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A COST ANALYSIS OF THREE STATE MANDATES TO REGULATE THE PROVISION OF PRESCRIPTION DRUG BENEFITS

Prepared for
The Health Insurance Association of America

The Wyatt Company
June 26, 1992

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A COST ANALYSIS OF THREE STATE MANDATES TO REGULATE THE PROVISION OF PRESCRIPTION DRUG BENEFITS

Executive Summary

Background

Insurance plans that traditionally paid for prescription drugs on the basis of unregulated charges are now using their market power to help consumers purchase pharmaceutical products in a more prudent manner. Although specific arrangements differ, they generally include financial incentives for beneficiaries to use a limited network of community and mail service pharmacies that have agreed to provide prescriptions and related administrative services at a discount. These arrangements help control the cost of medical care and medical insurance for the consumer, while fostering information systems that can be used to coordinate and enhance the quality of medical care.

Prescription drugs now account for about 10 percent of covered medical charges for active employees and their dependents. For retirees with primary coverage from Medicare, prescription drugs account for 30 to 50 percent of the medical charges not paid by Medicare. Awareness of these prescription drug costs is heightened by a new accounting standard about to be implemented for employer-sponsored retiree medical plans. For plan years that begin after December 1992, these plans must report their retiree medical liabilities on an accrual basis rather than the pay-as-you go basis that has been common. When employers calculate their retiree medical liabilities, many will find that they face liabilities of $10,000 or more per retiree in prescription drug costs alone.

unmanaged retail environment. Following this analysis of PPO and mail service savings, we examine the extent to which each of the state mandates would erode the savings that are currently available.

To calculate managed care savings, it is first necessary to estimate the baseline cost of prescription drugs in an unmanaged retail environment. This is complicated because traditional indemnity plans do not compile complete information about drug utilization and expenditures. These plans typically pay prescription drug benefits along with other medical benefits after a deductible is satisfied -- a deductible that currently averages $200 for a single person. A large portion of prescription drug charges fall below this $200 threshold, and beneficiaries often neglect to submit other claims for payment. The deductible and coinsurance provisions of a traditional indemnity plan can also suppress prescription drug utilization.

We developed a baseline retail cost model to serve as a standard of comparison for PPO and mail service savings. The model required assumptions concerning the annual number of prescriptions per person, the mix of drugs dispensed in the acute and maintenance categories, and the percentage of prescriptions filled in generic and trade forms. Similar cost models were developed for PPO and mail service arrangements. The discounts assumed for PPO and mail service models are available from multiple vendors with a national reputation and market presence -- we consider these discounts typical.

The PPO cost model indicates:

- o Savings of 18.6 percent from the retail baseline considering the PPO discount alone.

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A Review of

"A Cost Analysis of Three State Mandates to Regulate the Provision of Prescription Drug Benefits"

(The Wyatt Company, June 26, 1992)

Prepared by

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May 26, 1994

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numerous studies, surveys, analyses and other sources of information, this discussion - as well as the remainder of the report - is devoid of references. As a result, the reader is unable to confirm, or in some cases even fully interpret, the information that is presented or the conclusions that are drawn from this information.

Following this discussion, and in marked departure from the title and stated focus of the report, the authors suggest that "the initial objective of this study is to estimate the percentage savings that tightly managed pharmacy PPOs and mail service organizations can provide relative to the unmanaged retail environment." (page 13) The net effect of this statement is to reframe the originally stated objectives of the study entirely. Moreover, the authors do not explain why such a comparison - even if possible - would be relevant to a cost analysis of the three state mandates in question. Instead, the discussion that follows leaves the impression that these three limited regulatory initiatives are somehow in conflict with the concept of managed health care itself. In fact, the initiatives under consideration are merely recommended conditions related to how managed pharmacy benefit plans are best implemented and operated in the states where they serve patients.

Despite the authors' admission that data were not available to support the cost comparisons they wished to make, an unmanaged retail environment "model" is nevertheless constructed using a variety of mostly unstated and unsupported assumptions. The resulting "baseline retail cost model" is then contrasted with similarly constructed PPO and mail service estimates to arrive at the conclusion that significant cost savings are possible through managed care prescription drug programs when compared with an unmanaged retail environment.

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BACKGROUND

In 1991, the Health Insurance Association of America (HIAA) commissioned The Wyatt Company to perform an analysis of the costs associated with six state legislative initiatives to regulate managed health care practices. The results of this initial study subsequently led to the commission of a second analysis by The Wyatt Company.

The report of this second analysis was issued on June 26, 1992. Its stated purpose is to examine the potential impact of three proposed state mandates to regulate the provision of prescription drug benefits by managed care organizations (MCOs). The objective of the analysis was to estimate the impact on costs if health insurance plans were required to comply with the following three mandates:

1. *Any willing pharmacy provider* - that would require establishment of a specific, objective set of criteria for selection of participating pharmacies and would allow any pharmacy that met these criteria to participate in the preferred provider organization (PPO).
2. *Limited benefit differentials* - that would restrict the magnitude of payment differences that could be charged to patients for prescriptions filled in network and non-network pharmacies.
3. *Same state license* - that would limit participating network pharmacies to those that are licensed within the state in which covered beneficiaries reside.

REVIEW

The report begins with an expansive discussion of the managed care prescription benefit market. However, while alluding to the results from

numerous studies, surveys, analyses and other sources of information, this discussion - as well as the remainder of the report - is devoid of references. As a result, the reader is unable to confirm, or in some cases even fully interpret, the information that is presented or the conclusions that are drawn from this information.

Following this discussion, and in marked departure from the title and stated focus of the report, the authors suggest that "the initial objective of this study is to estimate the percentage savings that tightly managed pharmacy PPOs and mail service organizations can provide relative to the unmanaged retail environment." (page 13) The net effect of this statement is to reframe the originally stated objectives of the study entirely. Moreover, the authors do not explain why such a comparison - even if possible - would be relevant to a cost analysis of the three state mandates in question. Instead, the discussion that follows leaves the impression that these three limited regulatory initiatives are somehow in conflict with the concept of managed health care itself. In fact, the initiatives under consideration are merely recommended conditions related to how managed pharmacy benefit plans are best implemented and operated in the states where they serve patients.

Despite the authors' admission that data were not available to support the cost comparisons they wished to make, an unmanaged retail environment "model" is nevertheless constructed using a variety of mostly unstated and unsupported assumptions. The resulting "baseline retail cost model" is then contrasted with similarly constructed PPO and mail service estimates to arrive at the conclusion that significant cost savings are possible through managed care prescription drug programs when compared with an unmanaged retail environment.

The report continues to dwell on comparisons of the three "models" throughout two-thirds of its total length. It is not until much later that the report returns, if only briefly, to the three substantive issues in question: i.e., the estimated impact of the three proposed state mandates.

Mandate 1: Any Willing Pharmacy Provider

The report asserts that "the expansion of the network to include all pharmacies would completely eliminate the economic advantage of the network to pharmacists and consumers. As network participation approaches 100 percent, pharmacies can offer smaller and smaller discounts because potential gains in the market are so small." (page 5)

To support their conclusion, the authors offer a set of hypothetical scenarios "that projects the extent to which the PPO savings [would be] eroded by an 'any willing pharmacy provider' mandate." (page 27) However, given the absence of empirical data, the estimates that are made in these scenarios related to the percentage of pharmacies participating, and the number of prescriptions filled within and outside the network are purely speculative. In any event, the estimates are moot because the assumptions upon which the scenarios were based are fallacious.

The fallacy is the assumption that pharmacies in the managed care prescription market are price *setters*. In fact, evidence suggests that pharmacies in the managed care market are, for the most part, price *takers*. For example, a survey of independent pharmacies in the state of Maryland found that the top reason for pharmacy non-participation in a managed care network (42%) was due to the HMO not accepting additional pharmacy providers. Only three percent of respondents reported that exclusion from the network was due

in patients, that should represent the focus of our analyses in this area. Thus, savings that result from the optimal use of prescribed medications are of fundamental importance to a true cost analysis. Drug products are merely vehicles for the delivery of potential therapeutic benefits to patients. It is really these therapeutic benefits, in the form of desired patient outcomes, that patients and payers want from the pharmacy services they purchase.

CONCLUSION

The absence of references for information that is cited, and the heavy reliance on hypothetical scenarios that are largely devoid of empirical support suggest that this report is more accurately described as a position paper on the advantages of managed care and mail service pharmacy. Regrettably, the "models" that are constructed and the "analyses" that are performed are so heavily based on unstated and/or unrealistic assumptions, unsupported conjectures, questionable or nonexistent data, and superficial analyses, as to make the conclusions that were reached of virtually no usefulness in contributing to a better understanding of the important questions that were posed.

▸ Under their discussion of the limitations of the report, the authors state "this study does not attempt to determine whether some prescription drug delivery systems are better than others at identifying and eliminating waste." (page 16) Given the relatively large quantities that are routinely dispensed to beneficiaries of mail service prescription plans, and the problems inherent in attempting to consistently and completely perform all aspects of prospective drug utilization review from a remote location, this would appear to be a significant shortcoming in a "cost analysis" of this delivery system compared to a traditional community pharmacy-based system.

▸ The authors state "we do not attempt to quantify savings that may result when enhanced drug treatment compliance helps the beneficiary avoid hospitalization or other medical services." (page 13) Yet they also state that "studies show that failure to comply with drug treatment accounts for up to 15 percent of hospital admissions - an adverse consequence from both cost and quality perspectives." (page 11)

Clearly then, compliance and other factors related to ensuring the appropriate use of the medications that are dispensed to patients are relevant components in assessing the relative costs of prescription drug delivery. Ignoring these important elements eliminates perhaps the most important determinants in whether patients will receive the desired benefits from their prescription drugs. Indeed, the report's casual dismissal of these elements causes the reader to ask, "just what are the costs associated with a prescription benefit plan that we should be interested in analyzing?"

The answer to this question is something that the report ignores entirely. In the final analysis, it is not the cost of the drug products, but rather the cost of achieving the desired health and quality of life outcomes

of many mail service pharmacy organizations, and therefore access to affordable prescription drug care for patients, no attempt is made to quantify either of these purported effects.

Having thus ignored the central issue, the report instead turns to estimating the potential cost savings of a mail service prescription plan when compared to a "full retail baseline." To do so, the report once again makes use of hypothetical scenarios in combination with various assumptions to create imaginary examples that illustrate "the range of savings that might be lost to a retired group making regular use of mail service." (page 36) On the basis of this elaborate construct, the report concludes that substantial savings are realized through prescription drug plans, savings that would presumably be threatened if same state license mandates initiatives became law.

MISCELLANEOUS CONCERNS

Beyond the numerous inadequacies and inconsistencies in the methodology that was used in the report, a careful examination reveals several additional concerns.

- The support expressed in the report for mail service pharmacy on the grounds that it increases access to care by elderly or mobility-impaired patients appears to be in conflict with the report's opposition to open pharmacy networks. Clearly, patients do not desire or value restrictions on their freedom of choice. Moreover, it seems likely that the reduced access which inevitably results from restrictive pharmacy networks would represent a significant barrier to care for some elderly, indigent or mobility-impaired beneficiaries.

percent with a corresponding 95 percent utilization of network pharmacies by eligible beneficiaries. They explain that this baseline assumption was developed by "borrowing" a model used in a previous study to estimate the impact of benefit differentials on the utilization of network providers across a full medical benefits plan. While the authors admit that they were "not aware of studies that have examined this dynamic as it applies to pharmacy benefits," (page 32) this fabricated "model" is nevertheless used as the foundation for subsequent estimates of potential decreases in network utilization corresponding to various levels of benefit differential.

The authors conclude that moving to a 20 percent differential would reduce utilization of network pharmacies from 95 percent to 88.9 percent. Further reduction in the benefit differential to 15 percent would reduce network utilization to 85.6 percent, but with a consequent increase in total pharmacy payments of only 1.7%.

The authors further qualify their conclusions by stating "the estimates from this model are illustrative because controlled research on beneficiary response to these pharmacy reimbursement options has not been performed." (page 33) As a result of the absence of empirical data, the reader is once again left to speculate upon the validity of the utilization and cost estimates that are made in the report.

Mandate 3: Same State License

The final issue addressed in the report is the "same state license" requirement that would limit pharmacy participation in benefit plans to those licensed in the states in which covered beneficiaries reside. Although the report suggests that such a condition would severely limit the participation

to their unwillingness to meet the established reimbursement level.[1] Indeed, it is the fear of losing more of their rapidly eroding customer base that has prompted community pharmacy organizations to routinely accept reimbursement levels from managed care plans that are at, or actually below, their costs of service delivery.[2]

As mentioned in the report, "any willing pharmacy provider" laws merely require managed care organizations to "establish a specific, objective set of criteria for selection of participating pharmacies and to allow any pharmacy that met these criteria to participate." (page 27) That is, the MCO itself still maintains complete control over the establishment of reimbursement rates, drug product selection policies, and any qualitative standards it deems necessary to ensure the consistent provision of high quality pharmacy care to its beneficiaries. Moreover, in contrast to the assertions made in the report, a 1991 white paper cited several specific examples in which pharmacy costs remained stable or actually decreased following the opening of restricted pharmacy networks.[3]

Mandate 2: Limited Benefit Differentials

To estimate the potential impact of limiting the size of payment differences for prescriptions filled in network and non-network pharmacies, the authors of the report assumed a "baseline" benefit differential of 30

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[1]Maryland Pharmacists Association; Pharmacy Network Exclusion and Maryland Health Maintenance Organizations. Baltimore, MD (June 1992).

[2]Norman V. Carroll "Forecasting the Impact of Participation in Third-Party Prescription Programs on Pharmacy Profit," Pharmacy Business (Spring 1993).

[3]Maryland Pharmacists Association: Consumer Access to Pharmacy Services. Baltimore, MD (1991).

