 1995

TO: Jack Hesch (341)

FAX: 907-463-3381

FROM: Jeanne Clark

CONFIDENTIAL INFORMATION

If you receive this fax in error, please call us immediately and destroy the faxed documents.

COMMENTS: Met Life denied. PA services are not recognized. For lab draws to be paid - must be drawn by a nurse (licensed nurse is covered) not PA

Number of pages 3 including this sheet. If you have any questions please call Barbara at 907-452-6610.

FISCAL NOTE

STATE OF ALASKA
1995 LEGISLATIVE SESSION

BILL NO. SB 100

Revision Date:
Title: An Act relating to unfair discrimination against a physician assistant or acupuncturist under a group health insurance policy
Sponsor: Senate Labor and Commerce Committee
Requestor:

Department Affected: All State Agencies
BRU: All State Agencies
Component: All State Agencies

COMPONENT SERIAL NO. 64

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 95) cost: $ zero

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Under the current health plan for active state employees, individuals are only reimbursed for services of a physician assistant if the physician assistant is under the supervision of a medical doctor. This bill will allow physician assistant services to be reimbursed under insurance even if the physician assistant is not being supervised by a medical doctor.

This bill would also allow insurance reimbursement for services provided by an acupuncturist in lieu of a medical doctor, if service or form of treatment provided would normally be covered by the health plan.

This bill is not expected to increase the state's health plan premium.

Prepared by: Robert F. Stalnaker
Division: Retirement & Benefits
Phone: 465-4470
Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration
Date: 3/3/95

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Rev 01/95

FISCAL NOTE

No. 1

STATE OF ALASKA
1995 LEGISLATIVE SESSION

Bill Version: SB 100
(S) Publish Date: 3/6/95

Revision Date:
Title: An Act relating to unfair discrimination against a physician assistant or acupuncturist under a group health insurance policy
Sponsor: Senate Labor and Commerce Committee
Requestor:

Department Affected: All State Agencies
BRU: All State Agencies
Component: All State Agencies
COMPONENT SERIAL NO. 64

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01
PERSONAL SERVICES	0 0	0 0	0 0	0 0	0 0	0 0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0 0	0 0	0 0	0 0	0 0	0 0
CAPITAL EXPENDITURES	0 0	0 0	0 0	0 0	0 0	0 0
CHANGE IN REVENUES ( )	0 0	0 0	0 0	0 0	0 0	0 0

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts	0 0	0 0	0 0	0 0	0 0	0 0
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
OTHER						
TOTAL	0 0	0 0	0 0	0 0	0 0	0 0

Estimate of any current year (FY 95) cost: $ zero

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Under the current health plan for active state employees, individuals are only reimbursed for services of a physician assistant if the physician assistant is under the supervision of a medical doctor. This bill will allow physician assistant services to be reimbursed under insurance even if the physician assistant is not being supervised by a medical doctor.

This bill would also allow insurance reimbursement for services provided by an acupuncturist in lieu of a medical doctor, if service or form of treatment provided would normally be covered by the health plan.

This bill is not expected to increase the state's health plan premium.

Prepared by: Robert F. Stalnaker
Division: Retirement & Benefits
Phone: 465-4470
Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration
Date: 3/3/95

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FISCAL NOTE

STATE OF ALASKA
1995 LEGISLATIVE SESSION

BILL NO. SB 100

Revision Date
Title: Discrimination Under Group Health Insurance

Department: Commerce and Economic Development
BRU: Insurance
Component: Operations

Sponsor: Senate Labor & Commerce Committee
Requestor:

COMPONENT SERIAL NO. #354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0 0	0 0	0 0	0 0	0 0	0 0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0 0	0 0	0 0	0 0	0 0	0 0

Estimate of any current year (FY 95) cost: $ 0 0

POSITIONS

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)
No fiscal impact

Prepared by: Joan Brown, Administrative Officer — Phone: 465-2597
Division: Insurance — Date: 3/6/95

Approved by Commissioner: William L. Hensley — Date: 3/7/95
Agency: Commerce and Economic Development

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SB

104

Alaska State Legislature

SENATOR
JOHN TORGERSON
DISTRICT D

SESSION ADDRESS
STATE CAPITOL, ROOM 427
JUNEAU, ALASKA 99801-1182
(907) 465-2828
FAX (907) 465-4779

Senate

SPONSOR STATEMENT

SB 104 - Joint Insurance Agreements
March 01, 1995

The Joint Insurance Arrangements (JIA) legislation was adopted in 1986. That legislation authorized municipalities, city and borough school districts, and regional educational attendance areas to enter into cooperative insurance agreements. The statute was amended in 1989, to allow the JIA's to use debt financing to establish self-insured reserves.

