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accurate and valid information on the quality of health plans, providers and facilities advances, consumers can wield their purchasing power to create incentives in the marketplace for improvements in health care quality.

- Third, consumers who have a role in the selection of their caregivers are likely to have greater confidence in those practitioners and are, therefore, more likely to seek appropriate care in a more timely fashion and follow agreed-upon care regimens.
- Fourth, having a choice of providers allows consumers to take action to preserve continuity of care within the health care system by selecting products and providers that allow them to continue provider relationships when continuity of care is especially important (e.g., prenatal care, care of individuals with complex chronic or disabling conditions).

Thus, a health care marketplace that promotes satisfied consumers, continuity of care, and continuous improvements in quality requires that an array of choices be available to consumers. Without consumers' ability to have and exercise choice, greater activities may need to be undertaken by group purchasers and regulators to ensure that the health care marketplace responds appropriately to consumers' health care needs.

Consumer Choice of Health Plans or Products

During the last decade, there has been a marked increase in the number and types of health insurance products available in most geographic markets. Prior to the widespread development of managed care plans, most Americans had limited choice of health insurance products. Indemnity products dominated the market with HMO and PPO products available primarily in certain metropolitan areas. The past 10 years have seen a significant increase of insurance products with the expansion of many health plans into new geographic markets and the development of multiple insurance product lines by indemnity insurers and managed care organizations. As a result, with the exception of sparsely populated areas, most communities now have available HMO, POS, PPO, and indemnity products offering consumers a variety of options in terms of benefits, premiums, copayments, and health care delivery systems.

At the same time, there has been a steady migration from traditional indemnity plans to various managed care products in both the public and private markets. Between 1991 and 1995, the percentage of American workers enrolled in indemnity plans decreased from 59 percent to 35 percent (EBRI, 1997). In 1997, more than 5 million Medicare beneficiaries were enrolled in 336 managed care plans, an increase of more than 100 percent since 1993. Under Medicaid, 13 million, or 35 percent, of all beneficiaries have been enrolled in managed care plans, an increase of more than 170 percent since 1993. The Balanced Budget Act of 1997 will increase those trends by expanding the types of products available to beneficiaries of those two public programs.

Although there is greater choice of health insurance products available in most markets, it is important to note that this choice often is exercised at the level of the group purchaser instead of by individual consumers. Between 1988 and 1997, health plan offerings by moderate- and large-sized employers declined (Gabel, 1997). Those offering three or more plans declined from 35 percent to 32 percent, while those offering only one plan climbed from 41 percent to 44 percent over that period. Notably, the percentage of employees in firms with 200 or more workers who were offered coverage of PPOs and POS plans increased from 12 percent in 1988 to 58 percent in 1997 (Gabel, 1997).

There also is evidence of variation in consumer preferences for various product characteristics. In the Kaiser-AHCPR survey (1996), 70 percent of survey respondents would prefer a high-cost product with a wide range of benefits over a low-cost product with a more limited range of benefits (26 percent). Respondents were more divided over other health product decisions. Fifty-three percent said they would pay more for unrestricted choice of physicians, while 43 percent would opt for a lower-cost product that limited choice to a list of physicians. Forty-six percent would pay more to have direct access to any specialist, whereas more than half (51 percent) would choose a lower-cost plan that requires a visit to the family physician for a referral (Robinson and Brodie, 1997).

The Commission is troubled by the limited choice of insurance products made available to many consumers through their employer group purchasers. Some of the reduction in choice of plan and

product has resulted from conscious decisions by employers to select high-quality products at the best price in the market. In other instances, employers may be seeking to minimize administrative costs associated with multiple offerings. Affording consumers greater choice of plans would allow consumers to select the product that best meets their individual preferences and would encourage health plans to be responsive to consumers' expressed needs. However, the Commission recognizes that, for many consumers, the availability of one plan is better than no plan at all.

The Commission was unable to achieve consensus on creating a "right" to a consumer choice of health plan or product but it is determined to find ways to encourage and assist employers and other group purchasers in providing consumers with a meaningful choice of health plans and products. Consumer choice of health plans is important and should be provided whenever possible and in a way that is affordable both to employers and consumers. In its final report, the Commission will address policy options to provide greater choice of health plans and products, including encouraging the development of purchasing coalitions and alliances to assist small employers who encounter the greatest difficulty in offering multiple options.

Consumer Choice of Physicians and Other Health Care Providers

The shift from indemnity coverage to managed care arrangements can affect consumers' choice of physicians and other health care providers. In a 1995 study, 41 percent of managed care enrollees who changed health plans over the prior 3 years also changed physicians (Davis et al., 1995). However, nearly all covered workers can now choose a health plan that covers non-network providers. In some cases, however, the additional cost of these products or of the option to go out of network effectively puts such choice out of the reach of some consumers.

It also is clear that consumers value some degree of choice of physicians. The 1997 Kaiser/Commonwealth National Health Insurance Survey found that respondents with a choice of physicians registered the highest level of satisfaction with their plans (Davis and Schoen, 1997). A Kaiser-AHCPR survey of consumers identified four reasons why consumers prefer a greater choice of physicians and other health care professionals:

- "So you can see whatever doctor you think is best qualified to treat a particular medical problem" (43 percent);
- "So you can change doctors if you become dissatisfied with the one you're seeing" (24 percent);
- "So you can continue seeing your regular doctor" (20 percent); and,
- "So it's easier to see someone else if your doctor is not available for an appointment" (9 percent).

The most frequently cited reasons speak to consumers' desire to use choice of physicians as a way to obtain quality care. The third is directed toward maintaining relationships with physicians with whom consumers have an existing relationship. In other words, 63 percent of consumers surveyed wanted a choice of physicians so that they can develop and maintain a relationship with a physician they trust to provide them high-quality care.

Therefore, it is important for all health plans and products to maintain an adequate network of physicians and other health care providers, to provide for continuity of care when consumers change plans, and to allow consumers with special health care needs to have adequate choice of physicians and other health care providers. This can lead to higher consumer satisfaction with providers and their health plans without undermining the efforts of provider groups and health plans to develop organized delivery systems.

The Commission's recommendations seek to build on these trends toward providing greater choice by taking several steps to ensure (1) network adequacy; (2) greater access for women to qualified specialists for women's health services; (3) ease of access to specialists for consumers with complex and serious conditions; and (4) greater continuity of care for consumers who enroll in new health plans or see their provider dropped from a plan for other than cause.

Provider Network Adequacy

When appropriately structured, a plan using a network of providers can improve the quality and coordination of care delivered to consumers through careful selection and credentialing of providers and through coordination of care by primary care physicians and those with specialty training. The National Association of Insurance Commissioners (NAIC, 1996) has developed standards for provider network adequacy that have been adopted by several States. The Commission believes universal adoption of these standards will improve both the quality of care and consumers' satisfaction with their health plans and their care. Because of its strong desire to maintain the integrity of health plan networks, the Commission has rejected approaches to mandate the inclusion of providers into networks (i.e., "any willing provider" laws) or to require plans to allow enrollees to go out of plan networks at will (i.e., "freedom of choice" laws).

Access to Specialists

Consumers with ongoing health needs often require regular access to physicians and other health care professionals who are specially trained to serve those needs (Bernstein, Dial, and Smith, 1995). This is especially true of those consumers who have disabling or terminal conditions. In such cases, the traditional "gatekeeper" approach used by some health plans can be an impediment to access to quality care and result in unnecessary inconvenience to consumers. The Commission's recommendations are designed to promote consumers' access to appropriately trained specialists while maintaining the integrity of network models of care. Consumers with complex and serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

Access to Qualified Specialists for Women's Health Services

Morbidity and mortality associated with breast cancer, cervical cancer, ovarian cancer, and sexually transmitted diseases in women can be significantly reduced through the provision of preventive and routine gynecological services. The U.S. Preventive Services Task Force has issued recommendations pertaining to the provision of Pap smears, mammograms, and other preventive services for women. Women should be able to choose a qualified provider offered by a plan—including gynecologists, certified nurse midwives, and other qualified health care providers offered by a plan—for the provision of routine and preventive women's health care services.

Transitional Care

Finally, consumers who are undergoing an extensive course of treatment (e.g., chemotherapy or prenatal care) at the time they join a new health plan should be able to continue to see their current providers for a period of up to 90 days (or through completion of postpartum care). Similarly, such consumers should be able to continue to see a provider who is terminated from a plan's network for reasons other than cause. Sudden interruption of care can compromise the quality of care and patient outcomes. Continuity of care has been shown to increase the likelihood that patients receive appropriate preventive services (O'Mailey et al., 1997). Appropriately transitioning of care can protect the quality of that care and improve consumers' satisfaction with a new health plan or product. The Commission's recommendations are designed to ease the impact of these transitions from one health insurance product to another and changes in the composition of health plan networks while maintaining the integrity of network models of care. Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or through completion of postpartum care) to allow for transition of care.

Implications of the Right

Health plans will need to comply with network adequacy standards. Because these changes are primarily to be carried out within existing networks, there should not be a significant increase in costs to

health plans or enrollees. Many licensed plans already meet these requirements as laid down by the National Association of Insurance Commissioners (NAIC) in its Managed Care Plan Network Adequacy Model Act. Plans also will need to develop processes to comply with requirements regarding continuity of care and ease of access to specialists within their network of providers.

Consumers will need to exercise their right to choice by using good judgment and providing direct feedback to plans about their level of satisfaction with the network provided for them.

Quality Oversight Organizations will need to incorporate network adequacy standards into their review activities.

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Chapter Three: Access to Emergency Services

Statement of the Right

Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

To ensure this right:

- Health plans should educate their members about the availability, location, and appropriate use of emergency and other medical services; cost-sharing provisions for emergency services; and the availability of care outside an emergency department.
- Health plans using a defined network of providers should cover emergency department screening and stabilization services both in network and out of network without prior authorization for use consistent with the prudent layperson standard. Non-network providers and facilities should not bill patients for any charges in excess of health plans' routine payment arrangements.
- Emergency department personnel should contact a patient's primary care provider or health plan, as appropriate, as quickly as possible to discuss follow-up and post-stabilization care and promote continuity of care.

Rationale

In 1995, Americans paid an estimated 96.5 million visits to emergency departments, nearly 37 visits per 100 persons (Stussman, 1997). By tradition, emergency departments (EDs) have handled a spectrum of illness, but have had the primary mission of treating those with acutely serious, even life-threatening, medical conditions. Emergency services can be defined as services that are needed or appear to be needed immediately because of injury or sudden illness that threatens serious impairment of any bodily function, and/or serious dysfunction of any bodily organ or part.

Patients go to the emergency department with nonurgent problems for various reasons. Economic and geographic barriers to other forms of care, the lack of a regular provider, and other factors can and do prompt patients to turn to the emergency department for primary and other nonurgent care. Apart from lack of health insurance coverage, nonfinancial barriers to primary care encourage patients to seek evaluation and treatment in the ED. These include problems with work schedules, access to transportation, and concerns about personal safety (Rask, Williams, Parker, et al., 1994). Physician offices and primary care clinics often have limited hours of operation, while EDs are open 24 hours a day. Medicaid beneficiaries, who have a history of limited access to regular providers, have particularly strong relationships with EDs as the provider of first and last resort. Nonurgent visits to the ED can be costly, contribute to overcrowded waiting rooms, divert resources away from other hospital-based care, and compromise the coordination and continuity of care.

But drawing the line between urgent and nonurgent use of the ED is not an easy decision for providers, health plans, and consumers. Criteria—both prospective and retrospective—for appropriate ED use are in many ways inadequate. By one criterion, a patient's ED visit might be deemed appropriate, and by another, not so (Lowe and Bindman, 1997). Health care professionals do not agree among themselves about the need for urgent care among emergency department patients (Gill, Reese, and Diamond, 1996). In a survey of 56 hospital EDs, 5.5 percent of patients initially classified by triage nurses as nonurgent were later admitted to the hospital from the ED (Young, Wagner, Kellerman, et al., 1996). Studies estimate that those presenting with nonurgent problems to the ED range from 6.3 percent (Cunningham, Clancy, and Cohen, et al., 1995) to 54.2 percent (Stussman, 1997) of ED visits.

To better manage care and costs in the ED setting, indemnity and managed care plans use a range of tools that includes requirements for prior authorization and imposition of higher cost-sharing for use of

out-of-network emergency departments. A 1989 survey of HMO medical directors found coverage policies for ED use across the HMO industry to be fairly uniform (Kerr, 1989). Unless the condition is life-threatening, patients must obtain prior authorization before seeking emergency care services in 80 percent of the responding HMOs, and 38 percent limited their coverage to the EDs of selected network hospitals. A study undertaken by the Center for Health Policy Studies shows that private indemnity insurers have adopted many of these same practices in their fee-for-service arrangements (PPRC, 1996).

A growing set of State and Federal laws and regulations clarify and protect consumers' access to appropriate emergency services. The Emergency Medical Treatment and Labor Act (EMTALA) requires all Medicare participating hospitals to evaluate whether a patient has an emergency medical condition and, if so, to stabilize the patient. The Balanced Budget Act of 1997 requires health plans participating in Medicare or Medicaid to reimburse for emergency services using a "prudent layperson" standard. Numerous States also have adopted this standard for access to emergency services. The Commission's recommendation seeks to create uniformity in all States.

Implications of the Right

Health care providers. Health care providers will need to work to educate consumers about the appropriate use of emergency department services while working to increase the hours and locations of primary care clinics and other facilities to ease access to such services outside of emergency departments. Emergency department personnel need to make strong efforts to ensure the continuity of care of emergency patients by communicating with patients' primary care providers. Efforts should be made to assist consumers with language, communication, or other barriers.

Health plans. Health plans need to expand consumer education efforts and, when it is within their control, expand hours and location of primary care facilities to facilitate access to such services outside of emergency departments. Plans need to ensure that their coverage and payment policies are consistent with the "prudent layperson" standard.

Consumers. Consumers need to become more familiar with the location and hours of nonemergency care settings and strive to make greater use of such facilities when appropriate. Consumers should communicate with their providers and plans to understand any restrictions on their access to emergency services.

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Chapter Four: Participation in Treatment Decisions

Statement of the Right

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

In order to ensure consumers' right and ability to participate in treatment decisions, health care professionals should:

- Provide patients with easily understood information and opportunity to decide among treatment options consistent with the informed consent process. Specifically,
 - Discuss all treatment options with a patient in a culturally competent manner, including the option of no treatment at all.
 - Ensure that persons with disabilities have effective communications with members of the health system in making such decisions.
 - Discuss all current treatments a consumer may be undergoing, including those alternative treatments that are self-administered.
- Discuss all risks, benefits, and consequences to treatment or nontreatment.
- Give patients the opportunity to refuse treatment and to express preferences about future treatment decisions.
- Discuss the use of advance directives—both living wills and durable powers of attorney for health care—with patients and their designated family members.
- Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process.

To facilitate greater communication between patients and providers, health care providers, facilities, and plans should:

- Disclose to consumers factors—such as methods of compensation, ownership of or interest in health care facilities, or matters of conscience—that could influence advice or treatment decisions.
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options.
- Be prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients.

Rationale

Consumers depend on health care professionals to provide them with expert consultation and advice on how to stay healthy or how to cure or palliate their health and medical problems. Unlike many other consumer transactions, the asymmetry of information between consumer and health care provider often is great. Decisionmaking also often occurs at a time of illness, which can undermine the patient's ability

to act most effectively in his or her own interest.

Patient and Provider Communication

Relationships between consumers and health care professionals are most rewarding and likely to result in positive outcomes when they are characterized by open communication and active participation of patients in the treatment process. Patient participation in treatment is an essential part of compliance, and compliance improves the effectiveness of care and treatment.

The benefits of patient participation go beyond just the anticipated therapeutic effect of the intervention (Czajkowski and Chesney, 1990). For example, the Coronary Drug Project Research Group (1980), which studied the efficacy and safety of several lipid-lowering drugs, found that even among patients who only took placebos, good adherers had a much lower 5-year mortality rate (15 percent) than did poor adherers (24.6 percent).

Patient participation in treatment decision making also leads to improved satisfaction with care and better quality of life. For example, in a study of patients with early breast cancer, it was found that those who believed they were more responsible for treatment decisions and had more choice of treatment reported higher quality of life than those who perceived themselves as less in control of the treatment decisions (Street and Voigt, 1997).

To participate in decisionmaking about their care, consumers must have complete information about treatment options—including the alternative of no intervention—as well as the risks, benefits, and consequences of such options. Yet evidence suggests that clinical practice often falls short of these expectations. A 1988 study of hospitalized patients found that physicians discussed test or treatment rationale in only 43 percent of cases and alternatives in 12 percent of cases (Wu and Pearlman, 1988). Physicians shared with patients information about benefits in 34 percent of cases and risks in 14 percent of cases.

The continued development of communications technologies to help consumers more fully understand their treatment options and to evaluate the potential risks and benefits of treatments should be encouraged, for example, the use of videos to help men with prostate cancer evaluate the risks and benefits of surgery versus a "watchful waiting" strategy (Wennberg, 1995) and to help men with benign prostatic hypertrophy sort out options for treatment (Wagner et al., 1995).

Increasingly, effective communication between providers and patients demands some degree of cultural competence. By the year 2000, nearly one-quarter of the U.S. population will be members of racial or ethnic "minority" groups; this will grow to 47.5 percent by the middle of the next century. Cultural competence refers to the "demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy" (Lavizzo-Mourey and Mackenzie, 1996). Effective communication for people with communication disabilities may require health care providers to provide auxiliary aids and services and remove certain communication barriers.

It also is imperative that providers be aware of and comply with their patients' decisions with respect to advance directives. Once a patient makes a decision, the health care team should respect this treatment choice. Yet there is clear evidence that this is not happening in far too many instances. Teno et al. (1995) studied 4,301 patients hospitalized in 6 hospitals and found that physicians often were unaware of their patients' wishes. In 47 percent of cases, physicians reported that they did not know of their patients' expressed desire for a "do not resuscitate" order. In another study focusing on nursing home residents transferred to hospitals, Davis, Southerland, Garrett, et al. (1991) found that medical treatment was consistent with advance directives in 75 percent of the 96 cases studied.

Organizational and Contractual Issues

There are a variety of organizational and contractual factors that also may influence communication between patients and providers. These include financial arrangements and contractual restrictions or

sanctions that may inhibit the free exchange of information.

Much attention has focused in recent years on the potential effects of providers' financial incentives on treatment. Methods of compensating physicians can be a powerful mechanism to change provider practice, either to improve the quality of care provided to consumers or to reduce the costs of that care. But poorly designed compensation arrangements also can result in inappropriate use (including both overuse and underuse) and barriers to care.

All methods of compensating physicians and other health care providers create some form of incentive for behavior. Various approaches are used to offset the potential adverse effects of compensation arrangements. For example, fee-for-service systems may use utilization review mechanisms to temper incentives toward overutilization of health care services. Capitation systems may incorporate measures of quality and consumer satisfaction to minimize incentives toward overutilization. Similarly, salaried arrangements may use bonuses to encourage higher provider productivity and exemplary performance.

In 1996, the Health Care Financing Administration promulgated rules concerning the use of certain types of financial arrangements on behalf of health plans serving Medicare or Medicaid beneficiaries. These rules stipulate that compensation arrangements "may not include any direct or indirect payments to physicians or groups as an inducement to limit or reduce necessary services furnished to an individual enrollee who is covered under the managed care organization's contract." These regulations also require disclosure of information about arrangements that transfer substantial financial risk to the health care provider. If the compensation methods used places the physician or physician group at substantial financial risk, then the health plan must survey enrollees about access and satisfaction with the quality of services, and institute adequate and appropriate stop-loss protections.

In addition to financial incentives, contract rules that restrict providers' ability to advise patients about medically necessary treatment options have been the subject of much concern. Health care providers must be able to advocate for their patients without constraint or fear of reprisal. A report by the General Accounting Office (GAO, 1997) reported: "Of the 529 HMOs in our study, none used contract clauses that specifically restricted physicians from discussing all appropriate medical options with their patients. Two-thirds of responding plans and 60 percent of the contracts submitted had a nondisparagement, nonsolicitation, or confidentiality clause that some physicians might interpret as limiting communication about all treatment options. However, contracts with such business clauses often contained anti-gag language stating that the physician should not misconstrue the contract of a specific provision as restricting medical advice to patients or that the physician should foster open communication." As of mid-1997, 25 States had prohibited the use of such clauses in managed care contracts with physicians and legislation was pending in 23 other States (Health Policy Tracking Service, 1997). In December 1996, HCFA banned the use of gag rules under the Medicare program and in February 1997, HCFA took similar action regarding health plans' participating in Medicaid.

Implications of the Right

Consumers must take a more active part in the treatment decision process. Information can be empowering, but navigating the health care system requires patient effort, from completing advance directives to preparing questions for an office visit. This requires that the consumer ask questions, understand and give informed consent, and become a full partner in treatment decisions with his or her health care provider.

Health care providers also have the central role in ensuring the patient's participation in treatment decisions, including compliance with informed consent. They will need to improve their skills in providing information about the medical and scientific evidence underlying different treatment options to patients and their families; strive to overcome cultural and language and communication barriers; and keep abreast of the latest and best available treatment options. At the same time, they will need to do a better job of listening to their patients and following their decisions, including the decision to forgo treatment or certain types of treatment. Health care providers should assume this responsibility well before a patient reaches a hospital door. To hold the trust of patients, providers will need to disclose financial incentives that may introduce bias into treatment decisionmaking and to avoid such incentives

when the balance is tipped against the patient. To be above any potential bias, providers must avoid self-referral arrangements that can cloud their professional judgment. And, finally, health care providers are and should be the most effective advocates for their patients' rights.

Health care facilities and plans must create and maintain an environment supportive of consumer participation in treatment decisions. In the office practice, this means ensuring adequate visit time for patients and providing support for shared decisionmaking programs when questions about care linger, arise after hours, or require further explanation. Health plans can play a significant role in educating patients on how to get the most out of their visit with a health care provider. They can arrange for translator services for patients and continuing education courses for providers to assure cultural and language competency. By statute, health plans and hospitals have obligations to educate the public about the use of advance directives. As importantly, once advance directives are signed, these documents must become part of the patient's health record and must move with the patient from care setting to care setting. In establishing provider compensation arrangements, health plans and facilities must be vigilant in guarding against the unintended, negative consequences of financial incentives by implementing programs to monitor quality of care and patient satisfaction. The nature of these incentives ought to be disclosed to patients and providers. In contracting with health care providers, plans and facilities should not restrict the provider's ability to discuss treatment options with the patient and not take reprisal upon the health care provider who serves as patient advocate.

