ALASKA LEGISLATURE COMMITTEE FILES 1995-1996 8672
8938 SENATE LABOR & COMMERCE

TANANA CHIEFS CONFERENCE, INC.

122 FIRST AVENUE, SUITE 600
FAIRBANKS, ALASKA 99701-4897
PHONE 907/452-8251 • FAX 907/459-3850

March 25, 1996

Senator Georgianna Lincoln
State Capital
Juneau, Alaska 99801-1182

Dear Senator Lincoln:

For far too many years, Alaska Native artists and those seeking to purchase the products of their labor have been unsuspecting victims of fraud and embezzlement. The core of the problem and responsibility for such deceptions with those unethical individuals who make and/or profit from artwork, falsely portrayed as authentically Alaska Native. This problem has escalated from being a simple annoyance to the point today where bogus Alaska Native artworks pollute the market, outnumbering authentic pieces being sold. The extent of this problem was brought to the public's attention in the Anchorage Daily News feature on September 10, 1995.

Unfortunately, this is not a new trend. Deceitful profiteers have always sought out lucrative business markets to exploit for their personal benefit or gain. Illegally capitalizing on the demand for authentic Alaska Native artworks just happens to be today's focus of attention for these individuals. The reasons are many as to why the Alaska Native arts profession is being preyed upon. The margin of profitability, the low cost of manufacturing duplicate artwork overseas, the lack of applicable laws to minimize deceitful commerce, and the high demand for authentic Alaska Native artwork all contribute to the problem.

Common sense, morality, and legitimacy in business have never prevailed without government intervention when dealing with corrupt players who have no loyalty to anything other than money. If nothing is done, the numbers of genuine Alaska Native artists will diminish with time. This theory can come to pass because of the impact which will result from the high numbers of Alaska Native copied artwork being marketed and sold at cheap prices in Alaska. Eventually, genuine Alaska Native artists will be unable to compete and less likely to derive a living from that trade.

The loss of such an important part of our culture and history would not only be felt by our people, but also by the state who's potential tourist and consumer interests would be lessened by this fact. The successful passage of Senate Bill #273 and the subsequent enforcement and prosecution of violators of this new law will help ensure that illegal profiteering in the Alaska Native arts & crafts trade is kept to a minimum.

For this reason, I am encouraged by your sponsorship of SB #273 and urge your colleagues on behalf of the villages within our region to support this bill. Thank you for your time and consideration of my views on this most important legislation.

Sincerely,

TANANA CHIEFS CONFERENCE, INC.

Will Mayo
President

Post-it™ brand fax transmittal memo

To Rep. Richard Foster	From King Island Native Corp
Co. State Capitol	Co. King Island Native Corp
Dept. Rep. OK. State Leg	Phone # (907) 443-5494
Fax # (907) 465-2652	Fax # (907) 443-3622

KING ISLAND NATIVE CORPORATION

P. O. BOX 992 • NOME, ALASKA 99762 • (907) 443-5494

March 14, 1996

Mr. Richard Foster
Representative, Alaska State Legislature
State Capitol, Room 410
Juneau, AK 99811

RE: Senate Bill No. 273

Dear Honorable Representative Foster:

Both the King Island Native Community and King Island Native Corporation fully support the passage of Senate Bill No. 273 on behalf of their village members and their shareholders.

This legislation is a positive step forwards the eventual solution to the prevention's of unethical practices common in the Native Arts and Crafts industry within Alaska.

Therefore, we are requesting your full support for the enactment of this legislation.

Jimmy Carlisle, President
King Island Native Corporation

Gabriel L. Muktoyuk, Chief
King Island Native Community

Alaskan Treasures

Alaskan Treasures

"We Only Represent Authentic Alaskan Art"

205 E. Dimond, Suite 514
Anchorage, Alaska 99515

(907) 248-2323
FAX 248-2328

March 18, 1996

TO: Senator Georgianna Lincoln DATE: March 18, 1996

FAX #: 465-2652 PAGES TO FOLLOW: 1

FROM: Angie Larson

RE: Bill #273

MESSAGE:

As a legitimate wholesaler of Alaska Native Art (17 years), I strongly support this bill and I believe there is great need for it.

It has always been my policy to put in writing the name of the artist, their origins and the materials used. The bottom line is why would I or anyone else who is running a legitimate business refuse to do this?

The suggested certificate of origin is trying to prevent specific acts of fraud already regularly practiced in the State on a large scale. It provides a guarantee and creates uniform information for the consumer.

For the honest retailer, it will reinforce his market prospects. It is appropriate for the retail outlet to offer these certificates, as they are in direct contact with the consumer.

I have observed bogus Native art offered for as much as $3000.00 in retail stores.

While most of us have read the extensive investigative reports done by both the Anchorage and Juneau newspaper, many are not aware that these reports have been also published in Canada and the Lower 48. Even an American-Indian Native Art newspaper that is distributed all over the world.

There is a contact in the Federal Trade Commission, Eleanor Durham. She has been involved in a investigation dealing with the above subject in our State for the last two years. While she has said she cannot initiate a telephone call to you, she can speak to you about this matter if you call her. Her number is (206) 220-4476.

Your support and sensitivity for Bill #273 is needed.

Thank you.

Angie Larson

Angie Larson
Alaskan Treasures

cc: Bert Sharp
Randy Phillips
Loren Lemon
Dave Donely
Jim Duncan

TO: Senator Georgianna Lincoln DATE: March 8, 1996

FAX #: 465-2652 PAGES TO FOLLOW: 0

FROM: Johnny Weyiouanna

RE: Bill #273

MESSAGE: I support Bill #273 and appreciate all your efforts.

Johnny Weyiouanna Johnny Weyiouanna Sr Shishmaref, AK
signature

Edgar Nienuelook, IRA Village Council Vice President

TOTAL P.01

TOTAL P.01

Alaskan Treasures

Alaskan Treasures

"We Only Represent Authentic Alaskan Art"

205 E. Dimond, Suite 514
Anchorage, Alaska 99515

(907) 248-4328
FAX 248-4328

March 8, 1996

TO: Senator Georgianna Lincoln DATE: March 8, 1996

FAX #: 465-2652 PAGES TO FOLLOW: 0

FROM: Angie Larson

RE: Bill #273

MESSAGE: We support Bill #273 and appreciate all your efforts.

Eva Marie Larson

Fred Larson

Angie Larson

FISCAL NOTE

No. 3

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO:

Bill Version: SB 273
(S) Publish Date: 3-27-96

Revision Date: 3/18/96
Title: An Act relating to Native handicrafts and other articles made in the state
Sponsor: Senator Lincoln
Requestor: Senate State Affairs

Dept. Affected: Community & Regional Affairs
BRU: none
Component: none

COMPONENT SERIAL NO. none

EXPENDITURES/REVENUES: (Thousands of Dollars) (inflation not included)

OPERATING	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
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
CAPITAL EXPENDITURES	0	0	0	0	0	0
CHANGE IN REVENUES ( ) Revenue Code						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	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

Estimate of current year (FY 96) impact $ none

POSITIONS:

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

ANALYSIS (Attach a separate page if necessary)

This bill will have no fiscal impact on the department

Prepared By: Remond Henderson (Remond Henderson) Phone: 465-4708
Division: Director, Div. of Administrative Services Date: 3/18/96

Approved by Commissioner: Mike Irwin (Mike Irwin) Date: 3/18/96
Agency: Mike Irwin, Dept. of Community & Reg. Affairs

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[redacted]

Fiscal Notes

No. 2

FISCAL NOTE

Bill Version: SB 273

(S) Publish Date: 3-27-96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date:
Dept. Affected: Department of Law
Title: "An Act relating to Native handicrafts and other articles made in the state."
BRU: Criminal Division
Component: Criminal Division
Sponsor: Senator Lincoln
Requester: Senate State Affairs
COMPONENT SERIAL NO. 2085

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY96) cost: $ 0.0

POSITIONS

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill amends AS 45.65, dealing with handicrafts, to add new sections that: (1) require that a person who sells an authentic Native handicraft at retail shall display an 11 by 17 inch poster advising of the authenticity of Native handicrafts; (2) that require an authentic Native handicraft sold at retail must be accompanied by a written certificate of origin, if the handicraft has a retail fair market value of $100 or more; (3) that prohibit the alteration of an article of handicraft for business reasons by a person other than the maker of the article; and, (4) prohibit a person from removing a state authorized handicraft seal or emblem from an article of handicraft, unless the seal or emblem is removed by the person who made the article or is removed by a person who purchased the article for the person's personal use. A violation of these provisions would be punishable as a class B misdemeanor. The bill will probably not have a fiscal impact for the Department of Law, because the number of violations is expected to be small.

Prepared by: Richard J. Pegues, Director — Phone: 465-3672
Division: Administrative Services Division — Date: 3/18/96
Approved by Commissioner: Bruce M. Botelho, Attorney General — Date: 3/18/96
Agency: Department of Law

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No. 1

FISCAL NOTE

Bill Version: SB 273

STATE OF ALASKA

BILL (S) Publish Date: 3-27-96

1996 LEGISLATIVE SESSION

Revision Date: March 26, 1996 Department: Commerce and Economic Development

Title: An Act relating to Native handicrafts and other articles made in the state. BRU: Trade and Development

Component: Trade and Development

Sponsor: Sen. G. Lincoln

Requestor: Senate State Affairs COMPONENT SERIAL NO. 2056

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	16.0					
SUPPLIES	2.0					
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	18.0	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	18.0					
1006 GF/MHTTA						
Other						
TOTAL	18.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 96) cost: $ _____

POSITIONS

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Silver Hand Program receipts will be used to cover the expenses of Senate Bill 273. The sources of the receipts that will pay for printing and distribution of the poster will be:

1. The Silver Hand Program receipts
   - A Fines leveled by state and federal enforcement agencies for violations against Silver Hand Program and Native arts and crafts violations;
   - B Contributions solicited to support the printing of the poster; and.

Prepared by: Charles McGee, Development Specialist Phone 269-8112

Division: Trade & Development Date: March 26, 1996

Approved by Commissioner: William L. Hensley Date: 3-26-96

Agency: Commerce and Economic Development

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CMG/pb011.ed/3/26/96

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB 273

ANALYSIS: (continued)

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
Fiscal Note Calculations for SB 273

C. Other funds the division is able to raise through the Silver Hand Program

2. Federal and/or Foundation Grants

The Department of Commerce and Economic Development will design the poster. We anticipate the poster will be multicolored and show four Alaska Native artists making their handicraft. Each will be identified by name and village. The Institute of Alaska Native Art has agreed to provide the photographs without charge. The written comments required by the legislation will appear below the photographs. The objective is to make the poster aesthetically pleasing as well as fulfill the intent of the legislation.

Detail of Expenditures

Contractual Services			**16.0**
	Printing 10,000 posters	12.0	
	Postage for mailing posters	4.0	
Supplies			**2.0**
	Shipping containers for posters	2.0	
Total			**18.0**

SB

276

HOUSE BILL NO. 276

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE NAVARRE

Introduced: 3/22/95
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to legislative per diem; and providing for an effective date."

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

* **Section 1.** AS 24.10.130(c) is amended to read:

(c) The Alaska Legislative Council shall adopt a policy regarding reimbursement for moving expenses applicable to all legislators [AND AN APPLICABLE PER DIEM ALLOWANCE POLICY]. The policy must set conditions for the reimbursement for moving expenses [AND PAYMENT OF PER DIEM] and prescribe the amounts of reimbursement adapted to the special needs of the legislative branch as determined by the council.

* **Sec. 2.** AS 24.10.130 is amended by adding a new subsection to read:

(d) The Alaska Legislative Council shall adopt a policy setting the amount of and addressing entitlement to travel per diem and session per diem. A change in the amount of session per diem takes effect only if ratified by concurrent resolution.

* **Sec. 3.** (a) Notwithstanding AS 24.10.130(d), enacted by sec. 2 of this Act, until the Alaska Legislative Council acts in accordance with AS 24.10.130(d) to set travel per diem,

[New Text Underlined] [DELETED TEXT BRACKETED]

the travel per diem in effect on the day before the effective date of this section shall remain in effect.

(b) Notwithstanding AS 24.10.130(d), enacted by sec. 2 of this Act, until the Alaska Legislative Council adopts a policy setting session per diem that is ratified by concurrent resolution, legislators are entitled to session per diem in the amount of $100 per day.

*** Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

SB

282

The Managed Care Consumers' Bill of Rights

A Health Policy Guide for Consumer Advocates

1 2 3 4 5 6 7 8 9 10

The Public Policy and Education Fund of New York
In Cooperation with th[redacted]

Managed Care Policy Report

The Managed Care Consumers' Bill of Rights

A Health Policy Guide for Consumer Advocates

By
Ruth Finkelstein
Cathy Hurwit
Richard Kirsch

The Public Policy and Education Fund of New York
In Cooperation with the Citizens Fund
October, 1995

The Managed Care Consumers' Bill of Rights: A Health Policy Guide for Consumer Advocates is a publication of the Public Policy and Education Fund of New York.

To order the *Guide* please contact: PPEF, 94 Central Avenue, Albany, NY 12206. (518) 465-4600 (phone); (518) 465-2890 (fax). The email address is: ppef@aol.com.

The *Guide* may be ordered at a cost of $5.00 to cover postage and handling.

Acknowledgments:
Our thanks to Elisabeth Benjamin, Health Law and Public Benefits Specialist with Bronx Legal Services, for researching and writing the chapter on **Legal Rights and Managed Care**.

PPEF gratefully acknowledges funding support for *The Managed Care Consumers' Bill of Rights: A Health Policy Guide for Consumer Advocates* provided by The Robert Wood Johnson Foundation and by Consumers Union, the non-profit publishers of *Consumer Reports* magazine.

PPEF also expresses its appreciation to the Public Welfare Foundation for its support of PPEF's health policy research, support that enables PPEF to understand and contribute to key policy issues such as managed care.

Cover design: BangZoom Productions
Interior design and production: BangZoom Productions and Fair Earth Design

About the Authors:
Ruth Finkelstein has extensive experience in issues impacting on health coverage and care for people with chronic illness. She has served as Director of New Yorker's for Accessible Coverage, Health Policy Director of Gay Men's Health Crisis and as the Research Director of AIDS Action Council Foundation.

Cathy Hurwit, the Health Policy Director of the Citizens Fund, has widespread experience in the formulation of health policy and in drafting health care legislation. Ms. Hurwit has worked as the Director of Federal Health Policy for the National Health Care Campaign and as Legislative Director for Massachusetts Representative Edward Markey.

Richard Kirsch is the Research Director of the Public Policy and Education Fund of New York. He has published several studies on financing issues in health care reform. Mr. Kirsch serves as Executive Director of Citizen Action of New York and as the Chair of the New York State Health Care Campaign.

Table of Contents

Introduction

The Managed Care Revolution

The signs are unmistakable. Actually they can't be missed. Drive on the interstate into any city in the nation and there are more billboards claiming the virtues of Bluechoice or preferredcare or US Health than there are advertisements for the products whose side effects provide customers with those same health care plans: cigarettes, beer and cars. In the past few years, health insurance has been transformed from a business quietly marketed to employee personnel departments to a hot commodity, screaming for attention from consumers.

At first glance, it would seem that making health delivery into a consumer product would enhance the ability of consumers to choose among products in order to find the best combination of price and quality to meet their needs. All those billboards and all those companies must mean that consumers have more choices than ever before about where to get care.

But the reality is that the rise of managed care as a consumer product masks the loss of the traditional ability of insured consumers in the United States to choose any health care provider they desire. While doctors did not put up billboards, consumers were able to go to any doctor they wanted or seek care from any of the nation's finest medical centers. The system encouraged the development of the world's leading medical experts and technologies. Consumer choice was only limited by the lack of health coverage or by health coverage that did not pay the going rate for health care, usually provided only by the poor. For Americans with good coverage, whether provided at work or by Medicare — the nation's health system for senior citizens — choice of health care provider was a guarantee of access to the finest medical care in the world.

Managed care is a radical change in the way health care is delivered and insured. By changing the way health care providers are paid and by combining the financing of health care with its delivery, managed care is transforming the nation's health care system.

Managed care plans reimburse providers using a method known as capitation. Capitation pays providers on a "fee-per-head" (per capita) basis. Managed care plans are paid a set amount for each enrollee regardless of the types and amounts of services which are provided to that person. This directly contrasts with the traditional "fee-for-service" system in which providers are paid for each service delivered. Capitation means a plan gets the same amount of money for a person they never see as for a very sick person for whom they provide many services.

Unlike traditional insurance, managed care combines the roles of insuring against risk and arranging or providing for the actual delivery of medical care. Under the traditional insurance system, there was a clear distinction: providers delivered care and insurance companies paid at least a portion of the charge. Patients perceived that physicians were focused primarily on treating their health needs. Under the new system, providers generally work for or are under contract with the managed care plan, which not only acts as the insurer by bearing risk, but also, sets the rules under which care is delivered to patients. Today's managed care patients may perceive that their physician has two clients: the plan and the patient.

While managed care by its very nature reduces consumer choice of provider, it has gained a great deal of the health care market because it is perceived to solve some of the problems existing in the traditional health system. The first problem — and the one of overwhelming significance to purchasers of insurance, including employers and government — is increasing health care costs. The traditional fee-for-service system is one engine driving up utilization and costs. Unlike other consumer markets, the demand for health care is driven by those who provide services more than those who consume care. A consumer decides when to seek care, but most of the subsequent decisions are made by providers. Providers recommend the course of care to consumers, which tests and prescriptions to take, which specialists to see, which procedures to undergo. Under this traditional, fee-for-service system, providers increase their revenues each time they provide another service, regardless of whether the care is necessary.[1]

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[1] There are a number of mechanisms which have been incorporated into fee-for service systems to address the problem of rising costs due to over-utilization, including budgets, prospective payment reimbursement methodologies, volume performance standards, and frequent monitoring of actual vs. anticipated expenditures. The use of these mechanisms in counties such as Germany, Canada, and Japan have resulted in lower costs compared with the United States. For more information, see Health Care Spending Control: The Experience of France, Germany, and Japan, U.S. General Accounting Office, November 1991, (GAO/HRD-92-9) and German Health Reforms: Changes Result in Lower Health Costs in 1993, U.S. General Accounting Office, December 1994, (GAO/HEHS-95-27).

The second major problem in the current health care system is the lack of access to care for people who have no insurance or who have inadequate insurance. This was the fundamental objective of last year's failed effort to win universal coverage through federal health care reform. While most eyes were on Washington, D.C., the growth of managed care transformed the health care system back home. However, as enrollment in managed care plans accelerated, so, too, did the number of uninsured Americans. The number of uninsured Americans jumped from 37 million in 1992 to 43 million in 1995, casting doubt upon the claim that the lower costs typical of managed care plans would increase access to health insurance. The impacts on underinsurance — limited health coverage that doesn't meet peoples' needs — are less clear. Some consumers may obtain more comprehensive services, particularly in the area of preventive care, others may find new barriers to getting the care they need.