Mandate 1: Any Willing Pharmacy Provider

Wyatt constructed a pharmacy revenue requirement model and analyzed pharmacy behavior for a pharmacy network with 30 percent of a market's prescriptions. The model assumed that 40 percent of community pharmacies currently participate in the network, and that they offer a discount from retail of 18.6 percent. *Scenario 1 of this model produces an overall savings to the plan and plan members of 16.7 percent. (Savings are reduced from the 18.6 percent level because 5 percent of claims are out of network, and one percent of premium costs are consumed by network administration.) This savings would be reduced or eliminated if networks were mandated to accept any willing pharmacy provider.*

Given the above assumptions, expansion of the network to include all pharmacies would completely eliminate the economic advantage of the network to both pharmacies and consumers. As network participation approaches 100 percent, pharmacies can offer smaller and smaller discounts because the potential gains in market share are so small. At 100 percent pharmacy participation the health plan must still pay the fixed costs of network administration, but network pharmacies no longer have an incentive to give even a small discount.

Mandate 2: Benefit Differentials

We borrowed the benefit differential model from our previous study of state mandates to estimate the impact of moving from a 30 percent benefit differential to 20 and 15 percent differentials. The estimates from this model are illustrative, because controlled research on the response of beneficiaries presented with these differentials has not been performed. The model suggests that moving from a 30 percent differential to a 20 percent differential would reduce utilization of network pharmacies from 95 percent of the total to 88.9 percent. A benefit differential of only 15 percent would reduce network utilization to 85.6 percent of total prescriptions.

Although substantial savings might also be obtained through negotiations with community pharmacy networks, a plan's ability to negotiate discounts depends on competitiveness of the prescription drug market. The existence of mail service organizations does much to enhance this competition. Moreover, mail service fills some special needs that are poorly served through networks. Retired and disabled persons in rural areas, retirees who move out of state when they retire, and retirees who move south each winter are all problematic for health plans. It is difficult to obtain network discounts for these people because they represent only a small portion of the market in the areas which they reside. Moreover, those with disabilities can benefit greatly from the convenience of mail delivery.

Overall Conclusions

Managed care arrangements for prescription drugs, as for other medical benefits, give health care consumers the opportunity to obtain better value for the money they spend in the health care market place. PPO and mail service programs generally furnish beneficiaries more prescription drugs for less cost -- and they do so with an emphasis on quality. The information systems developed through these programs are opening new opportunities for monitoring, managing and improving the quality of care that beneficiaries receive.

Prescription drugs can no longer be viewed as an inconsequential part of the medical plan -- they represent major expenditures, particularly for retirees. In many ways the question is not whether the health plan should be able to pursue managed care opportunities, but whether employers will be able to continue funding medical benefits that are not managed. The new financial accounting standard for retiree medical plans is especially pertinent here, because employers must find a way to address this large cost that will be such a major factor in their profitability.

2. Benefit differentials. These laws would restrict the magnitude of payment differences for prescriptions filled in network and nonnetwork pharmacies. Such payment incentives are the principal means that plan sponsors use to encourage the use of network rather than retail pharmacies.

3. Same state license. These laws would limit participating pharmacies to those with an in-state license. Mail service pharmacies, as currently structured, would not meet this requirement because they serve national populations from a limited number of sites.

As in the original study, we attempt to estimate the prescription drug savings that are feasible under a variety of managed care scenarios and the extent to which these state mandates might reduce these savings. We focus on measurable savings that result from pricing discounts, generic substitution, and beneficiary choice to use in-network services. Other savings would result from those components of managed care that are intended to ensure quality of care and better compliance with prescription drug treatment regimens. We can offer only limited information about savings associated with these aspects of prescription drug managed care, but a growing literature suggests that they may be substantial.

Context of Managed Pharmacy Benefits

The costs of employer-sponsored health care have been escalating rapidly in recent years, and the costs of prescription drug benefits have risen even faster than other medical costs. The Wyatt Company's Compare™ Survey shows that the costs of health insurance for an employee with family coverage increased by about 15 percent between 1990 and 1991. A national survey of retail pharmacy outlets shows that the average prices consumers paid for prescriptions increased by 21 percent during this same period. Indeed, increases

First, health plan spending for prescription drugs was constrained because some beneficiaries hesitated to fill prescriptions that were below the plan deductible (known as the "hesitancy effect"), and because many prescriptions that were filled were never submitted as claims. This second factor is known as the "shoebox effect," because of the popular image that beneficiaries take their paper claims home and place them in a shoebox with the intention of filing them at a later date. Many of these claims are either lost or forgotten.

Although the hesitancy and shoebox effects are believed to reduce claims submission by as much as 30 to 40 percent, they also have adverse consequences. When prescriptions are never filled, the beneficiary fails to comply with the drug treatment prescribed by the physician. Studies show that failure to comply with drug treatment accounts for up to 15 percent of hospital admissions -- an adverse consequence from both cost and quality perspectives. This failure to comply may also be costly to the plan if adverse outcomes require additional medical care.

A second set of problems with the traditional reimbursement arrangement grows from the lack of information and incentives necessary to sustain a competitive market. Drug store receipts typically do not include sufficient information for the medical plan to determine whether prescription drug charges are reasonable, whether a generic medication might be available, or whether the pattern of prescription drug fills meets standards for quality care. Traditional plans simply check to see that the deductible is met, and then pay a fixed percentage of what was charged to the beneficiary. Given this lack of information, it is virtually impossible to manage the benefit to achieve either cost or quality objectives.

In this traditional environment, beneficiaries are not given financial incentives or the information needed to act as prudent purchasers of prescription drugs; third party payers are not empowered with information or the ability to steer market share to those

volume purchasing directly from manufacturers, through highly specialized dispensing and packaging systems, and through advanced information systems that collect clinical and reimbursement information. These organizations still account for less than 10 percent of the private sector drug volume dispensed in the U.S., but their very presence has enhanced competition and established a new standard of efficiency.

In recent years, third-party payers have experimented with various managed care arrangements designed to maintain comprehensive coverage of prescription drug benefits, while encouraging more prudent purchasing decisions. In contrast to the alternative of shifting costs to employees and retirees, these arrangements frequently represent an enhanced benefit in terms of the proportion of total prescription drug dollars paid by the health plan.

Study Overview

Model Development

The initial objective of this study is to estimate the percentage savings that tightly managed pharmacy PPOs and mail service organizations can provide relative to the unmanaged retail environment. Total savings to both beneficiaries and their third-party payers are considered. We do not attempt to quantify savings that may result when enhanced drug treatment compliance helps the beneficiary avoid hospitalization or other medical services.

Key determinants of modeled savings are price discounts, generic substitution, and the market penetration achieved by preferred providers. The first part of our analysis presents a variety of scenarios illustrating the savings that can be achieved when prescriptions are filled through PPO and mail service pharmacies.

Assumptions are used in this report both for purposes of simplifying the models and for purposes of testing a range of scenarios for potential savings. For example, we assume that the average supply of maintenance medications dispensed in a mail service setting does not differ for trade drugs with no generic substitute, those with a substitute, and the generic drug. The data used for this project show some minor differences among these categories, but an average supply is used for all these categories. Another kind of assumption concerns the range of scenarios to model. Few if any of today's indemnity plans have achieved the full potential for generic substitution, mail service market penetration, or channeling of beneficiaries into preferred provider arrangements.

Limitations of the Study

This study focuses on the cost savings that can be accomplished through PPO and mail service discounts, and through generic substitution. Managed care also addresses quality of care, including drug utilization review, information systems that integrate treatment profiles from medical and pharmacy providers, and provider education. This study does not evaluate the success of such programs.

A second limitation of this study is that we estimate cost savings using relative rather than absolute terms. The number of prescriptions per person will vary widely from plan to plan depending on plan demographics, community practice patterns, and beneficiary cost sharing. For example, one national card plan reports that the average number of prescription fills per year is 15 for an over-65 population, but one large retiree medical plan is reporting 30 per year. Similar issues occur in considering the average supply and average charges per prescription. Rather than attempt to define national standards for these parameters that vary from plan to plan, we have stated them as assumptions and calculated savings in percentage terms.

The second data base was that of a national card program with comprehensive benefits. This data base was not appropriate for estimating retail pricing or generic substitution, but it furnished better estimates of the average days supply of acute care and maintenance medications that occur when comprehensive pharmacy benefits are delivered in a community pharmacy setting. Taken together, these data bases yielded the profile of baseline 1992 retail costs presented in Table 1. This scenario indicates a generic substitution rate of just over 19 percent, and a relationship between AWP and retail prices that is closely approximated by the following formula:

Retail price = (AWP x 1.0825) + $4.00

This baseline model assumes an average of 7.5 prescription fills annually per covered person. This utilization rate is based on a population that includes both active employees and retirees, minimal cost sharing, and full submission of claims into the reporting system. Based on this level of utilization, the model projects a 1992 annual retail claims cost of $241.12 per person. This baseline cost serves as a benchmark for evaluating the savings of PPO and mail service delivery systems.

PPO Savings

Although the PPO market for prescription drug benefits is still evolving, substantial savings are currently available. Of course the network with the best discount may not offer sufficient geographic coverage, a commitment to generic substitution, or good performance on various other measures related to cost and quality. The discount level we selected for the PPO model is available from several national vendors with good records of performance on these measures.

The reimbursement formula used for the PPO models is as follows:

Prescription payment = (AWP -10%) + $2.75

This payment formula yields total savings of 18.6 percent when compared to prescription drugs purchased for a similar population in a retail environment (Table 2). This savings is accomplished on the basis of price discounts alone – the generic substitution rate is held constant at the same level used for the retail model.

When generic drugs are substituted for trade drugs, the savings can be enhanced as demonstrated by Table 3. In this model the average AWP for multisource trade drugs is $21.96 compared to an average of $8.15 for generic substitutes. Even after the PPO's dispensing fee is taken into account, the plan cost of a multi-source trade drug is still more than twice the cost of the generic substitute. Table 3 shows the impact of increasing the generic substitution by just seven percentage points above the 19.3 percent baseline rate of Table 2. This scenario produces savings of 21.2 percent compared to the 18.6 percent PPO savings based on price discounts alone.

Mail Service Savings

About 65 percent of all prescriptions and over 80 percent of the total prescription days supplied by our modeled plans are for maintenance medications. These are medications required on a long-term basis to treat chronic conditions such at diabetes, hypertension, and arthritis. Mail service plans can do little to address the costs of acute medications, but these plans do offer considerable savings for chronic medications.

Mail service savings result from deep price discounts, reduced dispensing fees, dispensing prescriptions in larger quantities, generic substitution, and the elimination of separate charges for claims administration. Table 4 indicates an 11.1 percent mail service savings in claims costs compared to the retail baseline. This mail service scenario is premised on a blend of retail and mail service delivery systems, with half of the

TABLE 2
1992 COST PER PERSON IN A PPO

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
PPO							
Acute Single Source	11.6%	0.9	35.52	34.72	11.0	9.6	30.19
Acute Multisource	13.4%	1.0	15.55	16.75	11.0	11.0	16.78
Acute Generic	10.0%	0.8	7.31	9.33	11.0	8.3	7.03
Total Acute	35.0%	2.6	19.80	20.57		28.9	54.00
Maint Single Source	42.5%	3.2	34.21	33.54	30.0	95.7	106.95
Maint Multisource	13.2%	1.0	27.89	27.85	30.0	29.7	27.59
Maint Generic	9.3%	0.7	9.10	10.94	30.0	20.9	7.61
Total Maintenance	65.0%	4.9	29.34	29.16		146.3	142.15
Total Single Source	54.1%	4.1	34.49	33.79	25.9	105.2	137.14
Total Multisource	26.6%	2.0	21.68	22.27	20.4	40.7	44.38
Total Generic	19.3%	1.4	8.17	10.10	20.1	29.1	14.64
Total	100.0%	7.5	26.00	26.15	23.4	175.1	196.15
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail				-18.6%			-18.6%

PPO Reimbursement = AWP - 10% + $2.75

TABLE 3
1992 COST PER PERSON IN A PPO
WITH 7% INCREASE IN GENERIC SUBSTITUTION

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
PPO							
Acute Single Source	11.6%	0.9	35.52	34.72	11.0	9.6	30.19
Acute Multisource	9.3%	0.7	15.55	16.75	11.0	7.7	11.73
Acute Generic	14.1%	1.1	7.31	9.33	11.0	11.6	9.84
Total Acute	35.0%	2.6	18.86	19.72		28.9	51.76
Maint Single Source	42.5%	3.2	34.21	33.54	30.0	95.7	106.95
Maint Multisource	10.1%	0.8	27.89	27.85	30.0	22.7	21.12
Maint Generic	12.4%	0.9	9.10	10.94	30.0	27.8	10.15
Total Maintenance	65.0%	4.9	28.45	28.35		146.3	138.22
Total Single Source	54.1%	4.1	34.49	33.79	25.9	105.2	137.14
Total Multisource	19.5%	1.5	21.96	22.52	20.9	30.5	32.85
Total Generic	26.4%	2.0	8.15	10.08	19.9	39.4	19.99
Total	100.0%	7.5	25.09	25.33	23.4	175.1	189.98
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail			-3.5%	-21.2%			-21.2%

PPO Reimbursement = AWP - 10% + $2.75

TABLE 4
1992 COSTS FOR RETAIL WITH MAIL OPTION

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPO $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	14.3%	0.9	35.52	42.45	11.0	9.6	36.92
Acute Multisource	16.5%	1.0	15.55	20.63	11.0	11.0	20.68
Acute Generic	12.4%	0.8	7.31	11.91	11.0	8.3	8.97
Total Acute	43.3%	2.6	19.80	25.44		28.9	66.77
Maint Single Source	26.3%	1.6	34.21	41.03	30.0	47.6	65.42
Maint Multisource	8.2%	0.5	27.69	34.19	30.0	14.9	16.94
Maint Generic	5.7%	0.3	9.10	13.65	30.0	10.4	4.62
Total Maintenance	40.2%	2.4	29.34	35.76		73.1	87.16
MAIL							
Maint Single Source	10.6%	0.7	83.2	74.92	73.0	47.6	49.09
Maint Multisource	1.5%	0.1	67.9	61.54	73.0	6.6	5.77
Maint Generic	4.2%	0.3	22.1	21.76	73.0	18.4	5.50
Total Maintenance	16.5%	1.0	66.39	60.26		73.1	60.36
SUMMARY							
Total Single Source	51.4%	3.1	44.66	48.55	33.7	105.2	151.43
Total Multisource	26.2%	1.6	22.47	27.39	20.6	32.7	43.59
Total Generic	22.3%	1.4	10.54	14.25	27.5	37.2	19.29
Total	100.0%	6.1	31.33	35.34	28.9	175.1	214.3
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail		-19.1%	20.5%	9.9%	23.7%		-11.1%

Retail Price = AWP + 6.25% + $4.00 Fee
Mail Reimbursement = AWP - 13% + $2.50
50% MAIL SERVICE PENETRATION OF MAINTENANCE MARKET

maintenance medications and all acute medications still delivered through traditional retail channels. Although mail order supplies only 73.1 of the 175.1 prescription days per capita under this scenario, the plan and beneficiary share a substantial savings.