In 1992, the statute was amended to read "municipalities and their public corporations", so that the newly formed port authorities would also be authorized to enter into joint insurance arrangements.

The history of this legislation is clearly intended to serve the municipal or governmental entities which were struggling with the extrememly high costs of insurance, or worse, the unavailability of any insurance.

Senate Bill 104 amends the statute by including quasi-governmental entities, providing that they are performing at least two of the general municipal powers described under AS 29.35.010 (copy attached).

Non-profit corporations which perform some "quasi-governmental" function will benefit from this legislation. As an example, a non-profit corporation which is providing a public service for a municipality (such as an animal shelter, fire department, public library, and so on) needs insurance coverage - normally very costly for public services. This bill authorizes those entities to enter into the joint insurance arrangements.

There are also Native associations and village councils which are providing some government services. Again, they struggle with both the availability of insurance coverage and the high costs involved when they are able to obtain such insurance. This bill authorizes their entry into joint insurance arrangements, as long as they provide at least two of the general municipal powers.

ALASKA MUNICIPAL LEAGUE

217 Second Street, Suite 200 • Juneau, Alaska 99801 • Tel (907) 586-1325 Fax (907) 463-5480

March 8, 1995

TO: Senator John Torgerson, Chairman
Senate Community and Regional Affairs

FROM: Kevin C. Ritchie
Executive Director

RE: SB 104 - Relating to joint insurance arrangements

The Alaska Municipal League supports SB 104, which would allow nonprofit corporations, Native associations, or Native village councils to participate in joint insurance arrangements.

At the Alaska Municipal League's annual meeting in November, the members unanimously passed Resolution 95-22 (copy attached) which urges the legislature to pass legislation expanding the types of entities which may participate in joint insurance arrangements.

We would like to express our appreciation to you for introducing this legislation. Please do not hesitate to call me or Julie Krafft at 586-1325 if you have any questions or need further information.

JK:Legis SB104.ltr

Resolution of the Alaska Municipal League

Resolution No. 95-22

A RESOLUTION URGING THE PASSAGE OF LEGISLATION EXPANDI THE TYPE OF ENTITIES WHICH MAY PARTICIPATE IN JOINT INSURA ARRANGEMENTS

WHEREAS, Alaska Statute 21.76 allows municipalities and their corporations, city and borough school districts, and regional education atten areas to enter into cooperative agreements with each other for the purpc establishing, operating, or participating in joint insurance arrangements th which the participating members agree to pool contributions in order to assume risks from losses to the participants on a group basis or purc coverage for the participants on a group basis; and

WHEREAS some Alaska municipalities are dissolving and associations and corporations and other non-profits are assu quasi-governmental roles; and

WHEREAS there is a trend for municipalities to shift service delive not-for-profit entities such as port authorities, library associations, and not-for-profit corporations performing governmental functions; and

WHEREAS not-for-profits and native associations and corporation finding it increasingly difficult and expensive to find commercial insurance for t exposures; and

WHEREAS, the pooling of risks, self-insurance management, joint purc of insurance, claims administration, loss prevention and control, insurance def and other related risk management services can assure significant long- economic savings for members of a joint insurance arrangement due to the buying power of the members, the non-profit tax-exempt status of the Associ the pooling and investment of premiums paid, and risk management ser provided for members;

NOW, THEREFORE, BE IT RESOLVED that the Alaska Municipal Le urges the Alaska Legislature and the Governor to pass legislation expandir type of entities which may participate in joint insurance arrangements.

John Torgerson, President

ATTEST:

Kevin C. Ritchie, Executive Director

ALASKA MUNICIPAL LEAGUE
JIA JOINT INSURANCE ASSOCIATION, INC.