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Chapter Five: Respect and Nondiscrimination

Statement of the Right

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system.

Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy or as required by law based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Consumers who are eligible for coverage under the terms and conditions of a health plan or program or as required by law must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Rationale

Consumers want to be treated with respect and they want to be treated fairly. An environment of mutual respect is essential to maintain a quality health care system. Incidences of discrimination—real and perceived—mar the relationship between consumers and their health care professionals, plans, and institutions. Multiple consumer surveys (Levinson et al., 1997; Davis et al., 1995; Edgeman-Levitan and Cleary, 1996) have found that many consumers' complaints about the current health care system have their root in the perception that people believe they are not being treated with respect.

Respect has been defined as recognizing a "person's capacities and perspectives, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs" (Faden and Beauchamp, 1986). Manifestations of disrespect in the health care setting described by consumers in recent research (Levinson et al., 1997) and interviews include: poor communication with their doctor, feeling rushed or ignored, lack of dignity during examinations, experiencing extensive waiting room delays, receiving inadequate explanations or advice, having inadequate time with the doctor during routine visits, feeling that complaints are not taken seriously by providers, and feeling that providers are more concerned with holding down the cost of medical care than with giving the best medical care. Conversely, consumers defined respectful treatment as that which takes into consideration the values, preferences, and expressed needs of the patient. In addition, consumers wanted providers to communicate well, to be respectful of the patient's time, and to give emotional support to alleviate the patient's fear and anxiety.

In order to extend consumers the respect they deserve, members of the health care industry should strive to:

- Provide consumers with assurances that disrespect or discrimination of any kind is intolerable.
- Provide consumers with information regarding existing laws prohibiting disrespectful or discriminatory treatment.
- Provide consumers with an appropriate amount of time to fully discuss their concerns and questions.
- Provide consumers with reasonable assistance to overcome language (including limited English proficiency), cultural, physical or communication barriers.
- Provide consumers with a timely notice and explanation of changes in fees or billing practices.
- Avoid lengthy delays in seeing a patient; when delays occur, explain why they occurred and, if appropriate, apologize for such delays.

A key element of respectful and fair treatment is protection against discrimination in the delivery of health care services and in marketing and enrollment, for those eligible for coverage under the terms and conditions of a health plan or program, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Sex. Disparities in medical treatment based on sex have been documented in a number of areas, including: diagnosis and treatment of coronary artery disease (Beery, 1995), kidney transplantation and dialysis, heart transplantation, cardiac catheterization, and diagnosis of lung cancer (AMA Council on Ethical and Judicial Affairs, 1991). Researchers have found that women are less likely to have diagnostic testing, even when functional disability and risk are higher. Women's complaints are seen as less urgent, and fewer referrals follow as a result of this belief (Tobin et al., 1987). Disparities have also been found in the quality of the doctor-patient relationship. For example, one-quarter of women (compared with 12 percent of men) reported that they have been "talked down to" or "treated like a child by a physician," and 17 percent of women (compared with 7 percent of men) had been told that a medical condition they experienced was "all in their head" (The Commonwealth Fund, 1993; Horton, 1995).

Race, ethnicity, national origin, and religion. Discrimination on the basis of race, ethnicity, national origin, or religion in the provision of health care has also been well documented. There is evidence of disparities in the quality of care, access to health care (because of language or geographic barriers), and the amount of care given to minorities as compared with others (Kahn et al., 1994; Giles et al., 1995; Rosenbaum et al., 1997; Smollar, 1988). In the case of facilities or individuals who accept Federal funds, Federal civil rights statutes prohibit the denial of services; the provision of a different service or services in a different manner from those provided to others; and the segregation of or separate treatment of individuals in any matter related to receiving services (Office of Civil Rights, 1990).

Age. Discrimination against consumers based on their age also occurs in the health care industry including: less aggressive treatment for elderly women with breast cancer and lower than average referral rates for mental health services in older people (Nattinger et al., 1992; Osteen et al., 1992; Ayanian et al., 1993). The Age Discrimination Act of 1972 also prohibits discrimination based on age by any institution or health care provider who accepts Federal funds.

Sexual orientation. Gay and lesbian patients have received reduced care or have been denied care because of their sexual orientation (AAPHR, 1994). Discrimination against gay/lesbian consumers has sometimes been compounded by fears of HIV.

Disability status. There is an extensive history of discrimination against people with disabilities and chronic illnesses that has led to action by Federal and State Government. The Americans with Disabilities Act of 1990 (ADA) prohibits discrimination against individuals with real or perceived disabilities in employment, public services, public accommodations, communications, and employer-provided health insurance. The Health Insurance Portability and Accountability Act of 1996 prohibits the exclusion of an individual from the group insurance market for more than 12 months based on a preexisting medical condition. The Mental Health Parity Act of 1996 prohibits differential lifetime or annual caps on coverage for physical and mental illnesses in certain situations.

Despite passage of these landmark laws, not all Americans living with disabilities or adverse medical conditions have access to health coverage at a cost they believe is fair or affordable. This is particularly true for consumers attempting to purchase coverage in the individual insurance market. Research into further refinements in the insurance market is needed to assist these individuals. The Commission strongly urges insurers, public and private purchasers, State and Federal Governments, and others to explore all policy options to make health coverage available and affordable to Americans who wish to obtain it, especially those who are living with mental or physical disabilities and chronic illnesses.

Finally, despite recent improvements, many health care facilities remain inaccessible to individuals with disabilities (Savage, 1997). The Commission believes that elimination of physical and communication barriers in health care facilities should be a higher priority for government agencies charged with enforcing the ADA.

Source of payment. The health care system currently is undergoing an historic transformation in which

Chapter Six: Confidentiality of Health Information(5)

Statement of the Right

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

In order to ensure this right:

- With very few exceptions, individually identifiable health care information can be used without written consent for health purposes only, including the provision of health care, payment for services, peer review, health promotion, disease management, and quality assurance.
- In addition, disclosure of individually identifiable health care information without written consent should be permitted in very limited circumstances where there is a clear legal basis for doing so. Such reasons include: medical or health care research for which an institutional review board has determined anonymous records will not suffice, investigation of health care fraud, and public health reporting.
- To the maximum feasible extent in all situations, nonidentifiable health care information should be used unless the individual has consented to the disclosure of individually identifiable information. When disclosure is required, no greater amount of information should be disclosed than is necessary to achieve the specific purpose of the disclosure.

(5) In the context of this chapter, health care information is defined as "any information, whether oral or recorded, in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university, health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual."

Rationale

The legal right to confidentiality of health care information and its essential role in the delivery of quality health care has been recognized by the United States Supreme Court, lower Federal and State courts, and Federal and State lawmakers. Similarly, a health care provider's obligation to protect the confidentiality of health information is universally recognized. The assurance that consumers' health information will remain confidential is "fundamental to effective diagnosis, treatment and healing" (Shalala, 1997).

At the same time, the quality of the health care system also depends on the regular exchange of information between providers, employers, plans, public health authorities, researchers, and other users. The changing structure of the health care system and rapid advances in information technology and medical and health care research have increased the demand for and supply of health information among traditional users such as the treating physician, and new users, such as large networks of providers, information management companies, quality and utilization review committees, and independently contracted service providers. Concerns have been raised that, under the current system of information exchange, various entities can access individually identifiable information without sufficient security safeguards and consent requirements.

Other activities undertaken to improve quality and efficiency may present new risks to the confidentiality of health information. For example, quality oversight activities by plans, providers, accreditation bodies, and regulatory agencies require detailed information about the treatment and benefit status of individual consumers. The growing role of employers in workforce health issues has also contributed to the confidentiality debate.

Congress has made repeated attempts to enact a comprehensive Federal confidentiality law but has, to date, been unsuccessful. The web of protections at the Federal and State level that has evolved in the absence of a comprehensive law leaves many aspects of health information unevenly protected. Specialized Federal protections already exist through statutes that address substance abuse, Medicaid beneficiaries, public health, research, government records, and those living with disabilities.

Several States have enacted comprehensive laws and an effort is currently under way at the National Association of Insurance Commissioners to draft a Protected Health Information Model Act for States. Other safeguards have evolved outside of the legislative arena. Accreditation bodies have incorporated requirements for confidentiality policies and patient consent (JCAHO 1996; NCQA 1997; URAC 1996) and continue to collaborate on security and confidentiality issues (JCAHO/NCQA Joint Session, 1997).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of Health and Human Services to submit to the Congress detailed recommendations on: (1) the rights that an individual who is a subject of individually identifiable information should have; (2) the procedures that should be established for the exercise of such rights; and (3) the uses and disclosures of such information that should be authorized or required (Public Law 104-191). On September 11, Health and Human Services Secretary Donna Shalala presented those proposals to the Congress (Shalala, 1997). Under the terms of HIPAA, if Congress fails to enact Federal confidentiality legislation by August 1999, the Secretary of HHS is required to promulgate regulations setting confidentiality standards.

The Secretary recommends a comprehensive Federal confidentiality law that would apply "floor preemption," meaning that the law would require that all States comply with a minimum set of confidentiality requirements but would not preempt stronger State laws.

Section 262 of HIPAA also requires the Secretary of HHS to adopt standards by February 1998 for electronic transmission of financial and administrative health care transactions (including information about claims, eligibility, payment, and injury), unique health identifiers (for individuals, employers, plans, and providers), and security.

The Commission believes that it is essential to establish a comprehensive confidentiality framework and encourages the Congress to move forward expeditiously.

Implications of the Right

Health plans, health providers, employers, and other group purchasers should examine existing confidentiality protections to safeguard against improper use or release of individually identifiable information. The Commission does not intend to impede employers or providers from complying with duties established by law. Health providers, facilities, and plans should develop procedures to ensure that when sensitive services (e.g., mental health, substance abuse, reproductive services, or treatment of sexually transmitted diseases) are involved, standard administrative techniques do not inadvertently disclose information to individuals other than the patient. This is not intended to create two standards of nondisclosure--one for sensitive medical conditions and another for all others. It is merely a recognition that there may be high level concern about confidentiality with certain medical conditions by some patients.

Law enforcement officers, researchers, and public health agencies should examine their existing policies to ensure that they access individually identifiable information only when absolutely necessary and provide proper safeguards to assure confidentiality.

Consumers should become more aware of the content of their health records and pay particular attention

to requests by providers, plans, employers, or others to gain access to those records.

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Chapter Seven: Complaints and Appeals

Statement of the Right

All consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

Internal appeals systems should include:

- Timely written notification of a decision to deny, reduce, or terminate services or deny payment for services. Such notification should include an explanation of the reasons for the decisions and the procedures available for appealing them.
- Resolution of all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).

- A claim review process conducted by health care professionals who are appropriately credentialed with respect to the treatment involved. Reviews should be conducted by individuals who were not involved in the initial decision.
- Written notification of the final determination by the plan of an internal appeal that includes information on the reason for the determination and how a consumer can appeal that decision to an external entity.
- Reasonable processes for resolving consumer complaints about such issues as waiting times, operating hours, the demeanor of health care personnel, and the adequacy of facilities.

External appeals systems should:

- Be available only after consumers have exhausted all internal processes (except in cases of urgently needed care).
- Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized (6).
- Be conducted by health care professionals who are appropriately credentialed with respect to the treatment involved and subject to conflict-of-interest prohibitions. Reviews should be conducted by individuals who were not involved in the initial decision.
- Follow a standard of review that promotes evidence-based decisionmaking and relies on objective evidence.
- Resolve all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (i.e., 72 hours).

(6) The right to external appeals does not apply to denials, reductions, or terminations of coverage or denials of payment for services that are specifically excluded from the consumer's coverage as established by contract

Rationale

Health care consumers, like other purchasers, have concerns about the service they receive. Unlike other consumers, however, health care consumers have special interests at stake--the length and quality of their lives. How consumer complaints are addressed has a significant impact on the quality of health services provided and on the satisfaction of consumers with the individuals and institutions that provide them.

Fair and efficient procedures for resolving consumer complaints about their health care serve many purposes. First and foremost, enhanced internal and external review processes will assist consumers in obtaining access to appropriate services in a timely fashion, thus maximizing the likelihood of positive health outcomes. Second, they can be used to bridge communication gaps between consumers and their health plans and providers, and to provide useful information to all parties regarding effective treatment and consumer needs. Third, the opportunity for consumers to be heard by people whose decisions significantly touch their lives evidences respect for the dignity of consumers as individuals and engenders their respect for the integrity of the institutions that serve them.

Properly structured complaint resolution processes should promote the resolution of consumer concerns as well as support and enhance the overall goal of improving the quality of health care. Internal and external complaint and appeal processes should be:

- Timely.

- Fair to all parties.
- Administratively simple.
- Objective and credible.
- Accessible and understandable to consumers.
- Cost and resource efficient.
- Subject to quality review.

Internal and external complaint and appeal processes should not interfere with communication between consumers and their health care providers. For example, in instances where consumers and their providers agree that a service should be reduced or terminated, no written notification of such decisions is needed. Additionally, health care providers who participate in the complaint and appeal processes on behalf of patients should be free from discrimination or retaliation. Likewise, consumers who file a complaint against a provider or plan should be free from discrimination or retaliation.

For the purposes of this chapter, the following definitions are used for the terms "complaints" and "appeals":

Complaint. A "complaint" is any expression of dissatisfaction to a health plan, provider, or facility by a consumer made orally or in writing. This includes concerns about the operations of providers, insurers, or health plans, such as waiting times, the demeanor of health care personnel, the adequacy of facilities or the respect paid to consumers, and claims regarding the right of the consumer to receive services or receive payment for services previously rendered, including the organization's refusal to provide services the consumer believes he or she is entitled to.

Appeal. An "appeal" is a consumer's request for a health plan, facility, or provider or other body to change an initial decision. An appeal process is a procedure for reconsideration of a specific determination made by a health provider, facility or plan.

Current Resolution Processes

Currently, many different procedures are used by group purchasers, health plans, and provider organizations to respond to consumer complaints. Licensed health plans are subject to numerous State and Federal laws, and many also comply with the standards of private accrediting bodies (e.g., NCQA, 1997; JCAHO, 1996; AAHCC/URAC, 1996). Virtually all private and public health plans provide consumers with some form of complaint resolution process. The Commission does not intend by these recommendations to weaken existing consumer protections. These include:

State Licensed Insurance Products. States traditionally have regulated the benefit structure, solvency, rates, and claims process of indemnity insurance companies doing business in the State. Some State insurance regulations require health insurers doing business in the State to provide certain complaint procedures to enrollees (Abraham, 1990). In addition, all 50 States have laws licensing or governing HMOs doing business in the State separate from their laws regulating indemnity insurance products. Many States' laws are based on the model HMO law drafted by the National Association of Insurance Commissioners (NAIC, 1996), which requires HMOs to establish complaint procedures approved by the State's insurance commissioner. An estimated 30 States have some specified complaint procedures that HMOs must follow and at least 7 States now require an expedited appeal for denials of urgently needed care.

ERISA Plans. All employers offering health benefits to their employees through managed care organizations or traditional indemnity insurers must comply with requirements of the Employee Retirement Income Security Act. ERISA requires private employer-provided health benefit plans to disclose certain information to plan participants, to report information to the Federal government, and to pay benefits that are promised under the plan. ERISA regulations generally require employer health plans to approve or deny claims within 90 days and to approve or deny appeals of claims denials within 60 days. Although ERISA health plans are required to establish and disclose complaint and appeals procedures to participants, and to notify participants of claims denials, the plans are not required to provide a particular complaint procedure (Butler and Polzer, 1996). An internal reconsideration of

denied claims is stipulated but appeals may be decided by the same plan administrators that initially denied the claim. Determinations must be in writing and state specific reasons for the decision.

Medicare. Under the Medicare fee-for-service system, fiscal intermediaries and carriers must provide a two-step internal review and notification of their final decision before a beneficiary is entitled to seek reconsideration from the Social Security Administration's payment division and the Health Care Financing Administration (Kinney, 1996). Medicare provides a graded appeal process that includes a hearing before an administrative law judge and administrative appeals council review for claims under Part A (hospital coverage) if the amount in controversy is more than \$100; and under Part B (physical and outpatient coverage) if the claims are more than \$500. Claims under Part A and Part B for more than \$1,000 are entitled to judicial review.

HMOs that participate in Medicare are required to provide meaningful internal procedures for resolving complaints about the quality of care, untimely provision of care, or the improper demeanor of health care personnel (Stayn, 1994). HMO decisions to deny coverage for certain treatment, referral outside a plan, or reimbursement for emergency or out-of-area care are subject to an external review and administrative appeal. HCFA has contracted with a private organization, the Center for Health Dispute Resolution, to perform these reconsiderations (Richardson, Phillips, and Conley, 1993). After external review, a Medicare beneficiary enrolled in an HMO who is "dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay" has a right to Social Security administrative review for controversies more than \$100 and judicial review for controversies more than \$1,000.

Medicaid. The Federal Medicaid statute requires State agencies to provide beneficiaries with a fair hearing and an administrative appeal when their eligibility or requests for services are denied or not acted upon within reasonable time. These State agency determinations can be challenged in State court under State administrative procedure acts or in Federal court. In addition, HMOs that contract to serve Medicaid beneficiaries must establish an internal complaint procedure that will resolve disputes promptly. These internal procedures are subject to review and approval by the State. Medicaid HMO enrollees have the same rights to administrative appeal as do fee-for-service enrollees and no recommendations are made concerning the changing of such rights.

Federal Employees Health Benefit Program. Federal employees and their dependents receive coverage through private insurance carriers, including more than 300 HMOs. Under the FEHBP complaint resolution process, enrollees may bring disputes concerning benefits or services to the Office of Personnel Management for review after asking the plan to reconsider its initial denial and failing to receive a satisfactory reply. OPM seeks to determine whether the enrollee or family member is entitled to the services or supply under the terms of the contract.

Other Approaches. The federal HMO Act requires that to be a "federally qualified HMO," a plan must provide meaningful procedures for hearing and resolving complaints between subscribers and the plan. The written procedures must be easily understood and provided upon request. HMOs are not required to comply with the Act's requirements but may do so to obtain favored status. Other approaches to complaint resolution exist in the Department of Defense's health programs, including the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Implications of the Right

Assuring that all consumers have access to both internal and external processes that satisfy the requirements of this right will require action on virtually every level of the health care industry.

Enhancing Internal Review Systems. Health plans will need to examine their existing internal review systems to assure that consumers receive a timely, understandable notice of decisions to deny, reduce, or terminate treatment or pay claims; notice of the reasons for that determination and of the complaint and appeals procedures available to them; and expedited processes for certain types of cases. While there do not appear to be reliable data indicating how many health plans currently provide internal complaint procedures, most apparently do. Thus, implementation of a general right to file internal complaints, to

appeal within a health plan, and to receive a response will not require a majority of health plans to change their current practices significantly. It will be important for quality oversight organizations (State licensure programs, Federal certification programs, and private accrediting bodies) to assure that their standards and review processes adequately address internal complaint and appeal processes of health plans.

Establishing Independent External Appeals Systems. Additional analysis must be done to identify the most effective and efficient methods of establishing the independent external appeals function. Issues to be considered include: mechanisms for financing the external review system; sponsorship of the external review function; design of review processes to assure evidence-based decisionmaking; qualifications of reviewers; consumer cost-sharing responsibilities (e.g., filing fees); and methods of overseeing and holding external appeals entities accountable. It will also be important to establish an ongoing evaluation mechanism to assess the impact of the external appeals process on access to appropriate services, rates of consumer disputes, litigation rates, consumer satisfaction, and costs. The evaluation mechanism should also assess the impact of certain design characteristics on the effectiveness and efficiency of the external appeals process.

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Chapter Eight: Consumer Responsibilities

Statement of Responsibilities

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. Such responsibilities include:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, health care providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

Rationale

In providing consumers with a set of rights and protections, the Commission believes that individual consumers must assume certain responsibilities. Responsibilities create benefits not only for individual consumers and their families but also for the health care system and society as a whole. Improved health status reduces medical costs for the patient, the payer, and society.

The Commission, however, does not intend to create a link between an individual's conduct in meeting his or her responsibilities and the obligations of plans and providers to provide covered services.

Increased patient responsibility can improve consumers' sense of self-worth. For example, increased responsibility among individuals living with disabilities has resulted in increased independence for that population (Rodwin, 1994; National Health Council, 1995). In fact, this is the principle behind the independent living movement, where people with disabilities live in their homes with personal assistant services rather than in institutions. Individuals report that increased responsibility for their health has led to improved self-esteem and a greater sense of empowerment.

Promoting consumer responsibility is an essential component of the effort toward involving consumers directly in decisionmaking about their health and medical care. Consumers often perceive that the medical professionals who care for them are acting in a condescending or paternalistic manner. They resent being put in a position of dependence and being treated as if they are infantile and object to the presumption that they are incapable of making choices themselves (Rodwin, 1994).

While the Commission believes that consumers must assume certain responsibilities, it also recognizes that reasonable accommodations must be made for numerous consumers with disabilities. For example,

some individuals with physical and mental disabilities require assistance with self care; for some individuals with mental disabilities, noncompliance with treatment regimes is a manifestation of their disability; and some individuals with mental and physical disabilities are unable—due to their disability—to clearly communicate their wants and needs and, therefore, rely on the assistance of a designated representative. In each case, the health care system must recognize these issues and accommodate these needs. The Commission also recognizes that there are many other factors, such as occupational hazards, language, and income status, that may pose significant barriers to consumers meeting these responsibilities.

Consumers who are able should take the opportunity to educate themselves with respect to the specifics of their benefit coverage and to learn how to access the health care and services available to them as a result of that coverage. This includes:

- Reading and understanding written information that explains benefit coverage
- Reading and understanding information that describes health plan processes and procedures to follow when seeking care by a physician, hospital, or other provider.
- Seeking information or clarification of information from the health plan as necessary.
- Using the health plan's processes for addressing complaints or grievances when disputes with providers or health plan procedures arise.