The discounts available through mail service plans are generally the best in the industry, with the reimbursement formula used here rather typical:

Reimbursement = (AWP -13%) + $2.50

The 13 percent discount from AWP is very favorable compared to the discounts available from community pharmacies, and the fixed dispensing fee is spread over a longer average days supply. In this mail service model, the maintenance medications dispensed through mail service average a 73 day supply compared to an average supply of 30 days dispensed in the retail community pharmacy setting. Although a lower percentage of maintenance medications have generic substitutes, many mail service firms have a good reputation for making such substitutions whenever possible. In this model, the mail service firm is able to substitute generics 25 percent of the time for maintenance medications compared with a 14 percent generic substitution rate for maintenance medications dispensed through retail channels.

Integrated PPO/Mail Service Plans

Table 5 illustrates the potential savings in claims costs that can be achieved by integrating the PPO and mail service options. Mail service can furnish convenience and maximum price discounts to beneficiaries who are dependent on maintenance medications, while the PPO can furnish the acute medications and initial fills for maintenance prescriptions. Some health plans boost the use of mail order by requiring that all maintenance medications after the first fill be through mail service.

TABLE 5
1992 COSTS FOR INTEGRATED PPO WITH MAIL SERVICE

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	PPC $/ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	14.3%	0.9	35.52	34.72	11.0	9.6	30.19
Acute Mult-Source	11.6%	0.7	15.55	16.75	11.0	7.7	11.73
Acute Generic	17.4%	1.1	7.31	9.33	11.0	11.6	9.64
Total Acute	43.3%	2.6	18.66	19.72		28.9	51.76
Maint Single Source	26.3%	1.6	34.21	33.54	30.0	47.6	53.46
Maint Multi-Source	6.3%	0.4	27.69	27.65	30.0	11.4	10.56
Maint Generic	7.7%	0.5	9.10	10.04	30.0	13.9	5.06
Total Maintenance	40.2%	2.4	28.45	28.35		73.1	69.11
MAIL							
Maint Single Source	10.6%	0.7	83.2	74.92	73.0	47.6	49.09
Maint Multi-Source	1.5%	0.1	67.9	61.54	73.0	6.6	5.77
Maint Generic	4.2%	0.3	22.1	21.76	73.0	16.4	5.50
Total Maintenance	16.5%	1.0	66.39	60.26		73.1	60.36
SUMMARY							
Total Single Source	51.4%	3.1	44.66	42.56	33.7	105.2	132.76
Total Multi-Source	19.4%	1.2	23.72	23.91	22.1	25.9	28.06
Total Generic	29.2%	1.6	9.90	11.53	24.6	44.0	20.42
Total	100.0%	6.1	30.56	29.89	28.9	175.1	181.2
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Retail		-19.1%	17.5%	-7.0%	23.7%		-24.8%

PPO Reimbursement = AWP - 10% + $2.75
Mail Reimbursement = AWP - 13% + $2.50
50% of maintenance medications through mail service
29% of prescriptions filled with generics

The integrated PPO/mail service model presented in Table 5 incorporates the PPO and mail service discounts described above, as well as relatively high generic substitution in both settings. Overall, this integrat .d plan is achieving a generic substitution rate of 29.2 percent; it is supplying half of total maintenance medications through mail service, and saving 24.8 percent of claim costs for the plan sponsor and beneficiary when compared to the retail baseline of Table 1.

Prescription Drug Benefits under an Indemnity Plan

Both the PPO and mail service approaches can offer a comprehensive prescription drug benefit to covered persons while achieving savings through price discounts and generic substitution. These managed care plans often offer a richer benefit than that offered under a traditional major medical plan. Today's typical indemnity plan has an individual deductible of $200 and a family deductible of $400. Consequently, many prescription drug claims fall below the deductible. After the deductible is satisfied, the plan typically pays 80 percent of covered charges up to an out-pocket-maximum of $1,000 per individual and $2,000 per family.

Moreover, the traditional indemnity plan normally requires the beneficiary to pay for the prescription and submit a paper claim for reimbursement. This fosters the shoebox and hesitancy effects that are estimated to reduce claims submissions by 30 to 40 percent. Table 6 illustrates the 35 percent reduction in submitted charges that might result simply from these two factors. This apparent plan "savings" is greater than that modeled in any of the managed care scenarios. Under this scenario, savings result from decreasing utilization and shifting costs to beneficiaries through the shoebox effect.

TABLE 6
1992 SUBMITTED CHARGES UNDER AN INDEMNITY PLAN

	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	RETAIL$ Rx	DAYS/ Rx	DAYS/ PERSON	COST/ PERSON
RETAIL							
Acute Single Source	11.6%	0.6	35.52	42.45	11.0	6.2	24.00
Acute Multisource	13.4%	0.7	15.55	20.83	11.0	7.2	13.57
Acute Generic	10.0%	0.5	7.31	11.91	11.0	5.4	5.83
Total Acute	35.0%	1.7	19.80	25.44		18.8	43.40
		0.0					
Maint Single Source	42.5%	2.1	34.21	41.03	30.0	62.2	85.05
Maint Multisource	13.2%	0.6	27.89	34.19	30.0	19.3	22.02
Maint Generic	9.3%	0.5	9.10	13.85	30.0	13.6	6.26
Total Maintenance	65.0%	3.2	29.34	35.76		95.1	113.33
		0.0					
Total Single Source	54.1%	2.6	34.49	41.34	25.9	68.4	109.05
Total Multisource	26.6%	1.3	21.68	27.47	20.4	26.5	35.59
Total Generic	19.3%	0.9	8.17	12.84	20.1	18.9	12.09
Total	100.0%	4.88	26.00	32.15	23.4	113.8	156.73
Retail Baseline	100.0%	7.5	26.00	32.15	23.4	175.1	241.12
Pct. Change from Baseline		-35.0%				-35.0%	-35.0%

Retail Price = AWP + 8.25% + $4.00

Assumes no incentives for generic substitution.

$200 deductible and 20% beneficiary cost sharing above deductible.

Mandate 1: Any Willing Pharmacy Provider

Background

These laws would require a managed care pharmacy plan sponsor to establish a specific, objective set of criteria for selection of participating pharmacies and to allow any pharmacy that met these criteria to participate. The underlying premise for analyzing the claims impact of this provision is that expanding the percentage of pharmacies in the PPO will lead pharmacies to offer less of a discount than they would if they anticipated that network beneficiaries would be directed to a more limited pharmacy network.

From a purely economic perspective, an independent pharmacy or chain elects to participate in a PPO based on:

(1) the anticipated number of new prescriptions that will be channeled to the pharmacy, and

(2) the proportion of current business that the pharmacy anticipates losing if no discount is offered (if beneficiaries are free to go out-of-network, then the pharmacy might attempt to retain this business at the non-discounted retail price).

Based on differing levels of pharmacy participation, Wyatt developed an economic model that projects the extent to which the PPO savings described in the previous section would be eroded by an "any willing pharmacy provider" mandate. This model demonstrates that there is a point at which further expansion is not economically feasible for either the health insurance plan or the pharmacy providers.

Methodology

The model is based on several assumptions that determine the point at which the PPO network arrangement is no longer viable to the insurer or the pharmacies, but the exact point is not the essential finding of this model. The important finding of this exercise is that such a point exists, and the viability of PPO networks is threatened by laws that promote unrestricted network growth.

Wyatt constructed a pharmacy revenue requirement model and analyzed pharmacy behavior toward a typical PPO network with 30 percent of a market's prescriptions. The model assumes that 40 percent of the community pharmacies participate under Scenario 1 -- a scenario that presumes adequate geographic accessibility together with a discount from retail of 18.6 percent. (Table 7) This discount is based on actual market observations, and is consistent with the PPO models presented in the previous section. It is assumed that pharmacies wish to maintain their current average net margins, and that pharmacies have an unlimited capacity to fill prescriptions in order to meet demand.

Scenario 1 represents the best estimate of current pharmacy participation levels in operation today. Scenario 4 depicts the worst-case scenario in which all pharmacies participate in the network, while Scenarios 2 and 3 fall between these extremes. Network pharmacies gain no market share under Scenario 4, and it is no longer in their best interest to offer the network a discount. The value of out-of-network benefits on line 17 assumes the availability of a major medical plan which covers prescription drugs at an 80 percent level of reimbursement.

Conclusions

Under Scenario 1, the 18.6 network discount yields an overall claims cost reduction of 17.7 percent, because 5 percent of claims are out of network and discounted. Claims

TABLE 7
PPO MARKET SHARE
NETWORK SIZE, AND CLAIMS SAVINGS

	Key Steerage Assumptions	Scenario 1	Scenario 2	Scenario 3	Scenario 4
1.	Percentage of Prescriptions filled in Network	30.0%	30.0%	30.0%	30.0%
2.	Percentage of Pharmacies in Network	40.0%	60.0%	80.0%	100.0%
3.	Network Prescriptions from New Claimants	18.0%	12.0%	6.0%	0.0%
4.	Network Prescriptions from Known Claimants	12.0%	18.0%	24.0%	30.0%
	Modeling Detail				
5.	Pharmacy's Current Prescriptions per Year	100,000	100,000	100,000	100,000
6.	Non-Network Prescriptions	88,000	82,000	76,000	70,000
7.	Network Prescriptions from New Claimants	18,000	12,000	6,000	0
8.	Network Prescriptions from Known Claimants	12,000	18,000	24,000	30,000
9.	Potential Prescriptions (lines 5 & 7)	118,000	112,000	106,000	100,000
10.	1992 Retail Charge Per Prescription	$32.15	$32.15	$32.15	$32.15
11.	1992 Network Charge Per Prescription	$26.17	$28.16	$30.16	$32.15
12.	Effective Discount (from Table 2)	18.6%	12.4%	6.2%	0.0%
13.	Network Use	95.0%	95.0%	95.0%	95.0%
14.	Network Co-Pay	15.0%	15.0%	15.0%	15.0%
15.	Value of Network Benefits	85.0%	85.0%	85.0%	85.0%
16.	Out-of-Network Use	5.0%	5.0%	5.0%	5.0%
17.	Value of Out-of-Network Benefits	80.0%	80.0%	80.0%	80.0%
18.	Reimbursement - Plan	69.7%	74.7%	79.7%	84.8%
19.	Reimbursement - Member	12.6%	13.5%	14.4%	15.3%
20.	Reimbursement - Combined	82.3%	88.2%	94.1%	100.0%
21.	Claims Cost Reduction	17.7%	11.8%	5.9%	0.0%

cost reductions evaporate as the network grows to include all pharmacies (Scenario 4), because participating pharmacies can no longer anticipate increased market share.

Table 8 shows that plan savings are further reduced due to the fixed costs of network administration. In this example, the marginal value of the network discount to the plan and plan member is 16.7 percent for Scenario 1, and -1.0 percent for Scenario 4. Under this worst case scenario, the incentive for pharmacies to grant a discount has disappeared, but fixed costs of network administration remain.

Mandate 2: Benefit Differentials

Background

Some states have placed restrictions on the maximum difference in benefit payments for drugs dispensed by participating and nonparticipating pharmacies. Such provisions may deflate the purchasing power of PPO plan sponsors by limiting their ability to steer beneficiaries to participating providers, thereby reducing the economic value of the contractual relationship between the sponsor and the pharmacy. The most common mandate, which applies not only to pharmacy but to PPO arrangements in general, limits the payment levels between in-network and out-of-network benefits to no more than 20 percent.

In the case of pharmacy PPOs, this mandate is particularly troublesome. It not only threatens the ability of the plan sponsor to steer beneficiaries to network pharmacies, it also presents administrative complexities in determining whether the plan is in compliance. Unlike the networks that are common for other medical services, a typical pharmacy network requires a fixed copayment per prescription. Nonnetwork prescriptions are either not covered at all or are covered under a traditional indemnity plan. If covered under an

TABLE 8
IMPACT OF ANY WILLING PROVIDER MANDATE ON MARGINAL VALUE OF PPO

	Non-PPO Model	PPO Scenarios 1	2	3	4
Network: % Pharmacies	N/A	40.0%	60.0%	80.0%	100.0%
Claims Cost Reduction	N/A	17.7%	11.8%	5.9%	0.0%
Network Adm.	N/A	$2,363	$2,363	$2,363	$2,363
Marginal Value of PPO with 15% Base Retention					
Projected Claims	$241,125	$198,518	$212,720	$226,923	$241,125
Projected Premiums	$283,676	$236,331	$253,040	$269,748	$286,457
% Non-PPO Premium	100.0%	83.3%	89.2%	95.1%	101.0%
Marginal Value	N/A	16.7%	10.8%	4.9%	-1.0%

Assumptions:

- o Network administrative expense = 1% of premium income
- o 1,000 subscribers
- o 7.5 prescriptions per year
- o Full retail cost = $32.15/prescription

indemnity plan, beneficiary cost sharing depends on whether the deductible has been met and on the level of coinsurance required by the indemnity plan. In short, it may be difficult to determine whether one plan is richer than the other, and the answer to this question may differ depending on the size of the prescription and whether the indemnity deductible has been satisfied.