A third problem with the traditional system is that consumers who do not select a primary care provider may discover that that no one is monitoring their overall health status. As a result, patients may receive conflicting treatments which could lead to the wrong kind of care, could have health problems misdiagnosed or not diagnosed, as specialty providers focus on one organ system at a time, missing a syndrome or symptoms.

A related problem is the frequent lack of emphasis within the health system on preventive care, ensuring wellness as opposed to curing sickness. Consumers have an interest in prevention, but might not know what to do in terms of lifestyle and health services to prevent health problems. And since traditional insurance only pays for sick care, consumers have to pay for any preventive services on their own. Such a system ignores the old adage, "an ounce of prevention is worth a pound of cure," since only the pound of cure is paid for by traditional insurance.

Managed care proponents argue that they can solve the cost concerns of private and public purchasers while actually enhancing the quality of care provided to consumers. Theoretically, by reversing the incentives for overutilization and use of expensive treatments, providers and services and by increasing primary and preventive care, managed care will save money. Managed care seeks to promote preventive and early care, replace specialty care with primary care and better coordinate care in order to avoid duplication and possible harmful care. There is evidence that some managed care plans do meet these goals, at least for some populations.

On the other hand, there is also evidence that many managed care plans do not meet the theoretical ideal. Some of the criticisms of managed care are also true of traditional health insurance, but many are exacerbated by the incentives created by capitation. The driving objective for many managed care plans is reducing costs, even at the expense of quality and access. While under the traditional system, consumers were free to see the provider of their choice, very often in today's market it is their employer or a government sponsor who selects the plan and who may put a higher priority on saving money than guaranteeing high quality.

There are a number of ways in which managed care plans have been found to reduce costs by denying access to high quality care. These include imposing financial incentives and penalties on providers to discourage services, requiring long waits for appointments, limiting the number of providers below that needed to adequately serve enrollees, and discouraging use of specialists. In addition, many managed care plans use discriminatory practices to avoid enrolling high-cost patients, or persons who they think may be high-cost. Some of these practices include refusing to hire or contract with doctors who serve high-risk populations, refusing to sell their product to high-risk businesses, and selectively marketing to healthy, low-risk populations.

While the policy debates about the effects of managed care continue, the increase in managed care enrollment continues to accelerate. Congress and state governments are providing incentives and requirements for Medicare and Medicaid beneficiaries to use managed care. This trend is mirrored in the private sector. Old-fashioned, fee-for-service insurance, without any review of medical utilization, is virtually a thing of the past.

The Managed Care Debate:

Throughout the nation, as Americans increasingly use the new health care system, consumers and their health care providers are asking basic questions about whether managed care means quality care. The questions cluster around these two themes. Who should make decisions about health care: consumers and their providers or insurance companies? Who should choose a health care provider: a consumer or a managed care plan? With the increase in managed care, the debate is growing about whether public policy has a role in setting rules about managed care and how best to guarantee that

Promise and Problems of Manged Care

Health System Problem	Promise of Manged Care	Problem with Managed Care
Costs are too high	• Capitation eliminates incentives for overutilization • Care coordination and prevention lower costs	• Capitation creates incentives for underservice • No evidence of significant savings • High administative costs • Saves money by denying referrals
Access barriers for uninsured and underinsured	• Lower costs allow more people to purchase insurance • Includes preventive services • Provides convenient, guaranteed souce of care (even for typically underinsured Medicaid beneficiaries)	• The number of uninsured has grown as managed care has expanded • Managed care results in underservice and denial of care
No provider to coordinate care	• Consumers assigned primary care providers as gatekeeper, coordinating access to specialized providers and all services	• Gatekeeper can serve as a barrier to care, denying access to needed treatments • Plans may lack gatekeepers with appropriate expertise for some enrollees • Plan may lack adequate capacity to serve enrollees while preventing them from obtaining care outside of plan
No incentive for preventative care	• Capitation provides incentive for early detection and preventive care to avoid higher costs for serious illness • Plans cover peventive services with little or no out-of-pocket costs	•Plans often lack adequate outreach and culturally appropriate health education and prevention services • Plans often fail to meet minimal standards, i.e. percentage of children receiving immunization

the promise of managed care is realized while the dangers to quality of care are avoided. Legislation to regulate managed care has been introduced in Congress and in every state legislature. Coalitions of consumers and providers are finding new common interests in seeing that managed care companies are held accountable to public standards.

The Managed Care Consumers' Bill of Rights: A Health Policy Guide for Consumer Advocates (the *Guide*) is designed to be a hand's on manual for consumers and others who want to be sure that managed care provides quality care and that the new health care system is an improvement over the old. It is not designed to answer the question of whether managed care is a better alternative than a reformed fee-for-service system. Instead, it gives background information and suggested approaches to ensure that where managed care does exist, consumers are empowered as much as possible to make it meet their needs.

At the heart of the *Guide* is the ***Managed Care Consumers' Bill of Rights***. The ***Managed Care Consumers' Bill of Rights*** describes ten rights that will provide access to affordable, quality health care for consumers who are enrolled in managed care plans and protections to enable their providers to make quality health care decisions. The ***Managed Care Consumers' Bill of Rights*** includes sample legislation that can be used as a model for consumer advocates and others in designing quality regulations for managed care.

The *Guide* is designed to be useful to many different individuals and organizations, including consumer and health care advocates, social service providers, legal service organizations, community-based health care providers, individual health care providers, labor union benefits negotiators and administrators, state and federal legislators, state and local health and insurance regulators, and academics concerned with health policy.

The *Guide* has four chapters:

Chapter 1, **The New World of Managed Care**, provides an overview of managed care, including: trends in the growth of managed care by type, region and payer; the different types of managed care entities; a review of Medicare and Medicaid managed care, and, a discussion of the evidence about whether managed care saves money.

Chapter 2, **So You Want to Regulate Managed Care....** discusses issues with regard to establishing quality issues in managed care, including the various venues for applying regulation, the role of legislation and regulation, existing legal rights under current laws, and, a discussion of the viewpoints of the interest groups which can be expected to engage in any public debate on regulating managed care.

Chapter 3 contains the ***Managed Care Consumer's Bill of Rights*** including 1)access; 2) choice, 3)comprehensive benefits, 4) affordability, 5) quality, 6) appeals, 7) information, 8) confidentiality and non-discrimination, 9) representation, and, 10) enforcement.

Chapter 4, ***Insurance Reform and Managed Care***, is a brief look at related issues in insurance regulation, since many of the issues that apply to the regulation of managed care also apply to other types of health insurance.

At the end of the *Guide*, there is a **Glossary** which defines terms used throughout the chapters and definitions for the model legislation contained in the ***Managed Care Consumers' Bill of Rights***.

The final section, **Resources for Consumer Advocacy**, includes a listing of sample federal and state legislation, the addresses and phone numbers of national organizations concerned with managed care and a bibliography.

☆ Chapter 1

The New World of Managed Care

:e first chapter of *The Managed are Consumers' Bill of Rights: A ealth Policy Guide for Consumer hocates* provides an overview of e emerging new world of managed :re. The chapter is divided into five irts:

:rends in Managed Care, describes e rapid growth of managed care in e 1990s and explains what types of anaged care have experienced the ost growth, the growth patterns by gions of the nation and the growth enrollment of Medicaid and edicare beneficiaries.

:ypes of Managed Care explains the any forms that managed care orga-zations may take - HMOs, PPOs c. - and how those forms vary by: nsumer choice as to the number of oviders; provider flexibility in lecting treatments for patients; who ars the risk of paying for care and ho is obligated to provide care.

edicare and Managed Care escribes in more detail trends in the velopment of Medicare managed re, the types of managed care rangements permitted under edicare regulation and some of the ality protections in place for edicare beneficiaries who enroll in anaged care.

edicaid and Managed Care escribes the types of managed care rangements permitted under edicaid regulations, how states have plemented Medicaid managed care, cluding the application for and use waivers and quality protections for edicaid enrollees in managed care

remium Dollars and Managed are reviews the available evidence to whether managed care reduces e growth rate of health care spend-g. The section also discusses the ue of spending by managed care plans on health care and administration and the conversion of non-profit managed care plans to for-profit corporations.

Part 1: Trends in Managed Care

The growth in enrollment in various forms of managed care has accelerated rapidly in the last few years. While the nation's attention was focused on the health care reform debate in Washington D.C.; health care was, in fact, being transformed by the shift to managed care back home. Three major trends have dominated for the past few years:

- A rapid increase in enrollment in all forms of managed care and in particular in the growth of plans used in the private sector that allow a wider choice of providers; more than 65% of workers at medium or large companies are now in such plans.

- A rapid increase in enrollment in for-profit HMOs. The majority of all people enrolled in HMOs are now in for-profit HMOs.

- A rapid increase in enrollment of Medicaid and Medicare beneficiaries into managed care plans. Twenty three percent of Medicaid recipients were in such programs by the end of 1994, compared to 14% one year earlier. Nine percent of Medicare recipients are already enrolled and that number is increasing by 75,000 a month.

Anyone looking at managed care trends should be forewarned of three potentially confusing factors. First, specific numbers often differ from one source to another because differences in definitions of managed care result in different estimates. Some

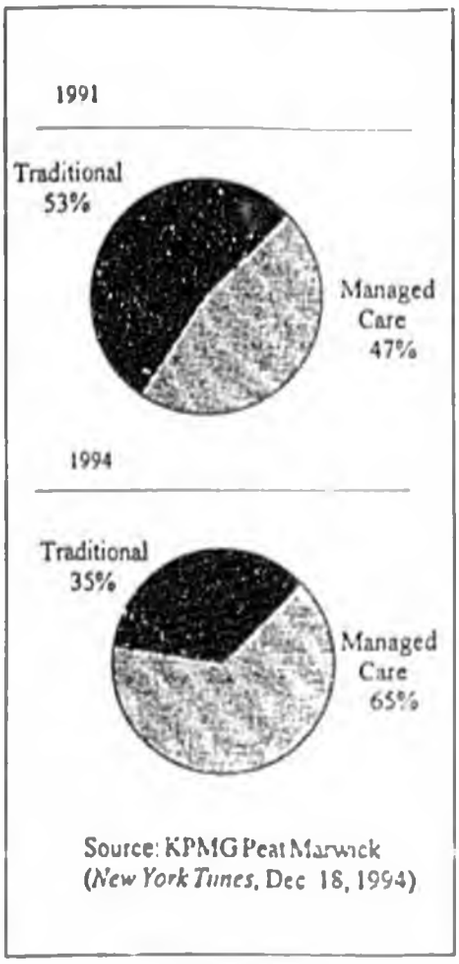
★Where can you get information on managed care enrollment for your state?

Either (or both) the Department of Health or the Department of Insurance is a place to start. The HMOs in your state may have some state-wide organization (in New York State, it's called the HMO Conference) that may know how many people HMOs cover in your state. The national HMO trade association, Group Health Association of America (GHAA), publishes figures on enrollees by state. For Medicaid recipients, the State agency that administers Medicaid will have data. The federal Health Care Financing Administration (HCFA) has the data on Medicare recipients in managed care as well as Medicaid recipients. Both the American Public Welfare Association and the Kaiser Foundation have a series of reports on Medicaid. In addition, there are a number of private research firms tracking the growth in managed care: KPMG Peat Marwick, Marion Merrill Dow, Interstudy, Foster Higgins, and Lewin-VHI. These studies are often summarized in the business section of the newspaper. In general, we have found the business sections and business newspapers (The Wall Street Journal and Crain's) to be covering these trends most closely. The section on **Resources** at the end of the *Guide* includes the addresses and phone numbers of many of the sources listed above.

studies, for example, count only HMO enrollment (and define HMOs differently); other studies count all forms of managed care. Second, studies may analyze trends for different populations. Some studies look at those insured through employers (often, only medium and large employers); others consider all people with private insurance; all people below age 65, or the entire population. Finally, enrollment is increasing very quickly, resulting in dramatically different numbers for time frames that are only slightly different.

The shift from traditional fee-for-service indemnity insurance to managed care has been most dramatic in the sector that began the movement: large, often self-insured, employers. Among these, in 1991, 47% of employees were in some form of managed care. By 1994, the percentage in some form of managed care had increased to 65%. While large employers have the highest rate of managed care enrollment, all employers have contributed to the very rapid increase. Regional differences remain, with the West having the highest overall enrollment in managed care by the end of 1994 (51% in HMOs; 29% in other forms), but the Northeast showing the most rapid growth from 1993 to 1994 (HMO enrollment up from 26% to 42% in one year; other managed care forms up from 8% to 21%).

Regional trends are depicted graphically in the Chart 1. It shows that from 1993 to 1994, the portion of insured workers with traditional indemnity insurance fell to 37% in the Northeast, second only to the West, where only 20% remain in traditional insurance. In the Midwest, 40% of insured workers remain in traditional insurance, and 42% do in the South.



Source: KPMG Peat Marwick (*New York Times*, Dec 18, 1994)

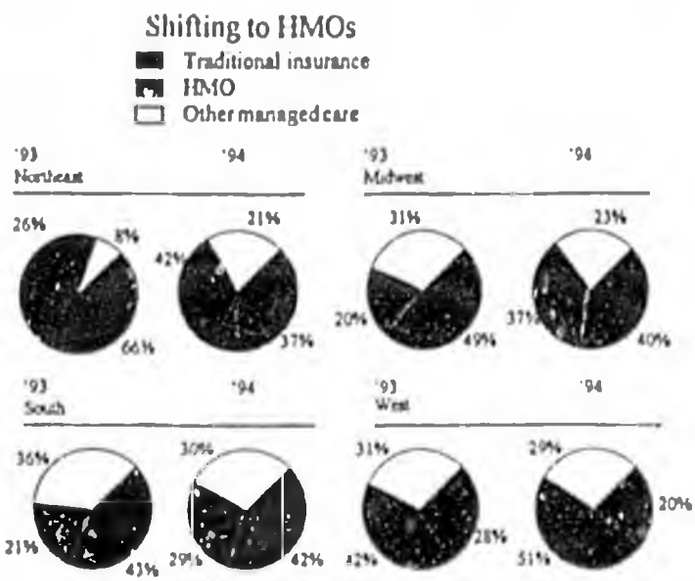
Chart 1

The rise in enrollment in for-profit HMOs is equally dramatic. The majority of people in some type of managed care are enrolled in an HMO (including staff, group, and point-of-service plans). From 1992 to 1994, nine million people joined HMOs. This brought the total number enrolled in HMOs — 50 million — to a fifth of the country's population. HMO enrollment is growing by more than 11% per year. Of those in HMOs, the majority are in for-profit HMOs. For-profit HMOs surpassed non-profit HMOs as the most prevalent form between 1993 and 1994. Between 1990 and 1994, for-profit HMO enrollment increased from 15 million to nearly 25 million. During the same time period, non-profit HMOs' enrollment increased from 18 million to just over 20 million. Of the ten largest HMO chains, the fastest growing are for-profit: FHP Inc, Aetna Health Plans, CIGNA Health Care and Pacificare. These trends are shown graphically by the New York Times (December 18, 1994).

Not surprisingly, given this rapid growth, many for-profit HMOs are "so awash in cash, they don't know what to do with it."[1] One of the options the companies are pursuing with the billions of available dollars they have on hand is the acquisition of other health plans. This move toward consolidation into fewer, larger, for-profit managed care companies is a major trend in the corporatization of medicine, and a factor in the growing replacement of indemnity insurance by managed care products. For example, United Healthcare Corporation, one of the nation's largest HMOs, bid at the end of June 1995 to acquire Metrahealth, a primarily indemnity insurer that was recently formed by the merger of the Travelers and Metropolitan Life health insurance companies. This merged corporation would be the nation's largest provider of health care plans, insuring over 14 million people. United Healthcare was able to pursue such a major acquisition because it was unusually cash-rich due to its sale of its prescription drug benefits management business directly to the pharmaceutical giant SmithKline Beecham in 1994 for $2.3 billion.[2]

[1] The Wall Street Journal, December 21, 1994, page 1

[2] For a discussion of how mergers have affected areas with many managed care companies, see Strangled Competition: A Critique of Minnesota's Experiment with Managed Competion Kip Sullivan, Minnesota COACT and the COACT Education Foundation, July 1995



Source: Foster Higgins National Survey of Employer Sponsored Health Plans
(*New York Times*, Mar. 25, 1995)

Chart 2

st managed care chains are gionally based, and states vary as to e total proportion of the population rolled in HMOs. As of the end of 93, HMO enrollment varied from a gh of 39% in Massachusetts, with lifornia at 36%, Maryland at 35%, d Minnesota at 34%, to the last two remaining states without HMOs — Alaska and Wyoming. The West has the highest proportion of its population in HMOs, but the Northeast is catching up rapidly, as the 1994 activity shown in Chart 2 indicates. No group is being enrolled into managed care faster than Medicaid recipients. In many states, this rapid enrollment is occasioned by new federal waivers which allow states to require that Medicaid beneficiaries enroll in an HMO. In other cases, enrollment is officially voluntary, but state and local governments have set ambitious targets for enrollment, and rewards and penalties for HMOs for their achievement. As will be discussed in the following section on Medicaid, many states have, or plan to obtain, waivers to increase their use of managed care. Another factor is new, aggressive marketing by HMOs which believe that there are large profits to be made serving the Medicaid population.

The ten largest HMO chains:

Chain	1994 Enrollment*	% growth since '92
Kaiser Permanente	6,597,667	0%
Prudential Health Care	3,811,408	37
CIGNA Health Care	3,237,123	42
United Health Care	3,159,100	87
Aetna Health Plans	2,858,000	92
U S Healthcare	1,737,000	24
FHP, Inc	1,712,000	139
Health Systems Int'l	1,439,018	23
Humana	1,431,000	15
Pacificare	1,358,219	42

*Includes plans that allow use of outside doctors for a fee; enrollments are given as of various points in mid- to late-1994

Source: Group Health Association of America
(*New York Times*, Dec. 18, 1994)

The number of patients, in millions, covered by HMOs of each type

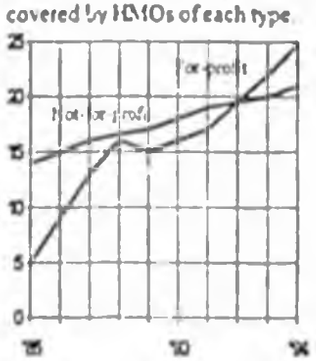


Chart 3

Nineteen-ninety-four saw a stunning 63% increase in enrollment of Medicaid recipients into managed care programs. At the end of 1993, 14% of those eligible for Medicaid were enrolled in such programs; by the end of 1994, 23% of those eligible were enrolled. Unlike the private sector where PPOs and other network arrangements predominate, full-risk capitated HMOs (HMOs which are paid a flat amount per enrollee, who in turn must receive all care through the HMO) are the rule in Medicaid. One reason for this trend is that federal laws limit the amount of cost-sharing which can be imposed on Medicaid beneficiaries, so practices which vary cost-sharing to encourage use of network providers cannot be implemented. Also, full-risk HMOs are more appealing to state policymakers because costs can be accurately projected and controlled.