Consumer responsibility is particularly relevant to the broad right to information established in this Consumer Bill of Rights and Responsibilities (see Chapter One). The Right to Information requires the disclosure of information to consumers either directly or upon request on such things as benefits, cost-sharing, complaints and appeals processes, licensure, accreditation, and performance measures. The Right to Information will improve health outcomes only to the extent that consumers have a choice of health plans and use that information in exercising the choice.

Although there is significant value in promoting the consumers' participation in their own health care by increasing their level of responsibility, it is important to set limits on the amount of responsibility expected. The patient's responsibility to comply with medical advice is limited by the principle of informed consent (Benjamin, 1985). The patient retains the right to choose whether to follow medical advice or not, as long as he or she is willing to accept the health outcome consequences that may result from noncompliance, and the noncompliance does not adversely affect the public (Brock and Wartman, 1994).

Consumers do not have a duty to be subjected to a treatment regime they have good reason to avoid—for instance, one whose negative side effects outweigh its benefits (Mayer, 1992), or when excessive medication in an institutional setting is used to "control" residents. Most consumer responsibilities do not extend to those who are incompetent to make decisions, including infants, those who are judged to be mentally incompetent, and comatose patients (Emson, 1995; Mayer, 1992; National Health Council, 1995).

In addition, certain high-risk behaviors (smoking, use of smokeless tobacco, illegal drug use) are addictive and cannot be considered fully under the volitional control of the individual consumer. Caution must be used to avoid "blaming the victim." For example, Bayer (1996) notes that during the history of the AIDS epidemic, "the emphasis on personal responsibility was often associated with condemnation of those whose sexual or drug-using behavior had exposed them to HIV, as well as with calls for invasion of privacy and deprivations of liberty."

Compliance with agreed-upon treatment protocols is a particularly important consumer responsibility. Noncompliance with the taking of medication has particular implications for the health status of consumers. Noncompliance includes taking too much medication, taking medication not prescribed, not taking medication prescribed, altering the prescribed dosage, or altering the time between doses.

Finally, it is important to recognize that while consumers should seek to assume the responsibilities discussed in this report, many factors influence consumers' acceptance of medical advice. Some are related to the health care system itself and others are related to the patient's individual psychology. Imanaka, Araki, et al. (1993) identified patient dissatisfaction with their health care providers and plans

as a primary cause of patient noncompliance. Several studies have identified inadequate provider-consumer communication as a contributing factor (Imanaka, 1993; Ross, 1991; Donovan and Blake, 1992; Sluijs, Kok, et al., 1993). This leads to situations where:

- The patient and the prescriber have a different understanding of what the patient is supposed to do.
- The patient lacks information or understanding about the disease, pathology, or symptoms.
- The patient does not understand the correct purpose of the intervention.
- The patient and the health care provider have insufficient time to discuss the full range of issues concerning compliance.

Noncompliant patients also may have underlying psychiatric disorders. Yellowless and Ruffin (1989) found that 40 percent of patients who experience a life-threatening asthma episode have psychiatric disorders. Patients often are trying to balance the requirements of their prescribed medical regimen with other aspects of their life (Donovan and Blake, 1992). Finally, some patients choose not to comply with medical instructions as a way of expressing their attempts to cope with their disease; as a reaction to the way they have been treated by doctors; or as a way of fighting the system by breaking its "symbolic" rules (Ross, 1991).

Implications of the Responsibilities

Consumers will have to play an active role in the treatment and management of their health. Consumers will need to ask more questions of their health care providers, insurers, and institutions. They will need to express their wishes and desires clearly to those who care for them and to their family members in the event of incapacity; this should be done *before* an incapacity occurs. They will need to make sure that they understand a treatment regimen that is prescribed for them before they agree to follow it. Once they have made such an agreement, consumers will need to make every effort to comply and, if they cannot, to notify their provider of their desire or need to change that regimen. Consumers will need to recognize the financial and societal impact of their health care decisions and their health care choices should reflect this consideration.

Health care providers will need to communicate more clearly with their patients and their patients' families about diagnoses, treatment options, and treatment protocols. They will need to make greater efforts to ensure that those matters are clearly understood and agreed to. They will need to work with their patients to ensure that treatment regimens are possible to follow and that changes in treatment are made when possible to meet patients' needs or demands.

Health plans will need to consider ways to encourage greater communication between consumers and health care professionals, including incentives for such communication and acceptance of treatment regimens.

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Acknowledgments

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Much of the initial work on this report was done by the Commission's Subcommittee on Consumer Rights, Protections, and Responsibilities under the leadership of Chair Peter Thomas and members Christine Cassel, James Chao, Nan Hunter, Sylvia Drew Ivie, Randy MacDonald, Ronald Pollack, and Stephen Wiggins.

The Commission wishes to pay special tribute to Executive Director Janet Corrigan for her superb leadership and staff direction and to Deputy Director Richard Sorian for his outstanding policy guidance and operational and editorial skills. The Commission also extends its sincere appreciation to Commission staff members John Dicken, Elizabeth Docteur, Mary Gerald, Edward (Chip) Malin, Ann Page, and Karen Titlow for their work. From the Department of Labor: Olena Berg, Meredith Mille, Peter Nixon, Marilyn Park, Margaret Farrell, Holly Nelson, Cheryl Dorsey, William Taylor, Richard Hinz, Monica Healy, and Avis McKnight.

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During the course of its deliberations, the Commission heard public testimony from dozens of witnesses, including Theresa Alberghini, Larry Bedard, Bob Boland, Winifred Booker, Laura Braun, John Brumsted, Tracy Buchholz, Alfred Chiplin, Richard Curtis, Lauren Danc, Helen Darling, Justin Dart, Karen Davis, Thomas Delbanco, Steve deMontmollin, Laurie Flynn, Jon Gabel, Bob Griss, Sandra Harmon-Weiss, Paul Harrington, Cathy Hurwit, Jeanne Keller, Deborah Lisi-Baker, Dwight Marsh, William Michael, Anya Rader, Michael Rapp, David Reynolds, David Richardson, Diane Rowland, Sandra Sands, Gai! Shearer, Henry Simmons, Helen Smits, and Deborah Klein Walker.

The Commission also appreciates the testimony of Rep. Sherrod Brown, Rep. Ben Cardin, Gov. Howard Dean, Rep. John Dingell, Sen. James Jeffords, Sen. Joseph Lieberman, Rep. Charles Norwood, Rep. Marge Roukema, Rep. Bernie Sanders, Rep. Pete Stark, and Rep. Henry Waxman.

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Advisory Commission on Consumer Protection and Quality in the Health Care Industry

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DONNA E. SHALALA is U.S. Secretary of the Department of Health & Human Services.

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November 20, 1997

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President's Advisory Commission Releases Consumer Bill of Rights and Responsibilities

A Presidential Advisory Commission today released a proposed Consumer Bill of Rights and Responsibilities in health care. In a report to President Clinton, the Commission said, "American consumers and their families are experiencing an historic transition of the U.S. system of health care financing and delivery."

The Commission states that a Consumer Bill of Rights and Responsibilities "can help to establish a stronger relationship of trust among consumers, health care professionals, health care institutions, and health plans by helping to sort out the responsibilities of each of these participants in a system that promotes quality improvement."

The Consumer Bill of Rights has three goals:

To strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.

To reaffirm the importance of a strong relationship between patients and their health care professionals.

To reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

President Clinton created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry on March 26, 1997, and charged it with "recommend[ing] such measures as may be necessary to promote and assure health care quality and value and protect consumers and workers in the health care system." As part of that charge, the President asked the Commission to develop a "Consumer Bill of Rights" in health care.

Co-Chaired by Secretary of Labor Alexis M. Herman and Secretary of Health and Human Services Donna E. Shalala, the Commission has 34 members, including broad-based representation from consumers, businesses, labor, health care providers, health plans, and health care quality and financing experts. Commission members have vast expertise on a wide range of health issues, including the special challenges facing rural and urban communities, children, women, older Americans, minorities, and people living with mental and physical disabilities.

In developing the Consumer Bill of Rights and Responsibilities, the Commission established a Subcommittee on Consumer Rights, Protections, and Responsibilities, which held a series of six public hearings in Washington, D.C., Burlington, Vermont, and Chicago, Illinois. The Subcommittee and the Commission heard public testimony from nearly three dozen expert witnesses and considered consumer protection proposals by nearly two dozen national and regional organizations.

The Commission also is working on a final, comprehensive report on creating a quality improvement framework for the health care industry. That report is due to President Clinton by March 30, 1998.

Free copies of the Consumer Bill of Rights and Responsibilities are available on the World Wide Web from the Commission's Website (www.hcqualitycommission.gov). To obtain a free printed copy of the report, call 1/800/732-8200 or write to Consumer Bill of Rights, Box 2429, Columbia, MD 21045-1429.

#

Consumer Bill of Rights and Responsibilities

Following is a summary of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry proposed Consumer Bill of Rights and Responsibilities:

INFORMATION DISCLOSURE. Consumers have the right to receive accurate, easily understood information, and some consumers require assistance in making informed health care decisions about their health plans, professionals and facilities. Such information includes:

Health plans. Covered benefits, cost-sharing, and procedures for resolving complaints; licensure, certification, and accreditation status; comparable measures of quality and consumer satisfaction; provider network composition; the procedures that govern access to specialists and emergency services; and care management information.

Health professionals: Education, board certification and recertification; years of practice; experience performing certain procedures; and comparable measures of quality and consumer satisfaction.

Health care facilities: Experience in performing certain procedures and services; accreditation status; comparable measures of quality and worker and consumer satisfaction; and procedures for resolving complaints.

Consumer Assistance Programs: Programs must be carefully structured to promote consumer confidence and to work cooperatively with health plans, providers, payers, and regulators. Sponsorship that ensures accountability to the interests of consumers and stable, adequate funding are desirable characteristics of such programs.

CHOICE OF PROVIDERS AND PLANS. Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care. To ensure such choice, the Commission recommends the following:

Provider Network Adequacy. All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without unreasonable delay—including access to emergency services 24 hours a day and 7 days a week. If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers.

Women's Health Services. Women should be able to choose a qualified provider offered by a plan—such as gynecologists, certified nurse midwives, and other qualified health care providers—for the provision of covered care necessary to provide routine and preventative women's health care services.

Access to Specialists. Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan.

Transitional Care. Consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days (or

through completion of postpartum care) to allow for transition of care.

Choice of Health Plans. Public and private group purchasers should, wherever feasible, offer consumers a choice of high-quality health insurance plans.

ACCESS TO EMERGENCY SERVICES. Consumers have the right to access emergency health care services when and where the need arises. Health plans should provide payment when a consumer presents to an emergency department with acute symptoms of sufficient severity—including severe pain—such that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

PARTICIPATION IN TREATMENT DECISIONS. Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

Physicians and other health professionals should:

- Provide patients with sufficient information and opportunity to decide among treatment options consistent with the informed consent process.
- Discuss all treatment options with a patient in a culturally competent manner, including the option of no treatment at all.
- Ensure that persons with disabilities have effective communications with members of the health system in making such decisions.
- Discuss all current treatments a consumer may be undergoing.
- Discuss all risks, benefits, and consequences to treatment or nontreatment.
- Give patients the opportunity to refuse treatment and to express preferences about future treatment decisions.
- Discuss the use of advance directives—both living wills and durable powers of attorney for health care—with patients and their designated family members.
- Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process.

Health plans, providers, and facilities should:

- Disclose to consumers factors—such as methods of compensation, ownership of or interest in health care facilities, or matters of conscience—that could influence advice or treatment decisions.
- Assure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict health care providers' ability to communicate with and advise patients about medically necessary treatment options.
- Be prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients.

RESPECT AND NONDISCRIMINATION. Consumers have the right to considerate, respectful care from all members of the health care industry at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality health care system. To assure that right, the Commission recommends the following:

- Consumers must not be discriminated against in the delivery of health care services consistent with the benefits covered in their policy, or as required by law, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Consumers eligible for coverage under the terms and conditions of a health plan or program, or as required by law, must not be discriminated against in marketing and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

CONFIDENTIALITY OF HEALTH INFORMATION. Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

COMPLAINTS AND APPEALS. Consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

CONSUMER RESPONSIBILITIES. In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. Such responsibilities include:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about their health plan coverage and health plan options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, health care providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

Free copies of the full report to the President on the Consumer Bill of Rights and Responsibilities are available on the World Wide Web at the White House Website (www.whitehouse.gov) or from the Commission's Website (www.hcqualitycommission.gov). To obtain a printed copy of the report, call 1/800/732-8200 or write to Consumer Bill of Rights, Box 2429, Columbia, MD 21045-1429.

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THE FOLLOWING DOCUMENT HAS NOT
BEEN FILMED BUT IS AVAILABLE IN THE
ORIGINAL FILE.

Legislative Research Report 98.056

March 16, 1998

Alaska Health Insurance Statistics and Federal Laws Preempting State Regulation of Health Insurance Benefits

Legislative Research Services
Division of Legal and Research Services
Legislative Affairs Agency
Alaska State Legislature

Prepared for Representative Norman Rokeberg
Prepared by Paul Brandt, Legislative Analyst



*Legislative Research Services
130 Seward Street, Room 218
Juneau, AK 99801
907-465-3991
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www.legis.state.ak.us/legres/legres.htm*

HB

300

File 2

ALASKA STATE LEGISLATURE

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Labor and Commerce Committee

JUST THE FAX

Date: 4/20/98

TO: Quyr

FAX: 463-3979 Telephone: _____

FROM: Shirley

FAX: 465-2040 Telephone: _____

Number of Pages: 6 (including this page)

Comments:

Have a Nice Day

Alaska State Medical Association

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

March 18, 1998

Honorable Norman Rokeberg, Chair
State of Alaska
House of Representatives
Labor & Commerce Committee
Room 17
State Capitol (MS 3100)
Juneau, Alaska 99501-1182

RE: HB 300

Dear Representative Rokeberg:

The Alaska State Medical Association (ASMA) represents nearly 500 private practice physicians and their patients. Thank-you for the opportunity to provide comments on CSHB 300. Attached is a copy of a letter to this bill's sponsor, Representative Con Bunde, that provides ASMA's commentary.

Specifically, ASMA wishes to make several suggestions for modification to CSHB 300.

1. AS 21.42.390 (b) (page 2, line 1 though 3) provides that a health insurer may not deny, reduce, or terminate health care benefits unless that action is approved by a physician licensed in the United States.

Practically speaking, this language would have the effect of requiring that a physician also approve termination of coverage for non-payment of premium. Additionally, a physician would also have to approve the denial of payment for a claim that did not exceed the required deductible. This would appear to be an unintended result that would not best utilize a physician's training. It is expected the purpose of this section is to require that claim determinations involving medical decisions (e.g., medical necessity), be done by a licensed physician. Language found in HB 359 at 21.07.040 (p. 4) is the type of language that would seem to accomplish the intended result. However, ASMA would also suggest that, as suggested in its letter to Representative Bunde, a "peer" approach be adopted. For example, it would be most appropriate for an ophthalmologist to be making judgements of the medical necessity of services provided by another ophthalmologist; and

2. AS 21.42.390 (c) (1) (page 2, lines 5 and 6) prohibits a health insurer from reimbursing a covered person at a different rate because of that person's choice of

Honorable Norman Rokeberg, Chair
March 18, 1998

Page 2

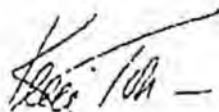
provider. Assumedly, this language is to prevent an insurer from penalizing a covered person based on his or her choice of provider. This is good. However, the language as constructed may have an unintended consequence in that it may also prevent an insurer from paying a provider, chosen by the covered person, a higher amount because that provider has more education, training, or experience. For example, a board certified neonatologist may warrant a higher rate of compensation than a family practitioner. Suggested alternative language is as follows:

AS 21.42.390 (c)

"(1) directly or indirectly penalizes a covered person because of the person's choice of provider".

Thank you for this opportunity.

Sincerely,



By: Kevin Tomera, MD, President

For: Alaska State Medical Association
Board of Trustees

cc: Representative John Cowdery
Representative Bill Hudson
Representative Joe Ryan
Representative Jerry Sanders
Representative Tom Brice
Representative Gene Kubina
Representative Con Bunde, Chair, House HESS Committee

>

Transfer interrupted!

T="Retirement, Benefits, Retirement Incentive Program, SB130, PERS, TRS, Public Employees' Retirement System, Teachers' Retirement System, Alaska">

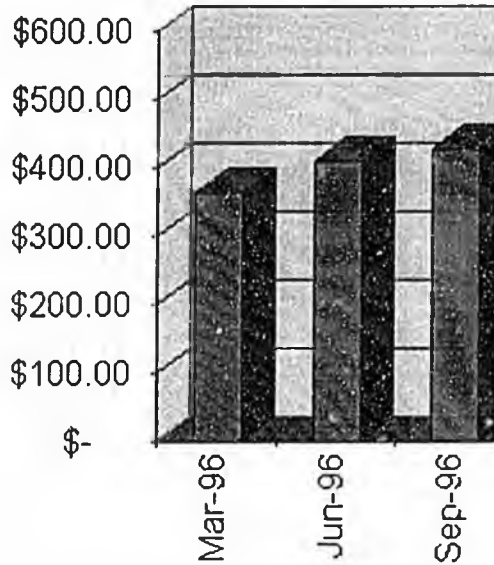
State of Alaska Health Benefits Fact Sheet

The State of Alaska went self-insured effective July 1, 1997. Under self insurance all health premiums are retained by the state and are used to pay claims and administrative costs. Health claims are paid through a third party administrator, NYLCare. NYLCare receives a flat fee per employee per month to cover its cost of paying claims and other administrative services requested by the state.

To develop "premiums" the State uses a health benefits consulting firm, Watson Wyatt. This firm reviews the plan's actual claims and administrative costs and estimates future claims costs (to allow for inflation and increased plan usage). Based on its analysis of recent trends, Watson Wyatt has initially projected premiums to increase approximately 12% for FY 99. The following graph shows the

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increase in claims costs per employee per month over the last 18 months (based on 3 month averages). Higher than expected utilization and medical CPI continue to drive these costs higher. Administrative costs are not included.



To put this in perspective, under the state's collective bargaining agreement with the GGU, the state's health insurance contribution is capped at \$473.50 per employee per month and the employee's contribution is capped at \$50 per month. Current contributions are \$462.50 (employer) and \$39.00 (employee). In addition, the bargaining agreement also states that the health benefits cannot be changed. The projected premium will exceed these contractual caps in FY 99 if

the current plan of benefits is provided. The State and the GGU Labor Management committee on health insurance have been working the last 4-5 months to look at options. Alternatives include increasing premiums, modifying benefits, some combination of those options, or providing Select Benefits, the State's flexible benefits alternative.

Most Select Benefits employees receive a benefit credit of \$450.00. The same 12% trend is being experienced in this plan as a result of both inflation and increased utilization. Select Benefits employees have the option of designing their health care coverages to better meet their personal needs, fit within the contractual employer limitations or their own financial resources. Select benefits maximizes employee choice.

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Claudette_Kreuzenstein@admin.state.ak.

ALASKA STATE LEGISLATURE

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Jerry Ritter
Press Secretary
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For Immediate Release: February 18, 1998

Contact: Rep. Brian Porter
(907) 465-4930

Alaska Insurance Rates Begin Downward Trend Tort Reform May Be Partially Responsible

(JUNEAU) -- State Farm Mutual Automobile Insurance Company and United Services Automobile Association (USAA) have announced in excess of twelve million dollars in premium dividends and rebates to their policy holders in Alaska. Between them, State Farm and USAA account for about one-third of the private passenger automobile insurance market in Alaska.

In a recent letter to policy holders, the Chairman and CEO of USAA, Robert T. Herres, wrote: "Safer cars and highways, tort reforms and reduced growth in medical costs are driving factors involved (in this reduction) . . . we can expect future dividend distributions to be impacted accordingly."

"This is good news," said House Majority Leader Brian Porter (R-Anchorage), who sponsored the tort reform legislation passed last year by the legislature. "Obviously, it's too early to tell how much, if any, impact tort reform has had on stabilizing insurance rates, but preliminary indications are that it is helping to head those rates in the right direction, which is down."

Tort reform was expected to result in improved claims loss figures for insurance companies doing business in Alaska. Such changes which reflect long-term trends typically are reflected in rate adjustments. As an example, State Farm Mutual reduced its auto insurance rates an average of 2.4 percent effective September 15, 1997.

"While it's going to take at least two more years to assess the full impact of the 1997 tort reform legislation, the future is already looking brighter," Porter said. "But we now know for certain that Alaskans are finally enjoying some direct and substantial relief from rising insurance rates and it looks as though tort reform is playing a part."

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Broadcasters note: Actuality from Rep. Porter is available at 1-800-478-6540



White House Press Release

PRESIDENT ENDORSES QUALITY COMMISSION'S FINAL REPORT AND ISSUES EXECUTIVE MEMORANDUM TO IMPROVE HEALTH CARE QUALITY

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 13, 1998

PRESIDENT ENDORSES QUALITY COMMISSION'S FINAL REPORT AND ISSUES EXECUTIVE MEMORANDUM TO IMPROVE HEALTH CARE QUALITY

March 13, 1998

Today, the President accepted the final report from his Advisory Commission on Consumer Protection and Quality. The report calls for a health quality council to develop unprecedented national quality improvement goals and a privately-administered forum to develop new tools to empower consumers and businesses to purchase quality health care. The President praised the Commission's work and endorsed its new recommendations for a national effort to improve quality throughout the health care system.

Hundreds of thousands of Americans each year are injured and even die from avoidable medical errors in the health care system, and millions more receive unnecessary services or substandard care that cause needless health complications and increase health care costs. Establishing uniform standards will help ensure that health plans finally begin to compete on the basis of quality -- not just costs and benefits.

To implement these new recommendations, the President also issued an Executive Memorandum that directs five Federal agencies to establish immediately an interagency task force to ensure the Federal government takes the lead on improving health care quality. The President also asked the Vice President to hold a blue ribbon planning meeting this June, to kick off the work of the health care forum recommended by the Quality Commission.