Recently, some network plans have been implementing substantial benefit differentials based on traditional cost sharing arrangements. Some of these plans take advantage of point-of-service technologies to pay in-network services under the provisions of a major medical plan that includes a deductible and 80 percent coverage of in-network services, while some plans are keeping network drug benefits in a carveout plan with its own deductible and a beneficiary coinsurance requirement of 10 to 20 percent. In either of the new arrangements, nonnetwork prescription fills might require up to 50 percent coinsurance.

Methodology

In our previous study of state benefit mandates we examined the impact of benefit differentials between in-network and out-of-network services. At that time we surveyed actuarial opinion concerning the differentials that are considered optimal to encourage use of network providers, and we developed a model that was applied to the full range of medical benefits. We are not aware of studies that have examined this dynamic as it applies to pharmacy benefits, although we are aware from discussions with industry sources that a 30 percent benefit differential is considered strong enough to move 95 percent of utilization into the network when the network offers good geographic coverage.

Consequently, we borrowed the benefit differential model from our previous study to compare the impact of moving from a 30 percent benefit differential to 20 percent and

15 percent differentials. The estimates from this model are illustrative because controlled research on beneficiary response to these pharmacy reimbursement options has not been performed.

Conclusions

Modeied estimates of three levels of pharmacy benefit differential are presented in Table 9. In this model, the 30 percent benefit differential between in-network and out-of-network services corresponds with the level of PPO savings developed in Table 2. Under this scenario the plan and beneficiary share the advantages of an 18.6 percent network discount, and the 30 percent benefit furnishes sufficient incentive to channel 95 percent of utilization into network pharmacies. The result of this arrangement is that the plan and beneficiary together pay 82.3 percent of what they would have paid in the unmanaged retail setting.

The model suggests that moving to a 20 percent differential would reduce utilization of network pharmacies from 95 percent of the total to 88.9 percent. Assuming that the same discounts can be retained for in-network services, this would increase the sum of plan and member payments to 83.5 percent of the baseline retail level of Table 1. A benefit differential of only 15 percent would reduce network utilization to 85.6 percent of total prescriptions and increase average pharmacy payments to 84.1 percent of the retail level.

All of this assumes that decreases in network utilization would not result in a reduction of the discount that network pharmacies are willing to offer. This is contrary to the findings of Tables 7 and 8, which demonstrate that it is not in the economic interest of pharmacies to offer discounts unless they are able to anticipate an increase in market share. Consequently, reducing the benefit differential would not only increase plan and beneficiary costs due to increased payments for out-of-network services, it would tend to reduce the

TABLE 9

IMPACT OF BENEFIT DIFFERENTIALS ON TOTAL REIMBURSEMENT

	30% Differential (Baseline)		20% Differential		15% Differential	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Network Savings	16.6%	0.0%	18.6%	0.0%	16.6%	0.0%
Network Use	95.0%	5.0%	88.9%	11.1%	85.6%	14.4%
Value of Network Benefits	90.0%	60.0%	90.0%	70.0%	90.0%	75.0%
Reimbursement - Plan		72.6%		72.9%		73.5%
Reimbursement - Member		9.7%		10.6%		10.6%
Reimbursement - Total		82.3%		83.5%		84.1%
Change from Baseline		0.0%		-1.1%		-1.7%

discounts offered by network pharmacies. Finally, no administrative cost impact -- a potentially significant factor -- was estimated for this mandate.

Mandate 3: Same State License

Background

In an extreme form, same state licensure would mean that the dispensing pharmacy must be located within the state's boundaries, a condition that would severely limit the ability of mail service providers to offer the discounts they currently offer. In less extreme forms, the state might require that at least one pharmacist in the mail order facility be licensed in the state to which the prescription is sent, and that a defined set of facility standards be met. The immediate and intended effect would be to eliminate mail service pharmacies from competing on an equal footing with retail pharmacies.

From a consumer perspective, it is clear that mail service firms have been an important factor in introducing competition into the retail market. With 65 percent of prescriptions and an even higher percentage of total days supply in the maintenance medication category, there is considerable potential for mail service. Mail service is especially important to vulnerable populations such as the elderly and disabled. These populations use a high percentage of the total maintenance medications dispensed through mail service. For many of these users, mail service furnishes not only a means of reducing their costs but also a convenient way to receive their medications on a routine basis.

Methodology

To demonstrate the importance of mail service pharmacies to special populations, we constructed 5 scenarios that show mail service savings compared to the retail baseline

for a retired population. In the baseline retail environment, these retirees average 15 prescriptions per year and 70 percent of all prescriptions are for maintenance medications.

Conclusions

Same state licensing requirements would increase the operating costs of mail service pharmacies and narrow the cost advantage they offer in comparison to community pharmacies. A same state licensure law that required a mail pharmacy to locate within the state of the beneficiary would be a costly requirement for even the largest mail service firms. Less onerous licensing requirements would impose considerably less compliance costs.

Table 10 illustrates the range of savings that might be lost to a retired group making regular use of mail service. When 90 percent of maintenance medications are furnished under the mail discount the prescription drug expense for these retirees is reduced by 21.2 percent. In this example, mail service alone produces savings of more than $100 per retiree each year.

The mail service savings would be even greater for populations that use more prescriptions, or for plans that have negotiated better discounts. As noted above, some retiree groups use as many as 30 prescriptions per retiree per year. The discount arrangement assumed in Table 10 is widely available (AWP -13% plus a fee of $2.50). One national medical plan recently negotiated a mail service discount of AWP -22% with no dispensing fee.

Although substantial savings might also be obtained through negotiations with community pharmacy networks, mail service fills some special needs that are poorly served through network arrangements. Retired and disabled persons in rural areas, retirees who

TABLE 10
1992 COSTS PER RETIREE WITH
VARIOUS LEVELS OF MAIL SERVICE PENETRATION OF MAINTENANCE DRUG MARKET

MAIL SERVICE SHARE OF ALL MAINTENANCE DRUGS DISPENSED	PCT OF FILLS	FILLS/ PERSON	AWP $/ Rx	REIMB $/ Rx	DAYS/ Rx	DAYS/ PERSON	Rx/ PERSON	PCT SAVINGS
90% MAIL	1.000	9.4	40.04	40.92	38.6	364.5	386.04	21.2%
70% MAIL	1.000	10.7	35.81	38.34	34.2	364.5	409.14	16.5%
50% MAIL	1.000	11.9	32.45	36.30	30.6	364.5	432.24	11.8%
30% MAIL	1.000	13.1	29.73	34.64	27.7	364.5	455.34	7.1%
10% MAIL	1.000	14.4	27.47	33.27	25.3	364.5	478.44	2.4%
0% MAIL (Full Retail Baseline)	1.00	15.00	26.48	32.67	24.3	364.5	489.99	0.0%

Assumptons:

78% of prescriptions in baseline retail setting are for maintenance medications.
Utilization averages 15 prescriptions per retiree in baseline retail setting.
Retail service maintenance prescriptions average 30 days and mail service averages 73 days.

move out of state when they retire, and retirees who move south each winter are all problematic for health plans. It is difficult to obtain network discounts for these people because they represent only a small portion of the market in the areas which they reside. Moreover, those with disabilities can benefit greatly from the convenience of mail delivery.

The indirect effect of restricting mail service programs could be the most significant impact of a same state license mandate. Community pharmacies might be far less willing to offer discounts if they perceive that mail service firms are no longer competitive.

Overall Conclusions

Managed care arrangements for prescription drugs, as for other medical benefits, give health care consumers the opportunity to obtain better value for the money they spend in the health care market place. PPO and mail service programs generally furnish beneficiaries more prescription drugs for less cost -- and they do so with an emphasis on quality and convenience. The information systems developed through these programs are opening new opportunities for monitoring, managing and improving the quality of care that beneficiaries receive. For the first time it is possible to link the detailed prescription drug data with medical claims -- creating important opportunities for coordinating the care of medical providers; informing patients and physicians when there are contraindications for the drugs prescribed; and educating physicians and patients.

Prescription drugs can no longer be viewed as an inconsequential part of the medical plan -- they represent major expenditures, particularly for retirees. In many ways the question is not whether the health plan should be able to pursue managed care opportunities, but whether employers will be able to continue funding medical benefits that are not managed. The new financial accounting standard for retiree medical plans is especially pertinent here, because employers must find a way to address this large cost that will be such a major factor in their profitability.

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Alaska

Individual Enrollment Application

Thank you for selecting Blue Cross of Washington and Alaska for your health care coverage needs. To expedite the processing of your application, please take a moment to make sure the following steps have been completed before you submit your application. Omission of, or incomplete information will result in return of the application and may delay the effective date of coverage.

- Have you signed and dated the application on page 5?
- Did you indicate your program selection?
- Have you answered all enrollment and health questions?
- Did you provide related explanations, dates, and physician names for those medical conditions checked "Yes" on page 2 of the application?
- Did you complete page 3? (Complete only if you wish to have your subscription charges debited monthly from your bank account.) If you do not want to participate in the Automatic Bank Charge program, please detach and discard page 3.
- Individuals eligible for Medicare may not apply for health care coverage programs offered in this application. Upon eligiblity for Medicare, however, individuals may apply for a Medicare Supplement contract offered by Blue Cross of Washington and Alaska, provided you are enrolled on Medicare Part A and Part B.

Individual Enrollment Application

Blue Cross
of Washington and Alaska
An Independent Licensee of the Blue Cross and Blue Shield Association

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. Omissions or incomplete answers may delay the effective date of coverage. Please print. *You are welcome to submit medical records to clarify any condition.* ***Remember to sign page 5. Applications submitted without the applicant's signature will be returned.***

EFFECTIVE DATE If approved, your effective date will be the first day of the month following receipt of your application by Blue Cross of Washington and Alaska unless you specify an alternate date below.

(An alternate effective date must be: 1. within 60 days of the date you signed the application, and 2. at least two days after the application was postmarked.) Alternate effective date (optional): Month ____________ Day _______ Year ______

The effective date is activated after the application is approved and complete and correct payment is received by Blue Cross.

APPLICANT INFORMATION

Last Name	First	Middle Initial	Social Security Number			
Address of Residence			Sex ☐ Male ☐ Female	Birthdate Mo. Day Yr.	Height Ft. In.	Weight
City	State	Zip Code	Home Phone Number ( )			
Mailing/Billing Address (if different than residence address)			Work Phone Number ( )			
			Occupation/Industry Applicant: Spouse:			

LEGAL SPOUSE AND DEPENDENTS TO BE COVERED

Everyone listed must be under age 65. Only unmarried children under age 23 who are primarily dependent on you for support are eligible to apply for coverage as a dependent:

Last Name	First	Middle Initial	Sex	Relationship to above applicant	Birthdate Mo.	Day	Yr.	Height Ft.	In.	Weight	Social Security Number
			☐ Male ☐ Female								
			☐ Male ☐ Female								
			☐ Male ☐ Female								
			☐ Male ☐ Female								
			☐ Male ☐ Female								

MEDICARE INFORMATION:

Individuals eligible for Medicare may not apply for health care coverage programs offered in this application.

TYPE OF APPLICATION (check one):

1. ☐ New Applicant (not currently enrolled in an Individual Program)
2. ☐ Program Change
3. ☐ Inter-Plan Transfer (Transfer from another Blue Cross/Blue Shield Plan)

SELECT PAYMENT MODE:

1. ☐ Monthly Payment by Automatic Bank Charge (A.B.C.)
2. ☐ Bill me for 2 months payment every other month

PROGRAM OPTIONS (select one):

☐ Traditional $200 Deductible
☐ Traditional $500 Deductible
☐ Traditional $1,000 Deductible
☐ Traditional $2,500 Deductible
☐ BasicOne $500 Deductible
☐ BasicOne $1,000 Deductible
☐ ____________________
☐ ____________________

TOBACCO USE INFORMATION:

(a) I (☐ have ☐ have not) used any tobacco products during the 12 months immediately preceding the date of this application.
(b) My spouse (if included on this application) (☐ has ☐ has not) used any tobacco products during the 12 months immediately preceding the date of this application.

ALASKA ONLY: Dental/Vision/Hearing coverage is available to Alaska residents **only.** I request additional information and an enrollment application. ☐ Yes ☐ No

FOR COMPANY USE ONLY

Agent Number [| | | |] Group Number [| | | | | |] Effective Date Mo | Day | Yr.

Have you or any family member listed on this application EVER had, been advised of, diagnosed with, received treatment or had treatment recommended for any of the following conditions? (Also be certain to complete height and weight information requested on page 1.)