To date, the use of Medicaid managed care has been used selectively, both geographically and in terms of which segment of the Medicaid population is included. Low-income pregnant women and children have typically been the focus of state managed care efforts, probably because

their health costs are generally lower and health needs less complicated. Some states, however, are beginning to explore managed care options for other Medicaid beneficiaries: persons with disabilities, low-income seniors and persons needing long-term care.

On the other hand, relatively few Medicare beneficiaries have had experience with managed care. Medicare has had special programs to allow beneficiaries to enroll in three different types of managed care programs since 1982. (These will be described more fully in the Medicare section of this chapter.) The percentage of Medicare beneficiaries in managed care is far below that of the general population: 9% compared to over 50%. However, like in every other payor group, the numbers are increasing rapidly for Medicare managed care enrollment. In 1985, only 300,000 Medicare beneficiaries were in managed care plans. Today, there are 3.1 million, although they remain concentrated in five states: California, Florida, Arizona, New York, and Oregon.

Between 1993 and 1994, enrollment in full-risk HMOs grew by 25% in Medicare, compared to an 11% growth in the general population. Reasons for this rapid expansion include expansion of availability of HMOs to more areas, aggressive marketing to Medicare beneficiaries (for the same reasons of profitability motivating HMOs to market to Medicaid recipients), and perceived benefits to seniors, including some reduction in out-of-pocket costs and some supplemental insurance needs. It is important to note, though, that some HMOs often do not provide the same level of benefits for Medicare recipients as they do for other enrollees.[1]

In summary, managed care enrollment is growing rapidly, and is, in fact, eclipsing indemnity insurance in many markets. Market forces and public policy trends have combined to accelerate this growth among all payors, and current developments will only hasten existing trends. For example, many of the federal proposals to cut Medicare expenditures prominently feature managed care. The majority of the individual states are working to expand enrollment of the Medicaid population in managed care. More and more institutional and individual providers are forming managed care companies or negotiating contracts with them (89% of doctors who work in group practices have signed at least one managed care contract [2]), so it will be increasingly difficult for providers outside these systems of care to survive economically. And, as the managed care giants acquire the indemnity insurers, there may be no indemnity insurance available in some markets, even if there remain individuals and employers willing to purchase it. Since managed care has arrived, it is clear that consumers need to participate in its regulation.

Part 2: Types of Managed Care Plans

As recently as 1980, over 90% of all Americans were in traditional indemnity insurance plans, where the patient went to the provider of his/her choice, the provider performed whatever services were deemed necessary and the insurer paid the bill. Most of the remaining insured people were covered by health maintenance organizations (HMOs). The vast majority of HMO enrollees (more than 80%) were enrolled in staff model HMOs, where the providers practiced in large, multi-specialty group settings. However, by 1995, just as the market share of managed care entities has increased dramatically, so have the variations on types of managed care entities. Despite their differences, all managed care entities have the common characteristic of a degree of integration between the roles of insurance and service delivery.[3]

Consumers, advocates, and policymakers all need to understand the different types of managed care entities. Consumers need to understand the different kinds of managed care because they provide different answers to the questions that concern consumers most.

- Can I continue to see my own doctor?

[1]For example, in 1993, 50% of Medicare enrollees in full-risk HMOs received outpatient prescription drug services, compared to 97% of the non-Medicare population enrolled in such HMOs.

[2]New York Times, *While Congress Remains Silent, Health Care Transforms Itself*, December 18, 1994.

[3]For a physician's perspective on the effects of managed care on patient-provider relationships, see *Preserving the Physician-Patient Relationship in the Era of Managed Care*, Emmanuel and Dubler, Journal of the American Medical Association, January 25, 1995.

an I change doctors or go see a
ecialist when I want to?

Who decides what care I will get
d who pays for it?

r advocates who are trying to
prove the ability of consumers to
cess appropriate and affordable
ality health care, it is critical to
derstand the distinctions between
pes of managed care entities
cause each operates according to
ferent rules. Similarly, policy-mak-
s need to understand differences in
anaged care types even to make
nse of data and information — for
ample, there is not an agreed-upon
finition of managed care. This con-
butes to differences in estimates of
w many people are in managed
re plans. More importantly, how-
er, since the structures of managed
re entities are changing so rapidly,
e regulatory frameworks tend to lag
behind the current forms, leaving
nsumers with little or no protec-
n.

hile there are multiple variations,
sic forms of managed care include
veral forms of health maintenance
ganizations, point of service plans,
d preferred provider organizations
aditional indemnity fee-for-service
ans still exist and will be described
show how they differ from man-
ged care. The following provides a
ief description of basic forms of
anaged care; their specific charac-
ristics are described in more detail
elow.

**Health maintenance organiza-
ons (HMOs)** are capitated health
ans that cover preventive services
nd medical care by a selected group
f providers. Each patient's care is
anaged by one case manager or
atekeeper. There are two primary
nds of HMOs: the staff or group
odel and the independent physician
association (IPA). In staff or group model HMOs, there are salaried doctors serving only plan members, who, in turn, are covered only when they use HMO providers. IPAs are HMOs that contract with independent doctors and hospitals to provide care for their enrollees according to the treatment protocols, per-case fees, and review and approval rules set by the plan. In both cases, care is prepaid and members are covered only when using HMO-designated providers and hospitals.

- **Point of service plans** are hybrids, allowing enrollees to use services outside of the HMO in exchange for higher premiums and out-of-pocket payments, but providing the bulk of services within a prepaid HMO.

- **Preferred Provider Organizations (PPOs)** offer enrollees a network of "preferred" providers who provide care according to set fee schedules. (PPOs are sometimes referred to as "network plans"). The managed care company may review individual providers' treatment and care decisions, but they do not control decision-making as closely as HMOs and reimburse providers according to negotiated rates by the service (fee-for-service) rather than through capitated payments. PPO members may choose out-of-plan providers, but will be charged higher out-of-pocket costs for doing so.

- **Indemnity fee-for-service plans** represent the traditional system, where a patient goes to any provider they choose; the provider sets fees for the services provided. The enrollee pays a deductible and a portion of the fee (co-insurance), the insurer pays the rest based on fees which it deems to be "reasonable." Many fee-for-service plans today use some managed care features, such as review of treatment decisions by providers.

Before describing a few key dimensions of variation across plan types, it is helpful to define the "parties" to the health care contract.

Consumers are the first party, that is, those who receive medical services. Consumers usually pay a portion of the cost of insurance coverage, but less than 8% of the population pays the entire cost on their own.

The second party is **the provider of services**: doctors, other health providers, hospitals, etc. If people simply contracted with doctors to purchase care (as we do with lawyers or hairdressers), two parties would be enough. However, because we tend to spread the risk (and cost) of illness by purchasing health insurance, there is a third party in the equation.

The third party used to be simply the **insurer**, which in exchange for premium payments assumed the risk of paying a specified portion of the cost of covered services. Insurers sometimes paid providers directly; often they reimbursed consumers who paid medical bills. Today, the insurance role is more complicated. Increasingly, employers, trade associations and labor unions take on the insurance role by operating their own plans, although they may hire traditional insurance companies to administer those plans for them. Other third parties actually combine the functions of managing the delivery of care and bearing risk (more about both later).

Finally, in many cases, there is a fourth party in the health contract, namely a purchaser of insurance, other than the consumer. This party is known as the **sponsor** or **payor**.

Sponsors include employers or unions who contribute to the cost of health coverage for their employees or members. Only those people who purchase health coverage on their own do not have a separate sponsor paying at least part of the bill.

As with private employers, who may operate their own health plans or purchase coverage on behalf of their employees, governments can serve as the third party insurer (as is the case with fee-for-service Medicaid and Medicare) or as a sponsor (the case with Medicaid and Medicare managed care). From the consumer perspective, the critical point is the existence of another party — private or public — that makes key decisions on what benefits to purchase at what cost from which providers.

The different forms of managed care plans vary in their approaches to dealing with the "parties" described above. The major dimensions that differentiate the plans center on their approaches to the following questions:

- How much choice does the consumer have in selecting providers?
- How much choice does the provider have in selecting treatment?
- Who bears the risk of paying for care?
- Who has the contractual obligation to provide care?

Consumer Choice of Provider

Both consumers and providers have the most choice in traditional fee-for-service insurance, where the insurer merely pays the bills (although, as indicated previously, even fee-for-service insurers today are reviewing provider treatment decisions before paying for services). At the opposite end of the spectrum is the staff or group model HMO, where the consumer may see only those providers employed by the plan or with whom the plan has a direct contract (unless they are willing and able to pay the entire cost of going outside of the HMO). Intermediate degrees of consumer choice are present in various preferred provider organizations (PPOs) and point-of-service plans. Specific selection and payment arrangements vary; but, in those plans, consumers typically pay significantly more out of their own pockets (in co-payments or co-insurance and deductibles) in order to choose "out-of-network" providers. In many instances, it will be the sponsors, not individual consumers, who determine which option or options are available. Employers, for example, may offer their employees a choice of fee-for-service and managed care plans, only fee-for-service coverage, or only a managed care plan. Where sponsors pay at least a portion of the cost of the plans they offer, employees and their families may be limited in their selections, (again, unless they are willing and able to pay for different coverage on their own). Similarly, as the Medicare and Medicaid section of this chapter details, increasingly these government sponsors determine the amount of providers choice for enrollees. (For more on this issue, see Chapter 3, Right 2, ***Choice***).

Provider Choice of Treatment Options

Many consider the issue of provider choice to be the pivotal one in defining whether a plan is "managed" or not. In traditional fee-for-service insurance, providers had the freedom to prescribe services using their own clinical judgment. (Today, however, even in fee-for-service plans, insurers often review treatment decisions to determine whether services are "medically necessary or appropriate" before agreeing to pay their share of costs.) One of the key tenets of managed care is that the old system led to unnecessary, or at least inefficient, use of often costly health services. The goal of managed care is to employ various methods to review and change clinical practice in order to contain costs without adversely affecting care and, ideally, to improve health status by promoting preventive and early care. The evidence is equivocal about whether managed care actually achieves both parts of this equation: lowering costs and maintaining or improving health status. Utilization control may indeed lower costs, but most evaluations have looked at the younger and healthier populations typically enrolled in managed care. There is a dearth of data on the impact on costs or quality with sicker, higher cost patient population

Managed care plans use a variety of mechanisms to restrict providers' practices, including requiring prospective approvals for many procedures before they may be performed, issuing practice guidelines that providers are required to follow, and after-treatment utilization review to determine whether a claim for reimbursement should be paid.

In addition, various case management and gatekeeping arrangements that restrict the practice of individual practitioners are common to most managed care plans. In these arrangements, a consumer may only receive care from other providers or services if approved by his/her case manager or gatekeeper. Advocates of this approach argue that it is important to coordinate care in order to prevent duplication of treatment and

Factors Distinguishing Types of Managed Care

Factor	FFS/Insurance	PPOs/Networks	POS	HMOs
Consumer Choice	YES	YES	SOME	NO
Provider Choice	YES	YES	YES/NO	NO
Risk on Insurer	YES	YES	YES	YES
Risk on Provider	NO	NO	YES/NO	YES
Obligation to Serve	NO	NO	YES	YES

to ensure that the most appropriate services are provided. Particularly for persons with multiple health problems or complicated illnesses, case management is seen as a way to compare and select the most appropriate course of treatment. On the other hand, critics of these arrangements argue that they can serve to prevent access to specialists, a particular problem when the cost of specialty referral is reimbursed as part of the capitated rate paid to the gatekeeper. If gatekeepers receive a capitated payment and must pay specialists out of that payment, the financial incentive will be for the gatekeeper to avoid referrals. Once again, HMOs tend to be the most restrictive setting.

It is rare today to find any form of insurance, including fee-for-service insurance, with no form of utilization control; however, the form varies between types and, often, within a plan type. For example, a point-of-service plan could apply practice guidelines and retrospective utilization review for its in-network providers, but only utilization review for the out-of- network providers. (Utilization review is discussed in Chapter 3, Right 3, ***Comprehensive Benefits***). Clearly, the issue of who decides how patients will be treated is a contentious and critical one for all parties.

Risk

The third major dimension differentiating types of managed care plans is who assumes the financial risk of paying for care. As soon as a consumer or sponsor purchases insurance of any type, the basic financial risk of illness is shifted to the insurer. In today's complicated health financing, risk can be spread among insurers, providers, consumers and payors.

In the old system of indemnity fee-for-service insurance, consumers and payors transferred most of the risk to "traditional" insurance companies, which paid the medical bills (after any cost-sharing requirements were met) in exchange for a set premium. If the cost of the services used exceeded the amount of premiums collected, the insurer was stuck with the loss, though premiums would rise in the future to accommodate such loss. Under this system, insurers either sought to spread risk widely or to match the premiums they charged to the anticipated health needs of their policyholders. (For a more complete discussion, see Chapter 4, **Insurance Reform and Managed Care**).

Driven largely by the concerns of self-insured employers and other insurers about rising medical costs, numerous new financing models have emerged which change the way risk is spread among all four parties: consumers, payors, insurers and providers. The simplest way in which costs and risks have been moved away from insurers is through the shifting of costs to consumers, an approach that requires little reorganization of the health system. In recent years, consumers have been required to pay higher portions of premium payments, larger deductibles and greater co-payments for care, or have had some services dropped from their benefits. These new requirements apply to many workers whose employer sponsors previously paid 100% of health insurance costs.

The newest development, causing the most reorganization of the entire system, is to shift the risk to the

provider. The pure form of this shift is capitated reimbursement, where a provider is paid a set amount and is responsible for providing all care for each enrollee, whether at a profit or loss. More modest steps toward provider risk bearing are various prepaid arrangements, including partial capitation arrangements, where the capitated rate covers only some services while others are reimbursed on a fee-for-service basis; prospective reimbursement (like Medicare DRGs) where providers are paid a set fee per diagnosis; and other payment systems (like "withholds") where the provider is rewarded (or penalized) for lowering costs by making fewer referrals and ordering fewer tests. Employer sponsored and self-insured plans have made increasing use of these options by encouraging their employees to enroll in managed care plans which are paid on a capitated basis. And, over the past five years, there has been a rapidly accelerating trend by state and federal governments to shift risk from themselves onto providers by enrolling Medicaid and Medicare beneficiaries into capitated managed care plans.

While managed care plans are paid on a capitated basis, they differ in the method by which they reimburse individual practitioners or facilities. In HMOs, providers are more likely to be paid on a capitated basis and more likely to bear the risk. In PPOs and other network plans, where managed care entities contract with a network of providers, these individual practitioners rarely bear direct financial risk for their patients.

Thus "risk-bearing" differentiates self-insured companies and the government (which bear risk) from non-self-insured companies, and HMOs (where providers bear risk) from various managed care networks (where providers typically do not). Some risk can be shifted directly back to consumers in the form of out-of-pocket expenditures in any of the models.

Responsibility for Care

The fourth dimension which distinguishes types of health coverage is the degree to which the plan has a contractual responsibility to provide services to an individual enrollee. In indemnity fee-for-service insurance, the insurer has no responsibility to provide care to the enrollee, merely to pay bills for covered services. In networks, the plan takes on the responsibility to provide services to its enrollees, at least within the network; for services outside the network, these plans function like an indemnity insurer, paying some of the costs but with no contractual obligation to deliver services. In HMOs, the insurer and the provider of services are fully integrated, literally the same entity. Thus, there is a continuum from no responsibility to total contractual responsibility to provide care that correlates directly with the level of integration between the insurer and provider of care.

The actual operation of specific managed care plans is further complicated because functions may be contracted out or performed by one integrated entity. For example, utilization review can be performed under contract by a separate company or performed by the plan. Utilization review contracts are most common between a utilization review company and a managed care plan, but a self-insured sponsor wishing to cut costs could contract with a utilization review company directly, or a group of providers interested in improving their "efficiency profile" could contract with a utilization review company. Provision of certain services, such as rehabilitative or mental health services, may be contracted out, as well as functions such as quality assurance.

Complications also arise at the provider level. For example, most individual providers (or provider groups), hospitals and other facilities have multiple contracts, within multiple types of arrangements, with different managed care entities. So one provider can be both an "in network" provider and an "out-of-network" provider for many different plans, each with different rules for utilization review and reimbursement. Only those providers on staff or under exclusive contract for one plan (IPA plans) have limitations on the number of plans in which they can participate.

In this section, managed care entities have been described, and contrasted with indemnity insurance in terms of 1) level of consumer choice; 2) level of provider choice; 3) location(s) of the risk bearing among the contracting parties; and 4) level of contractual obligation to provide care. For each of these dimensions, there is a continuum of variation, with old indemnity fee-for service insurance representing one end of the continuum and closed HMOs representing the other. In the middle are a plethora of network arrangements with fluid and unstandardized characteristics, with new variations appearing each year.

Part 3: Medicare and Managed Care

Medicare is a federally administered program which provides health services to persons 65 years old and older, persons with permanent kidney failure, and persons with a permanent, total disability. Of the 36 million Americans covered by Medicare, 3.1 million beneficiaries are enrolled in some form of managed care.

Trends in Medicare Managed Care

As this *Guide* goes to press, the U.S. Congress is debating a number of proposals which would have profound consequences in the use of managed care by Medicare beneficiaries. Some proposals would offer more managed care choices to beneficiaries, such as PPOs and HMOs with a point-of-service option. Another approach would greatly increase the incentives for senior citizens and persons with disabilities to select a managed care option by increasing the out-of-pocket costs of Medicare's traditional fee-for-service alternative. In light of the ongoing Congressional debate, the situation must be seen as being extremely fluid and subject to change. It is possible that, as a result of action this fall, Medicare beneficiaries will be far more become more dependent upon managed care.

Today, the percentage of Medicare beneficiaries in managed care is far below that of the general population, 6% in Medicare compared to over 50% in the general population. Medicare beneficiaries have been slow to enroll in managed care plans for a number of reasons. Many beneficiaries, particularly those with ongoing relationships with their providers or with chronic health care problems, are reluctant to give up the ability to choose their own physicians. Opting for a managed care option would prevent them from exercising their choice and, in the case where they have an ongoing relationship with a provider, could force them to disrupt the continuity in their source of care.