The President created the 34-member Advisory Commission on Consumer Protection and Quality in the Health Care Industry on March 26, 1997, charging it with "recommend[ing]" such measures as may be necessary to promote and assure quality and value and protect consumers in the health care industry. In November, the Commission recommended to the

President a "Consumer Bill of Rights." The President endorsed these protections and directed the Federal Government to come into compliance with this bill of rights and called on Congress to pass legislation to make these protections real for all Americans.

NUMEROUS INCONSISTENCIES AND AVOIDABLE ERRORS IN THE NATION'S HEALTH CARE SYSTEM COST LIVES AND UNDERMINE HEALTH. Too many Americans receive substandard health care, causing avoidable injuries and death, needless complications, and increased health care costs, including:

Avoidable errors: Hundreds of thousands of Americans are injured each year with tens of thousands dying as a result of avoidable errors in hospital care.

Underutilization of services: Millions of Americans do not receive necessary care and suffer needless complications that can add to health care costs. For example, far too many Americans do not get the preventive care they need.

Overuse of services: Others receive unnecessary health care that can increase costs and even endanger a patient's health. For example, 80,000 women every year undergo unnecessary hysterectomies.

Wide variation in health care quality: There is tremendous variation in health care services including wide regional disparities and different hospitalization rates for similar conditions.

ENDORSED COMMISSION'S NEW RECOMMENDATIONS TO IMPROVE QUALITY HEALTH CARE. The President endorsed the Commission's recommendations which call for:

Creating an Advisory Council for Health Care Quality. This public advisory panel would establish, for the first time, national goals to improve health care quality and develop strategies to achieve them. The Council would emphasize areas such as ensuring consumers have access to clear information to make decisions about health plans and professionals, identifying strategies to reduce avoidable medical errors, reducing variation in health care services, and promoting evidence-based medicine. Such a council, which would include representatives from both the public and private sector, would make an annual report to Congress on the nation's progress in improving health care quality.

Creating a Health Care Forum and Asking the Vice President to Hold the First Planning Meeting This June. The absence of uniform quality standards means that consumers do not have the necessary information to choose health plans based on quality. The forum would bring together the public and private sectors to identify a core set of measures to be adopted by health plans across the country. This would ensure that, for the first time, consumers have a consistent set of standards so they can choose health plans based on quality -- not just on cost. The President asked the Vice President to hold a blue ribbon planning meeting this June to kick off the work of the health quality forum as recommended by the Commission.

ISSUED A PRESIDENTIAL MEMORANDUM DIRECTING AGENCIES TO DEVELOP A FEDERAL TASK FORCE TO COORDINATE AND IMPROVE HEALTH QUALITY. The President directed the Departments of Health and Human Services, Labor,

Veterans Affairs, Defense, and the Office of Personnel Management to establish the "Quality Interagency Coordination" (QuIC) task force. He directed this task force to ensure better collaboration and coordination across the Federal government, through initiatives such as developing consistent goals, models, and timetables; sharing information about evidence-based medical research and quality outcomes, and coordinating Federal programs' quality reporting and compliance requirements.

RENEWED HIS CALL ON CONGRESS TO PASS A PATIENTS' BILL OF RIGHTS THIS YEAR. Following his speech earlier in the week to the American Medical Association, the President urged Congress to step up its efforts to pass a Patients' Bill of Rights this year. He also asked Congress to ensure that the Patients' Bill of Rights includes the health care quality council the endorsed today. With fewer than 70 working days in this legislative session, the President urged Congress not to adjourn without passing a Patients' Bill of Rights that includes important protections for patients such as: access to the specialists they need, access to emergency room services, and an external appeals process to address grievances with their health plans.



To comment on this service: feedback@www.whitehouse.gov



White House Press Release

**STATEMENT BY VICE PRESIDENT GORE ON THE PATIENTS' BILL OF RIGHTS AND
WOMEN ON INTERNATIONAL WOMENS' DAY**

THE WHITE HOUSE

Office of the Vice President

For Immediate Release

March 11, 1998

**STATEMENT BY VICE PRESIDENT GORE
ON THE PATIENTS' BILL OF RIGHTS AND WOMEN
ON INTERNATIONAL WOMENS' DAY**

President Clinton and I have made improving women's health a top priority and that is why we are calling on Congress to enact the Patients' Bill of Rights immediately.

The President has proposed unprecedented investments in medical research, treatment, and prevention to improve the health of women. We have also called on Congress to enact a Patient's Bill of Rights and taken steps to give these rights to millions of Americans who receive health care through a government program. In order to give women and all Americans the kind of protections they deserve, Congress must act quickly to pass a Patient's Bill of Rights.

With only 70 days left in this legislative session, time is running out. By enacting the Patients' Bill of Rights, we can provide important protections to address grievances with health plans, give all women access to the specialists they need, allow women access to an OB/GYN and assure them access to an appeals process.

As we celebrate International Women's Day, we mark what I hope will be only a beginning of a new commitment in quality health care for women. To continue our efforts, the President and I have made improving women's health care a priority in our 1999 budget where we have included funding for more research for breast and cervical cancer and allow Medicare beneficiaries access to certain cancer clinical trials.

This Administration has made a historic commitment to women's health and it is time to take the next step. I urge Congress to enact the Patients' Bill of Rights, a strong step toward ensuring women the kind of quality health care they deserve.



To comment on this service: feedback@www.whitehouse.gov



White House Press Release

PRESIDENT CLINTON RELEASES NEW REPORT AND URGES CONGRESS TO PASS PATIENT BILL OF RIGHTS, COMPREHENSIVE TOBACCO LEGISLATION, AND THE MEDICARE BUY-IN PROPOSAL

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 9, 1998

**PRESIDENT CLINTON RELEASES NEW REPORT
AND URGES CONGRESS TO PASS PATIENT
BILL OF RIGHTS, COMPREHENSIVE TOBACCO
LEGISLATION, AND THE MEDICARE BUY-IN PROPOSAL**

March 9, 1998

In a speech to the American Medical Association (AMA) today, the President renewed his call to Congress to pass 1) a patients' bill of rights; 2) comprehensive tobacco legislation to reduce teen smoking; and 3) his proposal to allow hundreds of thousands of Americans ages 55 to 65 to buy into Medicare. In his speech, which marks the first time a President has spoken to the AMA in fifteen years, President Clinton highlighted the fact that he and the AMA are united on the need for a patients' bill of rights and tobacco legislation, and he urged the AMA to lend its strong support to his Medicare buy-in proposal. Underscoring the bipartisan support for a patients' bill of rights, the President released a report showing that 44 states -- including 28 states with Republican Governors -- have enacted the "Consumer Bill of Rights" that the President's Quality Commission recommended, and the President endorsed last year. In his speech, the President:

RELEASED NEW REPORT SHOWING THAT 44 STATES -- INCLUDING 28 STATES WITH REPUBLICAN GOVERNORS -- HAVE ENACTED AT LEAST ONE OF THE PROVISIONS IN THE PATIENTS' BILL OF RIGHTS. The President released a new report that underscores the bipartisan support for the patients' bill of rights he endorsed last year. Highlights from this report are as follows:

Forty-four states have enacted at least one of protections in the patients' bill of rights.

Patient protection laws have been enacted by Democratic and

Republican Governors alike. Twenty-eight of the 32 states with Republican Governors have enacted at least one of these protections.

Each of these patient protections has been enacted in at least eight states around the country and some have been enacted in as many as forty-one states. For example:

- Twenty-eight states -- including 16 with Republican Governors -- have enacted protections to ensure access to emergency room services.
- Thirty states -- including 15 with Republican Governors -- have enacted protections to give direct access to certain specialists, including access to qualified specialists for women's health services.

(See Attached Fact Sheet for Details
on Report on State Patient Protections)

URGED CONGRESS TO PASS FEDERAL LEGISLATION BECAUSE, DESPITE STATE LAWS, STATES HAVE NO JURISDICTION OVER MORE THAN 100 MILLION AMERICANS. A patchwork of non-comprehensive state laws cannot provide Americans with the protections they need -- especially because state laws do not have jurisdiction over more than 100 million Americans. For example, they do not cover tens of millions of Americans in self-insured plans covered under the Employee Retirement Income Security Act (ERISA). The only way to ensure that all health plans serving all Americans provide the protections envisioned by the Quality Commission is to pass and enact bipartisan Federal legislation.

CALLED ON CONGRESS TO PASS COMPREHENSIVE TOBACCO LEGISLATION THIS YEAR. The President today also reiterated his call for Congress to pass comprehensive tobacco legislation this year that includes his five key principles:

A comprehensive plan to reduce youth smoking, including: significant price increases; tough penalties on tobacco firms that continue to market to youths; public education and counter advertising; and expanded efforts to restrict access and limit appeal.

Full authority of the Food and Drug Administration to regulate tobacco products.

Changes in how the tobacco industry does business, including an end to marketing and promotion to children and broad document disclosure.

Progress towards other public goals, including a reduction of second hand smoke; promotion of cessation programs; public health research; and the strengthening of international efforts to control tobacco.

Protection for tobacco farmers and their communities.

REITERATED THAT THIS TOBACCO PROPOSAL COULD PREVENT UP TO ONE

MILLION PREMATURE DEATHS OVER THE NEXT FIVE YEARS. The recent Treasury Department study, based on conservative estimates from well-respected analytical models, concluded that the Administration's proposal to increase the price of cigarettes by \$1.50 per pack -- coupled with proposed sales and advertising restrictions -- would:

Keep up to 1.9 million American youths from smoking in 2003 -- a 39 to 46 percent reduction in youth smoking. Over the next five years, the cumulative number of young people kept from smoking would be up to 2.8 million.

Spare as many as 1 million of today's young people from premature deaths resulting from smoking-related diseases over the next five years.

URGED CONGRESS TO ACT NOW TO PASS HIS TARGETED PROPOSAL TO GIVE AMERICANS AGES 55 TO 65 ACCESS TO HEALTH INSURANCE.

Americans ages 55 to 65 are among the most difficult populations to insure: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems.

The President has a carefully-targeted, fiscally-responsible proposal that would allow hundreds of thousands of vulnerable Americans to gain access to more affordable health care coverage by: allowing Americans ages 62 to 65 to buy into the Medicare program; allowing displaced workers age 55 and over a similar buy-in option; and allowing Americans age 55 and over who have lost their retiree health benefits to buy into their former employers' health plan.

The Congressional Budget Office just confirmed that this proposal would help hundreds of thousands of Americans without burdening the Medicare Trust Fund or the budget.

PRESIDENT CLINTON RELEASES WHITE HOUSE REPORT
REVEALING THAT STATES HAVE ENACTED EACH OF
THE PATIENT PROTECTIONS HE HAS ENDORSED -
INCLUDING MANY STATES WITH REPUBLICAN GOVERNORS

March 9, 1998

Thirty-four states -- including 21 states with Republican Governors -- have enacted information disclosure provisions. At least 34 states have enacted provisions that require health plans to disclose information to help consumers make informed decisions about their health plans, health professionals, and health facilities.

Ten states have enacted provider network adequacy provisions -- including four states with Republican Governors. At least ten states have enacted provisions to help ensure that health plan networks provide access to sufficient numbers and types of providers without unreasonable delay.

Thirty states -- including 15 states with Republican Governors -- have enacted protections to give direct access to certain specialists, including qualified specialists for women's health services. At least 30 states have enacted provisions to give patients greater access to needed specialists, including giving women greater access to qualified specialists for women's health services.

Seventeen states have enacted continuity of care protections -- including ten states with Republican Governors. At least 17 states have enacted protections to help ensure continuity of care for enrollees who are involuntarily forced to change providers.

Twenty-eight states have enacted protections to ensure access to emergency room services -- including 16 states with Republican Governors. At least 28 states have enacted legislation to help ensure that patients have access to emergency room services when and where the need arises. These provisions require health plans to pay for the initial screening examination and stabilization care -- regardless of whether the emergency room is in the plan's network -- when an enrolled person needs emergency services. Twenty of these states require the use of a "prudent layperson standard" to determine whether an emergency exists, to ensure that any person who reasonably thought they were having an emergency is covered by their health plan.

Forty-one states have enacted anti-gag clauses -- including 26 states with Republican Governors. At least 41 states have enacted "anti-gag" clauses prohibiting health plans from using contract clauses that restrict providers' communications with their patients.

Eighteen states have enacted provisions that require health plans to disclose financial incentives -- including 12 states with Republican Governors. At least 18 states have passed protections requiring health plans to disclose any financial arrangements with their physicians.

Nineteen states have enacted provisions to protect confidentiality of health information -- including ten states with Republican Governors. At least 19 states have enacted some type of provision to help protect the confidentiality of health information for health plan enrollees.

Eight states have enacted anti-discrimination provisions, including six states with Republican Governors.

Twelve states now require that health plan enrollees have access to an external appeal process, including eight states with Republican Governors. At least 12 states now require that health plan enrollees have access to specially designated and independent external appeals entities, which are funded and empowered to hear and act upon such appeals.

Last November, the President endorsed the "Consumer Bill of Rights" recommended by his Advisory Commission on Quality and Consumer Protection. These rights included: information disclosure; a choice of providers including provider network adequacy provisions, access to specialists (including qualified specialists for women's health services), and transitional care provisions; access to emergency room services; participation in treatment decisions including prohibiting anti-gag clauses and requiring disclosure of financial incentives; protection of the confidentiality of health information; anti-discrimination provisions; and access to an appeals process.



To comment on this service: feedback@www.whitehouse.gov

ALABAMA MARKET SHARE AND ASSESSMENT ALLOCATIONS
FOR CIPA ASSESSMENT MAIL.8D 6/9/96

1996 Assessment amount to be allocated: \$1,500,000

May 1996 Assessment

Amount of
Allocation

ICV DE SET 05:01 PM 05/11/96

ALIC	LINE COMPANY NAME	Written Premiums	Market Share	Assessment Amount	ATTN	STREET ADDRESS	CITY	STATE ZIP
	71854 AAA LIFE INSURANCE CO	11,019	.0031%	11	ATTN: FAROOQ N KAHN	1900 AAA DRIVE	DEATHROW	FL 21746-6083
	60046 ACADEMY LIFE INSURANCE CO	16,371	.0045%	5	ATTN: TAX DEPARTMENT	20 MOORES ROAD	FRAZER	PA 19355
	60054 AETNA LIFE INSURANCE CO	163,290,208	42.4716%	37	ATTN: BRYCE HUNT, MD1P	151 FARMINGTON AVE	HARTFORD	CT 06156
	60097 A.L. AMERICAN LIFE INS CO	8,443	.0010%	14	ATTN: TAX DEPARTMENT	3600 RTE 66 PO BOX 1650	NEPTUNE	NJ 07754-1650
	90511 ALLIANZ LIFE INS CO OF NORTH AMERIC	511,179	.1416%	2,124	ATTN: TAX DEPARTMENT	1750 HENNEPIN AVENUE	MINNEAPOLIS	MN 55403-2196
	84424 A.L. AMERICA FINANCIAL LIFE & ANNUITY	4,817	.0013%	20	ATTN: TAX DEPARTMENT	440 LINCOLN STREET	WORCESTER	MA 01658
	75914 AMERICAN CHAMBERS LIFE INSURANCE CO	492,572	.1385%	2,047	ATTN: TAX DEPARTMENT	1905 HIGH POINT DRIVE	NAPERVILLE	IL 60563-9376
	60410 AMERICAN FIDELITY ASSURANCE CO	99,226	.0275%	412	ATTN: STEPHEN GARNETT, SENIOR V.P.	PO BOX 25623	OKLAHOMA CITY	OK 73126-0523
	91226 AMERICAN FRANKLIN LIFE INS CO	1,669	.0004%	7	ATTN: STEVEN HORVAT			
	60534 AMERICAN HERITAGE LIFE INS CO	23,703	.0066%	99	ATTN: TAX DEPARTMENT	1776 AMERICAN HERITAGE LIFE DR	JACKSONVILLE	FL 32224-6688
	60607 AMERICAN INTERNATL LIFE ASSUR CO OF N	383	.0001%	2				
	60704 AMERICAN LIFE INS CO OF NEW YORK	6,994	.0019%	29	ATTN: TAX DEPARTMENT, 6TH FLOOR	320 PARK AVENUE	NEW YORK	NY 10022
	60739 AMERICAN NATIONAL INS CO	18,482	.0051%	77	ATTN: TAX DEPARTMENT	ONE MOODY PLAZA	GALVESTON	TX 77550-7999
	71773 AMERICAN NATIONAL LIFE INS CO OF TX	7,078	.0020%	29	ATTN: TAX DEPARTMENT	ONE MOODY PLAZA	GALVESTON	TX 77550-7999
	60836 AMERICAN REPUBLIC INS CO	13,454	.0037%	56	ATTN: TAX DEPARTMENT	PO BOX ONE	DEB MOINES	IA 50301-
	63452 AMERICAN STANDARD LIFE & ACC INS CO	164	.0000%	1				
	78325 AMERICAN TRAVELERS LIFE INS CO	16,241	.0045%	67	ATTN: TAX DEPARTMENT	3220 THILMAN DRIVE	BENSALEM	PA 19020
	60885 AMERICAN UNITED LIFE INS CO	710	.0002%	3				
	67982 AMEX LIFE ASSURANCE CO	226,549	.0625%	937	ATTN: TAX DEPARTMENT	1650 LOS GAMOS DR	SAN RAFAEL	CA 94903-1899
	86286 ANTHEM LIFE INS CO	11,019	.0031%	46	ATTN: TAX DEPARTMENT	4040 VINCENNES CIRCLE	INDIANAPOLIS	IN 46268-9027
	60160 BALBOA LIFE INS CO	146	.0000%	1				
	61263 BANKERS LIFE & CASUALTY CO	147,509	.0409%	613	ATTN: TAX DEPARTMENT	11815 N PENNSYLVANIA STREET	CARMEL	IN 46032
	61390 BANKERS SECURITY LIFE INS SOCIETY	1,843	.0005%	8				
	61387 BANKERS UNITED LIFE ASSURANCE CO	1,964	.0005%	8				
	90086 BCS LIFE INS CO	8,516	.0024%	35	ATTN: TAX DEPARTMENT	676 N ST CLAIR STREET	CHICAGO	IL 60611-2297
	61417 BENEFICIAL STANDARD LIFE INS CO	10,703	.0038%	57	ATTN: TAX DEPARTMENT	11815 N PENNSYLVANIA ST	CARMEL	IN 46032
	161433 BERKSHIRE LIFE INS CO	8,047	.0022%	83	ATTN: TAX DEPARTMENT	700 SOUTH ST	PITTSFIELD	MA 01201
	90638 BEST LIFE ASSURANCE CO OF CA	438,958	.1216%	1,824	ATTN: TAX DEPARTMENT	PO BOX 19721	IRVINE	CA 92713-9721
	BLIE CROSS OF WASHINGTON AND ALAS	116,874,614	32.3819%	485,729	ATTN: BOB NAKAHARA	PO BOX 397	SEATTLE	WA 98111-0327
	61476 BOSTON MUTUAL LIFE INS CO	71,887	.0189%	299	ATTN: TAX DEPARTMENT	120 ROYALL ST	CANTON	MA 02021-1098
	61493 BUSINESS MENS ASSURANCE CO OF AM	22,292	.0062%	93	ATTN: TAX DEPARTMENT	PO BOX 419458	KANSAS CITY	MO 64141
	60799 CANTIC LIFE INS CO	100,542	.0279%	418	ATTN: TAX DEPARTMENT	233 SOUTH WACKER DR SUITE 700	CHICAGO	IL 60606-6393
	61054 CENTENNIAL LIFE INS CO	52,113	.0144%	217	ATTN: TAX DEPARTMENT	P.O. BOX 470	SHAWNEE MISSION	KS 66201
	61735 CENTRAL SECURITY LIFE INS CO	891	.0003%	4				
	61751 CNTRAL STATES II & L CO OF OMAHA	63,802	.0177%	265	ATTN: TAX DEPARTMENT	PO BOX 84360	OMAHA	NE 68134
	61778 CERTIFIED LIFE INS CO	25,062	.0069%	104	ATTN: TAX DEPARTMENT	1816 N PENNSYLVANIA STREET	CARMEL	IN 46032
	78254 CHUBB LIFE INS CO OF AMERICA	16,959	.0044%	66	ATTN: TAX DEPARTMENT	ONE GRANITE PLACE	CONCORD	NH 03301
	78236 CINCINNATI LIFE INS CO	215	.0001%	1				
	62065 COLONIAL PENN LIFE INS CO	8,648	.0024%	36	ATTN: STEVE COHEN	399 MARKET ST 6TH FLR	PHILADELPHIA	PA 19181
	62146 COMBINED INS CO OF AMERICA	405,861	.1125%	1,687	ATTN: TAX DEPARTMENT	123 NORTH WACKER DRIVE	CHICAGO	IL 60608-0611
	66508 COMMERCIAL LIFE INS CO	32,790	.0091%	188	ATTN: TAX DEPARTMENT	PO BOX 1387	PISCATAWAY	NJ 08855-1387
	81425 COMMERCIAL TRAVELERS MUTUAL INS CO	28,107	.0078%	117	ATTN: TAX DEPARTMENT	70 GENESKE ST	UTICA	NY 11502
	69617 COMMUNITY NATIONAL ASSURANCE CO	1,110	.0003%	5				
	72504 CONGRESS LIFE INS CO	1,852	.0005%	8				
	62308 CONNECTICUT GENERAL LIFE INS CO	698,940	.1937%	2,905	ATTN: TAX DEPARTMENT	S-360	HARTFORD	CT 06162-2160
	62413 CONTINENTAL ASSURANCE CO	160,385	.0444%	667	ATTN: TAX DEPARTMENT	CNA PLAZA	CHICAGO	IL 60685
	71404 CONTINENTAL GENERAL INS CO	38,856	.0108%	161	ATTN: TAX DEPARTMENT	8901 INMAN HILLS DR	OMAHA	NE 68114-7007
	62472 CONTINENTAL LIFE INS CO	753	.0002%	3				
	62510 CONTINENTAL WESTERN LIFE INS CO	48	.0000%	0				
	62622 COUNTRY LIFE INSURANCE CO	37,748	.0105%	157	ATTN: TAX DEPARTMENT	1711 GE ROAD	BLOOMINGTON	IL 61704-2386