Please check each item either YES or NO.	☐ Yes	○ No
Alcohol or Drug Abuse		
1. Alcohol or Drug Abuse	☐	○
2. DWI Violations	☐	○
Blood Disorders		
3. Anemia	☐	○
4. Leukemia	☐	○
Congenital Conditions		
5. Congenital Disorder/Defect	☐	○
Ear, Nose or Throat Conditions		
6. Ear Infections Number in past 12 months ____	☐	○
7. Hearing Impairment	☐	○
8. Nasal Malformation	☐	○
9. Deviated Nasal Septum	☐	○
10. Sinus Disorder	☐	○
Eye Injury or Disorders		
11. Crossed Eyes	☐	○
12. Detached Retina	☐	○
13. Cataract(s)	☐	○
14. Glaucoma	☐	○
Gastrointestinal Conditions		
15. Gallbladder Disorder/Gallstones	☐	○
16. Hernia	☐	○
17. Hiatal Hernia	☐	○
18. Ulcers	☐	○
19. Colitis	☐	○
20. Ulcerative Colitis	☐	○
21. Crohn's	☐	○
22. Other Stomach, Intestine, Bowel or Rectal Disorder	☐	○
Glandular or Hormonal Disorders		
23. Diabetes	☐	○
24. Goiter	☐	○
25. Thyroid Disorder	☐	○
Growths (Benign or Malignant)		
26. Cysts	☐	○
27. Tumors	☐	○
28. Cancer	☐	○
29. Polyps	☐	○
Heart Conditions		
30. Heart Murmur	☐	○
31. Irregular Heartbeat	☐	○
32. Valve Problem	☐	○
33. Rheumatic Fever	☐	○
34. Chest Pain	☐	○
35. Heart Attack	☐	○
Immune Disorders		
36. Acquired Immune Deficiency Syndrome (AIDS)	☐	○
37. HIV+ or AIDS Related Complex	☐	○
Liver Conditions		
38 Hepatitis	☐	○
39. Cirrhosis	☐	○
Musculoskeletal Conditions		
40. Arthritis (indicate type)	☐	○
41. Gout	☐	○
42. Lupus	☐	○
43. Joint Disorder (Indicate joint involved)	☐	○
44. Back, Neck or Spinal Column Disorder/Chiropractic Adjustments	☐	○
45. Fractures (indicate which limb(s) and location of any screws, pins or plates)	☐	○
46. Dislocations	☐	○
47. Muscular Dystrophy	☐	○
48. Polio	☐	○
49. Loss of Limb(s)	☐	○
50. Bone Disorders	☐	○
Nervous or Emotional Conditions		
51. Schizophrenia	☐	○
52. Attempted Suicide	☐	○
53. Depression	☐	○
54. Anorexia/Bulimia	☐	○
55. Attention Deficit Hyperactivity Disorder	☐	○
Neurological Conditions		
56. Paralysis	☐	○
57. Stroke/TIA	☐	○
58. High Blood Pressure (indicate most current reading)	☐	○
59. Epilepsy/Seizures	☐	○
60. Headaches (recurrent or migraine)	☐	○
61. Multiple Sclerosis	☐	○
62. Cerebral Palsy	☐	○
63. Parkinson's	☐	○
64. Mental Retardation	☐	○
Reproductive System Conditions		
65. Enlarged Prostate/Prostatitis	☐	○
66. Menstrual Irregularity/Disorder	☐	○
67. Fibroid Uterus	☐	○
68. Abnormal Pap Smear	☐	○
69. Ovarian Cyst	☐	○
70. Breast Disorder/Fibrocystic Breast Disease	☐	○
71. Currently Pregnant?	☐	○
Respiratory Conditions		
72. Allergies/Hay Fever	☐	○
73. Pulmonary Embolism	☐	○
74. Asthma	☐	○
75. Emphysema	☐	○
76. Chronic Bronchitis	☐	○
Sexually Transmitted Diseases		
77. Genital Herpes	☐	○
78. Gonorrhea	☐	○
79. Chlamydia	☐	○
80. Syphilis	☐	○
81. Venereal Warts	☐	○
Skin Conditions		
82. Cystic Acne	☐	○
83. Psoriasis	☐	○
84. Severe Burns/Scars	☐	○
Urological System Conditions		
85. Bladder Infections	☐	○
86. Kidney Infections/Kidney Stones	☐	○
87. Kidney Failure	☐	○
Vein or Artery Conditions		
88. Aneurysm	☐	○
89. Clots	☐	○
90. Poor Circulation	☐	○
List any other condition not mentioned above:		
91.____________		
92.____________		

93. Are you or any listed family member currently taking any medication? Please list family member's name and name of drug(s).

____

____

94. If you have answered "Yes" to ANY of the questions 1 through 92, complete this section. Please provide complete details of the condition including cause of an injury and the specific location of a condition (e.g., left foot). Attach an additional sheet if necessary.

Item Number	Patient Name	When did you have this condition?	1. Diagnosis; 2. Treatment; 3. Medication and Dosage; 4. Nature of any further treatment; 5. Results	Were you Hospitalized?	Name and Phone Number of Doctor or Treatment Facility
		From: Mo.____ Yr.____ To: Mo.____ Yr.____	1. 2. 3. 4. 5.	☐ Yes ○ No	Name Phone Number ( )
		From: Mo.____ Yr.____ To: Mo.____ Yr.____	1. 2. 3. 4. 5.	☐ Yes ○ No	Name Phone Number ( )
		From: Mo.____ Yr.____ To: Mo.____ Yr.____	1. 2. 3. 4. 5.	☐ Yes ○ No	Name Phone Number ( )

Blue Cross
of Washington and Alaska
An Independent Licensee of the Blue Cross and Blue Shield Association

Customer Agreement
A.B.C. Monthly Payment Program

Please complete this form only if you wish to have subscription charges debited monthly from your bank account. (If you do not want to participate in the A.B.C. program, detach and discard this form.)

I hereby authorize Blue Cross of Washington and Alaska to initiate funds transfers from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

SUBSCRIBER NAME LAST		FIRST		MIDDLE
SUBSCRIBER ID NUMBER	ADDRESS STREET	CITY	STATE	ZIP
ACCOUNT HOLDER'S NAME	TYPE OF ACCOUNT ☐ Checking/Transaction ☐ Savings			
BANK or FINANCIAL INSTITUTION		CITY	STATE	ZIP
BANK TRANSACTION NUMBER		ACCOUNT NUMBER		

(Please indicate all dashes, spaces and zeros)

PLEASE ATTACH A DEPOSIT SLIP FROM THE ACCOUNT TO THIS FORM.

Please deduct my payment on: ☐ the 5th ☐ 20th of each month prior to my due date.
(CHECK ONE ONLY)

NOTE: If the automatic withdrawal date falls on a weekend or holiday, your deduction will be taken on the next business day.

ADDITIONAL TERMS AND CONDITIONS

I understand that 45 days are required to establish my automatic withdrawal, and that my health care coverage subscription charges must be paid in advance of my first debit.

This agreement will remain in effect until Blue Cross of Washington and Alaska has received a **written notice** from me that it should be cancelled. To ensure prompt cancellation of my A.B.C. program, this notice should be submitted at least **20 days prior to my next scheduled payment withdrawal.**

I have the right to stop payment of a specific transfer from my depository financial institution at least three days before the next scheduled payment date.

ACCOUNT HOLDER'S SIGNATURE

DATE SIGNED

BEFORE MAILING, PLEASE BE SURE THAT YOU:

1. **Attach** a deposit slip from your account.
2. **Confirm** with your bank that they will accept automatic withdrawals.
3. **Include** correct payment.
4. **Mark** the date on which you want your payment withdrawn.
5. **Keep** a copy of this form for your files and return the original.

120-2535 (3-96)

BASIC CONDITIONS OF ENROLLMENT

I, the undersigned, apply for enrollment with Blue Cross of Washington and Alaska (Blue Cross) for myself and family members listed. I certify that:

1. I have read this form, and I have supplied all of the requested information on this form. (If not, please attach a letter which explains why.)
2. **All statements and answers on this application are complete and true, and I understand that all entitlements to benefits are void if any statements or answers are found to be false or incomplete.**
3. No one listed on this application is eligible for Medicare. (Persons eligible for Medicare may apply for a Medicare Supplement contract offered by Blue Cross.)

I understand and agree that:

1. Coverage does not begin until this application is received, reviewed and accepted by Blue Cross and an effective date of coverage is assigned; and
2. Once approved, coverage does not begin until my complete and correct payment is received. Receipt of any money by Blue Cross prior to approval does not constitute coverage/enrollment under any Individual program.

I also understand and agree that Blue Cross may:

1. Accept this application, but exclude certain conditions by rider. A rider is a form which, when attached to the contract, becomes a part thereof, and lists medical conditions for which coverage is not available under the contract, for the person specified, based on his/her past medical history. If a rider is required for enrollment, I will be notified in writing. All riders will remain for the duration of the coverage, or will be reviewed, upon the subscriber's request, after a period of five years of continuous coverage; or
2. Deny this application; or
3. Cancel or modify my contract retroactively to its effective date if I have made intentionally false or misleading statements or answers on behalf of myself or any family members.

I also understand and agree that:

1. If accepted, this application becomes a part of my contract (a copy can be obtained upon request).
2. Further terms and conditions of enrollment are described in the contract.
3. Correct and complete payment of subscription charges must be made before benefits can be provided.
4. Any additions, deletions, or other alterations to the terms of conditions of enrollment are ineffective.

I also understand and agree that no soliciting agent may:

1. Accept risk for or waive any eligibility or underwriting requirements;
2. Make or modify the terms of the application or contract; or
3. Waive any of the Blue Cross rights or requirements.

I authorize any health care provider to furnish Blue Cross any and all records pertaining to medical history, services rendered, or treatment given to anyone making application, enrolled hereunder, or added hereafter. This authorization shall commence immediately and shall remain in effect as long as needed to enable Blue Cross to review, investigate or evaluate an application, a claim, or services to be provided or which have been provided.

I hereby authorize Blue Cross of Washington and Alaska to release to the agent any information including medical information obtained from me or any health care provider(s), pertaining to the medical history of myself or my family members, or this application for coverage.

If accepted, I authorize Blue Cross, at its option, to pay providers directly for services rendered.

If applying for BasicOne, I understand that any expenses applied toward the calendar year deductible of my previous Individual program will not be credited toward the calendar year deductible required under BasicOne, and that any benefits provided by my previous Individual program will not be used to determine any coinsurance amounts, benefit limits or maximums under BasicOne (unless directly transferring from another BasicOne program).

If transferring from another Blue Cross of Washington and Alaska Individual Program: I understand that I and all approved dependents may be transferred to the requested program and, once transferred, any existing riders previously assigned will still apply on the new program.

I ALSO UNDERSTAND THAT THE PROGRAM I AM APPLYING FOR WILL NOT COVER ME OR MY ENROLLED FAMILY MEMBERS FOR ANY CARE OR TREATMENT OF A PREEXISTING CONDITION AS DEFINED IN THE CONTRACT UNTIL 12 MONTHS AFTER MY EFFECTIVE DATE OF COVERAGE.

Waiting periods satisfied on current Blue Cross of Washington and Alaska Individual programs will be credited to the requested program. Any calendar year deductible satisfied and amounts applied toward benefit maximums will carry over to my new program on all transfers granted, with the exception of the BasicOne program.

If the applicant listed is denied coverage and the spouse is accepted, the spouse will assume the role of applicant for the purpose of coverage and agrees to and accepts all conditions of enrollment.

Have you received a product brochure containing benefit information and the exclusions and limitations of the Individual programs?

☐ Yes ☐ No

I certify that the information on this form is true, correct and complete.

Signature of Applicant/Subscriber (Parent/Legal Guardian, if minor) X ____________ **Date** ____________

Signature of Spouse (if applying) X ____________ **Date** ____________

FOR AGENT USE ONLY

AGENT CERTIFICATION

Completion of this section BY THE AGENT is required if the agent wishes to be considered the agent of record for this applicant.

All agent information must be provided below to ensure credit/commission for the application and to enable the agent to receive copies of correspondence.

1. Are you aware of any information not disclosed on this application relating to the health habits of the applicant which might have bearing on the risk? ☐ Yes ☐ No

2. Did you see the applicant at the time this application was completed? ☐ Yes ☐ No

If the answer is "YES" to question 1, and/or "NO" to question 2, please explain on a separate sheet.

Agent Name (Please Print) Shattuck & Grummett, Inc.			Agent Signature Shattuck & Grummett, Inc
Street Address 301 Seward Street Juneau, AK 99801			Blue Cross Agent Number #01627
City	State	Zip Code	Telephone Number

Juneau Empire 16 Mar 1998

Aetna buys New York Life Care

By KRISTAN HUTCHISON
THE JUNEAU EMPIRE

Most state employees' health insurance is switching back to Aetna.

Aetna is buying NYLCare Health Plans, less than a year after the state switched from Aetna to NYLCare. State and union officials said they will watch the transition closely for impacts on covered state workers' health insurance.

"The basic coverage a person has won't change," said Guy Bell, state director of retirement and benefits.

Regardless of what company is administering the health plan, the Alaska State Employees Association will be vigilant in making sure the terms of its contract with the state are followed, said Chuck O'Connell, business manager for the state employees union.

Roughly 12,000 Alaska state employees and 18,000 retirees are covered by NYLCare under the plan.

Aetna provided health insurance for most state workers until last summer, when the state switched to self-insurance, contracting with NYLCare to process its claims and make payments. That transition brought complaints from health-care providers and patients.

NYLCare has been providing better service since a January legislative hearing where the company was criticized for slowness, confusing explanations of benefits and paying less than the previous insurer, Bell said.

"The data shows that their payment schedule has much improved," Bell said. "From the date they receive a claim they're paying it within seven to 10 days."

Please see Aetna, Page 8

Aetna...

Continued from Page 1

Improvements, including weekly telephone conferences between state representatives and NYLCare staff in Seattle and in Concord, Calif., will continue as promised while the Aetna takeover is being worked out, said Allison Alkire, NYLCare administrative vice president.

"Right now at least there are no changes," Alkire said. "Things will go as they currently are until closing, which is not expected until third quarter."

After the purchase is completed in late summer, Aetna will meet with state representatives to discuss the health plan, said Bob Pena, an Aetna spokesman.

"We're going to be putting together a slower integration process that could go up to 24 to 30 months," Pena said. "The goal of the transition is definitely going to be to work closely with NYLCare and ensure a smooth transition for our members."

Pena said it is not even known yet whether NYLCare will keep its name after the purchase.

Aetna agreed to buy the health care unit of New York Life Insurance Co. for $1.05 billion in cash, the companies said today.

The purchase price could increase by as much as $300 million if the NYLCare Health Plans unit reaches earnings and enrollment targets during the next two years.

The agreement has been approved by the boards of both companies. It is subject to approval by federal antitrust and state regulators.