Other Medicare beneficiaries may be willing to give up choice in order to reduce their out-of-pocket spending but have been reluctant to do so because of reports of poor quality care in Medicare HMOs. In fact, despite the efforts to incorporate quality protections into the program, evidence persists that problems continue at many HMOs. A U.S. General Accounting Office report found that many Medicare HMOs lacked effective quality assurance programs and failed to keep adequate quality data to allow effective oversight.[1] A recent survey by the Inspector General of the Department of Health and Human Services (HHS) found that while many enrollees were generally satisfied, 16% of Medicare HMO enrollees either planned or wanted to leave their HMOs, while 66% of disabled Medicare enrollees with kidney failure wanted to leave but were afraid to because of cost issues. HHS has documented problems relating to lengthy waits and delays in getting treatment, unmet needs, and failure to provide emergency services.[2]

Finally, many beneficiaries have been unable to enroll because managed care plans have not existed in many parts of the country, particularly in rural areas and states where managed care is just beginning to be available.

Recently, however, there has been a substantial growth in managed care enrollment by Medicare beneficiaries. In 1985, only 300,000 Medicare beneficiaries were in managed care plans. Today, there are 3.1 million Medicare managed care enrollees. There are several reasons for this growth. Some 70% of Medicare enrollees purchase supplemental insurance to cover costs and benefits not included in Medicare. Medicare managed care plans may provide lower costs such as elimination of balance billing (additional physician fees charged to beneficiaries up to 15% above levels set by Medicare), lower premiums and reduced co-payments. Managed care may provide access to additional benefits not covered by Medicare, such as prescription drugs. The lower costs and benefits often come without any additional premium. Finally, three out of four Medicare beneficiaries live in areas now served by Medicare managed care plans, meaning that the option is more available to them. An increasing number of recent retirees - familiar with managed care from the workforce - are likely to be comfortable staying with managed care in Medicare.

Types of Managed Care Plans under Medicare

As a result of federal legislation passed in 1982, managed care may be offered to Medicare beneficiaries as an alternative to fee-for-service coverage. Three different types of managed care plans are allowed, each providing different levels of coverage to beneficiaries:

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[1] Medicare PRO Review Does not Assure Quality of Care Provided by Risk Contract HMOs, GAO/HRD-91-48.

[2] Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems, U.S. General Accounting Office, 5/24/95, GAO/T-HEHS-95-174

Risk contract HMOs. Plans with sk contracts provide all Medicare enefits and may offer extra services ot covered by Medicare, such as utpatient prescription drugs, dental are, hearing aids and eyeglasses. he plans receive monthly per nrollee payments from Medicare in xchange for assuming the risk of aying for covered services. ayments are equal to 95% of what ledicare estimates it would have aid under a fee-for-service basis djusted for factors such as age, sex, hether they are living at home or in health care institution, and ledicaid eligibility.[1] Beneficiaries ay be charged additional premiums o pay for additional services, as well s a deductible, co-payments or co-surance for some services. Enrollees risk contracts receive all services ithin the plan; if enrollees use hysicians or other providers outside f the plan for anything other than mergency care, the enrolllees must ay the entire bill themselves. Neither e plan nor Medicare will pay any hare of the cost.

Cost contract HMOs. As with risk ontract HMOs, cost contract plans rovide the full range of Medicare ervices and may offer additional enefits. These plans differ from risk ontract HMOs in several key espects. First, unlike enrollees in risk ontract HMOs, enrollees in cost contract HMOs must pay additional premiums in order to receive additional ervices, although they can decline to urchase them. Second, enrollees are llowed to use providers outside of e plan. If they choose a non-participating provider, Medicare will pay hat it would normally cover under fee-for-service coverage (i.e., 80% of the approved rate). Third, plans with cost contracts are not fully at risk for providing services. Instead of being paid a set (capitated) amount for each person they enroll, cost contract HMOs are paid according to the services they provide.

Health Care Pre-Payment Plans. Unlike risk and cost contract plans, these plans do not have to offer the full range of Medicare services and may deny enrollment on the basis of health status. Enrollees can receive services outside of the plan, with Medicare paying its share of the cost as under fee-for-service.

In addition to these three types of plans which cover some or all of Medicare-provided services, the Medicare SELECT program provides supplemental (Medigap) insurance with managed care features. Under this program, now operating in 15 states, beneficiaries purchasing Medigap coverage receive only partial or no benefits if they obtain services from providers outside of the managed care plan. The 15 states are: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin. Congress is considering legislation to expand the Medicare SELECT program to all 50 states.

Quality Protections

There have been a number of steps taken in the attempt to ensure that Medicare beneficiaries receive high quality care if they choose to enroll in managed care plans. (See Chapter 2, Part 3, **Legal Rights Under Managed Care**, for a description of due process protections legally available under Medicare).

First, managed care plans must be federally qualified HMOs or meet specified standards in order to obtain Medicare contract eligibility status. To apply, plans must provide information on the numbers and types of providers in their network, benefits, marketing strategies, quality assurance plans, enrollment and disenrollment procedures, and grievance and appeals procedures. Plans must comply with federal confidentiality requirements and, to be a full risk or cost contract HMO, cannot discriminate on the basis of health status.

Second, Medicare managed care plans are subject to external review by independent Peer Review Organizations (PROs) and by the federal government. Enrollees have the right to lodge complaints or to appeal denials of care or payments with the PRO and with the Health Care Finance Administration, the federal agency which oversees Medicare. If enrollees are not satisfied, appeals involving $100 or more can be made to an administrative law judge and appeals involving $1,000 or more can be brought in federal court. (For more information, see Chapter 2, Part 3, **Legal Rights Under Managed Care**.)

Third, at least 50 percent of plan enrollees must be private payers, not enrolled in either Medicare or Medicaid. This so-called "50/50 rule" is to guard against "Medicaid-mill" type plans which save on costs by cutting back services, presumably made easier by serving only publicly-insured persons.

Although evidence is that the rates paid by Medicare to HMOs are actually more than 5% higher than what would have been paid under fee-for-service coverage because of problems in accounting for the healthier status of those beneficiariesselecting the managed care option). See Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems, U.S. General Accounting Office, 5/24/95, GAO/T-HEHS-95-174.

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SB 288

United States General Accounting Office

Testimony

Before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives

For Release on Delivery
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June 30, 1994

HEALTH REFORM

Purchasing Cooperatives Have an Increasing Role in Providing Access to Insurance

Statement of Mark V. Nadel, Associate Director, National and Public Health Issues, Health, Education, and Human Services Division

GAO/T-HEHS-94-196

BACKGROUND

Cooperatives can be public, private, or state chartered systems that include public and private employers, and potentially Medicaid recipients.[2]

- **Private cooperatives** are voluntary associations of employers who band together to purchase insurance for their employees. Although pooled purchasing is generally discussed in the context of assisting small businesses, in fact, large firms have also organized cooperatives. Examples of private cooperatives are the Business Health Care Action Group, a relatively new association of large Minneapolis-based firms, and the Council of Smaller Enterprises (COSE), a small employer association founded in 1973.

- **Public cooperatives** were originally established by state governments to purchase insurance for state employees and were subsequently expanded to allow voluntary participation by county and municipal workers or other public entities. The largest public cooperative we visited, the California Public Employees' Retirement System (CalPERS), began offering health insurance over 30 years ago and now has nearly 1 million covered lives.[3] Recently, several states have again expanded public programs by creating voluntary cooperatives targeted at small businesses.

- Finally, **statewide systems of cooperatives** being established in some parts of the country are an amalgam of public and private cooperatives. They will eventually embrace state employees and Medicaid recipients and are open on a voluntary basis to a wider spectrum of groups, including private firms, the self-employed, and low-income individuals. The farthest along is Florida's statewide system of 11 regional cooperatives that began enrolling members in May 1994.

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[2]The 11 purchasing cooperatives we visited and some of their characteristics are listed in table 1.

[3]Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

Regardless of the outcome of the current national health reform debate, the growing number of states and businesses forming cooperatives suggests they are here to stay. We found that pooled purchasing is both a tested and effective mechanism to address recognized problems in the insurance market--especially for small employers.

EXISTING COOPERATIVES HAVE BROAD AUTHORITY OVER HEALTH INSURANCE ADMINISTRATION AND BENEFITS

Purchasing cooperatives have several administrative functions in common including enrollment, premium collection, and contracting with health plans. These functions are similar to those being considered for voluntary cooperatives by the Congress. But existing cooperatives are also empowered to perform additional policy and management functions. Notable among the broad policy functions assigned to existing cooperatives are the ability to (1) define benefits packages, (2) include or exclude individual health plans, (3) negotiate contracts, and (4) develop and analyze quality data.

Benefits Package

Existing cooperatives often play an active role regarding benefits. The state legislature gave the Health Insurance Plan of California (HIPC) responsibility for developing the benefits package offered to small employers. Using health maintenance organization licensing standards and information gathered during a series of public hearings, HIPC created a standardized benefit structure. Other cooperatives have also standardized benefits in order to (1) prevent plans from using the benefit structure to deter bad risk enrollees, (2) make it easier for consumers to compare plans, and finally (3) enable the cooperative staff to more easily evaluate each plan's efficiency. Private cooperatives generally work with insurance carriers to develop benefit structures that reflect the needs of their membership.

Contracting Authority Affects Consumer Choice

Cooperatives have significant power over the type and number of participating health insurance carriers and thus over consumer choice. Although states allow public cooperatives to exclude carriers, they tend to be inclusive. Thus, HIPC offers enrollees a choice of 18 competing carriers. Especially for small businesses, the broad choice of plans offered by public cooperatives expands the options available to their employees. On the other hand, COSE, typical of the private cooperatives we visited, contracts with only two carriers.

Because they believe managed care is more effective at controlling costs, both the private and public cooperatives we visited generally offer managed care options to enrollees. In

small business cooperative, contracts with only two carriers to obtain a volume discount. Constituting about 15 percent of Blue Cross's business in the Cleveland metropolitan area, COSE is the carrier's single largest customer. According to COSE officials, Blue Cross knows that the cooperative could "shop around" when the current contract expires.

Quality of Care

Reflecting the state of the art, programs to measure, improve, and report on the quality of care delivered by participating health plans are in their infancy. Compared to the public cooperatives we visited, however, private purchasing pools placed more emphasis on such programs. For example, the Business Health Care Action Group sponsored creation of a $2 million institute to develop practice guidelines and a system to monitor treatment and patient outcomes. Public cooperatives are now beginning programs that focus on the quality of the services obtained. Officials at the Minnesota State cooperative told us that they intend to create a new unit to collect and analyze quality outcomes data. Florida's statewide system of cooperatives will issue report cards on quality using health plan data analyzed by a state agency.

EXISTING COOPERATIVES OPERATE WITH MODEST BUDGETS AND STAFFS

Existing cooperatives are not big bureaucracies. Their operating costs range from about 3 percent of total insurance premiums for smaller or recently formed cooperatives such as the HIPC, to less than 1 percent of premiums for larger and more mature purchasing pools like the Wisconsin State Employee Group Health Benefits Program. Most cooperatives contract with private firms for enrollment and premium collection activities. Their relatively modest in-house staffs tend to focus on management and policy functions, including premium negotiations, plan monitoring, and contractor oversight.

CONCERNS REMAIN REGARDING GOVERNING STRUCTURES

To many Americans, purchasing cooperatives are an unfamiliar new entity, raising legitimate concerns about the role of government, employers, and employees in their operation. Governance is a central issue because under many reform proposals cooperatives are the vehicle through which many Americans would obtain portable health benefits. And for those unable to obtain or afford insurance under the current system, government subsidies channeled through purchasing cooperatives would facilitate access to coverage. This nexus of interests highlights the importance of establishing a proper balance between public and private accountability. Although many of the cooperatives we visited provide limited lessons for establishing such accountability, we

Legislative Research Services SB288

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March 27, 1996

MEMORANDUM

TO: Senator Jim Duncan

FROM: Maureen Weeks MW
Legislative Analyst

RE: **Census Bureau Estimates of Alaskans Without Health Insurance**

You asked for the most recent U.S. Bureau of the Census estimates of the number of Alaskans without health insurance. Specifically, you asked for the results of the bureau's March 1995 population survey reporting health insurance coverage for 1994. The estimates are presented on the table below. Please note that the bureau rewrote the questions about health insurance this year. As a result, the following estimates cannot be compared with estimates from earlier years.

Alaskans Without Health Insurance – 1994

Population	Percent	Number
All Alaskans	13.3%	80,000
Alaskans under age 65	13.8%	79,000

Source: Robert Bennefield, U.S. Bureau of the Census 301-763-8578

We have attached an article from the Bureau of National Affairs Health Care Policy Report describing national (but not state-by-state) estimates of health insurance coverage in 1994. The estimates quoted in the policy report are taken from the March 1995 survey cited above.

SURVEYS & STUDIES

Access

CENSUS BUREAU FINDS 39.7 MILLION LACK HEALTH INSURANCE COVERAGE IN 1994

In 1994, 39.7 million persons were without health insurance coverage, constituting 15.2 percent of the population, the Census Bureau reported Oct. 5.

In addition, the bureau's 1994 annual report on income and poverty indicated that 29 percent of the poor had no health insurance of any kind, about double the rate for all persons. Poor persons comprised 27.8 percent of uninsured persons.

Census officials pointed out that the 1994 survey questions on health insurance were changed from the prior years, suggesting that the results are not strictly comparable with 1993 and earlier periods.

Of the 139.1 million workers in 1994, 53.3 percent had employer-provided health insurance policies in their own names, Census found. There is no comparable figure for 1993 and earlier because there were no questions in the earlier surveys pertaining to types of insurance, a Census analyst said.

Some 70.3 percent of the population was covered by a private insurance plan for some or all of 1994. The remaining insured persons had government coverage, which included Medicaid (12.1 percent or 31.6 million), Medicare (12.9 percent or 33.9 million), and military health care coverage (4.3 percent or 11.2 million).

Part-time workers—those working 35 hours a week or less—had the lowest coverage. In 1994, 19.5 percent of these workers had no health insurance coverage.

State figures showed considerable variation in the proportion of populations that lacked health insurance coverage last year. The range was from 8.4 percent of persons in North Dakota lacking coverage to 24.2 percent in Texas.□

Post-Natal Care

PEDIATRICIANS ISSUE POLICY ON CRITERIA FOR RELEASING NEWBORNS FROM HOSPITALS

Minimum criteria should be met and the decision should be made mutually between a new mother and her physician to release newborns from hospitals, the American Academy of Pediatrics said in a policy statement issued Oct. 10.

Insurance companies set arbitrary newborn discharge policies based on few scientific data, AAP charged. But certain criteria and conditions should be met before an infant is released, the group said. It is unlikely that the recommended standards could be accomplished in less than 48 hours, according to AAP, which represents 49,000 pediatricians.

Among the minimum criteria are: pregnancy and labor are uncomplicated and delivery was vaginal; baby has urinated and passed one stool; no evidence of jaundice in first 24 hours of life; the baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding; the baby's vital signs are documented as being normal and stable for the 12 hours preceding discharge; and a physician-directed source of care for mother and baby has been identified.

AAP emphasized that each mother-infant pair should be evaluated individually to determine the optimal time of discharge. "The fact that a short hospital stay for healthy term infants can be accomplished does not mean that it is appropriate for every mother and infant," AAP said.

The policy, initiated by AAP's Committee on Fetus and Newborn, was published in the Oct. 4 issue of the AAP's journal *Pediatrics*.□

Cost Containment

STUDY FINDS COMPETITION MORE EFFECTIVE THAN REGULATION IN CONTROLLING COSTS

Based on a comparison study of state health care expenditures under competition-based managed care and state government rate regulation, researchers concluded that a properly structured competitive approach could play a significant role in controlling health expenditures in the United States.

For the study, published in the October *American Journal of Public Health*, researchers Glenn A. Melnick and Jack Zwanziger looked at data on cumulative growth in real per capita health expenditures between 1980 and 1991 to compare California—a state with a pro-competitive policy—with the national average and with four states with established hospital regulatory programs—Maryland, New Jersey, New York, and Massachusetts.

Selected measures studied included expenditures for hospital services, physician services, retail drugs, and the total of all three measures.

"Aggregate data show that California not only did much better than the national average in controlling growth in hospital expenditures per capita but also did better than all of the states with hospital rate regulation programs," the researchers stated.

Furthermore, the data provide no evidence that health expenditures were shifted from the hospital sector to other sectors in California as a result of competition, the researchers observed. "Rather, it appears that states with hospital regulatory programs are the ones that show evidence of the so-called 'ballooning or unbundling' effect, in which expenditures in the unregulated sectors grew much more than the national average for many of the regulatory states," they added.

The researchers noted that their data covered only 70 percent of total health expenditures and that there could have been shifts to the other sectors, such as long-term care.

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Legal PULSE

Prescription Drug Use and the ADA

A U.S. district court recently ruled that requiring employees to disclose what medications they are taking violates the Americans With Disabilities Act (*Roe vs. Cheyenne Mountain Conference Resort*, January 11, 1996).

In July 1995, Jane Roe filed suit in the U.S. District Court in Denver against her employer, Cheyenne Mountain Conference Resort in Colorado Springs, Colo., asking the court to prevent the resort from enforcing its policy requiring workers to tell their supervisors what prescription medications they were taking. The hotel argued that it was entitled to this information as part of its drug-testing program.

The court held that the ADA prohibits employers from asking employees to reveal their disabilities unless the inquiry is job-related and necessary.

This decision, the first involving ADA limits, contrasts with others that have allowed employers with drug-testing programs to obtain employee medical information.

The hotel will not appeal.

STATUS: Case closed.

Managed Care and Mental Health

A group of mental health therapists and patients have filed suit in Massachusetts state court against Blue Cross and Blue Shield of Massachusetts, claiming that the company engaged in deceptive practices by promising subscribers comprehensive mental health benefits without informing them that their benefits had been drastically curtailed through adoption of a managed care plan (*Schuffer vs. Blue Cross and Blue Shield of Massachusetts*).

When Blue Cross and Blue Shield acquired Bay State Health Care, it represented to subscribers that they would continue to receive 20 therapy sessions that were part of their benefit plan. In practice, however, says Frederick Schuffer, MD, a Harvard psychiatrist and the lead plaintiff in the case, the number of sessions was limited to six. In addition, subscribers were made to call an 800 number as the only way to access benefits and obtain therapists. Therapists who requested more sessions with patients, says Schuffer, were intimidated with threats of being removed from the list of recommended therapists.