NAIC CODE COMPANY NAME	Written Premiums	Market Share	Assessment Amount	ATTN	STREET ADDRESS	CITY	STATE ZIP
62826 CUNA MUTUAL INS SOCIETY	1,704,464	.4723%	7,084	ATTN: TAX DEPARTMENT	PO BOX 891	MADISON	WI 53701
78611 KFP LIFE INS CO	287,040	.0574%	860	ATTN: TAX DEPARTMENT	435 FORD RD	MINNEAPOLIS	MN 55426
73200 EMPLOYERS HEALTH INS CO	1,533,257	.4387%	6,580	ATTN: TAX DEPARTMENT	1100 EMPLOYERS BLVD	GREEN DAY	WI 54344
853 CASUALTY LIFE & CASUALTY INS CO	7,127	.0020%	30	ATTN: TAX DEPARTMENT	PO BOX 2460	SALT LAKE CITY	UT 84110-2460
2914 EQUITABLE LIFE ASSOC OF THE US	543,303	.1505%	2,253	ATTN: TAX DEPARTMENT	135 W 60 STREET 3 FL	NEW YORK	NY 10020
66877 EXECUTIVE FUND LIFE INS CO	307	.0001%	1				
63053 FAMILY LIFE INS CO	167	.0000%	1	ATTN: AUSTIN CENTER, TAX MGR.			
67695 FEDERAL HOME LIFE INS CO	1,339	.0004%	6	ATTN: TIM MARTIN, 6TH FLOOR			
63283 FEDERAL LIFE INS CO (MUTUAL)	50	.0000%	0				
71870 FIDELITY SECURITY LIFE INS CO	78,976	.0202%	304	ATTN: TAX DEPARTMENT	3190 BROADWAY	KANSAS CITY	MO 64111
69140 FIRST ALLAMERICA FIN LIFE INS CO	6,502	.0018%	27	ATTN: TAX DEPARTMENT	440 LINCOLN ST	WORCESTER	MA 01653
63401 FIRST COLONY LIFE INS CO	39	.0000%	0				
63517 FIRST NATIONAL LIFE INS CO	20,348	.0056%	85	ATTN: TAX DEPARTMENT	SEVEN CLAYTON STREET	MONTGOMERY	AL 36104-0000
63576 FORD LIFE INS CO	5,147	.0014%	21	ATTN: TAX DEPARTMENT	PO BOX 6027 THE AMERICAN BL	DHARBORN	MI 48121-0027
78408 FORTIS BENEFITS INSURANCE COMPANY	1,894,476	.4895%	7,042	ATTN: TAX DEPARTMENT	PO BOX 64271	ST PAUL	MN 55184-0271
63622 FRANKLIN LIFE INS CO	355,042	.0984%	1,476	ATTN: STEPHEN HORVAT	ONE FRANKLIN SQUARE	SPRINGFIELD	IL 62713
63665 GENERAL AMERICAN LIFE INSURANCE C	41,456	.0115%	172	ATTN: TAX DEPARTMENT	700 MARKET STREET	ST LOUIS	MO 63101
70425 GENERAL ELECTRIC CAPITAL ARE CO	122	.0000%	1				
91472 GLOBE LIFE & ACCIDENT INS CO	14,165	.0039%	59	ATTN: GARY ATKINSON	GLOBE LIFE CENTER	OKLAHOMA CITY	OK 73184
63205 GOLDEN RULE INSURANCE CO	2,161,969	.5990%	8,885	ATTN: TAX DEPARTMENT	712 ELEVENTH STREET	LAWRENCEVILLE	IL 62439-2815
60017 GREAT AMERICAN RESERVE INS CO	1,216	.0003%	5				
90213 GREAT SOUTHERN LIFE INS CO	19,443	.0037%	58	ATTN: TAX DEPARTMENT	PO BOX 219040	DALLAS	TX 75221-9040
68322 GREAT WEST LIFE & ANNUITY INS CO	5,940,123	1.6468%	24,687	ATTN: TAX DEPARTMENT	8515 E ORCHARD ROAD 7 FL	ENGLEWOOD	CO 80111
80705 GREAT WEST LIFE ASSURANCE CO	382,574	.1089%	1,632	ATTN: TAX DEPARTMENT	8516 E ORCHARD RD	ENGLEWOOD	CO 80111
64181 GUARANTEE LIFE INSURANCE CO	78,528	.0220%	331	ATTN: TAX DEPARTMENT	8801 INDIAN HILLS DR	OMAHA	NE 68114
64208 GUARANTEE RESERVE LIFE INS CO	1,728	.0005%	7				
64211 GUARANTEE TRUST LIFE INS CO	30	.0000%	0	ATTN: TREASURER			
64346 GUARDIAN LIFE INS CO OF AMERICA	8,013,486	2.4973%	37,480	ATTN: TAX DEPARTMENT	201 PARK AVENUE SOUTH	NEW YORK	NY 10003
70815 HARTFORD LIFE & ACCIDENT INS CO	146,292	.0405%	608	ATTN: MARY REID	PO BOX 2899	HARTFORD	CT 06104-2899
70872 HARTFORD LIFE INS CO	142,008	.0395%	583	ATTN: MARY REID	PO BOX 2989	HARTFORD	CT 06104-2989
14094 HERITAGE LIFE INS CO	24,985	.0069%	104	ATTN: TAX DEPARTMENT	30851 W AGOURA RD	AGOURA HILLS	CA 91301
73760 HOME LIFE FINANCIAL ASSURANCE COR	1,088,063	.3015%	4,522	ATTN: TAX DEPARTMENT	ONE CENTENNIAL AVENUE	PISCATAWAY	NJ 08855
64518 HORACE MANN LIFE INS CO	10,410	.0029%	43	ATTN: TAX DEPARTMENT	ONE HORACE MANN PL	SPRINGFIELD	IL 62715
66096 IDS LIFE INSURANCE CO	42,187	.0117%	176	ATTN: EXTERNAL REPORTS T8/27	IDS TOWER 10	MINNEAPOLIS	MN 55440-0810
81779 INDIVIDUAL ASR CO LIFE HEALTH & ACC	748	.0002%	3				
64734 INTERCONTINENTAL LIFE INS CO	188	.0001%	1				
64887 INVESTORS LIFE INS CO NORTH AMERL	794	.0002%	3				
71153 IFF HARTFORD LIFE & ANNUITY INS CO	1,497	.0041%	6	ATTN: MARY REID			
67865 JEFFERSON-PILOT LIFE INS CO	3,195	.0009%	13	ATTN: TAX DEPARTMENT	PO BOX 21008	GREENSBORO	NC 27402
65089 JOHN HANCOCK MUTUAL LIFE INS CO	501,693	.1390%	2,095	ATTN: TAX DEPARTMENT	PO BOX 111	BOSTON	MA 02117
65129 KANSAS CITY LIFE INS CO	181	.0000%	1				
62250 LAMAR LIFE INSURANCE CO	2,962	.0008%	12	ATTN: TAX DEPARTMENT	7887 E HILLVIEW AVENUE	ENGLEWOOD	CO 80111
65323 LIBERTY LIFE INS CO	578	.0002%	4	ATTN: FINANCIAL REPORTING			
65831 LIBERTY NATIONAL LIFE INS CO	6,158	.0017%	26	ATTN: TAX DEPARTMENT	PO BOX 2612	BIRMINGHAM	AL 35202
63498 LIFE INS CO OF NORTH AMERICA	309,070	.0858%	1,284	ATTN: TAX DEPARTMENT	S 880	HARTFORD	CT 06153-2980
65538 LIFE INS CO OF THE SOUTHWEST	320	.0001%	1				
64190 LIFE INVESTORS INS CO OF AMERICA	204,961	.0568%	852	ATTN: TAX DEPARTMENT	4331 EDGEWOOD ROAD NR	CEDAR RAPIDS	IA 52409
65076 LINCOLN NATIONAL LIFE INS CO	5,113,668	1.4168%	21,252	ATTN: TAX DEPARTMENT	1300 S CLINTON STREET	FORT WAYNE	IN 46802
65692 LONE STAR LIFE INS CO	81,746	.0226%	310	ATTN: TAX DEPARTMENT	PO BOX 708008	DALLAS	TX 75248-1908
65722 LOYAL AMERICAN LIFE INS CO	3,899	.0011%	16	ATTN: TAX DEPARTMENT	141 BOX 6408	MOBILE	AL 36660-0408
65900 MASSACHUSETTS GENERAL LIFE INS CO	678	.0002%	3				
65935 MASSACHUSETTS MUTUAL LIFE INS CO	79,216	.0210%	329	ATTN: TAX DEPARTMENT	1295 STATE STREET	SPRINGFIELD	MA 01111
71471 MEDICO LIFE INS CO	178,214	.0494%	741	ATTN: TAX DEPARTMENT	50 BOX 3477	OMAHA	NE 68103
97065 MIGA LIFE & HEALTH INS CO THE	713,438	.1977%	2,968	ATTN: TAX DEPARTMENT	PO BOX 809095	DALLAS	TX 75380-8095
88126 MEMBERS LIFE INSURANCE COMPANY	75	.0000%	0				

NOV 08 10:09 AM '08
 HEALTH PLAN RECEIVING

3,444

ATTN

5,357 → 23,211

→ 274

19,965

Handwritten notes at the top of the page, possibly a signature or reference number.

MARK	Written	Market	Assessment	ATTN	STREET ADDRESS	CITY	STATE	ZIP
CODE COMPANY NAME	Crystallina	Share	Amount					
79413 METRAHEALTH INS CO (THE)	44,370	.0123%	157,884 x	ATTN: TAX DEPARTMENT	450 COLUMBUS BLVD	HARTFORD	CT	06116 0150
65978 METROPOLITAN LIFE INS CO	715,488	.1982%	1,058,974 x	ATTN: TAX DEPARTMENT	ONE MADISON AVENUE	NEW YORK	NY	10010
95561 MIC LIFE INS CORP	3,407	.0009%	14 x	ATTN: TAX DEPARTMENT	3044 W GRAND BLVD	DETROIT	MI	48202
257 MODERN AMERICAN LIFE INS CO	100	.0000%	0					
65378 MONTGOMERY WARD LIFE INS CO	179,221	.0497%	1,174,530 x	ATTN: TAX DEPARTMENT	200 N MARTINGALE ROAD	SCHAUMBURG	IL	60173-2096
68281 MONUMENTAL LIFE INS CO	1,455,944	.4148%	6,221 x	ATTN: TAX DEPARTMENT	TWO EAST CHASE STREET	BALTIMORE	MD	21202
66270 MUTUAL LIFE INS CO OF NEW YORK	412,745	.1146%	1,720 x	ATTN: TAX DEPARTMENT	1740 BROADWAY	NEW YORK	NY	10019
71412 MUTUAL OF OMAHA INS CO	1,312,587	.3637%	5,455 x	ATTN: TAX DEPARTMENT	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175
61609 NATIONAL BENEFIT LIFE INS CO	5,615	.0018%	27 x	ATTN: TAX DEPARTMENT	333 W 34 STREET	NEW YORK	NY	10001-2408
92365 NATIONAL FOUNDATION LIFE INS CO	8,103	.0017%	25 x	ATTN: TAX DEPARTMENT	777 MAIN STREET	PORT WORTH	TX	76102
85583 NATIONAL GUARDIAN LIFE INS CO	997	.0003%	4 x					
82639 NATIONAL HEALTH INS CO	6,700	.0019%	28 x	ATTN: TAX DEPARTMENT	PO BOX 618929	DALLAS	TX	75261-9929
65980 NATIONAL LIFE INS CO	21,062	.0058%	87 x	ATTN: TAX DEPARTMENT	NATIONAL LIFE DRIVE	MONTPELIER	VT	05604
66828 NATIONAL TRAVELERS LIFE CO	951	.0003%	4 x					
86869 NATIONWIDE LIFE INS CO	446,958	.1238%	1,858 x	ATTN: TAX DEPARTMENT	ONE NATIONWIDE PLAZA	COLUMBUS	OH	43215
63222 NETWORK AMERICA LIFE INS CO	368	.0001%	2 x					
66893 NEW ENGLAND MUTUAL LIFE INS CO	14,090	.0039%	59 x	ATTN: TAX DEPARTMENT	501 BOYLSTON STREET	BOSTON	MA	02117
89915 NEW YORK LIFE INS CO	5,016,109	1.3888%	20,847 x	ATTN: RICH ZUCCARO, ROOM 604	61 MADISON AVENUE	NEW YORK	NY	10010
66974 NORTH AMERICAN CO LIFE & HLTH INS	553	.0002%	2 x					
87734 NORTHERN LIFE INS CO	523	.0001%	2 x	ATTN: FINANCIAL REPORTING				
67105 NORTHWESTERN NATL LIFE INS CO	278,219	.0771%	1,166 x	ATTN: CHRIS D. SCHREIER	BOX 20	MINNEAPOLIS	MIN	55440
87148 OCCIDENTAL LIFE INS CO OF NC	1,901	.0005%	8 x					
87644 PENN MUTUAL LIFE INS CO	14,021	.0039%	58 x	ATTN: TAX DEPARTMENT	630 WALNUT STREET	PHILADELPHIA	PA	19172
67660 PENNSYLVANIA LIFE INS CO	1,922	.0005%	8 x					
88231 PFL LIFE INS CO	2,504,746	.6940%	10,410 x	ATTN: TAX DEPARTMENT	4333 EDGEWOOD ROAD NE	CEDAR RAPIDS	IA	52499
87784 PHILADELPHIA AMERICAN LIFE INS CO	14,829	.0041%	62 x	ATTN: TAX DEPARTMENT	3121 BUFFALO SPEEDWAY	HOUSTON	TX	77088
80926 PHOENIX AMERICAN LIFE INS CO	4,030	.0011%	17 x	ATTN: TAX DEPARTMENT	100 BRIGHT MEADOW BLVD	ENFIELD	CT	06083-1900
67814 PHOENIX HOME LIFE MUTUAL INS CO	74,827	.0207%	311 x	ATTN: TAX DEPARTMENT	100 BRIGHT MEADOW BLVD	ENFIELD	CT	06083-1900
88578 PHYSICIANS MUTUAL INSURANCE CO	786,457	.2179%	3,289 x	ATTN: TAX DEPARTMENT	2800 DODGE STREET	OMAHA	NE	68131
87822 PIERCE NATIONAL LIFE INS CO	1,175	.0003%	6 x					
83380 PIONEER LIFE INS CO OF ILLINOIS	967,259	.2852%	3,978 x	ATTN: TAX DEPARTMENT	1760 E GOLF RD STE 1000	SCHAUMBURG	IL	60173
87268 PM GROUP LIFE INSURANCE CO	543,838	.1507%	2,260 x	ATTN: TAX DEPARTMENT	700 NEWPORT CENTER DRIVE	NEWPORT BRANCH	CA	92660
87989 PRAIRIE STATES LIFE INS CO	404	.0001%	2 x					
85979 PRIMERICA LIFE INS CO	15,082	.0042%	63 x	ATTN: TAX DEPARTMENT	3120 BRECKINRIDGE BLVD	DULUTH	GA	30199 8001
81271 PRINCIPAL MUTUAL LIFE INS CO	18,671,510	5.1732%	77,589 x	ATTN: TAX DEPARTMENT	711 HIGH STREET G-15	DES MOINES	IA	50392
88136 PROTECTIVE LIFE INS CO	11,820	.0033%	49 x	ATTN: TAX DEPARTMENT	PO BOX 2000	BIRMINGHAM	AL	35202
88177 PROVIDENT INDEMNITY LIFE INS CO	36,383	.0101%	151 x	ATTN: TAX DEPARTMENT	2500 DEKALB PIKE	NORRISTOWN	PA	19404-0511
68185 PROVIDENT LIFE & ACCIDENT INS CO	995,368	.2788%	4,101 x	ATTN: TAX DEPARTMENT	ONE FOUNTAIN SQUARE	CHATTANOOGA	TN	37402-1380
88225 PROVIDENT MUTUAL LIFE INS CO	8,260	.0023%	34 x	ATTN: TAX DEPARTMENT	PO BOX 7378	PHILADELPHIA	PA	19102
88606 PROVIDENT LIFE AND HEALTH INS CO	74,915	.0208%	311 x	ATTN: TAX DEPARTMENT	20 MOORES ROAD	FRAZER	PA	19355
88241 PRUDENTIAL INSURANCE CO OF AMERICA	4,029,028	1.1163%	16,745 x	ATTN: TAX DEPARTMENT, ELISABETH DUGAN	781 BROAD STREET	NEWARK	NJ	07102-3777
68357 RELIABLE LIFE INSURANCE CO	472	.0001%	2 x					
88381 RELIANCE STANDARD LIFE INS CO	34,762	.0098%	144 x	ATTN: TAX DEPARTMENT	2501 PARKWAY	PHILADELPHIA	PA	19139
87895 ROYAL MACCABEES LIFE INS CO	57,345	.0159%	238 x	ATTN: FINANCIAL ACCOUNTING	25800 NORTHWESTERN HWY BOX 2	SOUTHFIELD	MI	48037-2165
68608 SAFECO LIFE INSURANCE CO	519,112	.1438%	2,157 x	ATTN: TAX DEPARTMENT	PO BOX 34690	SEATTLE	WA	98124-1890
86721 SECURITY LIFE INS CO OF AMERICA	63,194	.0176%	263 x	ATTN: TAX DEPARTMENT	10901 RED CIRCLE DRIVE	MINNETONKA	MIN	55343-9137
68718 SECURITY LIFE OF DENVER INS CO	28,137	.0078%	117 x	ATTN: CONTROLLERS	1290 BROADWAY	DENVER	CO	80203
68780 SECURITY NATIONAL LIFE INS CO	105	.0000%	0					
68810 SENTRY LIFE INS CO	168,353	.0466%	700 x	ATTN: TAX DEPARTMENT	1800 N POINT DRIVE	STEVENS POINT	WI	54481
68950 SOUTHLAND LIFE INS CO	253	.0001%	1					
89018 STANDARD INSURANCE CO	1,918,645	5.316%	7,974 x	ATTN: TAX DEPARTMENT	PO BOX 711	PORTLAND	OR	97207-0711
69078 STANDARD SECURITY LIFE INS CO OF NY	4,285	.0012%	18 x	ATTN: TAX DEPARTMENT	485 MADISON AVENUE	NEW YORK	NY	10022 5872
84188 STATES WEST LIFE INS CO	932,119	.2583%	3,874 x	ATTN: TAX DEPARTMENT	7001 220TH ST SW MAIL STOP 367	MOUNTLAKE TERR	WA	98043
80802 SUN LIFE ASR CO OF CANADA	2,500,638	.7214%	10,422 x	ATTN: TAX DEPARTMENT	ONE SUN LIFE EXECUTIVE PARK	WELLESLEY HILLS	MA	02181
69272 SUNSET LIFE INS CO OF AMERICA	1,040	.0003%	4					

NOV 05 09:03 AM '97

NOV 06 '97 09:04AM AETNA HEALTH PLANS

NAME	Written Premium	Market Share	Assessment Amount	ATTN	STREET ADDRESS	CITY	STATE	ZIP
XYZB COMPANY NAME								
70491 TRG LIFE INSURANCE COMPANY	629,495	.1741%	2,616	ATTN: TAX DEPARTMENT	PO BOX 2173	MILWAUKEE	WI	53201-2173
67121 TRANSAMERICA OCCIDENTAL LIC	145,935	.0444%	607	ATTN: TAX DEPARTMENT	BOX 2101	LOS ANGELES	CA	90061-0101
77726 TRAVELERS INS CO (LIFE DEPT)	2,796,754	.7740%	11,623	ATTN: TAX DEPARTMENT	ONE TOWER SQUARE	HARTFORD	CT	06183
426 TRUMARK INS CO	74,787	.0207%	311	ATTN: TAX DEPARTMENT	400 FIELD DRIVE	LAKE FOREST	IL	60455-2681
701 UNION BANKERS INS CO	35,388	.0093%	147	ATTN: GENERAL ACCOUNTING	500 N AKARD STREET 12 FL	DALLAS	TX	75221-2699
80637 UNION CENTRAL LIFE INS CO	7,382	.0020%	31	ATTN: TAX DEPARTMENT	PO BOX 40888 1876 WAYCROSS ROAD	CINCINNATI	OH	45240
62596 UNION FIDELITY LIFE INSURANCE CO	159,400	.0719%	1,078	ATTN: TAX DEPARTMENT	123 N WACKER DRIVE	CHICAGO	IL	60605
68744 UNION LABOR LIFE INS CO	177,589	.0492%	788	ATTN: TAX DEPARTMENT	111 MASSACHUSETTS AVENUE NW	WASHINGTON	DC	20001
82916 UNITED AMERICAN INS CO	16,887	.0047%	70	ATTN: TAX DEPARTMENT	PO BOX 810	DALLAS	TX	75221-
68876 UNITED COMPANIES LIFE INS CO	60	.0000%	0					
87645 UNITED FIDELITY LIFE INS CO	7	.0000%	0					
66652 UNITED HEALTH & LIFE INS CO	157,544	.0437%	655	ATTN: TAX DEPARTMENT	PO BOX 1459	MINNEAPOLIS	MN	55440-1459
69688 UNITED OF OMAHA LIFE INS CO	4,463,093	1.2266%	18,549	ATTN: GOVERNMENT/REGULATORY DEPT	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175
70106 UNITED STATES LIFE INS CO IN NYC	223,657	.0620%	930	ATTN: TAX DEPARTMENT	6600 ROUTE 66 PO BOX 1580	NEPTUNE	NJ	07754-1580
72850 UNITED WORLD LIFE INS CO	58,339	.0162%	242	ATTN: TAX DEPARTMENT	MUTUAL OF OMAHA PLAZA	OMAHA	NE	68175
78181 UNIVERSE LIFE INS CO	5,312	.0015%	22	ATTN: TAX DEPARTMENT	PO BOX 588	LEWISTON	ID	83501-
69863 USAA LIFE INS CO	150,392	.0417%	635	ATTN: FINANCIAL STATEMENTS	9600 PENDERBURG ROAD	SAN ANTONIO	TX	78268
81827 VETERANS LIFE INS CO	68,803	.0193%	170	ATTN: TAX DEPARTMENT	20 MOORES ROAD	FRAZER	PA	19355
70246 VICTORY LIFE INS CO	38	.0000%	0					
92486 WARASH LIFE INS CO	857	.0002%	4					
70319 WASHINGTON NATIONAL INS CO	90,223	.0275%	412	ATTN: TAX DEPARTMENT	300 TOWER PARKWAY	LINCOLNSHIRE	IL	60069-3685
77879 WESTERN FIDELITY INS CO	813	.0002%	3					