ANCHORAGE 626 F Street, Suite 100 ■ Anchorage, Alaska 99501 ■ Tel (907) 258-2625 ■ Fax
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March 10, 1995

The Honorable Senator Torgerson
Alaska State Senate
Alaska State Capitol
Juneau, Alaska 99811

Dear Senator Torgerson:

Thank you for agreeing to sponsor SB104, an act relating to joint insurance arrangements. The AML/JIA offers the bill in response to the needs of quasi-governmental entities, such as Native tr councils, port authorities, and others, many of which cannot obtain insurance, or for which insura is prohibitively expensive. This bill will give these organizations an option — in some cases, their option — to obtain affordable liability coverage.

The current joint insurance statute limits participation to municipalities and their public corporatior school districts, and REAAs. The AML/JIA is one of two pools that have formed to serve these p entities. The bill would expand the scope of pooling so that pools — either those in existence or additional pools — can serve the unmet needs of tribal councils and other quasi-governmental bc In offering these public organizations another option for their insurance coverage, this expansion the statute would serve all of Alaska.

The AML/JIA does not receive State funds. It is a cooperative self-insurance arrangement that permits municipalities and schools to pool their resources to finance their losses. The AML/JIA w created in the mid-1980s, when many municipalities and school districts, particularly the small on found themselves unable to secure coverage commercially. The AML/JIA provides an important pooling option for these municipalities and schools, and wishes to be able to do the same for cer organizations that perform governmental functions but for which under the current statute, poolir not an option

You will see that the proposed expansion is limited to nonprofit organizations, Native associations Native village councils that perform at least two of the general municipal powers described under AS29.35.101.

Representative Ivan has agreed to sponsor a companion bill in the other body, and is aware that will be sponsoring a version in the Senate.

We look forward to working with you and Ms. Jackson in your sponsorship of the legislation, and thank you for your interest and assistance.

Sincerely,

Kevin Smith
Risk Control Manager

cc Representative Ivan Ivan
Steve Wells, Director of Risk Management, AML/JIA
Kevin Ritchie, Executive Director, AML

Sec. 29.35.010. General powers. All municipalities have the following general powers, subject to other provisions of law:

(1) to establish and prescribe a salary for an elected or appointed municipal official or employee;

(2) to combine two or more appointive or administrative offices;

(3) to establish and prescribe the functions of a municipal department, office, or agency;

(4) to require periodic and special reports from a municipal department to be submitted through the mayor;

(5) to investigate an affair of the municipality and make inquiries into the conduct of a municipal department;

(6) to levy a tax or special assessment, and impose a lien for its enforcement;

(7) to enforce an ordinance and to prescribe a penalty for violation of an ordinance;

(8) to acquire, manage, control, use, and dispose of real and personal property, whether the property is situated inside or outside the municipal boundaries; this power includes the power of a borough to expend, for any purpose authorized by law, money received from the disposal of land in a service area established under AS 29.35.450;

(9) to expend money for a community purpose, facility, or service for the good of the municipality to the extent the municipality is otherwise authorized by law to exercise the power necessary to accomplish the purpose or provide the facility or service;

(10) to regulate the operation and use of a municipal right-of-way, facility, or service;

(11) to borrow money and issue evidences of indebtedness;

(12) to acquire membership in an organization that promotes legislation for the good of the municipality;

(13) to enter into an agreement, including an agreement for cooperative or joint administration of any function or power with a municipality, the state, or the United States;

(14) to sue and be sued. (§ 10 ch 74 SLA 1985)

Notes to Decisions – The rule of strict construction did not apply to the mode adopted by the corporation to carry into effect powers expressly or plainly granted under a former, similar provision. The power having been granted, the municipal corporation

SB

108

Alaska
Wilderness
Recreation &
Tourism
Association
Sustainable recreation and tourism for a quality future

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To: Senator Kelly and Senate Labor & Commerce Committee
From: Nancy R. Lethcoe
Date: March 13, 1995

RE: SB 108 Reauthorization of the Alaska Tourism Marketing Council

REQUEST FOR TELECONFERENCE: I am writing to request that the Senate Labor and Commerce Committee meeting on Thursday, March 16 which is scheduled to consider SB 108 be made a teleconference meeting with public testimony. Valdez would like to be a teleconference site.

Please include our comments in the legislative package.