Schuffer says the case raises the important issue of whether insurance companies need to honestly disclose the true nature of the pending mental health benefits they provide. The plaintiffs' motion for summary judgment is pending. A trial date is expected to be set this month.

STATUS: Case pending.

Does Capitation Violate ERISA?

A mother of two children has filed suit against Aetna Health Plans, alleging that the company violated ERISA by requiring that her pediatrician switch from fee-for-service pricing to a capitation system (*Maltz vs. Aetna Health Plans*).

For 16 years, Mara Maltz of North Bellmore, N.Y., has taken her children to a local pediatrician. The children suffer from chronic intestinal disorders. The Maltz family had been covered by an Aetna group managed care plan through Maltz's husband's employer for a year and a half. Aetna notified the physician that for him to stay in the physician network, he would have to switch from fee-for-service pricing to a capitation system. The pediatrician told the Maltzes that he could no longer be their family doctor because he was opposed to two features of the HMO: the reimbursement per patient and the "physician incentive fund," under which Aetna pays bonuses for lower hospitalization rates and other cost savings.

Maltz's suit, filed in U.S. District Court for the Eastern District of New York, alleges that Aetna breached its fiduciary duty under ERISA by not acting in the interest of participants and beneficiaries. Maltz is seeking only attorneys' fees and court costs.

STATUS: Case pending.

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OCCASIONAL NOTES

PATIENT ADVOCACY IN THE 1990s

In this decade of cost containment in medicine,[1,2] many of us have encountered insurance carriers that denied coverage for certain medically indicated procedures or treatments. Managed care has also led to centralized planning and reimbursement for expensive treatments such as organ transplantation, with some insurers restricting the choice of institution on a contractual basis. Those of us in academic medicine have had less experience with these phenomena than other physicians, but that fact is rapidly changing.[3] A recent experience at our institution highlights the ethical conflicts that can arise during the referral of a patient in a managed-care system.

A pediatrician working for a national health maintenance organization (HMO) referred a three-month-old girl with pallor, bruising, and hepatosplenomegaly to our pediatric-oncology group. She was found to have leukocytosis, anemia, and thrombocytopenia. We diagnosed acute lymphoblastic leukemia and started intensive chemotherapy. Cytogenetic analysis revealed an abnormality of chromosome 11q23, an indication of a poor prognosis with conventional chemotherapy (less than 10 percent disease-free survival at five years). HLA typing showed that her older sister was a suitable donor. We recommended an allogeneic bone marrow transplantation in the first remission — the standard therapy for this subgroup of patients with acute lymphoblastic leukemia.[4] Even with transplantation, the prognosis is guarded in such patients.

We informed the referring physician of the results of our evaluation and the plans for transplantation. Shortly thereafter, we were contacted by an administrative physician from the HMO and asked to assist in the referral of the patient to the nearest "center of quality," a transplantation center in another state that had been selected by the HMO to perform all bone marrow transplantations in our region. We had previously referred patients to this center, and we had no doubts about the quality of care the patient would receive there.

After the plan had been discussed with the patient's family, as well as with the social worker and psychologist on our team, it became clear that treatment out of state for several months would be detrimental to the family. Both parents were distraught. The father would not be able to be involved because of employment restrictions. The mother, who obviously needed to be with the infant, would lose her position and be forced to take a lesser job with a pay cut. The older sister, who was having serious behavioral problems, would have to be separated from her mother for a prolonged period. The expenses associated with an extended stay in a city where the family had no relatives or friends would be difficult for the family to manage. There are two excellent transplantation centers nearby in our own state, and we were asked to request that the HMO make an exception to its policy on selecting a transplantation center.

When we explained why this family would be better served if the transplantation were performed nearby, we were informed that the HMO would not make an exception. The stated rationale was that the HMO examines the results of transplantation at all centers and chooses only the "best" for its clients. Noting that Johns Hopkins University and the University of Minnesota were not among this select group, we decided to investigate further. It turned out that the center selected for our patient has no particular expertise in acute lymphoblastic leukemia in infants or in the preparative regimen or transplantation procedure. All bone marrow transplantations are not alike, and we routinely refer patients to other institutions for specific indications and protocols. No published reports from the center chosen by the HMO suggested a reason for its selection. Furthermore, there are no differences between outcomes in large and small centers performing more than five allogeneic bone marrow transplantations per year.[5] Thus, although the two nearby (in-state) academic institutions that perform transplantations are relatively small, either one could have performed the procedure, according to current standards of care.

It was informative to see the reactions generated by our request for an exception to the HMO's transplantation policy. At our own institution, we were cautioned by a transplantation specialist not to offend this carrier, "because we are in the running for the next contract." Other colleagues merely shook their heads sadly, advising us to let it go, since nothing could be gained, and "this is the new medical-economic reality." The HMO administrator thought we were "interfering with the client–carrier relationship." He told us, "You should be glad we cover this procedure. Get used to it. It's happening everywhere. Your program may end up being a beneficiary of this approach." The assumption was that our primary interest was the development of our own transplantation program. This assumption was inaccurate; we often refer patients to other institutions. Most important, none of these responses spoke to the specific needs of the patient and her family.

Against the stated wishes of the family and in the absence of medical indications, the patient was referred to the transplantation center selected by the HMO. She underwent an allogeneic bone marrow transplantation, which she tolerated relatively well, and returned to our care five to six months later. In the meantime, the older sibling was sent to live with relatives in another state, the mother was demoted, and the father lost his job. Several weeks ago, a bone marrow aspiration performed at our institution showed that the patient was having a relapse. Reinduction chemotherapy was initiated, and the possibility of a second bone marrow transplantation was raised. The administrative physician at the HMO called to tell us that an appointment had already been made for our patient at yet another transplantation center. The family's HMO physician

had apparently contacted the HMO administrator. The previous center was no longer considered a "center of quality" (for reasons we were not told). Given the guarded prognosis for this patient, it would have been more appropriate to discuss with us whether another transplantation was in her best interest than to initiate another referral before a remission had been attained.

None of the psychosocial factors that made the first out-of-state transplantation problematic had improved. In addition, the first transplantation center had established an ongoing relationship with the family. To keep her family together, the patient's mother decided to quit her job, give up her HMO coverage, and apply for Medicaid. The parents have lost their home and their savings, and the older sister has had increasingly severe behavioral problems. Despite being the infant's primary oncologist and social worker, we have lost the autonomy to make decisions that take these factors into account.

What can we do to prevent such extreme disruption? As advocates for our patients, we must stand up for the doctor–patient relationship and for continuity of care. We must continue to act on the basis of our patients' best interests, not the bottom line. When the two conflict, we must speak out: write letters to the insurance carrier, the insurance commissioner, and elected officials when necessary. Academic physicians need to work more closely with managed-care groups to develop flexible policies that use rather than ignore subspecialty decision making. We cannot ignore published outcome measures[2] and must work together to perform additional studies designed by specialists. In some situations, physicians may need to educate families about their options for choosing a carrier. Certainly, employers or insurers should inform prospective enrollees about the restrictions on choice in each health plan, particularly if patients must travel substantial distances to obtain specialized care. We must provide the very best care we can for our patients, keeping psychosocial factors in mind. The trend toward insurance-mandated medical decision making is accelerating. We cannot allow national contracts and policies to harm the individual families and patients we serve.

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BOOK REVIEWS

EFFECTS OF ATOMIC RADIATION: A HALF-CENTURY OF STUDIES FROM HIROSHIMA AND NAGASAKI

By William J. Schull. 397 pp. New York, John Wiley, 1995. $45. ISBN 0-471-12524-5

This book discusses the short-term and long-term medical effects of atomic radiation in about 150,000 of the people who survived the atomic bombings of Hiroshima and Nagasaki in 1945. These people have been the subject of a continuing study conducted by the Atomic Bomb Casualty Commission and its successor organization, the Radiation Effects Research Foundation. The book is in one sense a history of the origin, objectives, growth, creative personnel, and contributions to radiobiologic knowledge of these organizations. The detailed evaluation of the medical effects of radiation appropriately occupies most of the book, since the author has been intimately involved with major facets of the atomic-bomb–survivor study for most of his professional career, specifically from 1949 to the present. The experience of the survivors constitutes the most powerful epidemiologic follow-up of radiation exposure, and the results of these studies are widely recognized as the principal source of our information on radiation-induced malignant disease, fetal effects, and genetic aberrations. The author presents an erudite and well-organized description of these studies and their results.

The history begins with a brief account of the human and property damage caused by the bombs, based on the assessment of a joint U.S.–Japanese commission in the autumn of 1945. More than 50 percent of the deaths in the immediate aftermath of the bombings in the two cities were due to burns, about 18 percent were due to the blasts themselves, and possibly as many as 30 percent were due to ionizing radiation. In 1946, the Atomic Bomb Casualty Commission, jointly funded and staffed by the United States and Japan, was created after approval by President Harry Truman. I found descriptions of the early history of space, personnel, and financial problems and diplomatic relations tangential to the main scientific objectives of the book. However, the studies conducted during the period from 1948 to 1955 show that many of the major delayed medical effects were already manifest, particularly in the high-dose region within 1 km of the epicenter of the blasts. Examples are adverse pregnancy outcomes, developmental delays among children, lens opacities (investigated by a team of United States ophthalmologists in 1949), and an excess rate of leukemia. The first 9 cases of leukemia were noted in 1949, there were 50 cases by 1953, with a risk of about 1 in 80 for those who were within 1 km of the epicenter, as compared with a risk of 1 in 12,000 for those who were farther away. In this section, the author provides the first of several excellent primers for general medical readers on the characteristics of important radiation effects — in this case, leukemia.

The initial studies were concerned with particular syndromes and were not part of a central, organized plan of study. This situation was transformed after 1955 by a National Research Council review committee under the leadership of

SB282

Perspective & Analysis

The author provides context for, and responses to, a recently released survey of consumer protections in state HMO laws.--Ed.

Plan Regulation

State HMO Consumer Protections Vary, Many Laws Inadequate, Consumer Group Says

State legal protections for health maintenance organization enrollees vary widely, and most do not provide adequate protections in the areas of access, quality of care and related data collection, and provision of HMO information to enrollees and the public, according to a study recently issued by the Center for Health Care Rights (CHCR), Los Angeles, a non-profit consumer advocacy organization.

"We were especially concerned about the lack of strong state mandates on monitoring of the care provided by HMOs, the lack of state standards by which to measure access and quality of care, the lack of information available to consumers on quality of care, and the lack of adequate grievance procedures for enrollees wanting to appeal an HMO's decision not to provide, or pay for, medical care," CHCR Executive Director Geraldine Dallek said in a statement announcing the study's release (1 MACR 507, 12/6/95).

However, CHCR's study has been criticized by the managed care industry as focusing too narrowly on state HMO licensure without discussing other federal and state HMO laws and regulations. Critics of the study also note that HMOs are more heavily regulated than are other types of managed care entities.

Source Of Variations

A review of laws in several states where HMO enrollment is fairly high among the population with health care coverage suggests that the variations may result from the different state agencies that regulate HMOs, as well as from the range in the underlying statutes' comprehensiveness.

For example, HMO statutes in Arizona, California, Florida, Maryland, Massachusetts, and Minnesota, reflect regulation by a variety of agencies, including the health department, the insurance department, and corporations department. Primary regulatory jurisdiction over HMOs may be exercised by any one of these departments. HMOs, like other businesses, also are regulated under state and federal tax, antitrust, and consumer protection laws.

About two-thirds of the states have had HMO statutes on the books since the 1970s, according to a recent 50-state profile issued by the Intergovernmental Health Policy Project, George Washington University. Perhaps the most striking feature of the laws is their diversity.

State laws often are fairly detailed regarding standards for HMO licensure, solvency, content of subscriber contracts, and coverage for specific conditions, but vary considerably as to the public availability of information that would aid consumers in judging the comparative quality of various plans on issues ranging from subscriber participation in HMO governance to provider access, quality assurance, and effective procedures for appealing benefit or claim denials.

The actual organizational information available to enrollees may be limited, with most disclosure requirements running from the HMO to state regulators, rather than to consumers.

The CHCR study, Consumer Protections In State HMO Laws, examined 10 categories of HMO consumer protections: marketing/enrollment; access and benefits; quality; grievance procedures; HMO data collection; enrollee and public information; enrollee participation in governance; conflicts of interest; insolvency; and state law penalties for violations.

Each section outlined key consumer concerns, the issues studied, and an analysis of state laws, including comparative charts on each issue.

Among some 150 detailed recommendations, CHCR called for greater regulation of HMO marketing materials and agent training; strict monitoring of care quality, including requirements for internal quality plans and assessment of financial risk arrangements for providers; improved procedures for contesting specific denials of care, including review by an independent entity; and cooperation among the states, the federal government, and private accreditation entities to standardize data reporting requirements.

Key Issues Identified

Some of the key consumer issues identified by the study included concern over delays in or restriction of access to appropriate care, financial risk arrangements that provide incentives undermining care quality, lack of adequate grievance procedures, and lack of standardized quality data.

With respect to health care access, the study noted that while 23 states mention or require HMOs to have a referral system, only five set out parameters under which these systems must operate. Four states require HMOs to maintain a specific physician/enrollee ratio, 10 establish a maximum travel time or distance from the HMO's provider or facilities to an enrollee's residence or workplace, and only one sets a maximum waiting time for care in a health care provider's office.

Of the 31 states that require some external monitoring of quality of care, three require a yearly review, 24 call for a review every two or three years, and two require a review once every five years. According to the study, only 13 states provide statutory standards for these evaluations.

Although all states require HMOs to have a grievance system, only 21 states specify the time within which HMOs must resolve enrollee grievances and none requires HMOs to provide for an appeal of a service denial to an entity, other than the state, that is independent of the HMO, the study found. And only 10 states require HMOs to provide a way for physicians to file grievances.

Study Called "Too Narrow"

GHAA criticized the CHCR study as focusing too narrowly on state HMO licensure statutes without examining other sources of federal and state HMO regulation providing protection for consumers, such as the HMO Act of 1973.

"We also make the point that consumers, patients in HMOs, have more protection than in any other type of health plan, including non-HMO plans," GHAA's Don White told BNA.

The HMO Group, an organization of non-profit HMOs, argued that other entities—such as physician-hospital organizations or other provider networks—providing the same types of managed care products do not always face the same type of state regulatory oversight. These entities "should have a level playing field and should be regulated the same," Curtis Kelley, government relations director, told BNA.

In a press release, GHAA noted that the CHCR study also did not cover private accreditation as another method of reviewing HMO operations. "The HMO community has taken the lead in the development and release of quality assurance data, physician credentialling standards, the formation of private accrediting bodies, and the release of report cards. We would like to call for a more complete study of all these consumer protections to see how other forms of health insurance measure up," GHAA said.

States Re-Examine Regulations

With recent explosive growth of managed care organizations in addition to more traditional HMOs, and a heightened emphasis on cost containment, states with 20-year-old HMO statutes have begun to revise their rules to reflect the new health care environment. The Medicare and Medicaid programs' increasing embrace of managed care also are likely to affect the changing regulatory picture.

Examples of statutory changes during 1995, featuring enhanced consumer protections, include:

• *Arizona*: A new statute is scheduled to take effect Jan. 1, 1996, that requires HMOs to provide comprehensive information to prospective enrollees on their referral systems, provider incentives to withhold services, restrict specialist referrals, and other standards that might limit care provided.

• *California*: A recently enacted law requires health care service plans to include dispute resolution procedures in their contracts with providers, and to allow enrollees to file grievances with the corporations department. Another new law establishes a toll-free consumer hotline for filing complaints against HMOs, requires HMOs to resolve grievances within specific time limits, and imposes monetary penalties for nonresponsiveness to grievances (1 MACR 383, 10/25/95; 1 MACR 402, 11/1/95).

• *Minnesota*: In addition to an existing comprehensive regulatory system with detailed standards for health care access, state monitoring, internal quality assurance plan requirements, and grievance systems, new reforms adopted this year call for greater accountability by integrated service networks, requiring them to establish internal quality improvement processes.

• *Texas*: Although the governor vetoed a bill altering managed care rules, the insurance commissioner Nov. 15 adopted comprehensive HMO and preferred provider organization rules governing emergency medical treatment, and requiring disclosure of financial arrangements between managed care plans and providers (1 MACR 480, 11/29/95).

• *New Jersey*: Health and insurance officials have proposed a comprehensive rewrite of HMO regulations (1 MACR 482, 11/29/95).

Instead of moving to increase regulation of managed care in whatever form, Kelley argued that it might be more effective for states to examine ways to make available data more understandable and to focus on verification of quality information through the accreditation process, like that presently conducted by the National Committee on Quality Assurance

CHCR's report, "Consumer Protections in State HMO Laws," may be purchased from the Center for Health Care Rights, 520 S. Lafayette Park Place, Suite 214, Los Angeles, CA 90057; tel. (213) 383-4519; fax (213) 383-4598.□

—By Leslie J. Gold

Invitation To Authors

In this section, *BNA's Managed Care Reporter* intends to offer the commentary and perspective of experts in the field on a range of important issues facing the managed care industry.

Articles can provide context for understanding trends or they can provide practical guidance. Individuals interested in contributing suggestions or articles are encouraged to call Managing Editor Deborah Spiegelman, (202) 452-7572.

*6 MANAGED CARE: SYSTEMS CREATING PAPERWORK BLIZZARD

While managed care has been billed as a more cost-effective way to deliver health care, a study released today in the 2/96 issue of AMERICAN JOURNAL OF PUBLIC HEALTH (AJPH) shows that "it has fattened up hospitals by forcing them to hire thousands of paper pushers and administrative staffers." Study co-author/Physicians for a National Health Program (PNHP) co-founder Dr. Steffie Woolhandler said the growing number of health workers employed for administrative purposes "is a trend that existed before managed care, but it has been accelerated by managed care" (Segal, WASH. POST, 2/15). She added that "managed care squeezes doctors, nurses and patients but eats up most of the savings with bureaucracy" (PNHP release, 2/15).

THE NUMBERS: According to the study, the number of managers and clerks in the health industry "ballooned" by almost 700% from 1968 to 1993, "making them an ever greater portion of the total health care workforce" (Segal, 2/15). In comparison, the number of physicians and nurses grew by only 77% and 164% respectively over the same period (PNHP release, 2/15). The number of health care "managers" topped one million in 1993, up from 129,000 in 1968. The number of "care-givers" -- doctors and nurses -- "shrank" from 51% to 43% of the total health care workforce over the period. The percentage of "administrative" staff, meanwhile, grew from 18% to 27% (Segal, 2/15). Woolhandler noted that "in 1993, administration accounted for 57 percent of health sector job growth and all of the growth in hospital employment" (PNHP release, 2/15).