10,533

15,418

Western Life Ins Co

4,717

368,826,241

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The information should be provided

ALASKA MARKET SHARE AND LOSS RATIO
FOR YEAR ENDING DECEMBER 31, 1996
ACCIDENT AND HEALTH - COMBINED
Assessment sent 10/23/96

October 1996

1996 Assessment Amount to be Allocated: \$1,200,000.00

Amt of Assessment
↓
Assessment Amount

NAIC CODE	COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	MARKET SHARE	DIRECT PREMIUMS EARNED	DIRECT LOSSES INCURRED	LOSS RATIO	Assessment Amount	CREDIT AMOUNT	STATUS
71854	AAA Life Ins Co.	DC	11,019	.0031%	0	0	0.0000	\$37	✓ \$0	TRUE
60046	Academy Life Ins Co.	MO	16,371	.0046%	0	0	0.0000	\$55	✓ \$0	TRUE
60054	Actna Life Ins. Co.	CT	151,290,208	42.7892%	0	0	0.0000	\$513,471	✓ \$0	TRUE
60097	All American Life Ins. Co.	IL	3,443	.0010%	0	0	0.0000	\$12	✓ \$0	TRUE
90611	Allianz Life Ins. Co. of North America	MIN	511,179	.1427%	0	0	0.0000	\$1,712	✓ \$0	TRUE
84824	Allmerica Financial Life & Casualty	DE	4,847	.0014%	0	0	0.0000	\$16	✓ \$0	TRUE
75914	America Chambers Life Ins. Co.	OH	492,572	.1375%	0	0	0.0000	\$1,650	✓ \$0	TRUE
60410	American Fidelity ASR Co.	OK	99,225	.0277%	0	0	0.0000	\$332	✓ \$0	TRUE
94226	American Franklin Life Ins. Co.	IL	1,669	.0005%	0	0	0.0000	\$6	✓ \$0	FALSE
60534	American Heritage Life Ins. Co.	FL	23,703	.0066%	0	0	0.0000	\$79	✓ \$0	TRUE
60607	American International Life ASR Co. of NY	NY	383	.0001%	0	0	0.0000	\$1	✓ \$0	FALSE
60704	American Life Ins. Co. of New York	NY	6,994	.0020%	0	0	0.0000	\$23	✓ \$0	TRUE
60739	American National Ins. Co.	TX	18,452	.0052%	0	0	0.0000	\$62	✓ \$0	TRUE
71773	American National Life Ins. Co. of TX	TX	7,078	.0020%	0	0	0.0000	\$24	✓ \$0	TRUE
60836	American Republic Ins. Co.	IA	13,454	.0038%	0	0	0.0000	\$45	✓ \$0	TRUE
63452	American Standard Life & Acc. Ins. Co.	OK	164	.0000%	0	0	0.0000	\$1	✓ \$0	FALSE
76325	American Travelers Life Insurance Co	IN	16,241	.0045%				\$54	LETIN \$0	
60895	American United Life Ins. Co.	IN	710	.0002%	0	0	0.0000	\$2	✓ \$0	FALSE
67962	Amex Life Assurance Co.	CA	225,549	.0630%	0	0	0.0000	\$756	✓ \$0	TRUE
85286	Anthem Life Ins. Co.	TX	11,019	.0031%	0	0	0.0000	\$37	✓ \$0	TRUE
68160	Balboa Life Ins. Co.	CA	146	.0000%	0	0	0.0000	\$0	✓ \$0	FALSE
61263	Bankers Life & Cas Co.	IL	147,509	.0412%	0	0	0.0000	\$494	✓ \$0	TRUE
61360	Bankers Security Life Ins. Society	NY	1,843	.0005%	0	0	0.0000	\$6	✓ \$0	FALSE
61387	Bankers United Life Assurance Co.	IA	1,964	.0005%	0	0	0.0000	\$7	✓ \$0	FALSE
80985	BCS Life Ins. Co.	IL	8,515	.0024%	0	0	0.0000	\$29	✓ \$0	TRUE
61417	Beneficial Standard Life Ins. Co.	CA	13,703	.0038%	0	0	0.0000	\$46	✓ \$0	TRUE
61433	Berkshire Life Ins. Co.	MA	8,047	.0022%	0	0	0.0000	\$27	✓ \$0	TRUE
90638	Best Life Assurance Co. of CA	CA	438,956	.1225%	0	0	0.0000	\$1,470	✓ \$0	TRUE
	Blue Cross of Washington and Alaska	WA	116,874,514	32.6242%	0	0	0.0000	\$391,491	✓ \$0	

CA
HEALTH PLANS

OCT 30 '97 09:00AM AETNA HEALTH PLANS

NAIC CODE	COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	MARKET SHARE	DIRECT PREMIUMS EARNED	DIRECT LOSSES INCURRED	LOSS RATIO	Assessment Amount	CREDIT AMOUNT	STATUS
61476	Boston Mutual Life Ins. Co.	MA	71,887	.0201%	0	0	0.0000	\$241	✓ \$0	TRUE
61492	Business Men's Assurance Co.	MO	22,292	.0062%	0	0	0.0000	\$75	✓ \$0	TRUE
80799	Celtic Life Ins. Co.	IL	100,542	.0281%	0	0	0.0000	\$337	✓ \$0	TRUE
61654	Centennial Life Ins. Co.	KS	52,113	.0145%	0	0	0.0000	\$175	✓ \$0	TRUE
61735	Central Security Life Ins. Co.	TX	991	.0003%	0	0	0.0000	\$3	\$0	FALSE
61751	Central States H & L Co. of Omaha	NE	63,802	.0178%	0	0	0.0000	\$214	✓ \$0	TRUE
61778	Certified Life Ins. Co.	CA	25,062	.0070%	0	0	0.0000	\$84	✓ \$0	TRUE
70254	Chubb Life Ins. Co. of America	NI	15,959	.0045%	0	0	0.0000	\$53	✓ \$0	TRUE
76236	Cincinnati Life Ins. Co.	OH	215	.0001%	0	0	0.0000	\$1	\$0	FALSE
62065	Colonial Penn Life Ins. Co.	PA	8,648	.0024%	0	0	0.0000	\$29	✓ \$0	TRUE
62146	Combined Ins. Co. Of America	IL	405,861	.1133%	0	0	0.0000	\$1,359	✓ \$0	TRUE
66508	Commercial Life Ins. Co.	WI	32,190	.0092%	0	0	0.0000	\$110	\$0	TRUE
81426	Commercial Travelers Mutual Ins. Co.	NY	28,107	.0078%	0	0	0.0000	\$94	✓ \$0	TRUE
69647	Community National Assurance Co		1,110	.0003%				\$4	\$0	
73504	Congress Life Ins. Co.	AZ	1,852	.0005%	0	0	0.0000	\$6	\$0	FALSE
62308	Connecticut General Life Ins. Co.	CT	698,940	.1951%	0	0	0.0000	\$2,341	✓ \$0	TRUE
62413	Continental Assurance Co		160,395	.0448%	0	0	0.0000	\$537	✓ \$0	
71404	Continental General Ins. Co.	NE	38,856	.0108%	0	0	0.0000	\$130	✓ \$0	TRUE
62472	Continental Life Ins. Co.	TX	753	.0002%	0	0	0.0000	\$3	\$0	FALSE
62510	Continental Western Life Ins. Co.	IA	48	.0000%	0	0	0.0000	\$0	\$0	FALSE
62553	Country Life Ins. Co.	IL	37,748	.0105%	0	0	0.0000	\$126	✓ \$0	TRUE
62626	Cumma Mutual Ins. Society	WI	1,794,464	.4758%	0	0	0.0000	\$5,709	✓ \$0	TRUE
78611	EBP Life Insurance Co		207,040	.0578%	0	0	0.0000	\$694	✓ \$0	
73288	Employers Health Insurance Co		1,583,257	.4419%	0	0	0.0000	\$5,303	✓ \$0	
62952	Equitable Life & Casualty Ins. Co.	UT	7,127	.0020%	0	0	0.0000	\$24	✓ \$0	TRUE
62944	Equitable Life ASR Soc of the US	NY	543,303	.1517%	0	0	0.0000	\$1,820	OK \$0	TRUE
66877	Executive Bond Life Insurance Co		307	.0001%	0	0	0.0000	\$1	\$0	
63053	Family Life Ins. Co.	WA	167	.0000%	0	0	0.0000	\$1	\$0	FALSE
67695	Federal Home Life Ins. Co.	IN	1,339	.0004%	0	0	0.0000	\$0	\$0	FALSE
63223	Federal Life Inc Co (Mutual)	IL	56	.0000%	0	0	0.0000	\$0	\$0	FALSE
71870	Fidelity Security Life Ins. Co.	MO	73,076	.0204%	0	0	0.0000	\$245	✓ \$0	TRUE
69140	First Allamerica Fin Life Ins Co	MA	6,502	.0018%	0	0	0.0000	\$22	✓ \$0	TRUE
63401	First Colony Life Ins Co.	VA	39	.0000%	0	0	0.0000	\$0	\$0	FALSE
63517	First National Life Ins Co		20,348	.0057%	0	0	0.0000	\$68	WATER \$0	
63576	Ford Life Ins Co	MI	5,147	.0014%	0	0	0.0000	\$17	✓ \$0	TRUE
70408	Western Life Insurance Co For the Benefit	NR	1,694,476	.4730%	0	0	0.0000	\$5,676	✓ \$0	TRUE
63622	Franklin Life Ins Co	IL	355,042	.0991%	0	0	0.0000	\$1,189	✓ \$0	TRUE
63655	General American Life Ins Co	MO	41,456	.0116%	0	0	0.0000	\$139	✓ \$0	TRUE
70025	General Electric Capital Assurance Co	DE	122	.0000%	0	0	0.0000	\$0	\$0	FALSE
91472	Globe Life & Accident Ins. Co	DE	14,165	.0040%	0	0	0.0000	\$47	✓ \$0	TRUE
62286	Golden Rule Ins Co	IL	2,161,959	.6035%	0	0	0.0000	\$7,242	✓ \$0	TRUE
64017	Great American Reserve Ins. Co	TX	1,216	.0003%	0	0	0.0000	\$4	\$0	FALSE
90212	Great Southern Life Ins Co	TX	13,443	.0038%	0	0	0.0000	\$45	✓ \$0	TRUE

OCT 30 '97 09:01AM AETNA HEALTH PLANS

NAIC CODE	COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	MARKET SHARE	DIRECT PREMIUMS EARNED	DIRECT LOSSBS INCURRED	LOSS RATIO	Assessment Amount	CREDIT AMOUNT	STATUS	
68322	Great-West Life & Annuity Ins Co	CO	5,940,123	1.6581%	0	0	0.0000	\$19,897	✓	\$0	TRUE
80705	Great-West Life Assurance Co	MI	392,576	.1096%	0	0	0.0000	\$1,315	✓	\$0	TRUE
64181	Guarantee Mutual Life Co	NE	79,526	.0222%	0	0	0.0000	\$266	✓	\$0	TRUE
64203	Guarantee Reserve Life Ins Co	IN	1,728	.0005%	0	0	0.0000	\$6		\$0	FALSE
64211	Guarantee Trust Life Ins Co	IL	30	.0000%	0	0	0.0000	\$0		\$0	FALSE
64246	Guardian Life Ins Co of America	NY	9,013,486	2.5160%	0	0	0.0000	\$30,192	✓	\$0	TRUE
70815	Hartford Life & Accident Ins Co	CT	146,292	.0408%	0	0	0.0000	\$490	✓	\$0	TRUE
88072	Hartford Life Insurance Co		142,608	.0398%				\$478	✓	\$0	
64394	Heritage Life Inc Co	AZ	24,985	.0070%	0	0	0.0000	\$84	✓	\$0	TRUE
67369	Home Life Financial Assurance Corp	OH	1,088,063	.3037%	0	0	0.0000	\$3,645	✓	\$0	TRUE
64513	Horace Mann Life Ins. Co.	IL	12,410	.0029%	0	0	0.0000	\$35	✓	\$0	TRUE
65005	IDS Life Ins Co	MN	42,185	.0118%	0	0	0.0000	\$141	✓	\$0	TRUE
81779	Individual ASR Co Life Health & Acc	MO	746	.0002%	0	0	0.0000	\$2		\$0	FALSE
64734	Intercontinental Life Ins Co	NJ	188	.0005%	0	0	0.0000	\$2		\$0	FALSE
63487	Investors Life Ins Co North America	WA	796	.0002%	0	0	0.0000	\$3		\$0	FALSE
71153	ITT Hartford Life & Annuity Ins Co	WI	1,497	.0004%	0	0	0.0000	\$5		\$0	FALSE
67865	Jefferson-Pilot Life Ins Co	NC	3,195	.0009%	0	0	0.0000	\$11	✓	\$0	TRUE
65099	John Hancock Mutual Life Ins Co	MA	501,593	.1400%	0	0	0.0000	\$1,680	✓	\$0	TRUE
65129	Kansas City Life Ins Co	MO	161	.0000%	0	0	0.0000	\$1		\$0	FALSE
65250	Lamar Life Insurance Co		2,862	.0008%	0	0	0.0000	\$10	✓	\$0	
65323	Liberty Life Ins Co	SC	878	.0002%	0	0	0.0000	\$3		\$0	FALSE
65331	Liberty National Life Ins Co	AL	6,158	.0017%	0	0	0.0000	\$21	✓	\$0	TRUE
65498	Life Ins Co of North America	PA	309,070	.0863%	0	0	0.0000	\$1,035	✓	\$0	TRUE
65528	Life Ins Co of the Southwest	TX	320	.0001%	0	0	0.0000	\$1		\$0	FALSE
64130	Life Investors Ins Co of America	IA	204,961	.0572%	0	0	0.0000	\$687	✓	\$0	TRUE
65676	Lincoln National Life Ins Co	IN	5,313,568	1.4271%	0	0	0.0000	\$17,129	✓	\$0	TRUE
65692	Lone Star Life Ins Co	TX	81,746	.0228%	0	0	0.0000	\$274	✓	\$0	TRUE
65722	Loyal American Life Ins Co	AL	3,899	.0011%	0	0	0.0000	\$13	✓	\$0	TRUE
65900	Massachusetts General Life Ins Co	MA	673	.0002%	0	0	0.0000	\$2		\$0	FALSE
65935	Massachusetts Mutual Life Ins Co	MA	79,216	.0221%	0	0	0.0000	\$265	✓	\$0	TRUE
71471	Medico Life Ins Co	NB	178,214	.0497%	0	0	0.0000	\$597	✓	\$0	TRUE
97055	Mega Life & Health Ins Co	OK	713,638	.1992%	0	0	0.0000	\$2,390	✓	\$0	TRUE
86126	Members Life Insurance Co	WI	75	.0000%	0	0	0.0000	\$0		\$0	FALSE
79413	Metzhealth Insurance Co		44,370	.0124%				\$149	✓	\$0	
65978	Metropolitan Life Ins Co	NY	715,483	.1997%	0	0	0.0000	loss \$2,397	✓	\$0	TRUE
85561	MFC Life Ins Corp	DB	3,407	.0010%	0	0	0.0000	\$11	✓	\$0	TRUE
66257	Modern American Life Ins Co	MD	100	.0000%	0	0	0.0000	\$0		\$0	FALSE
66273	Montgomery Ward Life Ins Co	IL	179,221	.0500%	0	0	0.0000	\$600	✓	\$0	TRUE
66281	Monumental Life Ins Co	MD	1,496,944	.4179%	0	0	0.0000	\$5,014	✓	\$0	TRUE
66370	Mutual Life Ins Co of New York	NY	413,745	.1155%	0	0	0.0000	\$1,386	✓	\$0	TRUE
71412	Mutual Of Omaha Ins Co	NE	1,312,587	.3664%	0	0	0.0000	\$4,397	✓	\$0	TRUE
61409	National Benefit Life Ins Co	NY	6,615	.0018%	0	0	0.0000	\$22	✓	\$0	TRUE
98205	National Foundation Life Ins Co	DE	6,103	.0017%	0	0	0.0000	\$20	✓	\$0	TRUE

OCT 30 '97 09:02AM GETING HEALTH PLANS

NAIC CODE	COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	MARKET SHARE	DIRECT PREMIUMS EARNED	DIRECT LOSSES INCURRED	LOSS RATIO	Assessment Amount	CREDIT AMOUNT	STATUS
66583	National Guardian Life Ins Co	WI	997	.0003%	0	0	0.0000	\$3	\$0	FALSE
82538	National Health Ins Co	TX	6,700	.0019%	0	0	0.0000	\$22	✓ \$0	TRUE
66680	National Life Ins Co	VT	21,052	.0059%	0	0	0.0000	\$71	✓ \$0	TRUE
66826	National Travelers Life Co	IA	951	.0003%	0	0	0.0000	\$3	\$0	FALSE
66869	Nationwide Life Ins Co	OH	446,958	.1248%	0	0	0.0000	\$1,497	✓ \$0	TRUE
63282	Network America Life Ins Co		368	.0001%	0	0	0.0000	\$1	\$0	
66893	New England Mutual Life Ins Co	MA	14,096	.0039%	0	0	0.0000	\$47	✓ \$0	TRUE
66915	New York Life Ins Co	NY	5,016,109	1.4802%	0	0	0.0000	\$16,802	✓ \$0	TRUE
66974	North American Co For Life & Health Ins	IL	553	.0002%	0	0	0.0000	\$2	\$0	FALSE
87734	Northern Life Ins Co	WA	523	.0001%	0	0	0.0000	\$2	\$0	FALSE
67105	Northwestern National Life Ins Co	MN	278,219	.0777%	0	0	0.0000	\$932	✓ \$0	TRUE
67148	Occidental Life Ins Co of North Carolina	NC	1,901	.0005%	0	0	0.0000	\$6	\$0	FALSE
67660	Pennsylvania Life Ins Co	PA	1,922	.0005%	0	0	0.0000	\$6	\$0	FALSE
86231	PFL Life Ins Co	IA	2,304,746	.6992%	0	0	0.0000	\$8,330	✓ \$0	TRUE
67784	Philadelphia American Life Ins Co	PA	14,829	.0041%	0	0	0.0000	\$50	✓ \$0	TRUE
80926	Phoenix American Life Ins Co	CT	4,030	.0011%	0	0	0.0000	\$13	✓ \$0	TRUE
67814	Phoenix Home Life Mutual Ins Co	NY	74,827	.0209%	0	0	0.0000	\$251	✓ \$0	TRUE
80578	Physicians Mutual Ins Co	NE	786,457	.2195%	0	0	0.0000	\$2,634	✓ \$0	TRUE
67822	Pizco National Life Ins Co	CA	1,175	.0003%	0	0	0.0000	\$4	\$0	FALSE
68330	Pioneer Life Ins Co of Illinois	IL	957,259	.2672%	0	0	0.0000	\$3,206	✓ \$0	TRUE
97268	PM Group Life Ins Co	AZ	543,836	.1518%	0	0	0.0000	\$1,822	✓ \$0	TRUE
67989	Prairie States Life Ins Co	SD	404	.0001%	0	0	0.0000	\$1	\$0	FALSE
65919	Primerica Life Ins Co	MA	15,082	.0042%	0	0	0.0000	\$51	✓ \$0	TRUE
61271	Principal Mutual Life Ins Co	IA	18,671,510	5.2119%	0	0	0.0000	\$62,543	✓ \$0	TRUE
68136	Protective Life Ins Co	TN	11,820	.0033%	0	0	0.0000	\$40	✓ \$0	TRUE
68187	Provident Indemnity Life Ins Co	PA	36,383	.0102%	0	0	0.0000	\$122	✓ \$0	TRUE
68195	Provident Life & Accident Ins Co	TN	995,368	.2778%	0	0	0.0000	\$3,334	✓ \$0	TRUE
68225	Provident Mutual Life Ins Co of Philadelphia	PA	8,250	.0023%	0	0	0.0000	\$28	✓ \$0	TRUE
66685	Provident Life and Health Ins Co		74,915	.0209%	0	0	0.0000	\$251	✓ \$0	
68241	Prudential Ins Co of America	NJ	4,029,028	1.1247%	0	0	0.0000	\$13,496	✓ \$0	TRUE
68357	Reliable Life Ins Co	MO	472	.0001%	0	0	0.0000	\$2	\$0	FALSE
68381	Reliance Standard Life Ins Co	IL	34,762	.0097%	0	0	0.0000	\$116	✓ \$0	TRUE
68608	Safeco Life Ins Co	WA	519,112	.1449%	0	0	0.0000	\$1,739	✓ \$0	TRUE
68721	Security Life Ins Co of America	MN	63,194	.0176%	0	0	0.0000	\$212	✓ \$0	TRUE
68713	Security Life of Denver Ins Co	CO	28,137	.0079%	0	0	0.0000	\$94	✓ \$0	TRUE
68780	Security National Life Ins Co	UT	105	.0000%	0	0	0.0000	\$0	\$0	FALSE
68810	Sentry Life Ins Co	WI	168,353	.0470%	0	0	0.0000	\$564	✓ \$0	TRUE
68950	Southland Life Ins Co	TX	253	.0001%	0	0	0.0000	\$1	\$0	FALSE
69019	Standard Ins Co	OR	1,918,645	.5356%	0	0	0.0000	\$6,427	✓ \$0	TRUE
69078	Standard Security Life Ins Co of New York	NY	4,285	.0012%	0	0	0.0000	\$14	✓ \$0	TRUE
94188	States West Life Ins Co	WA	932,119	.2602%	0	0	0.0000	\$3,122	✓ \$0	TRUE
69272	Suncoast Life Ins Co of America	WA	1,040	.0003%	0	0	0.0000	\$3	\$0	FALSE
70491	TMG Life Insurance Company	ND	629,495	.1757%	0	0	0.0000	\$2,109	✓ \$0	TRUE