The Associated Press contributed to this report.

ANNUAL REPORT
OF
ALASKA COMPREHENSIVE
HEALTH INSURANCE ASSOCIATION

JANUARY 1, 1996 - DECEMBER 31, 1996

ACHIA ANNUAL REPORT

Introduction

The Alaska Comprehensive Health Insurance Association (ACHIA) was established by the Alaska Legislature to provide access to health insurance to all residents of the state who are denied adequate health insurance or who are considered uninsurable. During 1997, legislation was passed that will also make ACHIA coverage available to individuals who are considered 'federally eligible individuals' under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

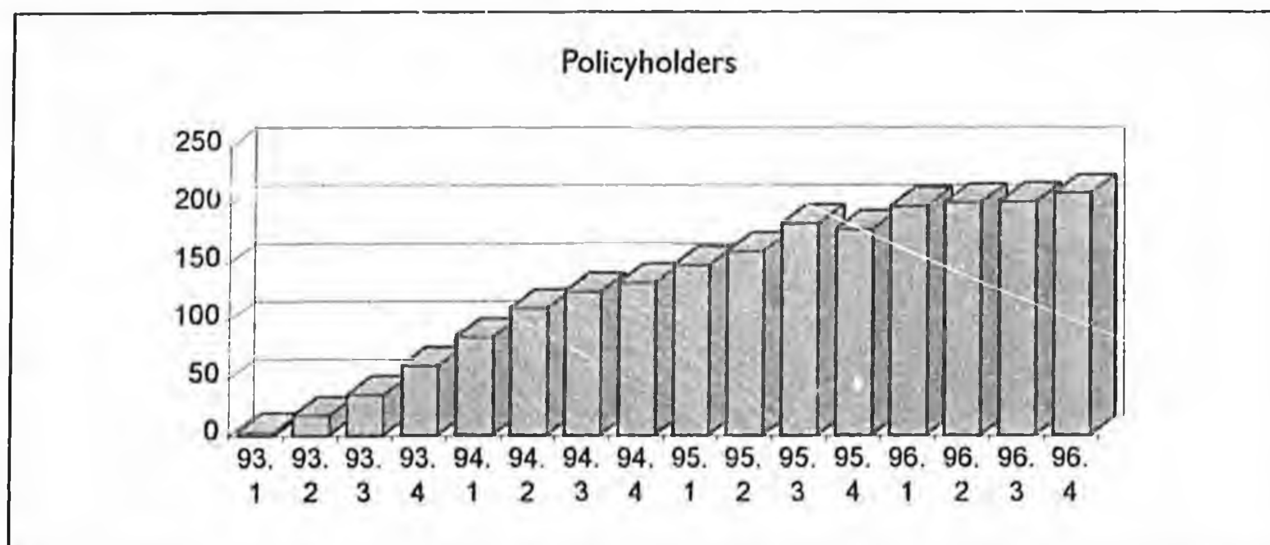
ACHIA is a nonprofit incorporated legal entity established under the provisions of Alaska Statute Title 21, Chapter 55, and is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property. The Plan is governed by a Board of Directors composed of seven individuals. Five Board members represent participating member companies of the association approved by the director of the Division of Insurance and two are consumers selected by the director of the Division of Insurance. The director of insurance or the director's designee serves as a nonvoting ex officio member of the Board.

Since the implementation date of the Plan, January 1, 1993, Aetna Insurance Company has served as the administrator of the Plan. As such Aetna processes applications for coverage under the plan, collects premium, pays claims on behalf of the association and performs other administrative functions as provided in the administrative contract.

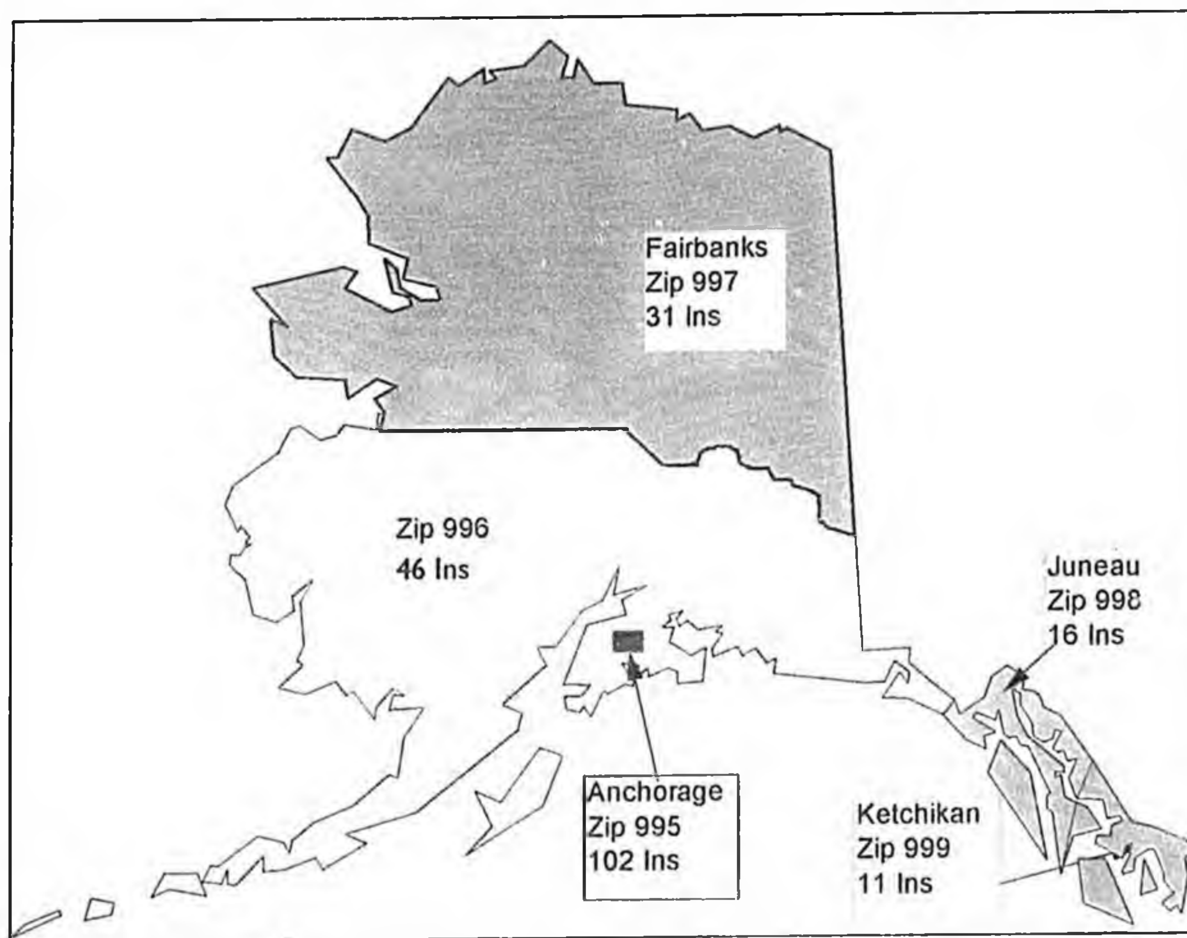
The Plan is funded through premiums collected from Insureds and assessments received from health insurers transacting business in Alaska.

At the beginning of 1996, there were 178 insureds on the plan. As of December 31, 1996, there were 209 insureds. During the year, there were 93 new issues and 62 terminations. Terminations were due to many reasons including the enactment in 1993 of Alaska Small Group Reform and insureds leaving the state.

In 1996, 93 policies were issued. 75 of these policies were still inforce and active on December 31, 1996.



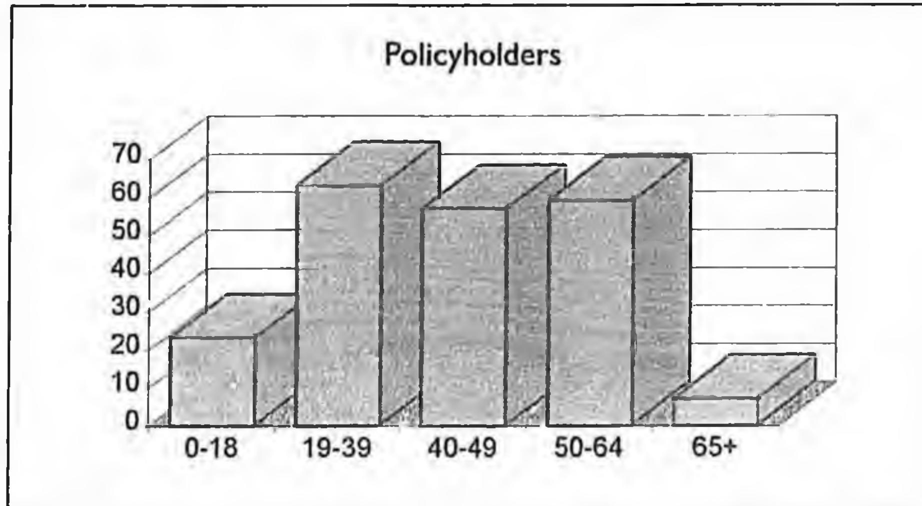
ACTIVE POLICYHOLDERS BY GEOGRAPHIC AREA



Note: Three Billing Addresses are Outside Alaska

Policyholders by
Issue Age at
Year End 1996

Ages 0-18	19-39	40-49	50-64	65+
23	63	57	59	7



Observations & Recommendations

During 1996, the number of policyholders covered by ACHIA continued to increase ending the year with 209 individuals covered. The year ending totals from 1993, 1994, and 1995 were 60, 132, and 178, respectively. On the other hand, incurred claim totals for the four years reflect a considerably different pattern; namely, $244,758 in 1993, $805,642 in 1994, $2,157,549 in 1995, and $1,323,651 in 1996. Claims peaked in 1995 reducing concern which had resulted from the increasing claim amounts. Early 1997 has seen a lower and more stable claims level which have been consistent with the second half of 1996.

Expected reasons for increased claim levels include the expiration of pre-existing condition limits as well as the initial behavioral changes that result when someone who has not had health insurance coverage for some period of time, obtains coverage and sees physicians for long standing conditions. This is exacerbated in the case of individuals who are eligible for ACHIA coverage since they must prove that they have significant health conditions in order to participate.

As a result of this worsening experience in 1995, it was necessary for the Board to accelerate assessments against the member companies. An initial assessment of $250,000 was made in September 1993 to establish operating capital. This assessment gave credit for the seed money assessment that had been made early in 1993, but which was based solely on a set level of $5,000 per company for each of the top twenty companies. Because paid claims were so modest during 1993 and early 1994, and since the Board had little upon which to estimate or project, it was difficult to anticipate the timing and level of the next assessment following September 1993.

Additional problems complicated the process of establishing the next assessment. It is important to note that the assessments are paid by the insurance carriers operating in Alaska based on their proportionate share of insured medical premium. First, the companies to be assessed had to be determined. Many companies are licensed in Alaska to write health insurance but do not actually write health insurance and must be excluded from the assessment calculations. Second, the premium upon which each company's assessment is based is determined based on annual statement data which includes amounts that are not assessable and therefore must be excluded from the calculations. Additional difficulty was encountered in establishing the necessary reports and the timing of those reports so that determination of the necessary assessments could be made by the Board.

Following a discussion between the Board and the Administrator that lasted for eight months, the Board ordered that a $600,000 assessment be made in April 1995. This assessment was followed in October 1995 by an assessment for $1,200,000. Thus, by year-end 1995, the pool had a positive cash balance of $86,017. However, claims for the first two months of 1996 eroded the cash balance and on May 9, 1996, a new assessment for $1,500,000 was mailed to member companies. With the stabilization of the pool and the peaking of claims in 1995, assessment needs can be anticipated far enough in advance to prevent negative cash positions. In line with that, the Board ordered an assessment for $1,200,000 in late October 1996. It was anticipated that this assessment would be needed to cover shortfalls during 1997.

High risk pool legislation across the country was never intended to result in an insurance operation that was self sustaining and Alaska is no exception. Legislative history indicates that this fact was discussed during the deliberations of the Alaska legislation. High risk pools were developed to cover individuals who have been deemed to be essentially uninsurable by insurance carriers. If actuarially sound premiums could be developed for these individuals, insurance carriers would sell them appropriately priced coverage and a high risk pool would be unnecessary.

The rapid increase in the claim to premium ratio (loss ratio) of the pool was very distressing to everyone connected with the pool, particularly those not familiar with this type of legislation. Normally, such a result would indicate the need to raise the premiums as that is the most direct way to reduce the loss ratio. However, in order to prevent the premium charged from getting too high, a maximum premium was established by statute. This maximum premium is developed by obtaining the average standard risk premium rates of the top 5 carriers in the state and multiplying that average by 2. The Board initially set the premiums at 1.75 times this average which is less than the maximum allowed. In early 1996, the Board decided to increase the rates in order to reflect inflation in claim levels and standard risk premium rates in the Alaska market. The Board chose to set the premium at 175% rather than 200% because they felt that the 200% level would drive away the individuals who were healthier and result in a loss ratio that would be unimproved or worsened. This premium increase which averaged around 25% to 30% was effective July 1, 1996. This was the first increase since the initial rates were determined in April 1993.

The Board devoted a great deal of time in late 1995 and early 1996 developing strategy for managing ACHIA's financial condition in order to limit losses and resulting future assessments. However, the Board's flexibility has been, and remains, limited since (1) the policy benefits are restricted by statute, (2) the premiums are limited by statute (and by practical affordability levels), (3) newer techniques being used elsewhere in the insurance industry, like managed care, are limited by statute and the nature of Alaska's health care market, and (4) statute allows only an ACHIA member to administer the pool which may not allow for the most efficient and effective administration of ACHIA.