BLAME THE GOVERNMENT: Hospital administrators in the Washington, DC, area responded to the survey by saying that "government regulations are equally responsible for larger administrative staffs." Alexandria (VA) Hospital's David Tatro said, "Health care institutions have had to answer to a lot more agencies in the past two decades. It takes people to deal with OSHA and the EEOC and other federal agencies we have to comply with." Sounding a similar note, Woolhandler said, "Doctors and hospitals now have to hire staff to handle a staggering number of forms for referrals and payments" (Segal, 2/15).

SINGLE-PAYER COMPARISON: The study's authors found that the U.S. "allocates far more of its health budget to paper-pushing and administration than does Canada," which relies on a government run, single-payer system. Canada's health care system, they found, employs more nurses, clinical hospital staff and nursing home staff than the U.S. system, "despite spending one-third less on health care per capita." In fact, the researchers found that if the U.S. duplicated "Canada's 1986 staffing patterns," the country's hospitals and outpatient facilities would require 1,407,000 fewer clerks and managers (PNHP release, 2/15).

ANOTHER SWIPE AT MANAGED CARE: In the study, the authors conclude, "Administration's growth spurt ... has coincided with promarket policies in the [U.S.] designed by managed care's architects to make providers' profitability 'the mandatory condition for survival.' Entrepreneurial incentives spur marketing, detailed cost tracking, and efforts to amplify profitable services, eliminate unprofitable ones, and battle insurers over payment. ... Recent U.S. policies have also assigned more regulatory power to insurance firms and employers. ... Curiously, we have exempted new administrative procedures from the evaluation we demand of clinical ones. Does managerial pressure to compress care save work or just accelerate the pace? Do managed care referral constraints husband scarce resources or merely keep clerks busy and specialists idle? Does more administration increase efficiency or waste time and trees?" (AJPH, 2/96 issue).

IS IT WORTH IT?: POST reports that some health care experts said the extra administrative personnel "are often worth the money because they help hospitals become more cost-effective." Taking the administrative efficiency line, Rand Corp. economist Glenn Melnick said that "using 27 percent of the health care work-force to handle administration could be an optimal use of manpower" (Segal, 2/15).

ABOUT THE AUTHORS: The study was co-authored by Woolhandler and Dr. David Himmelstein, both of Harvard University's Center for National Health Program Studies. Himmelstein also co-founded PNHP. Last year, he and Woolhandler co-authored a study in the NEW ENGLAND JOURNAL OF MEDICINE on "gag clauses" contained in many managed care physician contracts (see AHL 12/21).

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•2 CALIFORNIA: COALITION PUSHES ANTI-HMO BALLOT INITIATIVE

"A coalition of consumer groups and labor unions has launched an effort to diminish the growing power of California's managed care industry through a November ballot initiative," L.A. TIMES reports. The effort, which is "sweeping in scope," is being led by consumer advocate Harvey Rosenfield and the California Nurses Association. Several versions of the initiative have been submitted to state Attorney General Dan Lungren (R); each calls for banning the payment of certain bonuses to doctors or nurses for limiting care, eliminating "so-called physician gag orders" and prohibiting insurers from "forcing" members to give up their right to go to court to settle contractual differences.

BACKLASH: According to the TIMES, the effort "comes amid a growing backlash against managed care and its impact on the quality of medical care." HMOs have been criticized for their "hefty profits" and the lucrative salaries paid to some of their executives. As a result, legislatures in California and other states "have passed, or are considering, a flurry of managed care measures that seek to" protect consumers by placing restrictions on certain HMO practices. Rosenfield said that the initiative "is a response to the 'concentration and intrusion of managed care and its unprecedented emphasis on corporate profits rather than patient protection.'" Other supporters of the ballot initiative are: Oakland-based Neighbor to Neighbor, a health care advocacy group; San Francisco-based Health Access, a consumer health group; and the Service Employees International Union, which represents nurses and other health care workers in the state.

INTERNAL DISSENT?: Groups supporting the ballot measure are "divided over which version of the initiative to throw their collective support behind." The nurses union supports a version that would place fees on "certain health care mergers," on "'excessive' executive compensation and on hospitals that seek to reduce their numbers of patient beds." But some groups are concerned that this version "may go too far and erode support for the measure."

OPPOSITION: TIMES reports that managed care companies are opposed to the measure and "contend" it is "unnecessary because health plans are already well-regulated" and because "marketplace forces are providing adequate consumer safeguards." Kurt Davis, spokesperson for Foundation Health, one of the state's largest HMOs, said, "The market is pushing companies to address some of the issues that are behind this initiative." He added that passage of the initiative "would only add to the burden of doing business in California and make it more attractive to be in states that don't have these provisions."

A LOOK BACK: The initiative "marks the second attempt" by some of the groups involved "to bring changes to the state's medical delivery system." Voters were asked to consider Proposition 186 on the 1994 ballot, which would have established a "so-called single-payer health initiative" in order to "create a state-run health care system" (see AHL 4/22/94). TIMES notes that the measure was "resoundingly defeated" after businesses and the insurance industry mounted "fierce opposition" (Olmos, 1/18).

ALPHA CENTER

From Payer to Purchaser: State Strategies to Purchase Health Benefits

Rebecca R. Paul

November 1993

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The Robert Wood Johnson Foundation
Program on Health Care Reform

State Strategies Report

From Payer to Purchaser: State Strategies to Purchase Health Benefits

Rebecca R. Paul

November 1995

The views expressed in this report are those of the author and do not necessarily reflect the opinions of The Robert Wood Johnson Foundation or Alpha Center. Alpha Center is a non-profit health policy center, which serves as the national program office for the State Initiatives in Health Care Reform program. The author wishes to express appreciation to Kathy Burek, Julia Costich, Mary Kennedy, Patricia MacTaggart, Carole Ohnstein, Susan O'Laughlin, Michael Rothman, Laura Tollen and Anthony Tasi, as well as other officials from Kentucky for providing valuable information about their state purchasing programs and reviewing draft versions of this paper.

Executive Summary

States increasingly are recognizing their role as important players in the health care marketplace as buyers of health benefits. By increasing purchasing power, enhancing competition, coordinating administrative functions, and collectively negotiating for beneficiaries' benefits, several states are seeking to control the cost of health benefits for state government employees and retirees, employees and retirees at state higher education facilities, and other public employees. Some states may also include Medicaid beneficiaries, small employers, and individuals in their purchasing strategy.

To achieve their goal of reducing costs, some states are:

- Leveraging their own employees and Medicaid beneficiaries by allowing other groups to participate in their purchasing arrangements. As states enlarge existing risk pools, some are exploring ways to adjust payments based on risk differences.

- Implementing competitive features, including requiring employers to contribute some fixed dollar amount to their employees' premiums, standardizing benefit packages, enabling enrollees to compare price and service across participating health plans, and offering enrollees a choice among health plans.

- Coordinating the administrative activities of multiple purchasing programs.

- Collectively negotiating and contracting for beneficiaries' health benefits. Such efforts can reduce administrative costs for both the state and health plans, provide the state with better leverage in negotiations with health plans, and avoid the difficulties inherent in merging risk pools.

Several states also are striving to improve the quality and, therefore, the value of health benefits they purchase. By collecting additional, standardized, and more reliable data,

I. Introduction

States increasingly are recognizing their role as important players in the health care marketplace. Not only do states serve as regulators of providers and health plans, but they participate in the market as buyers of health benefits on behalf of their employees, Medicaid beneficiaries, and others. By using their purchasing power,[1] states have been better able to contain costs and increase the choice of health plans for their enrollees. Further, as large buyers of health care, the states are learning that they, like large private-sector employers, can catalyze changes in the market.

States' oversight of health care financing and delivery systems includes purchasing strategies and insurance market reforms that are intended to change the way health care coverage is bought and sold. Most states have enacted insurance market reforms to improve the availability of health insurance products. These reforms include rating restrictions, guaranteed issue and renewal, and portability. Available evidence suggests that these reforms reduce premiums for high-risk groups and individuals and may reduce gaps in coverage that result from pre-existing condition exclusions (Chollet and Paul, 1994). They may also concentrate the health insurance market among fewer insurers and promote greater penetration of managed care, although these latter effects have not been carefully measured.

Many states have begun to consider developing coordinated strategies for purchasing health care coverage. Some states have authorized the establishment of private voluntary purchasing cooperatives. At the same time, some states are reconsidering their own purchasing strategies in an effort to increase the value of the health benefits purchased by state-run programs. New state purchasing strategies typically include increasing the state's purchasing power (by maximizing enrollment and coordinating negotiations with health plans), enhancing competition (including greater enrollee choice of health plans), and consolidating or coordinating administrative functions. These state strategies typically apply

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[1] "Purchasing power" has been described as "the ability to get good prices and influence the health care and insurance industries to change in ways that will benefit people (quality, access, etc.)" (O'Loughlin, 1995a).

Alliance. Finally, Colorado is just at the point of discussing with various public employers the possibility of consolidating their health benefit purchasing activities.

These states have one aspect in common: each is making efforts to consolidate or coordinate purchasing across multiple health benefit programs. Based on their different approaches and experience, they provide varying perspectives on the opportunities and problems that consolidated state purchasing presents

Table 1

Administrative Functions of Health Benefits Purchasers
• Negotiate with health plans and providers
• Contract with health plans and providers
• Enroll and disenroll members
• Collect premium contributions from participating employers, enrollees, and public sponsors
• Disburse premiums: buy insurance policies and/or reimburse providers
• Assess and adjust for risk among health plans
• Collect data and analyze/monitor quality of care delivered
• Provide appellate and advocacy services
• Market to consumers
• Develop and maintain provider relations

To reduce the overall costs of the health benefits purchased by state programs, states may leverage their own employees and Medicaid beneficiaries by allowing other groups -- non-state public employees, private employers, and individuals -- to participate in their purchasing arrangements. A state may also encourage price competition among health plans and coordinate the purchasing functions of multiple purchasing programs, including collective negotiation for beneficiaries' health benefits. Although the primary goal of such strategies is containing the public-sector costs of health benefits, they may have a broader effect as well. That is, the state may achieve lower costs in the overall system if it catalyzes health plans to change how they manage and deliver health care more broadly.

Table 2

Groups for Which Purchasing Functions are Being Consolidated

	Kentucky	Minnesota	Washington
Purchasing Entity	Kentucky Health Purchasing Alliance	Department of Employee Relations[a]	Health Care Authority
Mandatory Groups	Employees of • State government • Public health departments • School districts • Local governments • Judiciary • State higher education State and other public sector retirees under 65	Employees of • State government • University of Minnesota State retirees	Employees of • State government • State higher education State retirees School district retirees
Voluntary Groups	Employees of • Firms with 2-100 employees • Affiliated groups or associations Individuals	Employees of • Counties[a] • Cities[a] • Townships[a] • School districts[a] • Private employers[a]	Employees of • Political subdivisions[b] • School districts Private employers and individuals[c]

[a]The Minnesota Department of Employee Relations operates three purchasing programs, one for state employees, one for other public employees (the Public Employees Insurance Plan (PEIP)), and one for private employers (the Minnesota Employees Insurance Program (MEIP)).
[b]In addition to local governments, political subdivisions include public hospitals and the port authority.
[c]The Washington State Health Care Authority purchases health benefits for private employers and individuals through the Basic Health Plan, which is run as a separate program. Subsidies are available to low-income individuals.

Minnesota. With 144,000 employees, dependents, and retirees, the state is the largest employer-based insurance group in Minnesota (OTA, 1994). Using this group as a base, the state has been able to instill competition based on price, service, and benefits into the market for state enrollees. The state also manages separate voluntary programs for non-state public employees (the Public Employees Insurance Plan (PEIP)) and private employers (the

some are exploring ways to adjust payments based on risk differences in order to avoid the jumps in rates that may result when higher-risk groups merge with lower-risk groups.

Kentucky. The state's insurance market reforms permit insurers to adjust premiums only for age, geography, and four family sizes in the nongroup, small group (under 100 employees), and Alliance markets. Further, insurers offering coverage to Alliance enrollees submit separate rates for the individual and group pools.[9] The Kentucky Health Policy Board administers a market-wide risk adjustment program that prospectively further adjusts these premiums on the basis of age, sex, retiree status, and COBRA status.[10] This program also retrospectively reimburses health plans when they incur a greater than average number of high-cost medical cases.[11]

Washington. The Washington Health Care Authority adjusts health plan premiums for age, sex, family size, and Medicare enrollment for all enrollees except those in the Basic Health Plan (BHP). The health plans providing coverage to BHP enrollees charge premiums adjusted only by age.

Minnesota. The Minnesota Department of Employee Relations (DOER) adjusts payments for risk both prospectively and retrospectively in both the Minnesota Employees

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[9]The Alliance originally planned to have three risk pools, one each for individuals, public employers, and small employers. Although public employees had been concerned that they would have to pay higher rates to subsidize small businesses, the initial bids received from health plans showed little or no difference between the proposed rates for small businesses and for public employees. The Alliance subsequently decided to merge all employer groups into one pool.

Although all employers will pay the same rates, premiums will be calculated differently for public and private employers. Large public sector employers will receive a composite rate at their request, while private and small public employers will pay an individually calculated premium for each employee. Disbursement to carriers will reflect the age- and geography-adjusted rates in all cases (Tassi, 1995; Costich, 1995).

[10]Relative risk factors are calculated prospectively. During the first year, debits and credits will be accrued quarterly, and payments made at the end of the year (Tassi, 1995).

[11]All health plans in the nongroup, small group, and Alliance markets are required to contribute one percent of premiums quarterly to finance this system. Payments will be made annually (Tassi, 1995).

Minnesota Departments of Employee Relations and Human Services now coordinate the release of RFPs and plan to conduct joint negotiation of contracts (see box on page 12)

Washington. The Public Employees Benefits Board (PEBB)[11] purchases health benefits for state and other public employees and retirees. Although contracts will remain separate, PEBB and the Basic Health Plan are releasing a single joint RFP and conducting negotiations jointly for the first time. (At present, carriers are not required to contract with one program in order to contract with another, although there is substantial overlap between the two programs (O'Loughlin, 1995b).) By combining the negotiating power of both programs, the Health Care Authority has developed a track record of encouraging health plans to reduce costs and improve the quality of benefits.

The Washington Health Care Authority and the state's Medicaid program have also begun coordinating and streamlining the requirements that they impose on health plans. The agencies' efforts have resulted in the coordination of RFPs and progress toward common contractual requirements for quality assurance and data collection. Authority and Medicaid representatives are also sitting in on one another's negotiations with health plans (O'Loughlin, 1995b).

3. Enhancing competition

By increasing competition among health plans at the point of enrollment, a number of states have attempted to increase their purchasing power and thus reduce their costs. Typically, these states require employers to contribute some fixed dollar amount to their employees' premiums (such as the price of the lowest cost health plan offered); standardize benefit designs, permitting enrollees to compare price and service across participating health plans; and offer enrollees a choice among health plans.

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[11]The PEBB makes eligibility and benefit design decisions for the Public Employees Benefit Program, which is administered by the Authority. The PEBB consists of one active employee, two retiree representatives, and three "experts" in health benefits and economics. The Authority Administrator chairs the Board and serves as the seventh vote.

Employers' Contribution Toward Employees' Premiums

By requiring employers to contribute a fixed amount to each employee's premium, states have effectively required enrollees to bear the cost of higher priced health plans. The hope is that enrollees will have an incentive to choose lower priced plans and that health plans will have an incentive to compete based on price.

Kentucky. The Kentucky Health Purchasing Alliance does not require participating employers to contribute any portion of their employees' premiums. However, its statutory language stipulates that if the employer does contribute, the same dollar amount must be paid for each employee. Because a strict interpretation of this policy would not allow for insurance adjustment factors such as age and family size, the Kentucky Health Policy Board has interpreted the equal-contribution requirement to mean an equal dollar amount within each age and family class. The State's own contribution toward employee premiums is sufficient to cover the price of a comprehensive policy for the employee or a less comprehensive family policy.[14]

Minnesota. Minnesota's State Employees Group Insurance Program calculates the employer (i.e., the state) contribution relative to the lowest-cost plan in the county where each employee works. DOER recognizes that this choice of premium base might be an issue in those areas where medical trade patterns do not coincide with county lines (Burek, 1995), but in practice finds the county of employment a workable base. Employers purchasing health benefits for their employees through MEIP and PEIP are required to contribute at least 50 percent of the price of single coverage for the lowest cost plan available.

[14]Any funds remaining after an employee has purchased coverage may be credited to the employee's flexible spending account (Cestich, 1995).

The Alliance has chosen to make 18 of those plans available to its members. (After reviewing insurer bids, Alliance officials eliminated plans if similar bids had been received for more comprehensive plans (Costich, 1995).) As of September 1995, 14 carriers had contracts to offer one or more of the standard benefit plans through the Alliance.[15] Four of these carriers -- Blue Cross/Blue Shield, John Deere Health Care, Humana, and American Medical Security -- will offer group benefits statewide (Tassi, 1995).

Minnesota. DOER negotiates the benefits of the State Employees Group Insurance Program with several different collective bargaining units. Although co-payment provisions differ only slightly among benefit plans, DOER hopes eventually to reduce even these differences in collective bargaining. Minnesota's MEIP and PEIP programs offer standardized benefit packages to their enrollees.[16]

Washington. The Washington State Health Care Authority offers a benefit package that is standard across the managed care plans offered to PEBB pool. (School districts are an exception in that they have the choice of determining their benefits through the union bargaining process, or of joining the PEBB pool.)

Enrollee Choice

States trying to increase competition in their purchasing also emphasize choice of health plan by enrollees. Enrollee choice of health plan, when combined with employee contributions to premiums, encourages enrollees to select less costly plans and may also encourage health plans to reduce costs and improve service delivery and quality. Purchasing programs in Kentucky, Minnesota, and Washington all permit enrollee choice of health plan,

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[15]The Kentucky Health Purchasing Alliance's authorizing statute requires the Alliance to offer (1) a plan that is identical to the Kentucky Kare Standard benefit package as of January 1, 1994, and (2) a basic plan (Kentucky Kare is the state's self-insured plan for state employees. Kentucky Kare Standard is the minimum health benefit plan available to most state employees.)

[16]For instance, MEIP offers its enrollees a standard plan, although cost sharing levels differ across the four managed care plans offered.

self-insured Minnesota employers, to explore alternative purchasing strategies such as contracting directly with competing provider networks. Beyond its agreement in principle with BHCAG and an interest in related initiatives such as quality monitoring and improvement, DOER has not committed to purchasing health benefits through BHCAG (Ohnstein, 1995).