OCT 30 '97 09:03AM AETNA HEALTH PLANS

P.5

NAIC CODE	COMPANY NAME	DOM	DIRECT PREMIUMS WRITTEN	MARKET SHARE	DIRECT PREMIUMS EARNED	DIRECT LOSSES INCURRED	LOSS RATIO	Assessment Amount	CREDIT AMOUNT	STATUS
67121	TransAmerica Occidental Lic	CA	145,935	.0407%	0	0	0.0000	\$489	✓ \$0	TRUE
87726	Travelers Ins Co (Life Department)	CT	2,796,754	.7807%	0	0	0.0000	\$9,368	✓ \$0	TRUE
61425	Trustmark Ins Co	IL	74,737	.0209%	0	0	0.0000	\$250	✓ \$0	TRUE
69701	Union Bankers Ins Co	TX	35,388	.0099%	0	0	0.0000	\$119	✓ \$0	TRUE
80837	Union Central Life Ins Co	OH	7,392	.0021%	0	0	0.0000	\$25	✓ \$0	TRUE
62596	Union Fidelity Life Insurance Co		259,409	.0724%	0	0	0.0000	\$869	✓ \$0	
69744	Union Labor Life Ins Co	MD	177,599	.0496%	0	0	0.0000	\$595	\$0	TRUE
92916	United American Ins Co	DE	16,887	.0047%	0	0	0.0000	\$57	✓ \$0	TRUE
69876	United Companies Life Ins Co	LA	60	.0000%	0	0	0.0000	\$0	\$0	FALSE
87645	United Fidelity Life Ins Co	TX	7	.0000%	0	0	0.0000	\$0	\$0	FALSE
65552	United Health & Life Insurance Co		157,544	.0440%	0	0	0.0000	\$528	✓ \$0	
69868	United of Omaha Life Ins CO	NE	4,463,093	1.2458%	0	0	0.0000	\$14,950	✓ \$0	TRUE
70106	United States Life Ins Co In New York City	NY	223,667	.0624%	0	0	0.0000	\$749	✓ \$0	TRUE
72850	United World Life Ins Co	NR	58,730	.0163%	0	0	0.0000	\$193	✓ \$0	TRUE
69663	USAA Life Ins Co	TX	150,392	.0420%	0	0	0.0000	\$504	✓ \$0	TRUE
81027	Veterans Life Ins Co	IL	40,803	.0114%	0	0	0.0000	\$137	✓ \$0	TRUE
70246	Victory Life Ins Co	KS	36	.0000%	0	0	0.0000	\$0	\$0	FALSE
92436	Wabash Life Ins Co	KY	857	.0002%	0	0	0.0000	\$3	\$0	FALSE
70319	Washington National Ins Co	IL	97,223	.0277%	0	0	0.0000	\$332	✓ \$0	TRUE
77879	Western Fidelity Ins Co	LA	813	.0002%	0	0	0.0000	\$3	\$0	FALSE
			358,244,725	100.0000%				\$1,200,000	\$0	
									\$1,200,000	

OCT 30 '97 09:04AM RETNA HEALTH PLANS

To: Rep. Rokeberg
Chair
Labor /Commerce Committee
Juneau, Alaska

I have read HB 300 sponsored by Rep. Con Bunde. I had the opportunity to speak with Rep. Bunde regarding some specific elements contained in the Bill. Under section 2 part 2 -c it states that "a health insurer may not: directly or indirectly reimburse a covered person at a different rate because of the person's choice of provider.

This will eclipse one of the last mechanisms left by which payors, {insurance companies and government funded programs} can negotiate special rates with various and willing providers. This bill if passed in it's present form will result in the continued escalation of Health Care Insurance Rates and the need for increased funding for State Sponsored Programs. (medicaid)

It is known that every time government mandates something into the Health Insurance Industry, the premium rates ratchet upwards to cover the additional costs. Premiums have doubled over recent years due to a significant degree Government interventions both State and Federal.

The end result is that Insurance as a business is being changed into a medical expense reimbursement program with very little insurance involved. I'd like to point out that Insurance in it's pure form is a combination of unpredictability in particular and predictability in general. We can determine how many times an event may happen, but not to whom. The distillation of these differences is what makes insurance a business. We can insure against the chance of having a disease, but we cannot insure against already having one.

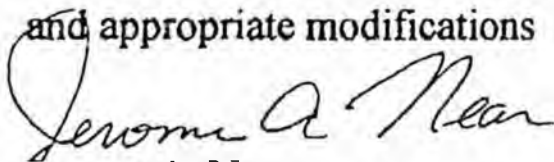
Ignoring these principles has helped drive Health insurance rates to all time highs.

The continued use of Insurance to achieve social goals will eventually eliminate Insurance as a Health Care funding mechanism. Very few private persons can afford it now. The balance of insured's have some one else paying for their coverage's, usually government or a deep pockets employer.

We did some work here on the Kenai when the original Rokeberg bill came out two years ago mandating the development of several managed care projects. To an extent HB. 300 reverses what the Rokeberg bill was trying to achieve.

As I mentioned I talked with Rep Bunde regarding the above portion of the bill. He indicated that it was now in your committee and any requests should funnel through your office.

I would hope that as the various legislators grapple with the Health Care Issue that serious consideration be given to this bill as written and appropriate modifications be developed.


Jerome A. Near
Soldotna, Alaska

IN MANAGED CARE, 'CONSUMER' LAWS BENEFIT DOCTORS

PATIENTS SEEN AS LOSING

Legislatures Wrestling With Growing Complaints About Quality and the Costs

By PETER T. KILBORN

SPRINGFIELD, Ill. — The debate over managed health care and consumer rights that is just beginning in Congress has been stirring a populist backlash in state capitals for several years. It is shattering historic alliances, turning doctors against doctors, doctors against business and business against otherwise pro-business Republicans.

Politicians and lobbyists frame the debate as a conflict over consumer desires for good quality care and for affordable care. But they say that in the back rooms of lawmaking, the debate is only tangentially about consumers. Mostly, they say, it is about protecting the incomes, jobs and turf of the health care system's biggest and richest vested interests.

Under the banner of consumer protection, legislators are wrestling with the complaints of specialist physicians who have been losing their patients, fees and autonomy, those of insurance and managed care companies whose profits have sunk in competition for patients, and those of employers who pay for much of the coverage.

"It's all over the place, all under the guise of consumer bills of rights," said Trish Riley, executive director of the National Academy for State Health Policy in Portland, Me., an association of state health officials and lawmakers.

So far, said Paul R. Ginsburg, president of the Center for Studying Health System Change, a research group in Washington supported by the Robert Wood Johnson Foundation, the providers, primarily doctors, are winning. "Elected officials feel their unhappiness," Mr. Ginsburg said. "It's the providers who are organizing and saying, 'This is what you want to do.' The quip going around is that this is physician protection, not consumer protection."

Probably no state illustrates the conflicts more clearly than Illinois. The State House of Representatives passed a sweeping managed care law last April, thanks to the nearly solid support of specialist physicians, and it now faces dismembering in the Senate, where business lobbies are stronger.

"We called it a patients' bill of rights," said Barbara Flynn Curry, a Democrat and House majority leader. "But it was certainly as much about the protection of physicians."

"The real issues in Illinois have nothing to do with patients," said Donna Ginther, the Springfield lobbyist for the American Association of Retired Persons. "They have to do with insurance companies and providers. How a bill will look depends for the most part on discussions be-

tween the providers and the health plans. We can influence the outcome. But is the debate about us? No."

Lawmakers, business and consumer advocates say that managed care is entrenched today, with 60 percent of the nation's insured population covered by it. By imposing businesslike disciplines on health services, they say managed care has wrung excess from the system and stopped the rising cost of care.

But many also condemn the industry for going too far, with delays, denials and limitations on essential care. So in the aftermath of Congress's rejection of President Clinton proposed overhaul of the health care system four years ago, state politicians have been seizing upon consumers' and doctors' complaints of abuses under managed care.

Molly Stauffer, a senior policy analyst for the National Conference of State Legislatures, said that 17 states enacted comprehensive consumer rights laws last year, and she predicted that at least six more would this year. Ms. Riley said most of the provisions states were enacting were high on the agendas of specialist physicians.

She said more than half of the provisions let women choose obstetrician-gynecologists as personal physicians, bypassing primary care doctors who act as gatekeepers under managed care plans, and mandate hospital stays, typically of at least two days, for childbirth. Many also require plans to make quicker referrals to specialists and to let patients appeal rejections of care to outside arbitrators.

Now the Federal Government has joined the debate. In his State of the Union Message last month, President Clinton urged enactment of a

"Consumer Bill of Rights," and in Congress, improbable alliances of liberal Democrats and conservative Republicans are weighing similar bills.

Ms. Ginther said that in Illinois, as in most states, the rights that consumers are winning are a few that all the lobbies can live with, like allowing some emergency room visits without a health plan's prior approval.

But on other issues, consumer groups are losing out to the large special interests. Examples include Government-subsidized health care

Arguments over managed care bring complaints from all sides.

for all, access to official records of complaints against doctors and health plans, expanding consumer rights to sue both for malpractice, or penalties for overbooking patients and keeping them waiting.

"When you cut through all of this, there are certainly some things that are helping consumers," said Jay Dee F. Shattuck, lobbyist for a coalition of employers that includes the Illinois plants of General Motors, Ford and John Deere. "But when you get down to the political fight, it's about physicians' rights and a business community that's saying, 'Whoa! We remember the days when there was double-digit inflation.'"

In Springfield as in Washington, lawmakers describe the conflict in predictable ways. "We're struggling

here with a balance of public sentiment and affordable coverage," said State Representative William E. Brady, Republican of Bloomington, who voted against the House bill. "My personal fear is that if the Government gets overly involved, we would eliminate the free enterprise aspects of the issue."

Representative Mary E. Flowers, Democrat of Chicago and one of the bill's two chief sponsors, said, "To be a roofing contractor in this state, you have to be licensed and regulated. Health maintenance organizations are not regulated. They are dealing with people's lives. They would have to comply with some kind of rules. They would have to be accountable."

For the most part, however, lawmakers are grappling less with matters of big and small government and consumer rights than with the conflicting agendas of physicians and business. "What this issue has done," Mr. Shattuck said, "is put two very strong Republican interest groups at loggerheads."

Managed care is shredding the physicians' image as independent entrepreneurs allied closely with business. As they lose prerogatives in dispensing care and submit to cuts in their fees to hold onto managed care patients, their perspective has changed from button-down white to factory-floor blue.

"When I see a patient," said Dr. Jane Jackman, president of the 18,000-member Illinois State Medical Society and a family doctor in Springfield, "she needs a quick diagnosis. But I have to get permission for any test that costs more than \$100 that I don't do in my own office. I have to call an 800 number to the managed care office for a decision of whether it can or cannot be done. Quite often you're asked for more documentation and about why you have to do it."

In the debate over consumer protection, doctors promise better quality care, which they equate with consumer desires for a choice of doctors and easy access to specialists. But for doctors outside a patient's health plan, choice also means a patient's right to choose them and thus to assure them work.

Managed care plans, for their part, warn that tighter regulation and provisions like those in Ms. Flowers's House Bill 626 expanding consumer and physician rights jeopardize their control of the cost of care.

Bob Burger, executive vice president of the Illinois Association of Health Maintenance Organizations, cites one provision in the bill requiring each H.M.O. to appoint an independent medical staff to share medical decisions with management.

Mr. Burger said the law also gave doctors special privileges. "We'd have to provide them with legal due process before dismissing them," he said. "That's very expensive. We can't operate like that."

In the face of such constraints, managed care companies warn that they would have to charge much more for premiums, co-payments and deductibles, making insurance less affordable for all consumers.

Were it not for the inclusion of the Illinois State Medical Society's agenda, the House consumer protection bill would have died aborning. Ms. Flowers and Representative Carolyn Krause, Republican of Cook County, developed most of the initial provisions with the Campaign for Better Health Care.

But in a house in which Democrats have just a two-seat majority, most Republicans and some Democrats opposed the bill. Then on the night of April 24, on the eve of the vote, doctors agreed to drop a bill of their own and persuaded the authors to remove provisions from their bill that doctors opposed.

One of those provisions gave subscribers access to consumer satisfaction surveys of physicians; another let an ombudsman intervene with doctors in health care decisions on behalf of consumers. Both provisions were retained, however, as restraints on H.M.O.'s.

With that agreement, 19 Republicans, mostly supporters of the medical society's bill, joined most Democrats in approving Bill 626 by a 73-to-34 vote.

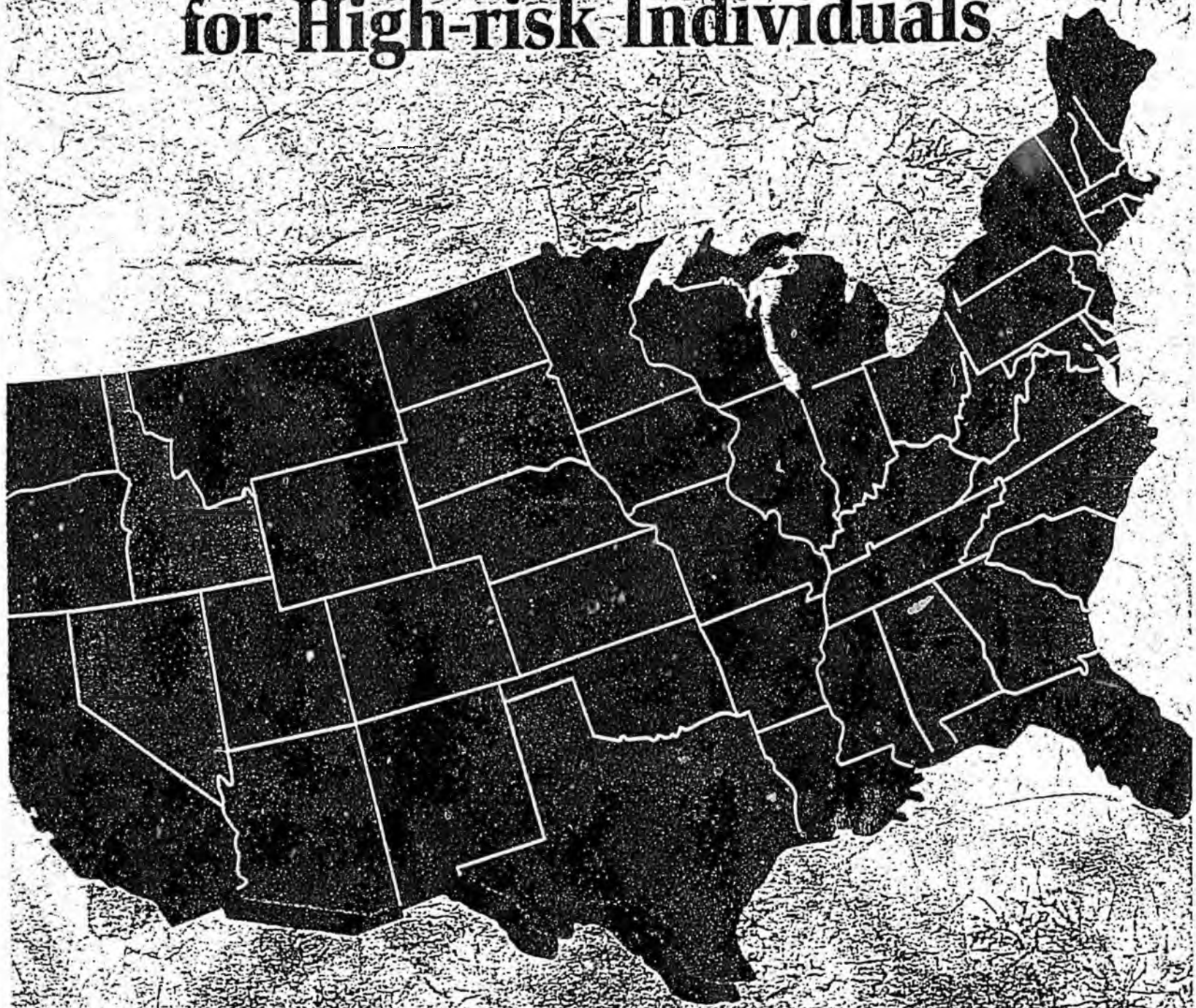
Now the bill is before the Illinois Senate, where Republicans have a 31-to-28-seat majority. There, the H.M.O.'s, the Chamber of Commerce, the Illinois Manufacturers Association, the National Federation of Independent Business and Mr. Shattuck's Employment Law Council, along with family doctors who serve as the H.M.O.'s gatekeepers, are putting together a very different version of their own.

Michael Murphy, chief lobbyist for the H.M.O. Association, said his industry had asked for the anti-consumer image that has fueled the popular backlash. "We became green eyeshade accountants," he said. "We need to do whatever we can to show we care about prevention and good care." But, he added, "we're not about to die on the cross of specialist physicians' rights to get there."

A bill that excludes provisions deemed to protect doctors might have little left for consumers. House Speaker Michael J. Madigan of Chicago predicted that a compromise bill that the House and the Senate ultimately write might still wear the label of consumer protection, but it would be a dim shadow of 626.

"Do we stand our ground?" he asked. "That could mean no bill at all. My expectation would be to accept a watered down version."

Comprehensive Health Insurance for High-risk Individuals



A State-by-State Analysis

Includes: Operating Statistics, Model Legislation,
Current Premiums, Funding Mechanisms, State Contacts

TENTH EDITION, 1996



Communicating for Agriculture

See our state summary
"Quick Check"

Quick Check:

Risk Pool Participation and Operations

Risk Pool Participation

Compiled by Communicating for Agriculture, the following statistics are the number of participants with in-force policies in state risk pools. All statistics are for the end of 1995, unless otherwise noted.

State	Participants	Year Operational
Alaska	179	1993
Arkansas	0	1996
California*	19,200	1991
Colorado.....	1,572	1991
Connecticut*	1,419	1976
Florida	1,689	1983
Illinois	4,805	1989
Indiana	4,483	1982
Iowa	1,099	1987
Kansas*	952	1993
Louisiana.....	532	1992
Minnesota.....	30,470	1976
Mississippi	835	1992
Missouri	1,107	1992
Montana	321	1987
Nebraska.....	3,366	1986
New Mexico	858	1988
North Dakota	1,334	1982
Oklahoma	0	1996
Oregon*	4,422	1990
South Carolina	1,078	1990
Tennessee**	NA	1987
Utah*	680	1991
Washington	862	1988
Wisconsin.....	9,512	1981
Wyoming.....	279	1991

QUICK CHECK

*Notes: California data through July 1996; Connecticut data, unaudited at time of publication, includes number of policies and not individuals; Kansas data is through March 31, 1996; Oregon figures through June 1996; Utah through June 1996.
 **Note: Tennessee risk pool participants have been merged into the TennCare Medicaid program. High risk individuals are not tracked separately from other Medicaid-eligible participants.

Risk Pool Operations

States With Programs For The Medically Uninsurable:

Open Enrollment or Comprehensive Health Insurance Plans For High-risk Individuals

NOTE: Comparisons of uninsureds between states with risk pool programs and those without should be made with caution. Many factors affect the overall uninsured population and do not always compare directly from state to state. Data is presented for informational purposes only. States identified as having open enrollment for the state Blue Cross and Blue Shield plan are according to the Blue Cross and Blue Shield Association. Source of statistics of the uninsured and percent of population uninsured is the Employee Benefits Research Institute of Washington, D.C., Issue Brief, February 1996.

<i>State</i>	<i>Plan Status</i>	<i>Nonelderly uninsured¹</i>	<i>Percent of population²</i>
Alabama.....	BCBS Open Enrollment.....	800,000.....	21.9
Alaska.....	Program in effect - 1992.....	100,000.....	15.5
Arizona.....	None.....	900,000.....	23.3
Arkansas.....	Program in effect - 1996.....	400,000.....	20.2
California.....	Program in effect - 1991.....	6,600,000.....	23.7
Colorado.....	Program in effect - 1991.....	500,000.....	13.9
Connecticut.....	Program in effect - 1976.....	300,000.....	12.2
Delaware.....	None.....	100,000.....	15.6
Florida.....	Program in effect - 1983.....	2,400,000.....	20.8
Georgia.....	Passed 1989. Not yet operational.....	1,200,000.....	18.3
Hawaii.....	State comprehensive program.....	100,000.....	11.6
Idaho.....	None.....	200,000.....	15.6
Illinois.....	Program in effect - 1989.....	1,300,000.....	12.9
Indiana.....	Program in effect - 1982.....	600,000.....	11.8
Iowa.....	Program in effect - 1987.....	300,000.....	11.3
Kansas.....	Program in effect - 1992.....	300,000.....	15.5
Kentucky.....	None.....	600,000.....	17.4
Louisiana.....	Program in effect - 1992.....	800,000.....	21.5
Maine.....	Program withdrawn - 1995.....	200,000.....	15.2
Maryland.....	BCBS Open Enrollment.....	600,000.....	14.3
Massachusetts.....	BCBS Open Enrollment.....	700,000.....	14.3
Michigan.....	BCBS Open Enrollment.....	100,000.....	12.3

Minnesota	Program in effect – 1976	400,000	10.6
Mississippi	Program in effect – 1992	500,000	20.6
Missouri	Program in effect – 1992	600,000	14.3
Montana	Program in effect – 1987	100,000	16.1
Nebraska	Program in effect – 1986	200,000	12.3
Nevada	None	200,000	17.8
New Hampshire	BCBS Open Enrollment	100,000	12.3
New Jersey	BCBS Open Enrollment	100,000	14.7
New Mexico	Program in effect – 1988	400,000	26.4
New York	Open Enrollment	2,900,000	18.3
North Carolina	None	900,000	15.7
North Dakota	Program in effect – 1982	100,000	10.1
Ohio	None	1,200,000	12.5
Oklahoma	Program in effect – 1996	600,000	21.0
Oregon	Program in effect – 1990	400,000	14.8
Pennsylvania	BCBS Open Enrollment	1,300,000	12.2
Rhode Island	BCBS Open Enrollment	100,000	13.5
South Carolina	Program in effect – 1990	500,000	15.9
South Dakota	None. Enacting legislation repealed – 1995	100,000	11.5
Tennessee	TennCare – 1995. Risk Pool 1987-1994	500,000	11.5
Texas	Passed 1989 – Not yet operational	4,500,000	26.6
Utah	Program in effect – 1991	200,000	12.9
Vermont	BCBS Open Enrollment	100,000	9.6
Virginia	BCBS Open Enrollment	800,000	13.9
Washington	Program in effect – 1988	700,000	14.6
West Virginia	None	300,000	19.1
Wisconsin	Program in effect – 1981	400,000	9.8
Wyoming	Program in effect – 1991	100,000	17.3
District of Columbia	BCBS Open Enrollment	100,000	18.3
Total uninsured		39,400,000	17.3%

1. Number of nonelderly uninsured. Source: Employee Benefits Research Institute (Washington, D.C.) Issue Brief, February 1996.