Some of the strategies that the Board has taken to manage ACHIA's financial condition are as follows: (1) implementation of higher deductible/out-of-pocket maximum plans that are priced at lower rates and encourage individuals to manage their costs better, (2) hiring of a case manager to help control costs while achieving better care for the individuals, (3) raising the premium levels to offset inflation, (4) requiring, in cooperation with the Administrator, better and more timely financial reports with which to monitor the plan, (5) establishment of more efficient and appropriate assessment procedures and (6) development of a PPO plan that will take advantage of hospital discounts.

On March 7, 1996, Cecil Bykerk, Chairperson, testified in Juneau before a joint Senate and House hearing concerning the status of ACHIA. Following that hearing, the Board worked with the Division to draft legislation that addresses the limitations mentioned above. This draft legislation addressed the following issues: (1) technical corrections regarding representation on the Board which will allow proper input from consumer representatives and smaller member companies, (2) flexibility to allow development of cost containment methods including incentives to use PPO networks, (3) technical adjustments to the language to allow reduced complexity more appropriate in the determination of premium rates, (4) creating more competitive bidding on the administration of the plan by allowing entities other than member companies to administer ACHIA and (5) additional technical corrections that have become apparent over the early years of operation of the pool.

While these legislative changes were introduced, they did not progress to enactment during 1996. The Board strongly recommended enactment of the legislation in 1997. However, an additional need for legislation was created by the enactment at the Federal level of the Health Insurance Portability and Accountability Act of 1996. This Act requires that states enforce certain portability and renewability standards. The states had several options in meeting these standards. One option is met through having a pool in place much like ACHIA. However, in order for ACHIA to satisfy the necessary requirements, the statute had to be amended to include automatic eligibility for individuals 'who are considered eligible for coverage under HIPAA.' Any individual who purchases coverage through this eligibility route will not be required to serve a pre-existing condition period. The Board strongly recommended enactment of these necessary changes.

At first, it appeared that the necessary changes required by HIPAA and the changes previously described might be combined into one piece of legislation. However, since HIPAA required legislation that was beyond the scope of the ACHIA statute, it was determined that the bills should be split into two separate pieces of legislation. Since the Alaska HIPAA legislation had extremely tight time deadlines as mandated under HIPAA, focus was given to passage of this legislation and not to the Board sponsored legislation. The Board sponsored legislation did not get introduced. On April 2, 1997, Cecil Bykerk again testified before a joint Senate and House hearing concerning ACHIA and the potential impact of HIPAA on ACHIA. Ultimately, the bill was enacted and signed by the Governor. The Board plans to seek a sponsor for the bill in 1998.

In summary, the Board feels that ACHIA has served a useful purpose to the citizens of Alaska. With the HIPAA legislation, ACHIA has provided a vehicle which will allow the private insurers continued flexibility to provide private health insurance to the citizens of Alaska as well as allow them to help fund ACHIA. In response to the HIPAA legislation in 1997, the ACHIA Board will revise the Plan of Operation, application, contracts and other support information. However, changes to statute are still needed in order to allow the Board, with approval and input from the Director of Insurance, to better manage ACHIA.

What are the Benefits ?

The lifetime maximum benefit is $1,000,000 for all injuries and sicknesses combined. The Plan provides benefits which include inpatient and outpatient hospital care, office visits, surgery and anesthesia, x-ray and lab, radiation and chemotherapy, ambulance, oxygen, durable medical equipment, prosthetics, home health care, mammography, hospice services, prescription drugs, phenylketonuria treatment, treatment for complications of pregnancy, mental or nervous, alcoholism and drug abuse.

What Is Not Covered ?

The following is a brief list of expenses not covered under the Plan and may not reflect the full extent of the policy limitations: services that are not medically necessary, well baby care, eyeglasses, contact lenses, hearing aids, dental care, acupuncture therapy, routine physical or preventive exams, normal pregnancy, TMJ, experimental procedures (including related services, drugs and other supplies), and reconstructive or cosmetic surgery.

Does a Waiting Period Apply ?

The Plan will not cover expenses incurred during the first six months after the policy date for a preexisting condition. Payments will be in accordance with the provisions of the policy, however, if the person had coverage under another medical plan which was involuntarily terminated and coverage is applied for under ACHIA within 60 days after such involuntary termination, the preexisting condition waiting period will apply only to the excess, if any, of six months over the time coverage was in force under the prior plan. Additionally, 'federally eligible individuals' under the HIPAA legislation will have all waiting periods and preexisting condition limitations waived provided they apply for ACHIA coverage within 90 days after coverage under an employer-sponsored group.

Who Is Eligible ?

Any person is eligible for the ACHIA plan if he or she:

*is not currently covered by any other health plan or health insurance policy;
*is not eligible for coverage under AS 21.56, Small Employer Health Reform;
*has been a resident for the past 12 months and continues to be a resident of Alaska; **and**
*__at least one of the following__ :

- has received from two health insurers notice of rejection for health insurance dated within the last six months;
- has received restrictive riders that substantially reduce coverages; __or__
- has any of the conditions listed below:

Acquired Immune Deficiency Syndrome (AIDS)
Alzheimer's
Angina Pectoris
Anorexia Nervosa
Arteriosclerosis Obliteran
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 (Periarteritis 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)
Topectomy and Lobotomy
Ulcerative Colitis
Wilson's Disease

Individuals covered by Medicare may still be eligible for coverage under this plan.

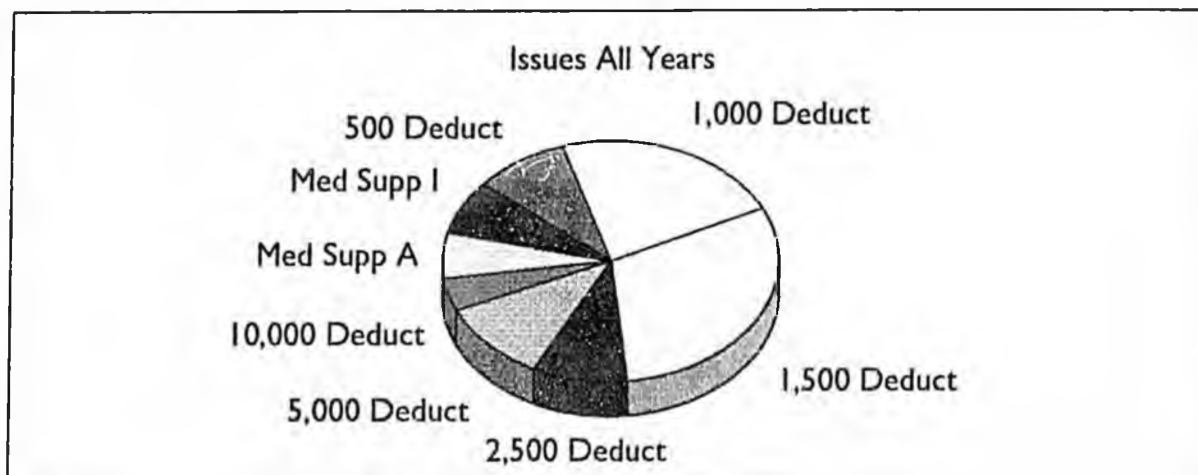
Additionally, effective July 1, 1997, a 'federally eligible individual' may purchase ACHIA coverage provided they are a resident of Alaska at the time of application

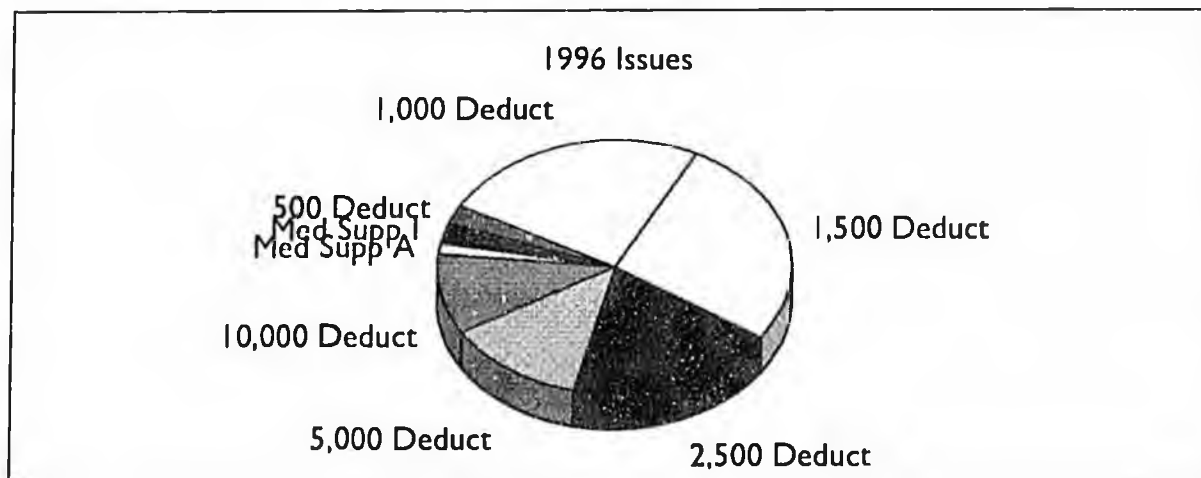
What Deductible Options are Available ?

Seven deductible options were available during 1996, $200, $500, $1,000, $1,500, $2,500, $5,000, and $10,000. As of December 31, 1996, the plan insured the following:

1996 Year-End Active Policyholders by Plan Type

Issues	Deductible 200	500	1,000	1,500	2,500	5,000	10,000	Medicare Supplement A	I	Total
All	0	19	47	64	19	23	9	13	15	209
1996	0	2	19	21	15	10	5	1	2	75





What are the Rates ?

Major Medical Rates, 1993 - June 30, 1996

Deductible:	$ 500		$1,000		$1,500	
Out of Pocket Maximum :	$2,000		$2,000		$2,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly
-18	135.00	405.00	98.00	294.00	89.00	267.00
19-24	240.00	720.00	175.00	525.00	159.00	477.00
25-29	243.00	729.00	180.00	540.00	163.00	489.00
30-34	289.00	867.00	212.00	616.00	193.00	579.00
35-39	306.00	918.00	225.00	675.00	204.00	612.00
40-44	363.00	1,089.00	268.00	804.00	243.00	729.00
45-49	418.00	1,254.00	308.00	924.00	279.00	837.00
50-54	510.00	1,530.00	380.00	1,140.00	344.00	1,032.00
55-59	586.00	1,758.00	438.00	1,314.00	397.00	1,191.00
60-64	694.00	2,082.00	520.00	1,560.00	471.00	1,413.00

Deductible:	$2,500		$5,000		$10,000	
Out of Pocket Maximum :	$3,500		$7,500		$10,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly
-18	74.00	222.00	52.00	156.00	38.00	114.00
19-24	131.00	393.00	92.00	276.00	67.00	201.00
25-29	135.00	405.00	94.00	282.00	68.00	20[illegible]0
30-34	159.00	477.00	112.00	336.00	81.00	243.00
35-39	169.00	507.00	118.00	354.00	86.00	258.00
40-44	201.00	603.00	141.00	423.00	102.00	306.00
45-49	230.00	690.00	162.00	486.00	118.00	354.00
50-54	284.00	852.00	199.00	597.00	145.00	435.00
55-59	328.00	984.00	230.00	690.00	167.00	501.00
60-64	389.00	1,167.00	273.00	819.00	198.00	594.00

Medicare Supplement Rates, 1993 - June 30, 1996

	Plan A		Plan I	
Age	Monthly	Quarterly	Monthly	Quarterly
-69	79.00	237.00	182.00	546.00
70-74	90.00	270.00	205.00	615.00
75-79	96.00	288.00	222.00	666.00
80+ .	102.00	306.00	236.00	708.00

What are the Rates ?

Major Medical Rates, July 1, 1996

Deductible:	$ 200		$ 500		$1,000		$1,500	
Out of Pocket Maximum :	$2,000		$2,000		$2,000		$2,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly
-18	285.25	855.75	182.00	546.00	141.75	425.25	117.25	351.75
19-24	425.25	1,275.75	273.00	819.00	211.75	635.25	175.00	525.00
25-29	484.75	1,454.25	309.75	929.25	243.25	729.75	201.25	603.75
30-34	540.75	1,622.25	344.75	1,034.25	269.50	808.50	224.00	672.00
35-39	609.00	1,827.00	388.50	1,165.50	306.25	918.75	253.75	761.25
40-44	705.25	2,115.75	449.75	1,349.25	353.50	1,060.50	292.25	876.75
45-49	826.00	2,478.00	526.75	1,580.25	414.75	1,244.25	344.75	1,034.25
50-54	987.00	2,961.00	630.00	1,890.00	497.00	1,491.00	413.00	1,239.00
55-59	1,172.50	3,517.50	745.50	2,236.50	595.00	1,785.00	495.25	1,485.75
60-64	1,394.75	4,184.25	885.50	2,656.50	708.75	2,216.25	595.00	1,785.00