Washington. One of the Washington Health Care Authority's goals is to generate program savings by reducing the administrative burdens that multiple programs place on health plans and providers (Health Care Authority, 1990). The Authority centralizes functions previously performed separately for the PEBB and the Basic Health Plan. Functions such as health plan contracting, quality assurance, data collection, legislative relations, media relations, accounting, and information systems are integrated in the hope of developing a "cohesive State policy in the areas of health care purchasing, regulation, and public health" and creating a single "consistent focal point for partnerships with the private sector" (Health Care Authority, 1990). Only enrollment and beneficiary services remain separate functions. Further, a steering committee of three agencies (the Health Care Authority, Medicaid, and Workers' Compensation) maintains an RBRVS fee schedule.

Washington State's Development of an RBRVS Fee Schedule

In response to a budget proviso during the 1991 legislative session, a steering committee of representatives from three state agencies—the Health Care Authority, Medicaid, and Workers' Compensation—formed to develop and maintain an RBRVS fee schedule. Although the committee does not exist in statute (only the Health Care Authority was charged with the creation of the fee schedule), the Medicaid and Workers' Compensation programs joined in the effort mainly to coordinate the three state agencies' relationships with providers. (Medicaid also wanted to reallocate the proportion of benefit dollars being paid to different provider types.)

The committee has modified the fee schedule to provide incentives for performing services in the most appropriate setting and, over time, has added services to the fee schedule such as anesthesiology and chiropractic, as well as services historically performed in hospitals but now commonly performed in outpatient settings. The committee is currently developing a fee schedule for durable medical equipment (DME) and has developed common billing and coding procedures as part of its efforts.

To assist the steering committee, a Technical Assistance Group (TAG), comprising representatives of the state medical society and other provider professional societies, serves in an advisory role. The TAG meets three to four times per year.

and service, as well as price. At present, twenty states collect data to measure the quality of care, and eight states collect consumer satisfaction statistics (NIHCM, 1995).

Minnesota. Minnesota's Department of Employee Relations conducted surveys of consumer satisfaction in the State Employees Group Insurance Program in 1991, 1993, and 1995. Using data from these surveys, the state developed reports to help enrollees compare health plans (Burek, 1995).[18] The State plans to coordinate with the Minnesota Health Data Institute and the National Committee on Quality Assurance (NCQA) to include HEDIS[19] information as well as consumer survey information in these reports (Burek, 1995).

While not now coordinating with DOER, Minnesota's Medical Assistance (MA) program, including its Prepaid Medical Assistance Program (PMAP), also has conducted activities to improve the value of health benefits. MA monitors enrollees' access to medical care and discusses potential problems with participating health plans. PMAP conducts ongoing review of participating health plans' quality improvement systems, complaint procedures, service delivery plans, and summary information about health service use as part of Minnesota's participation in the Quality Assurance Reform Initiative (QARI).[20]

Washington. The Washington Health Care Authority currently uses cost, utilization, and quality data to negotiate with health plans and is exploring also collecting HEDIS data. Although the Authority does not presently provide enrollees with such information, it is

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[18]Comparative reports based on the most recent survey will be sent to enrollees prior to the open enrollment period this fall (Ohnstein, 1995).

[19]The Health Plan Employer Data and Information Set (HEDIS) provides standardized, comparable information on health plans' quality, access, patient satisfaction, membership, utilization, and plan financing. Using HEDIS, plans can be compared on measures such as preventive services delivered, prenatal care and related outcomes, and incidence of acute and chronic illnesses.

[20]The Quality Assurance Reform Initiative (QARI) is a demonstration program developed by HCFA to test national quality standards for Medicaid managed care systems. The Henry J. Kaiser Family Foundation is funding three states (Minnesota, Ohio, and Washington) to participate in the demonstration.

III. The Effects of State Purchasing Strategies

Although little supporting documentation exists, state efforts to use their purchasing power strategically seem to be effective in reducing the states' own health care costs. However, information regarding the impact of these strategies on systemwide health care costs is much more scarce.

A. *What We Know*

A fundamental goal of state purchasing programs is to reduce the state's costs in purchasing health care, including both its administrative and benefit costs. Available evidence of the states' success in achieving this goal is encouraging.

Administrative Costs: While a number of states have reduced the administrative costs of their indemnity plans by self-insuring (Schoen, *et al.*, 1994),[21] the states discussed in this monograph have implemented various additional purchasing strategies which appear also to have had an impact on administrative costs. For instance, the operating costs of the Minnesota Department of Employee Relations average 1.8% of premiums (ranging from 0.83% for state employees to approximately 3.0% for MEIP and PEIP) (GAO, 1994). While information documenting earlier administrative costs of these programs is unavailable, they compare favorably to national averages.

Similarly, the operating costs for programs managed by the Washington Health Care Authority average 2.3% of benefit expenditures (GAO, 1994), ranging from 1.5% of benefit expenditures for the public employee pool to 7.0% of benefit expenditures for the Basic Health Plan (O'Loughlin, 1995b). The Health Care Authority believes that its efforts also have played a role in reducing *health plans'* administrative costs (O'Loughlin, 1995b).

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[21] "Ten states report indemnity plan administrative costs of 5 percent or less of plan expenses, while four operate insurance plans with administrative costs of under 3 percent. These rates are much lower than both the 14 percent national average for private health insurance administrative costs as a percent of total expenses, and the 13 percent administrative/profit cost average reported by HMOs" (Schoen, *et al.*, 1994).

may reduce systemwide costs, and the shifting of health care costs from large purchasers to groups with less purchasing power -- is unknown.

However, emerging evidence suggests that the impact of states' purchasing strategies on the larger market is generally positive. The Washington Health Care Authority believes that its competitive procurement process has had an impact on the rest of the market by encouraging health plans to manage costs more effectively (O'Loughlin, 1995b), although they have not sought out objective evidence of such an effect. Washington also has produced evidence that its purchasing strategies do not lead to cost shifting and that its costs are justified by the experience of its programs' enrollment (O'Loughlin, 1995b). Officials of the Kentucky Health Purchasing Alliance have observed health plans entering rural markets since they began requesting bids for the coverage of public employees around the state.

Finally, Colorado was concerned that contracting insurers might shift costs to smaller purchasers in the market. However, it concluded that insurers would not be able to shift their costs from such a large purchaser without risking their competitive position in the larger market. Moreover, it concluded that the same market power that could result in cost shifting also could induce the delivery system reforms needed to reduce health care costs (Office of Public and Private Initiatives, 1995).

2. Consolidation of Activities and Agency Organization

The Washington Health Care Authority believes that they have achieved economies of scale by consolidating the administrative functions that support the purchase of health services. When the Washington Health Care Authority merged with the Basic Health Plan, the Authority consolidated many of the administrative activities common to both programs. These include health plan contracting, quality assurance, data collection, legislative relations, media relations, accounting, and information systems. However, the Authority decided to manage separately the enrollment and beneficiary services functions as public employees and the beneficiaries of the Basic Health Plan have different customer service needs (O'Loughlin, 1995b).

Since the Alliance was formed, Kentucky has made many decisions about the organization of purchasing activities. The Board made an early decision to maintain a separate program for Medicaid enrollees, largely because of the contractual barriers. For instance, in the absence of a Section 1115 Medicaid waiver, the state would be unable to alter the benefit package for Medicaid enrollees. Also, Medicaid's month-to-month eligibility would have posed a significant cost to health plans that sell only guaranteed issue products, as Kentucky requires in the nongroup market (Costich, 1995).

3. Contractual Barriers to Consolidating Risk Pools

In developing their purchasing strategies, several states have considered consolidating financial risks across different groups. However, these states have determined that it is

Finally, spreading financial risk across a consolidated risk pool can create a number of problems related to the contractual relationships and obligations of groups participating in the pool. For instance, because some groups of Medicaid beneficiaries are likely to have significantly higher health care costs on average than the employed population, a community rate that includes Medicaid beneficiaries would shift the burden of Medicaid costs to other populations that share the same community rate. As the average (and total) cost of the Medicaid program decreased, so would federal matching funds provided to the state. To the extent that Medicaid costs would be shifted to state employees (the other large group for which states purchase health benefits), the state's fiduciary responsibility to its employees is not served. For private employers, ERISA's fiduciary responsibility provisions may also prohibit them from participating in a community rate that obviously does not reflect the group's risk. As a result of these considerations, all parties -- entitlement programs and both public and private-sector employees -- may demand separate rates and benefits within a common purchasing alliance.

B. Implementation Issues

The confluence of activities involved in implementing a purchasing strategy pose obstacles at every stage in the process. Again, the experience of several states at different points in implementing their purchasing strategies provide examples.

1. Political Viability of the Purchasing Strategy

In contemplating changes in the way that they purchase health benefits, some groups have expressed a number of reservations about consolidated purchasing. For instance, in Kentucky, several universities' health insurance premium rates were lower than most of the initial Alliance rates (Tassi, 1995). Although cooperating with the statuatory requirements to participate in the Alliance, university officials are concerned about the initial rates, as well as about the impending administrative changes

Governor (O Loughlin, 1995b).[15] Once the appropriation is made, the PEBB determines how to purchase the unions' health benefits within that appropriation. Because the Authority does not directly negotiate with unions, it has greater freedom to consolidate purchasing functions than other states might have. Nevertheless, the Washington Health Care Authority cites efforts to keep communications open as an important factor in their on-going relationship with employee unions.[16]

As with other states, Minnesota negotiates health benefits directly with the state employees' unions. The DOER attributes its ability to make revisions to its purchasing strategy to the unions' understanding that health care costs affect salary increases and the fact that the leadership of the largest union has an interest in health care reform. In 1989, Minnesota's employee unions established the Joint Labor-Management Committee on Health Plans and the state separated out the union insurance article from the general bargaining agreement. The Joint Labor-Management Committee, which includes both DOER and union representatives, meets regularly between bargaining sessions to monitor health plan performance and set broad strategic direction for the insurance program. For example, when one of the plans experienced severe financial difficulties in the late 1980's, the state and the unions cooperated to develop a self-insured PPO (Burek, 1995).

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[15]The only exception to this case is the school districts, where collective bargaining is maintained at the local level. Further, the bargaining units for public school employees decide whether to enroll in the Authority or in their own health plan.

[16]The focal point of the communication between the Authority and the public school unions over the last two years has been the mandate that public school employees purchase health benefits through the Authority. Although public school districts have been allowed to purchase their health benefits through the Authority since it was created in 1988, the 1993 Health Services Act mandated that all public school districts purchase their health benefits through the Authority by October 1995. Because the unions have anticipated that the legislature might reconsider the mandate, however, they have been uncertain how to proceed in retooling their systems to coordinate with the Authority. Furthermore, the unions expected the Authority to be knowledgeable about the Legislature's intent, making communication between the parties even more important to maintaining a cooperative relationship. The Legislature repealed in 1995 the mandate that public school districts purchase health benefits through the Authority.

V. Conclusion

Several states have found that strategies to coordinate health care purchasing among multiple programs can achieve some of the major goals of health care reform. One of the most successful outcomes of state purchasing strategies appears to be a reduction in the administrative and heath benefit costs of government programs. But states also hope their strategies will increase the choice of health plans available to enrollees and improve the quality and value of care delivered. State purchasing strategies include maximizing the number of enrollees for which a state directly purchases health benefits (although the state may not finance all of these enrollees), coordinating or consolidating negotiating, contracting, and other administrative functions across programs; and enhancing price and service competition among health plans.

States in the forefront of innovative purchasing have achieved many of their goals, despite a number of obstacles. Wishing to enhance their bargaining position with health plans, these states have effectively demonstrated that purchasing pools can be enlarged without actually merging risk pools. For some programs (such as Medicaid), incorporating outside populations is probably unnecessary if enrollment is large enough to enable the state to make a difference in the market for health benefits (Holahan, 1995).

Washington State's experience illustrates the important role that legislatures can play in states' purchasing strategies. Having first created the Health Care Authority, the Legislature in 1993 then charged the Authority with integrating purchasing for all public-sponsored health services (O'Loughlin, 1995a). The Legislature also has directed the Health Care Authority to develop an RBRVS fee schedule (having removed the expected savings from the Authority's budget). More recently, the legislature again cut the Authority's budget by $60 million, forcing it to find additional ways to reduce the cost of health benefits (O'Loughlin, 1995b).

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SENATOR JIM DUNCAN

ALASKA STATE LEGISLATURE

Alaska State Senate

State Capitol • Room 119 • Juneau, Alaska 99801-1182 • (907) 465-4766 • Fax 465-4748

MEMO

Date: February 23, 1996

To: Senator Tim Kelly, Chair
Senate Labor & Commerce Committee

From: Senator Jim Duncan

Subject: Request to hear SB 288, establishing the Alaska Health Purchasing Alliance

I request that you schedule a Senate Labor and Commerce Committee hearing on SB 288 which will establish an Alaska Health Purchasing Alliance.

The Alaska Health Purchasing Alliance will collectively purchase health insurance for public employers and provide health insurance purchasing opportunities for all Alaskan employers and individuals. Other states have successfully reduced their health insurance costs and provided coverage for more individuals through the use of collective negotiation and contracting.

The Purchasing Alliance is charged with conducting a study to determine if pooling insured groups under one state policy will result in cost savings and whether participation by public entities should be voluntary or mandatory.

I feel there are economies we as a state can achieve through use of the Alaska Health Purchasing Alliance and urge you to schedule a hearings as soon as possible.

Attachments

[redacted]

Sponsor Statement

SB

299

Unicom

UNITED UTILITIES, INC (UNITED)

United provides local telephone service to approximately 20,000 people in 58 rural Alaskan communities. Most of these communities (46) are in western Alaska and range in size from 25 to 800 people. The first map (Attachment 1) shows the 46 locations that United serves in western Alaska. The second map (Attachment 2) shows all of the locations that United serves including eleven communities north of Fairbanks and Chenega Bay in Prince William Sound.

United jointly owns and operates 46 satellite earth stations with AT&T Alascom. United is owned by United Companies, Inc. (UCI), an Alaskan native owned company.

UCI also owns Unicom and Manley Utility. Unicom provides cellular telephone service in Bethel and has also applied to the Alaska Public Utilities Commission and the Federal Communications Commission to provide long distance services. Manley Utility provides electric services in Manley, Alaska.

United is a member of the Alaska Telephone Association.

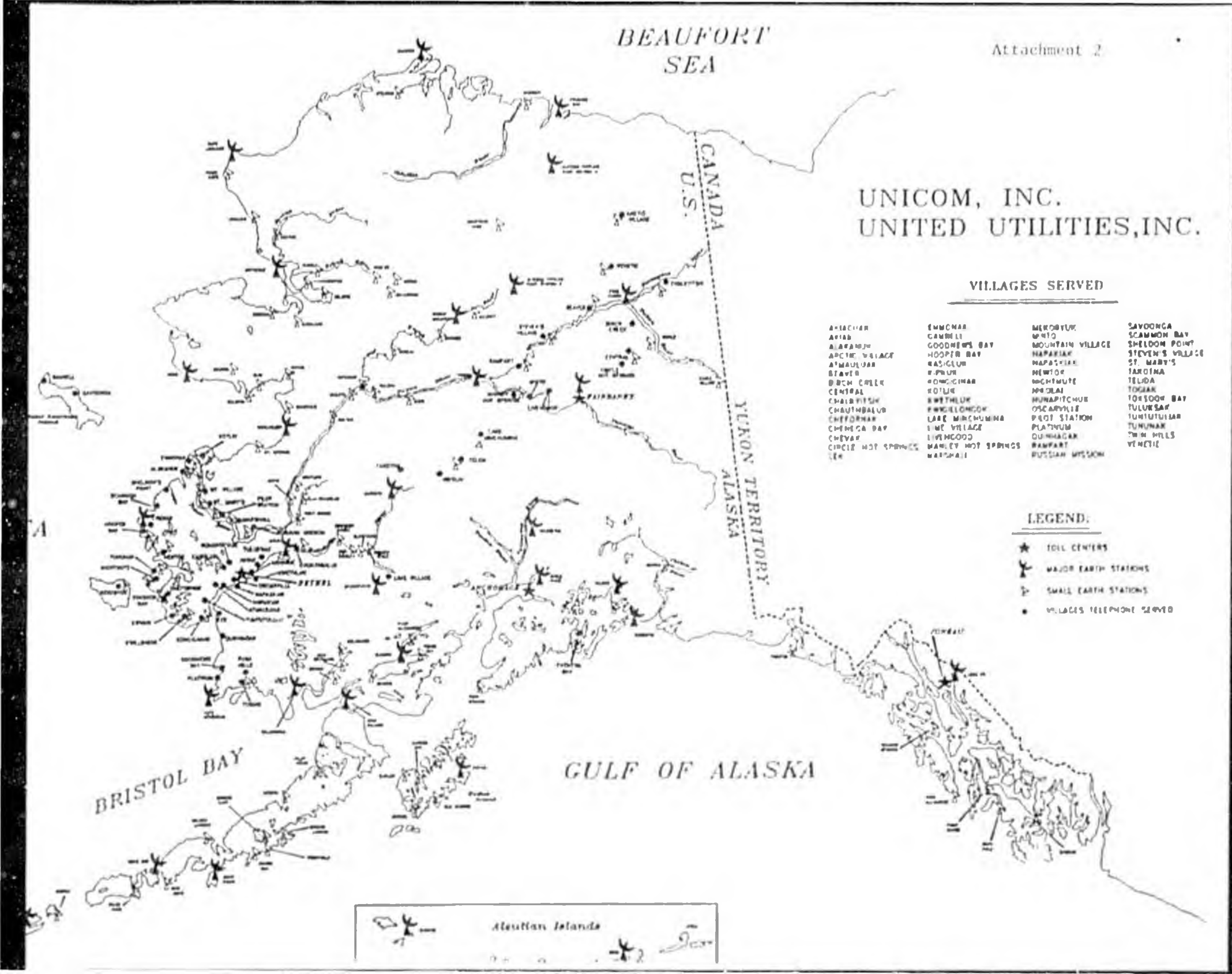
United Utilities, Inc.
Yukon - Kuskokwim Serving Area

0 25 50 75

SCALE in MILES

Population 14,800
Access Lines 3,660

Attachment 2



"TELECOMMUNICATIONS ACT OF 1996"

On February 8 Congress passed the Telecommunications Act of 1996. As a consequence, the State of Alaska needs to update its telecommunications statutes. While the Federal Communications Commission (FCC) has been assigned the responsibility to implement the act, there are a number of areas that have been left up to the individual states to address. These areas include:

1. Promoting and maintaining the availability of telecommunications services (universal service).

2. Providing pricing flexibility to existing carriers so that they can operate in a competitive environment.

3. Establishing policies for the APUC to act in a timely manner on utility applications.

4. Deregulating services that are competitively offered.

5. Providing a level playing field for incumbants and new entrants in markets that can sustain competition.

6. Removing barriers of entry to long distance service.

With the new federal legislation being passed there's a need for the legislature to address these areas that have been reserved to the individual states. Legislation will avoid unnecessary administrative and legal proceedings. Legislation will also allow consumers to benefit from competition and the introduction of new technologies and services.