2. Number of nonelderly uninsured as percent of state population.

Benefits and Criteria

Maximum Lifetime Benefits Provided

State	Benefit
Alaska	\$1 million Lifetime Benefit
Arkansas.....	\$500,000 Lifetime Benefit
California	\$500,000 Lifetime Benefit - \$50,000 Annual
Colorado.....	\$500,000 Lifetime Benefit
Connecticut	\$1 million Lifetime Benefit
Florida.....	\$500,000 Lifetime Benefit
Illinois.....	\$500,000 Lifetime Benefit
Indiana.....	No Maximum Lifetime Benefit
Iowa.....	\$250,000 Lifetime Benefit
Kansas.....	\$500,000 Lifetime Benefit
Louisiana.....	\$500,000 Lifetime Benefit - \$100,000 Annual
Minnesota.....	Regular Plan - \$1.5 million Lifetime Benefit Medicare Plan - unlimited Lifetime Benefit
Mississippi	\$250,000 Lifetime Benefit
Missouri	\$1 million Lifetime Benefit
Montana	\$250,000 Lifetime Benefit
Nebraska	\$500,000 Lifetime Benefit
New Mexico.....	\$750,000 Lifetime Benefit (with certain benefit exceptions)
North Dakota.....	\$1 million Lifetime Benefit
Oklahoma.....	\$500,000 Lifetime Benefit
Oregon	\$1 million Lifetime Benefit
South Carolina	\$250,000 Lifetime Benefit
Tennessee	None
Utah.....	\$500,000 Lifetime Benefit - \$150,000 Annual
Washington	\$500,000 Lifetime Benefit
Wisconsin.....	\$500,000 Lifetime Benefit
Wyoming.....	\$300,000 Lifetime Benefit

Deductibles

NOTE: Many states offer more than one plan. Unless stated, the amounts listed are all deductibles available.

State	Deductibles Offered					
Alaska	\$200	\$500	\$1,000	\$1,500		
	\$2,500	\$5,000	\$10,000			
Arkansas.....	\$1,000	\$5,000	\$10,000			
California	\$500 for PPOs - None for HMOs					
Colorado.....	\$300	\$750	\$2,000			
Connecticut	see plan coverage options in state section					
Florida.....	\$1,000	\$1,500	\$2,000	\$5,000	\$10,000	
Illinois.....	\$500	\$1,000	\$2,500/Individual			
	\$1,000	\$2,000	\$5,000/Family			
Indiana	\$500	\$1,000	\$1,500			
Iowa	\$500	\$1,000	\$1,500	\$2,000		
Kansas.....	\$1,000	\$5,000				
Louisiana.....	\$1,000	\$2,000				
Minnesota.....	\$500	\$1,000				
Mississippi	\$500	\$1,500				
Missouri	\$500	\$1,000				
Montana	\$1,000					
Nebraska	\$250	\$500	\$1,000	\$2,000		
New Mexico	\$500	\$1,000	\$2,000			
North Dakota.....	\$500	\$1,000				
Oklahoma.....	\$500	\$1,000	\$1,500	\$2,000	\$5,000	\$7,500
Oregon	\$500	\$1,000 medical/\$1,000 prescription				
South Carolina	\$500					
Tennessee	\$250/Individual, \$500/Family (incomes of 101-199% of poverty) optional \$1,000/Individual, \$2,000/Family (incomes of 200% of poverty or higher)					
Utah.....	\$500	\$1,000				
Washington	\$500	\$1,000	\$1,500			
Wisconsin.....	\$1,000	\$500 Medical Disability Supplement Plan				
Wyoming.....	\$500 Type A, \$2,000 Type B, \$3,000 Type C — See Benefit Structure					

History

The Alaska Legislature created the Alaska Comprehensive Health Insurance Association to provide access to health insurance to all residents of the state who are presently denied adequate health insurance or who are considered uninsurable.

The plan is to be funded through subscriber premiums and assessments to members in proportion to the percentage of total health insurance premiums each member writes in the state. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the plan or allocated to reduce plan premiums.

Effective in 1995, additional deductibles of \$2,500, \$5,000, and \$10,000 have been made available, and the eligibility requirements have been eased by including a list of specific eligibility conditions.

Plan Summary

1. Alaska Contact:

Rodney Beetch
Alaska Division of Insurance
3601 C Street
Suite 1324
Anchorage, Alaska 99503-5948
(907)269-7900
1-800-467-8725

2. Plan Administrator:

Aetna Health Plans
P.O. Box 810
Seattle, WA 98111
1-800-562-6648

3. Operational Date:

January 1, 1993

4. Board Composition:

The board is made up of seven individuals, including five who shall be selected by participating members, subject to approval by the director of the division of insurance; and

two members who shall be consumers selected by the director of the division of insurance. The director or the director's designee shall serve as a non-voting ex-officio member of the board.

5. Eligibility Requirement:

The individual applying for coverage must be: a state resident — upon ceasing to be a resident, a person is not eligible to purchase or renew coverage under the plan, but previously purchased coverage remains in effect for the period covered by payments made while a resident. Participants in the pool also must not be covered by the state plan while covered by another health insurance policy or subscriber contract.

6. Maximum Benefit:

\$1 million lifetime maximum

7. Deductibles Offered:

\$200* \$500 \$1,000 \$1,500
\$2,500 \$5,000 or \$10,000 per individual

*New option for 1996.

8. Premium Cap:

200 percent

9. Waiting Period and Pre-existing Conditions:

Benefits will not be payable for six months following the effective date of coverage if the condition 1) first manifested itself within the period of three months immediately before the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care or treatment; or 2) medical advice or treatment was recommended or received within the period of three months immediately before the effective date of coverage.

10. Waiver of Waiting Period:

If an individual's previous subscriber contract, health policy, or Medicare supplement policy was involuntarily terminated, the state plan shall credit the time covered under the previous contract or policy toward an

exclusion for pre-existing conditions if the person applies for a state plan within 31 days after termination of the previous contract or policy. If a person is accepted by the writing carrier and pays a specified premium for retroactive coverage, the state plan is effective retroactively to the date that the person's previous contract or policy terminated.

11. **Stop Loss/Out of pocket:**
 \$2,000 per individual for the \$200, \$500, \$1,000, and \$1,500 deductibles
 \$3,500 per individual for the \$2,500 deductible
 \$7,500 per individual for the \$5,000 deductible
 \$10,000 per individual for the \$10,000 deductible
12. **Agent Fee:**
 \$25
13. **Application/Premiums:**
 For general information:
 Alaska Division of Insurance
 Suite 1324
 3601 C Street
 Anchorage, Alaska 99503-5948
 (907)269-7900
 1-800-467-8725
14. **Medicare Supplement Plan:**
 Plans A, and I are offered.

Operational Data

1. Total number of participants in the plan at the end of:

1993.....	57
1994.....	128
1995.....	179
2. Breakdown of participants using various plans:

\$200*	NA
\$500 deductible	21
\$1,000 deductible	49
\$1,500 deductible	59
\$2,500 deductible	8
\$5,000 deductible	12
\$10,000 deductible	4
Medicare Supplement Plan A.....	10
Medicare Supplement Plan I.....	16

*New option for 1996.

3. Total premiums collected from insureds by the plan:

by the end of 1993.....	\$88,375
1994.....	348,744
1995.....	479,001
4. Total claims paid by the plan:

by the end of 1993.....	\$154,910
1994.....	474,619
1995.....	1,903,747
5. Total cost to administer the plan:

by the end of 1993.....	\$79,469
1994.....	113,403
1995.....	178,909
6. Total assessments to members of the plan:

by the end of 1993.....	\$338,874
1994.....	0
1995.....	1,775,615
7. Financing mechanism used to fund losses of the pool:

The Alaska plan is funded through subscriber premiums and assessments to association members in proportion to the percentage of total health insurance premiums each member writes in the state.

Benefits

The plan uses usual, customary, reasonable or prevailing charges.

- Hospital services.
- Professional services rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions.
- Mental conditions rendered during the year on other than an inpatient basis, up to a yearly maximum of \$4,000.
- Legend drugs requiring a physician's prescription.
- Skilled nursing facility, limited to 120 days in a policy year.
- Home health agency services up to a maximum of 270 visits a calendar year if services commence within seven days following hospital confinement.

- Hospice services for up to six months in a calendar year.

- Use of radium or other radioactive materials.
- Outpatient chemotherapy.
- Oxygen.
- Anesthetics.

- Non-dental prostheses and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis.

- Rental or purchase, whichever is more cost effective, of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed.

- Diagnostic X-rays and laboratory tests.

- Oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth.

- Services of a licensed physical therapist rendered under the direction of a physician.

- Transportation by a licensed, local ambulance.

- Confinement in a licensed or certified facility established primarily for the treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment for a period of at least 45 days within any calendar year.

- Alternatives to inpatient services as defined by the association in the state plan benefits.

- Second surgical opinions.

- Other services that are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the director.

See policy for complete list of covered services.

Who is eligible?

Even though Medicare is provided, a person may still be eligible for coverage under this plan. Any person is eligible for the ACHIA plan if he or she:

- is not covered by any other form of health insurance that is similar to this plan;
- is not eligible for coverage under AS 21.56;

- has been a resident for the past 12 months and continues to be a resident of Alaska; *and*
- *at least one of the following:*

- 1) has received from two health insurers notice of rejection for health insurance dated within the last six months;
- 2) has received restrictive riders that substantially reduce coverages;
- 3) is currently insured under similar insurance and the current premium exceeds the CHIA plan premium;
- 4) has been offered coverage at a rate higher than the CHIA plan premium, based upon comparable deductibles, coinsurance and benefits; *or*
- 5) has any of the conditions listed below:

Acquired Immune Deficiency Syndrome (AIDS)
 Alzheimers
 Angina Pectoris
 Anorexia Nervosa
 Arteriosclerosis Obliterans
 Artificial Heart Valve
 Ascites
 Brain Tumors
 Cardiomyopathy
 Cerebral Palsy
 Chronic Pancreatitis
 Cirrhosis of the Liver
 Coronary Insufficiency
 Coronary Occlusion
 Crohn's Disease
 Cystic Fibrosis
 Dermatomyositis
 Diabetes
 Epilepsy
 Friederich's Disease
 Heart Disorders
 Hemophilia
 HIV+
 Hodgkin's Disease
 Huntington's Chorea
 Hydrocephalus
 Intermittent Claudication
 Kidney Failure
 Lead Poisoning with Cerebral Involvement
 Leukemia
 Lupus Erythematosus Disseminate
 Malignant Tumor (if treated or has occurred within last 4 yrs)
 Mental Retardation
 Metastatic Cancer
 Motor or Sensory Aphasia
 Multiple or Disseminated Sclerosis
 Muscular Atrophy or Dystrophy
 Myasthenia Gravis
 Myotomy
 Obesity - Surgical Treatment
 Open Heart Surgery
 Paraplegia or Quadriplegia
 Parkinson's Disease
 Peripheral Arteriosclerosis (if treatment within last 3 yrs)
 Poliomyelitis
 Polyarteritis (Penarantlis Nodosa)
 Postero-lateral Sclerosis
 Psychotic Disorders
 Rheumatoid Arthritis
 Sickle Cell Anemia
 Silicosis
 Splenic Anemia (True Banti's Syndrome)
 Still's Disease
 Stroke (CVA)
 Syringomyelia
 Tabes Dorsalis (Locomotor Ataxia)
 Thalassemia (Cooley's or Mediterranean Anemia)
 Topyectomy and Lobotomy
 Ulcerative Colitis
 Wilson's Disease

NASCHIP/CA State Risk Pool Benefit Survey

State:	Alaska	Deductible:	\$500/1,000/1,500/2,500
Plan Name:	Alaska Comprehensive Insurance Association		/5,000/10,000
Plan Version:	medical	Co-insurance:	80-20
		Lifetime Maximum:	\$1,000,000
		Pre-ex Condition	
		Waiting Period:	6 months

Benefits/Features <i>Brief description</i>	Covered?	Benefits/Features <i>Brief description</i>	Covered?
Out of Pocket Maximum <i>Deductibles \$500/1,000/1,500 > \$2,000 out of pocket; \$2,500 > \$3,500; \$5,000 > \$7,500; \$10,000 > \$10,000.</i>	YES	Preventative Care	NO
Outpatient Care/Doctor Visits <i>After deductible, medical necessity and UCR.</i>	YES	Dental Care	NO
Inpatient Care/Hospital <i>After deductible, medical necessity and UCR.</i>	YES	Vision Care	NO
Surgery <i>After deductible, medical necessity and UCR.</i>	YES	Other Significant Services (list)	
Prescription Drug Coverage <i>After deductible, medical necessity and UCR.</i>	YES	SIGNIFICANT LIMITATIONS	
Maternity <i>Only major complications; after deductible, medical necessity and UCR.</i>	NO	AIDS <i>\$1,000,000 maximum.</i>	
Ambulance <i>After deductible, medical necessity and UCR.</i>	YES	Transplants <i>\$1,000,000 maximum.</i>	
Diagnostic/X-Ray <i>After deductible, medical necessity and UCR.</i>	YES	Specific Diseases <i>\$1,000,000 maximum.</i>	
Skilled Nursing Care <i>120 days per year; after deductible, medical necessity and UCR.</i>	YES	Waiting Periods other than Pre-ex	NO
Home Health Visits <i>Maximum of 270 visits per year.</i>	YES	Other (list)	
Hospice Care <i>Up to 6 months per year; after deductible, medical necessity and UCR.</i>	YES		
Transplant Coverage	YES		
Rehabilitation Inpatient <i>Under direction of physician.</i>	YES		
Rehabilitation Outpatient <i>Under direction of physician.</i>	YES		
Durable Medical Equipment	YES		
Mental Health & Chemical Dependency <i>Maximum \$8,300 in 2 consecutive calendar years or \$16,600 for life; drug and alcohol treatment 45 days per year; mental outpatient payable 50% after deductible annual maximum \$4,000.</i>	YES		
Physical Therapy	YES		
Speech Therapy	YES		
Occupational Therapy	YES		

The American Chiropractic Association Presents

Chiropractic ONLINE

Your Internet Source for Information on the Chiropractic Profession

Patients Are Suffering at the Hands of Health Plan Cost-Cutting

In recent years, the media has reported numerous instances managed care negligence. The following are a few of the more than 170 reports that the Patient Access to Responsible Care Alliance has compiled:

⑥ A 27-year-old man from central California received a heart transplant and was discharged from the hospital after only four days because his HMO wouldn't pay for additional hospitalization. Nor would the HMO pay for the bandages needed to cover the man's infected surgical wound. The patient died. (Mitchell, Larry, "Butte urged to immunize against potential HMO ills," *The Enterprise-Record*, Jan. 21, 1996.)

⑥ A 54-year-old man who just had prostate surgery was told by his HMO that he must leave the hospital within 24 hours of his surgery or the HMO wouldn't pay. He had to go to his home, where there was no one to care for him even though he was still bleeding, had to wear a catheter to drain his bladder, and couldn't walk. (Morgan, Peggy and Sarah Robertson, "Can this medical plan be saved?" *Prevention*, April 1997.)

⑥ An otherwise healthy two-year old boy who had suffered a fall was taken to a local hospital with a stick lodged between his upper lip and gums. Once there, health care providers repeatedly misdiagnosed the boy's condition and refused to authorize an \$800 CT scan that would have confirmed that the boy was developing a brain abscess. As a result, the boy was left blind and brain-damaged. (Anagnos Liapakis, Pamela, "The Malpractice Epidemic: Don't Let the industry Get Away with," *Trial*, February 1996.)

⑥ For more than four years a Virginia man sought treatment for his school-age daughter's nausea and severe recurring headaches. HMO doctors prescribed adult-strength narcotic pain medication, but did not consult a neurological specialist. Finally, in May 1996, at the request of the girl's school psychologist, HMO doctors ordered an EEG and MRI, which revealed a tumor that had invaded over 40 percent of the patient's brain. She underwent surgery and radiation therapy to remove the tumor and will require future surgery and continuing intensive care. ("ERISA Governs Challenge to HMO Policy Encouraging Physicians to Limit Care," *BNA's Managed Care Reporter*, May 14, 1997.)

⑥ An Arkansas woman suffered a broken neck in a car wreck and was rushed to the hospital. Her managed care company refused to pay her emergency room claim because she failed to get preauthorization. ("Too many HMOs stint on emergency-room care," *USA Today*, April 11, 1997.)

 <http://www.amerchiro.org/managed/horror.html>

4/27/98

March 18, 1998

Norman:

You asked me to find the President's bill on patient's rights.

The Congressional Office here in town advises that the President has not yet submitted language concerning his patient's bill of rights.

I then asked what bill was moving through Congress. Elizabeth at the Juneau Office advised that H.R. 1415 by Rep. Norwood was the one to look at.

Attached is a copy of H.R. 1415 from the internet as well as other information on the bill.

Janet

cc: Shirley (w/attachments)



*Department of Revenue
Blair
Tanner*

**LEGISLATIVE TELECONFERENCE NETWORK
SIGN-IN SHEET**

81502

PLEASE PRINT

SPONSOR: Lower Labor & Commerce
 SUBJECT: HR 300 - The Patients Bill of Rights
 START/END TIME: 3:45 DATE: 3/20

Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1. Lynn Hartz / Alaska Practice	3104 Brookside Dr Supts	99517	248-4877	<input checked="" type="checkbox"/>		HB 300
2. Karen Dorris - Primary	2200 Shore Dr (S)	99515	522-7294	<input checked="" type="checkbox"/>		HB 300
3. Kathy Vole / Physical Therapist Assoc	2031 Saratoga Av (S)	99517	244-6899	<input checked="" type="checkbox"/>		HB 300
4. Miss Beale Astoria	4302 Rd 8, Astoria (O)	99503	523-0433	<input checked="" type="checkbox"/>		HB 300
5. Terry Allard / The Wisconsin Health Ins. Agents	01600 A St. Suite 300	99504	277-1616	<input checked="" type="checkbox"/>		HB 300
6. Debra Thoman / Alaska Chambers	10721 St Ives Pl (O)	99504	337-6014	<input checked="" type="checkbox"/>		HB 300
7. Sherry Stacey / NANA	1001 E Benson (O)	99508	265-4159	<input checked="" type="checkbox"/>		HB 300
8. Tom Tierney / Mural Panchonville	Wille Blvd (O)		343-4290	<input checked="" type="checkbox"/>		HB 300
9. Jimmie McKeena / PFSH	(O)		261-3134	<input checked="" type="checkbox"/>		HB 300
10. MAILO FILEY / MK. AC. CID	2501 Commercial Dr 1	99501	272-4571	<input checked="" type="checkbox"/>		
11. GREG STOKES / AK ELECTRIC FUNDRAISER	2600 DENALI SUITE 200 (O)	99503	276-1246	<input checked="" type="checkbox"/>		
12. Bruce Cole / Will's Concept	4300 R ST, Anchorage (O)	99503	275-1115	<input checked="" type="checkbox"/>		HB 300
13. Hank O'Donnell - ASFA ASSUME	3510 Snowbird Rd (O)	99503	278-5200	<input checked="" type="checkbox"/>		HB 300
14. Jamie Slack / VECO Corp.	813 W. Northern Lights (O)	99503	264-8127	<input checked="" type="checkbox"/>		HB 300
15. Vertu & Weaver National Bank of Alaska	301 W Northern Hts - Anch	99503	265-2920		<input checked="" type="checkbox"/>	HB 300



LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

40502

SPONSOR: 1H) L+C

SUBJECT: HB 300

START/END TIME: _____ DATE: _____

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Tastify	Observe	Bill No.
1.	Just Call PROVIDENCE	P.O. Box 196604 Anchorage AK	99519	861 4996		✓	HB 300
2.	Ed BURMAN left	946 P. KENNE TREE DR	99516	257-6311	✓		
3.	Frank L. Thompson-Morris left	12541 Alhambra Anchorage	99516	345-7191	✓		
4.	Larry K. Walker left	610 W 54th Ave Anchorage 99518	99518	562-2810	✓		HB 300
5.	Jim Chase (S)	880 N St A/A 99501	99501	274-2528	✓		HB 300
6.	↳ DDS						
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							



COMMITTEE:
House Labor & Commerce Standing Committee

DATE: March 20, 1998

Subject of meeting:

HB 300 - ALASKA PATIENTS' BILL OF RIGHTS

SIGN-IN

PLEASE PRINT!
NAME

ADDRESS (MAILING / ZIP)

PHONE

REPRESENTING

DO YOU
WANT TO
TESTIFY?

NAME	ADDRESS (MAILING / ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
TIM WOLLER	3529 College Rd #205 FAIRBANKS AK 99709 (S)	907-479-6747	Alaska Dental Society	Yes
TOM HIPSTER	800 E. DIAMOND BLVD ANCHORAGE, AK 99515 (S)	907-349-5585	ALASKA DENTAL SOCIETY	YES
Mary Veale	PO Box 240286 Douglas AK 99824 (S)	(907) 364-2164	AK Physical Therapy Association	Yes
Linda Fink	319 Seward Street Juneau AK 99801 (C)	907 586-1790	AK State Hospital + Nursing Home Assoc.	Yes
Mariann Burke	505 9th Floor Juneau, AK X	907 465-2515	Division of Insurance	Yes
GORDON EVANS	211 4th St. Suite 305 Juneau, AK	586-3210	ATAA	YES
Jerry Reinwand	2 Marina Way - Suite 219 Juneau, AK	586-5966	Blue Cross	Yes
David Logan	POB 24236 Juneau 99803	780-6066	Alaska Dental Society	Yes