On behalf of AWRTA's more than 250 members I am writing to solicit the help of the Senate Labor and Commerce Committee in obtaining some amendments to SB 108 which we believe will help correct an in balance in representation of the types of tourism and geographic areas on the ATMC. Improving the geographic and type of tourism representation on ATMC seems the most appropriate and least disruptive way of bringing a wider range of marketing expertise to the ATMC marketing program.

The changes we would appreciate receiving your help on are:

1. Add section amending the definition of "qualified trade organization:" (5) "qualified trade association" means a private, nonprofit organization whose primary purpose is the promotion of tourism to and within the state and which has a statewide membership comprised of representatives of all major sectors of the visitor industry, including without limitation hotels, lodges, bed & breakfasts, airlines, cruise lines, tour and charter boats, wholesale and retail travel agencies, visitor attractions, (AND) convention and visitors bureaus, and hunting, sport fishing, and wilderness outfitters and guides. (This expands the definition of "qualified trade organization," to include types of tourism not mentioned in the current definition.)

AWRTA, P.O. Box 1353, Valdez, AK 99686

2. Section 2. AS 44.33.705(c): change line 17: the number 11 to 8 so the line reads "the contract shall provide that the trade association may select up to 8 board members; then change line 21: change 10 to 12, so the line reads "the governor shall appoint 12 other board members." (This gives the governor the ability to balance the ATMC more if the trade association's appointees do not reflect the various types of tourism and geographical areas).

3. Section 2. AS 44.33.705(c) (2) (line 17); amend to insert after the words to 10 (8) board members; these must members must be representative of the sectors of the visitor industry as defined in "qualified trade organization;" (This the trade organization to make appointments that reflect all types of tourism and geographic areas).

4. Section 2. AS 44.33.705(c) (3) (line 23); change SHALL to must; "paragraph, the governor must (SHALL) ensure that the board . . . (This strengthens the chances that appointments will be made which reflect all types of tourism and geographic areas).

Background: The ATMC currently has seven members from the cruise/tour boat industry or 35% of the council members represents just one type of tourism, whereas there are no representatives for hunting, sport fishing, or wilderness guides and outfitters. There are three representatives from CVBs, but all from major population areas. Geographically, 6 (30%) are from out-of-state; 9 (45%) from the greater Anchorage area; 5 from various communities in SE Alaska; and 1 from Fairbanks. AWRTA appreciates the expertise marketing representatives from large companies bring to ATMC; however, we have noted that ATMC lacks expertise in the marketing of small, rural Alaskan businesses that make up AWRTA's membership. This is reflected in the *Alaska Visitor Statistics Program* , ATMC's *1993 Conversion Study*, and in the drop in narrative ads in the *Alaska Vacation Planner.*

Obtaining greater depth in marketing expertise seems to be the best way to approach solving problems which have been highlighted by the *Alaska Visitor Statistics Program* , ATMC's *1993 Conversion Study*, and in the drop in narrative ads in the *Alaska Vacation Planner.* These include:

1) although the average visitor age is 48, the average visitor age of the marketing program is 58, which gives an unintentional bias towards marketing businesses attractive to older visitors rather than to younger ones;

2) only 20% of the visitors requested a *Vacation Planner* and only 25% of the

independent travelers who purchased trips in Alaska used the *Vacation Planner*; since the *Vacation Planner* is meant to be a primary marketing tool for small, and especially rural, Alaskan businesses, it is not reaching the majority of their market;

3) between 1989 and 1993, the Inde-package (independent visitors who purchase a package trip in Alaska) lost 6% of its market share. In-state package trips, owned and operated by Alaskans, circulate tourism dollars within the local and statewide economy;

4) when the legislature increased the percentage the industry must contribute to the cooperative marketing program, ATMC increased the narrative advertising rates (those used by small Alaskan businesses) 100%. This was the largest increase in any advertising category. As a result, there was an approximately 30% drop in advertisers indicating that businesses did not find the number of inquiries generated by the *Vacation Planner's* to be cost effective. This, in turn, reflects on ATMC's program for marketing the *Vacation Planner*, which is unintentionally biased towards older travelers.

We believe the ATMC program can be improved by some fine tuning to bring broader marketing expertise for the types of tourism and geographic areas to the council.