United Utilities, Inc.
Alaska Telephone Association

SB

305

Proposed 1996 Amendments to Alaska's Accountancy Statute
Rationale for Change

JAN 22 1996

The Alaska Board of Accountancy, the Alaska Society of Certified Public Accountants, faculty from both the University of Alaska Anchorage and the University of Alaska Fairbanks and other interested parties have jointly drafted and endorse this proposed legislation. All parties agree that the proposed changes will protect the public interest while maintaining a dynamic, competitive and efficacious public accounting profession The proposed changes are limited to three areas where altered conditions require adjustment. This proposed legislation does not result in radical change to our accountancy statute and no such sweeping change is recommended by the drafting parties.

Change is proposed in the following areas:

I) the education requirement for licensure as a Certified Public Accountant.
II) the applicability of the Limited Liability Company statute to public accounting practice units.
III) reciprocity for Certified Public Accountants moving into Alaska from another domestic jurisdiction.

Herein, we present the rationale for each of these proposed changes to Alaska's Accountancy Statute.

I) The Educational Requirement -

In 1991, the Accountancy Statute was amended to require completion of 150 semester credit hours to meet the educational requirement for licensure as a certified public accountant. The effective date of this requirement is September 1, 1997. Both the Alaska Board of Accountancy and the Alaska Society of Certified Public Accountants were active supporters of this increased educational requirement as the 1991 legislation was debated. As the technical requirements of generally accepted accounting principles and generally accepted auditing standards have expanded over the last twenty-five years, and as technology and communications of our business society have similarly expanded, the accounting profession has recognized the need to improve and lengthen educational requirements. The Model Accountancy Act of the American Institute of Certified Public Accountants (AICPA) and the National Association of State Boards of Accountancy (NASBA) includes a 150 hour educational requirement. Additionally, the AICPA by-laws require such an educational requirement for AICPA membership after the year 2000. We have not wavered in our support for the 150 hour requirement . We are proposing, however, to delay the effective date until January 1, 2001. Several factors have contributed to this proposal to delay the effective date.

The original 1991 draft legislation proposed an effective date after the year 2000. A later effective date would have correlated better with the AICPA membership requirements and would have allowed our educational institutions more time to plan and initiate 150 hour credit programs. The 1991 legislation was amended to move the effective date up to 1997. While we continued to support the amended legislation, all parties in the professional accounting community realized the difficulties inherent in the establishment of the earlier effective date. Our educational institutions have established curriculum planning and approval processes which require significant lead time. Additionally, prospective CPA applicants must work a minimum of two years after completion of their educational programs to fulfill experience requirements. Our educational institutions needed to have 150 hour programs approved and in operation for the 1994/95 academic year to comply with the 1997 effective date. Unfortunately, the programs could not be implemented so rapidly. The 150 hour MBA with Accounting concentration became operational at UAF this academic year and the UAA 150 hour program is only now in the final planning stages. It does seem unfair to potential CPA applicants to require the 150 credit hours for licensure when the programs are just being established at our educational institutions. Additionally, there has been significant confusion with regard to the implementation of the 1997 requirement. Many members of the professional accounting community, recognizing the time

required for our educational institutions to implement formal programs, believed the State Board of Accountancy would pass a transition regulation to ease into the increased educational requirement. Such a transition rule might have allowed applicants who received a baccalaureate degree prior to September 1997 to be certified without meeting the 150 credit requirement during a transition period of two or three years. However, the Board has been advised that such a transition period cannot be made available through regulation. The 1997 date is enacted in legislation. The office of the Attorney General advises that the legislative date cannot be altered through regulation by the Board of Accountancy.

A significant number of accounting students throughout our state believe they are being treated unfairly with the 1997 effective date. They argue that they were advised to expect a transition regulation and that the 1997 date would not apply to them provided they completed their undergraduate degree before September, 1997. They also argue that, even now, 150 hour programs are not in place and functioning at all the educational institutions of our state.

Additionally, as the statute presently reads any CPA licensed in another jurisdiction who applies for a license in Alaska after September 1, 1997 will have to meet the 150 hour education requirement. The present law does not allow any other means of licensing a CPA from another state (see proposed changes for reciprocity). This was not the intent of the 150 hour provision. The vast majority of CPA's licensed in other states will not have the 150 hours of education and will not be eligible to practice in Alaska.

This proposed change would alleviate all of these concerns. If Alaska revises the effective date of the 150 hour requirement to January 1, 2001 we will exactly agree with the effective date of the AICPA By-Law change and allow our educational institutions three additional years to initiate formal programs. The extra years would give the program already implemented at UAF time to establish a track record and allow UAA sufficient time to have their proposed program approved and implemented.

The second proposed change to Section 8.04.120 (a) (1)would allow either a baccalaureate degree with additional semester hours or post graduate study hours to meet the 150 hour requirement. (A technical change from the word "of" to "or.") Again, this was the original intent but subsequent interpretations have stated that the statute requires post graduate hours. It is believed that this change would ease applicants understanding of this provision and alleviate some future problems for the Board.

The third part of the educational proposal (new Section 8.04.120 (b))gives the Board of Accountancy the authority to establish a transition period when the new requirement becomes effective in 2001. We expect the necessary educational programs to be operational for a significant period prior to 2001 and do not foresee the necessity of enacting a transition regulation when the increased educational requirement becomes effective. However, we believe that the Board should have the flexibility to respond to environmental conditions that might exist as the new requirement becomes effective. The proposed Sec 08.04.120 (b) would give the Board of Accountancy the flexibility to react to such unforeseen circumstance without seeking statutory relief.

II) Limited Liability Company Statute -

In 1992, the Alaska legislature enacted statute allowing for the establishment of limited liability companies in Alaska. Since that time, various professional entities have organized as limited liability companies. Certified Public Accounting practice units, however, have been unable to organize as limited liability companies because the form of entity is governed under the Alaska Accountancy statute which has not been revised to recognize this new form of organizational structure. The legislature has already determined the acceptability of this form of organizational structure with the passage of legislation allowing formation of the limited liability company type of entity. We feel that Certified Public Accounting practice units should be granted the opportunity to organize in this manner just as other professional organizations.

The statutes will need to be amended throughout wherever corporations and partnerships are discussed as acceptable forms of accounting entities.

III) Reciprocity -

There are 54 separate accounting jurisdictions in the United States. Each jurisdiction requires potential Certified Public Accountant applicants to pass the national CPA exam, but experience and educational requirements differ significantly among states. Currently, the Board of Accountancy must apply the same certification requirements to an established CPA moving into Alaska as they are applied to a new applicant just beginning a public accounting career. The Board has in some instances not been able to grant a reciprocal license to a relocating CPA because the rules under which he or she was initially certified differ slightly from Alaska. On other occasions obtaining the documentary evidence to satisfy Alaska's requirements has been difficult to obtain due to the passage of time, lack of any physical records at the prior employer or due to the fact that the prior employing firm no longer exists. Documentary evidence on file in the applicants prior jurisdiction does not always comply with Alaska's requirements due to the differing statutory requirements and regulations. Other State Boards of Accountancy experience similar problems in granting reciprocity.

Reciproc

As a result, the AICPA/NASBA model act adopts the 5/10 interstate reciprocity provision which is proposed in this legislation. An established CPA who has worked in public accounting for five of the preceding ten years would be granted a reciprocal certificate in Alaska without regard to Alaska's requirements. This proposal would significantly lessen the Board's work in granting the license. We do not feel that the public interest is threatened. This individual has already completed at least five years in public accounting practice. Our entry requirements are designed to ensure that the newly licensed CPA possesses the necessary technical competence and experience to practice public accounting. An individual who has already served five or more years as a CPA in public practice has proven the necessary technical competence and experience. We feel the public interest in Alaska is best served by allowing experienced CPA's to relocate to Alaska with a minimum amount of regulatory oversight.

f:\wksadmin\CPA\RATIONAL.DOC

CHARLES R. GRIFFIN
CERTIFIED PUBLIC ACCOUNTANT

P.O. BOX 870 • PALMER, ALASKA 99645
TELEPHONE (907) 745-3239

March 18, 1996
VIA FAX 907-465-3756

Senator Tim Kelly, Chairman
Senate Labor & Commerce Committee
Alaska State Legislature
State Capitol, Room 101
Juneau, Alaska 99801-1182

Dear Chairman Kelly:

Thank you! - the Alaska State Board of Public Accountancy sincerely appreciates your efforts in introducing SB 305. This bill, amending our Accountancy Act, contains provisions for only three changes and was unanimously endorsed and supported by our Board on January 25, 1996.

The three amendments include:

1. Sections 22 and 23 of the bill provide for deferral of the 150 hour education requirement until January 1, 2001, and the "grandfathering" of degrees obtained prior to that date. We seek this change to accommodate the current students and graduates of both UAA and UAF who feel that the September 1, 1997, effective date and lack of a transitional rule is causing them an undue hardship.

2. Sections 2 through 21 of the bill provide for statutory authority so that the Board may recognize the limited liability company form of practice unit for the purpose of issuing permits to accounting firms. Absent this provision we are unable to even permit limited liability companies organized under the Alaska Act which became effective July 1, 1995.

3. Section 1 of the bill provides for permissive licensure through reciprocity and would enable our Board to recognize an applicant's credentials based upon both current good standing and recent experience in another jurisdiction. This "five in ten" provision could enable the Board, where appropriate, to license an active practicing CPA moving to Alaska in a manner much more efficient than we do now in requiring application and complete documentation.

I look forward to participating in tomorrow's teleconference and again express the Board's appreciation for your time and efforts in getting this legislation introduced.

Very truly yours,

Charles R. Griffin, C.P.A., Chairman
Alaska State Board of Public Accountancy

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

MAR 18 1996

Board Name. PUBLIC ACCOUNTANCY		BILL NUMBER SB 305	SPONSOR SENATE L&C/SEN KELLY

SHORT TITLE OF BILL
AN ACT RELATING TO THE REGULATION OF ACCOUNTANTS AND AMENDING EFF DATE FOR SEC 6, CH 62, SLA91

Board POSITION
BOARD UNANIMOUSLY ENDORSED AND SUPPORTS; ON THE RECORD DURING JAN 25, 1996 MEETING SESSION

PREPARED BY	DATE		
CHARLES GRIFFIN, CHAIRMAN	3/18/96		

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUPS AFFECTED BY BILL
NONE	COLLEGE GRADUATES ENTERING PROFESSION FIRMS WHICH HIRE GRADUATES FIRMS WISHING TO ORGANIZE AS LLCs
ORGANIZATIONAL SUPPORT FOR BILL	**ORGANIZATIONAL OPPOSITION TO BILL**
ALL CONSTITUENCIES SUPPORT (BILL PER REQUEST)	NONE

FISCAL IMPACT: ☒ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

1. DEFER 150 HOUR EDUCATION REQUIREMENT UNTIL 1/1/2001 AND GRANDFATHER APPLICANTS WHO GRADUATE BEFORE 1/1/01; DEFERS 9/1/97 EFFECTIVE DATE AND PROVIDES TRANSITION.
2. ENABLE BOARD TO RECOGNIZE AND PERMIT FIRMS ORGANIZED AS LIMITED LIABILITY COMPANIES; NO CURRENT AUTHORITY IN STATUTE; PROVISIONS ADVISED BY OUR AAG COUNSEL.
3. ENABLE THE BOARD TO ADOPT A LIMITED FORM OF RECIPROCITY FOR LICENSING APPLICANTS WHO ARE LICENSEES IN ANOTHER JURISDICTION; A FIVE IN TEN PROVISION.

ANALYSIS OF BILL/PROGRAM EFFECTS

1. THE 150 HOUR EDUCATION REQUIREMENT DEFERRAL UNTIL 1/1/2001 AND THE GRANDFATHER PROVISION WILL ENABLE CURRENT GRADUATES AND STUDENTS WHO GRADUATE PRIOR TO THAT DATE TO CONTINUE TO ENTER THE PROFESSION WITHOUT HAVING A FIFTH YEAR OF COLLEGE. IT WILL ALLOW THE BOARD TO LICENSE FUTURE APPLICANTS WHO MEET TODAY'S REQUIREMENTS AND ENABLE FIRMS TO HIRE/TRAIN/RETAIN EMPLOYEES WHO MAY BECOME LICENSED.
2. THE LLC RECOGNITION FOR FIRM PERMIT PURPOSES WILL ENABLE THE BOARD TO PERFORM ITS LICENSING FUNCTION IN AN EXPEDITOUS MANNER. CURRENTLY WE MUST SEEK DEPT OF LAW ADVICE FOR EVERY SUCH APPLICATION FOR FIRM PERMIT. WE HAVE BEEN IN THIS POSITION SINCE THE ENACTMENT OF ALASKA'S LLC STATUTES (AND, AS I UNDERSTAND, THE AELS BOARD IS IN A SIMILAR SITUATION).
3. THE PROVISION FOR RECIPROCITY WILL ALSO ENABLE THE BOARD TO MORE EXPEDITOUSLY LICENSE APPLICANTS WHO POSSESS CURRENT LICENSES AND RECENT EXPERIENCE IN PUBLIC ACCOUNTING OBTAINED IN ANOTHER STATE. PROFESSIONALS ARE MOBILE AND MOVE TO ALASKA TO WORK IN ALASKAN FIRMS.

AMENDMENTS PROPOSED

1. BILL SEC 1/AS 08.04.195(a)(1) WILL BE AMENDED TO READ "PASSED THE UNIFORM CERTIFIED PUBLIC ACCOUNTANT EXAMINATION..."
2. BILL SEC 22/AS 08.04.120(b) WILL BE AMENDED TO READ "....RECEIVED A BACCALAUREATE DEGREE, OR ITS EQUIVALENT BEFORE JANUARY 1, 2001,..."

THESE TWO AMENDMENTS SHOULD BE ADOPTED ON 3/19/96 DURING HEARING/TELECONFERENCE CONDUCTED BY SENATE LABOR & COMMERCE COMMITTEE.

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

BILLANAL.FRM
KEYBOARD01

UNIVERSITY OF ALASKA ANCHORAGE

3211 Providence Drive
Anchorage, Alaska 99508-8244

SCHOOL OF BUSINESS
(907) 786-4100
FAX (907) 786-4119

March 18, 1996

Senator Tim Kelly
Capital Building
Room 101
Juneau, Alaska 99801

Dear Senator Kelly:

On behalf of the faculty of the University of Alaska Anchorage School of Business, we would like to thank you and your staff for introducing SB 305. We feel that the changes incorporated into SB 305 will have a significant effect on the CPA profession and on students preparing to enter the profession.

The UAA School of Business supports the three areas of change in the accountancy statute. The extension of the 150 hour education requirement to January 1, 2001 will give the Board of Accountancy the authority to establish a transition period for accounting students entering the profession. This is of particular concern to us as we work with and advise our accounting students on the career opportunities and requirements relating to the profession.

The second change dealing with reciprocity would ease the administrative burden on the Alaska State Board of Accountancy and allow experienced CPAs to relocate to Alaska with a minimum amount of regulatory oversight.

The third change in the accountancy statute allowing certified public accounting practice units to organize as limited liability companies, will allow CPA firms the same organizational alternatives already available to other professional organizations in Alaska.

We would like to thank you for introducing SB 305 and for your continued support.

Sincerely,

G. Hayden Green, Ph.D.
Interim Dean

Robert C. Maloney, MBA, CPA
Department Chair, Accounting

UNIVERSITY OF ALASKA FAIRBANKS
School of Management
Department of Accounting and Information Systems
PO Box 756080
Fairbanks, Alaska 99775-6080

March 18, 1996

To: Senator Tim Kelly
Senate Labor and Commerce Committee

From: E. Thomas Robinson, Associate Professor

RE: Senate Bill 305

I am a senior faculty member of the Accounting and Information Systems department of the School of Management at the University of Alaska Fairbanks. I also serve as co-chair (along with Lynn Koshiyama from the University of Alaska Anchorage) of the Relations with Higher Education Committee for the Alaska Society of Certified Public Accountants. Our committee along with students and accounting faculty from the University, actively participated in the decision to request an extension of the effective date of the one hundred fifty hour requirement for becoming a certified public accountant in the State of Alaska.

This memo serves to document the University of Alaska's accounting faculty support for the extension of the effective date of the one hundred fifty hour requirement for Certified Public Accountants. We hope that your committee will act favorably and expeditiously in the passage of Senate Bill 305.

UNIVERSITY OF ALASKA FAIRBANKS
School of Management
Department of Accounting and Information Systems
PO Box 756080
Fairbanks, Alaska 99775-6080

April 10, 1995

Chuck Griffin, CPA
Chair, Alaska Accounting Board of Public Accountancy
State of Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
Board of Public Accountancy
PO Box 110806
Juneau, AK 99811-0806

Dear Mr. Griffin:

The below signed students in UAF's Accounting program and Great Alaska Accounting People (GAAP) members encourage the ASCPA's consideration of the following issue and our proposal.

According to revised section 08.04.120 of the Alaska Accountancy statute, effective September 1, 1997, all persons wishing to become a CPA in Alaska will be required to complete 150 credit hours. We believe these requirements will unfairly impact recent graduates and those students currently enrolled in the Accounting Program. It appears that when the law was written there was an oversight regarding CPA candidates who have earned an undergraduate degree but have not yet fulfilled the experience requirement. The impact of the new rules extends beyond students currently enrolled in the Accounting Program. Public accounting firms will find it risky to hire recent graduates because they run a greater chance of not qualifying for certification in Alaska. While smaller firms are likely to be disproportionately impacted, all firms are sensitive to high costs of employee turnover. Without some transition rule firms will either face higher training costs or a smaller pool of job candidates.

A secondary concern is the increased pressure on students holding undergraduate degrees in accounting who have not yet passed the CPA exam. This appears to put an unintended risk on them that failure to pass the exam by May 1997 will result in their having to satisfy the higher educational requirement at tremendous personal cost. This would impose a cost that many will not be able to bear.

The issuance of a transition rule would give candidates with baccalaureate degrees awarded prior to September 1997 a reasonable period of time to fulfill the experience requirement and pass the CPA exam without being subjected to the revised education requirement. We propose the following transition regulation for the Board's consideration.

> Applicants completing baccalaureate degrees before September 1997 will fall under the education requirements in effect on the date of their graduation until September 1, 1999. After September 1, 1999, the revised requirements of 08.04.120 will apply to all applicants for certification.