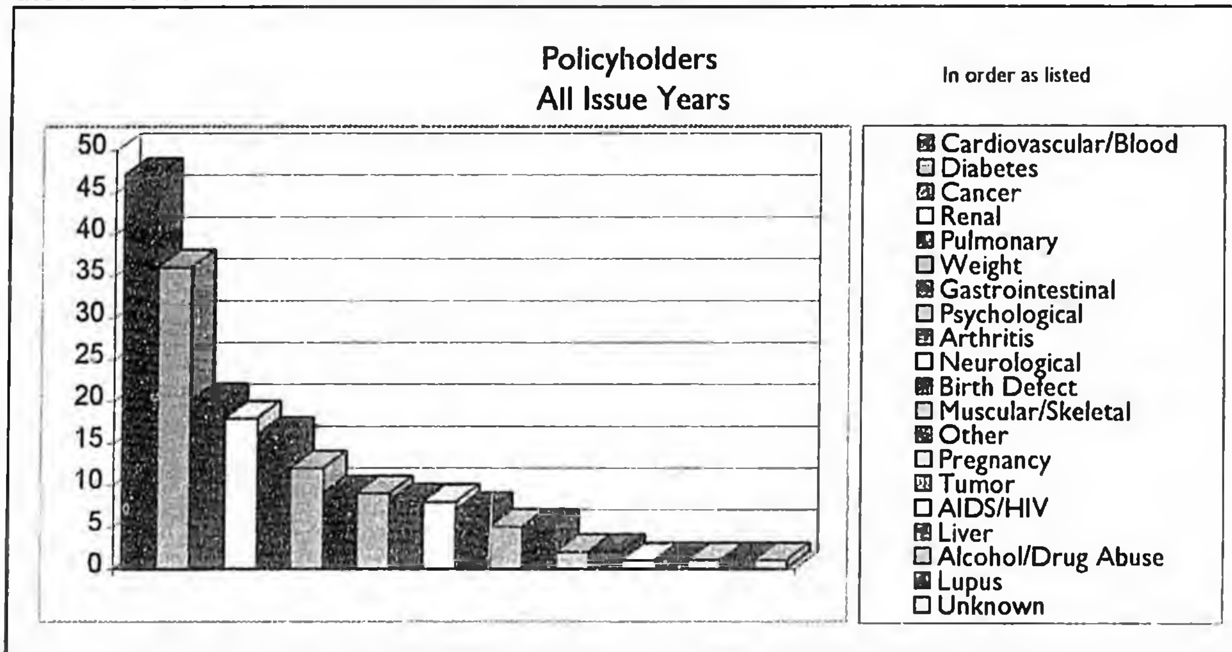
Deductible:	$2,500		$5,000		$10,000	
Out of Pocket Maximum :	$3,500		$7,500		$10,000	
Age	Mon	Qrtly	Mon	Qrtly	Mon	Qrtly
-18	99.75	299.25	66.50	199.50	57.75	173.25
19-24	148.75	446.25	99.75	299.25	89.25	267.75
25-29	171.50	514.50	115.50	346.50	103.25	309.75
30-34	190.75	572.25	129.50	388.50	113.75	341.25
35-39	215.25	645.75	143.50	430.50	129.50	388.50
40-44	248.50	745.50	168.00	504.00	148.75	446.25
45-49	292.25	876.75	196.00	588.00	175.00	525.00
50-54	350.00	1,050.00	234.50	703.50	208.25	624.75
55-59	420.00	1,260.00	283.50	850.50	250.25	750.75
60-64	502.25	1,506.75	341.25	1,023.75	299.25	897.75

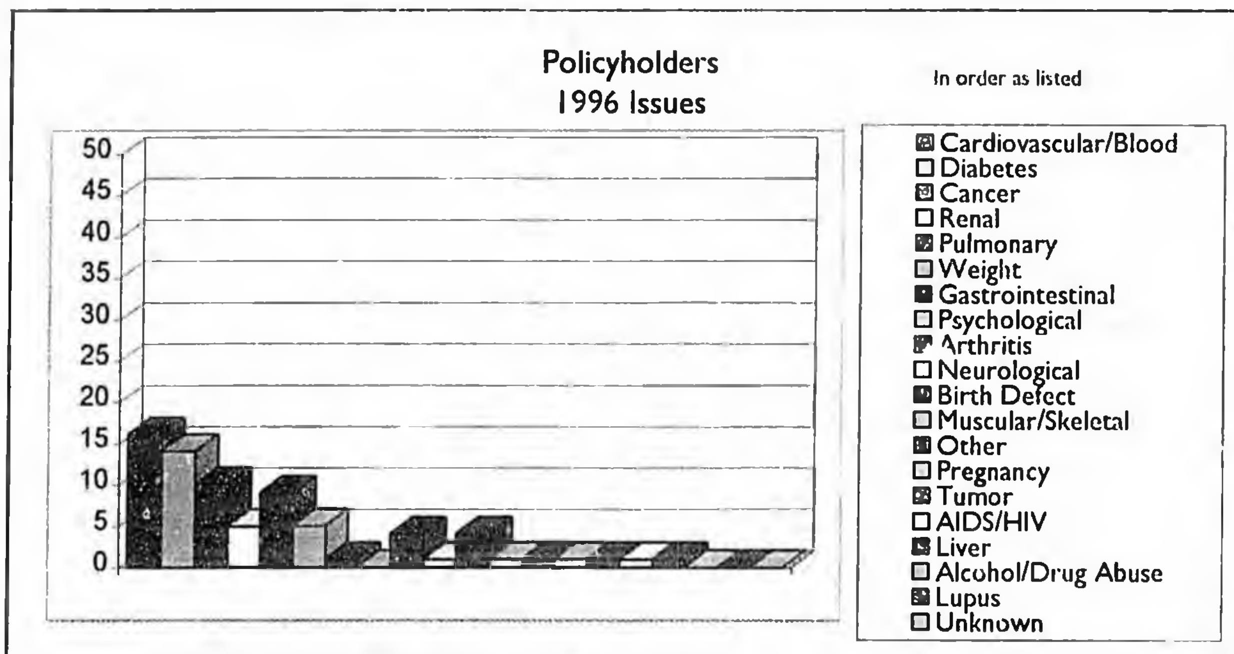
Medicare Supplement Rates, July 1, 1996

	Plan A		Plan I	
Age	Monthly	Quarterly	Monthly	Quarterly
-69	110.25	330.75	288.75	866.25
70-74	124.25	372.75	316.75	950.25
75-79	136.50	409.50	343.00	1,029.00
80+ .	147.00	441.00	388.50	1,165.50

Primary Medical Condition

Applicants for ACHIA coverage are asked to identify their primary medical condition. The most frequently listed category includes conditions related to a history of cardiovascular conditions. The next most frequently listed conditions include diabetes, cancer, and renal problems, followed by pulmonary, weight, gastrointestinal, psychological, arthritis, or neurological conditions. These conditions, as well as experience from member companies, make up the list of specified conditions for which eligibility in ACHIA will be considered without the normal requirement that individuals have at least two rejections for coverage in the last six months.





Financial

This section details the policy year financial experience for ACHIA. Exhibit 1 is the ACHIA balance sheet for years ended 1995 and 1996. Exhibit 2 shows the revenues, expenses and changes in the fund balance. ACHIA began 1996 with a deficit of $570,063, and ended with a deficit of $88,301. Revenues for the year were $2,095,223, and expenses were $1,613,461. Exhibit 3 shows the cash flow for 1995 and 1996.

Board of Directors

The Board of Directors for 1996 are:

Cecil D. Bykerk, Chairman
Executive V.P. & Chief Actuary
4 Actuarial
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
phone: (402) 351-2534
fax: (402) 351-2465

Robert Niebrugge, Vice Chairman,
Consumer Representative
Box 4187
3521 Sky Ranch Loop
Palmer, Alaska 99645
phone: (907) 746-3256
fax: (907) 745-3110

Ross Blaker, CEBS
Aetna Life & Casualty
4300 B Street, Suite 205
Anchorage, Alaska 99503
phone: (907) 563-0433
fax: (907) 561-2362

Sandra Cole, Consumer Representative
Box 874165
Wasilla, AK 99687
phone: (907) 376-2939
fax: (907) 376-2939

Eileen Gallagher
New York Life Ins. Co.
51 Madison Avenue
New York, NY 10010
phone: (212) 576-7807
fax: (212) 576-4473
home: (907) 522-1097

Chet Lozowski
Pioneer Financial Services
1750 East Golf Road
Schaumburg, IL 60173
phone: (847) 413-7328
fax: (847) 413-7198

James Tysver
Blue Cross of Washington & Alaska
7001 220th Street S.W., Bldg. 3
Mountlake Terrace, Washington
98073-2124
phone: (206) 670-4553
fax: (206) 670-4900

Katie Campbell, Director's Designee
ex-officio member
State of Alaska Division of Insurance
333 Willoughby
Juneau, Alaska 99801
phone: (907) 465-4607
fax: (907) 465-3422

Exhibit I

BALANCE SHEET

December 31, 1996 and 1995

Assets

	1996 (Audited)	1995 (Audited)
Cash	$ 1,350,840	$ 86,017
Funds held by administrator (note 3)	126,906	50,206
Assessments receivable	18,104	46,213
	1,495,850	182,436

Liabilities and Deficit

	1996	1995
Reserve for claims and claim adjustment expenses	$ 325,834	$674,673
Unearned premiums	55,509	34,198
Assessments collected in advance	1,202,808	43,628
Defici:	(88,301)	(570,063)
	1,495,850	182,436

See accompanying notes to financial statements.

Exhibit 2
STATEMENTS OF REVENUES, EXPENSES
AND CHANGES IN FUND BALANCE (DEFICIT)

Years ended December 31, 1996, and 1995

	1996 (Audited)	1995 (Audited)
Revenues:		
Member assessments	$1,503,803	$1,775,615
Premiums earned	588,862	480,708
Interest income	2,558	1,054
	2,095,223	2,257,377
Expenses:		
Claims paid	$1,672,490	$ 1,903,747
Change in claims and claim adjustment expense reserves	(348,839)	253,802
Administrative services (note 3)	244,710	156,297
Interest (note 3)	19,100	-
Accounting services	9,230	12,720
Secretarial services	5,258	4,090
Board meetings	9,285	1,881
Telephone	80	1,658
Bank fees	609	1,054
Postage	116	171
Miscellaneous	1,422	1,038
	$1,613,461	2,336,458
Excess (deficiency) of revenues over expenses	481,762	(79,081)
Deficit at beginning of year	(570,063)	(490,982)
Deficit at end of year	$ (88,301)	$ (570,063)

See accompanying notes to financial statements.

Exhibit 3
STATEMENTS OF CASH FLOWS

Years ended December 31, 1996, and 1995

	1996	1995
Cash flows from operating activities:		
Assessments collected from members	$2,691,092	$ 1,729,402
Premiums collected from insureds	610,173	479,001
Interest received	2,558	1,054
Interest paid	(19,100)	-
Claims expenses paid	(1,672,490)	(1,903,747)
Cash paid to administrators and suppliers	(270,710)	(178,909)
Cash advanced from (transferred to) administrators in excess of claims and other expenses paid by administrator	(76,700)	(70,071)
Net cash provided by operating activities and net increase in cash	1,264,823	56,730
Cash at beginning of year	86,017	29,287
Cash at end of year	1,350,840	86,017
Reconciliation of deficiency of revenues over expenses to net cash provided (used) by operating activities:		
Excess (deficiency) of revenues over expenses	481,762	(79,081)
Adjustments:		
Decrease (increase) in assessments receivable	28,109	(46,213)
Increase in funds held by administrator	(76,700)	(70,071)
Increase (decrease) in reserve for claims and claim adjustment expenses	(348,839)	253,802
Increase (decrease) in unearned premiums	21,311	(1,707)
Increase in assessments collected in advance	1,159,180	-
Total adjustments	783,061	135,811
Net cash provided (used) by operating activities	$ 1,264,823	$ 56,730

See accompanying notes to financial statements.

Notes to Financial Statements

December 31, 1996 and 1995

(1) History

The Comprehensive Health Insurance Association (Association) was established by the Alaska State Health Insurance Act of 1992 (Act) to provide an individual state plan of health insurance to Alaska residents who are considered high risks and are otherwise unable to obtain health insurance.

The Association is a nonprofit organization whose membership consists by statute of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage, and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense-incurred basis.

The Association is empowered by Alaska statutes to assess its members amounts to cover underwriting losses of the state plans and amounts to cover the operating and administrative expenses incurred by the Association to conduct its affairs.

In preparing the financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities as of the date of the balance sheets and revenue and expenses for the period. Actual results could differ from those estimates. The more significant accounting and reporting policies and estimates applied in the preparation of the accompanying financial statements are discussed below.

(2) Summary of Significant Accounting Policies

Income Taxes

The Association is nontaxable for state income tax purposes under the provisions of the Act. The Association's application for federal tax exempt status under code section 501(c)(6) has been pending with the Internal Revenue Service (IRS) since 1994. Subsequent to December 31, 1996, the IRS requested that the Association resubmit its application under code section 501(c)(26), established in 1996 specifically for state health plans. The Association intends to resubmit under the new code section, which would grant tax exempt status effective January 1, 1997. The Association's federal tax status for years prior to January 1, 1997 is uncertain. However, given the annual and cumulative operating deficits incurred by the Association through December 31, 1996, the Association's tax liability, if any, is not expected to be material.

Member Assessments

Assessments levied on all members are reported in the period for which such assessments are levied. Member assessments are charged to each member based on the ratio of the member's total fees for subscriber contracts or total health insurance premiums, received from or on behalf of state residents, as divided by the total subscriber fees and health insurance premiums received by all members from or on behalf of state residents.

In May 1996, the Association assessed its members $1,500,000 to cover claims and expenses through 1996. In October 1996, the Association assessed members $1,200,000 to cover anticipated claims and expenses in 1997. The October 1996 assessment is included in assessments collected in advance on the accompanying 1996 balance sheet.

Notes to Financial Statements

Reserve for Claims and Claim Adjustment Expenses
The reserve for claims and claims adjustment expense represents management's estimate of the ultimate settlement of reported and unreported claims. Management believes that such reserves are adequate to cover the ultimate net cost of claims expense incurred; however, reserves are necessarily based on estimates and the amount ultimately paid may be more or less than such estimates. Adjustments to reserves are charged or credited to expense in the period in which they are made.

Premiums
Premium income is recognized on a pro rata basis over the respective terms of the policies. Unearned premiums represent the portion of premiums written which relate to future periods.

(3) Related Party Transactions
Board meeting expense consists partly of reimbursements to certain members of the Board of Directors of the Association for travel costs incurred on behalf of the Association.

Aetna Life Insurance Company (Aetna) administers the state plan by collecting the premium payments and adjusting and settling claims. Aetna is paid a fee by the Association for administering the plan. Total fees paid to Aetna were $243,842 in 1996 and $155,183 in 1995.

Funds held by Aetna at December 31, 1996 and 1995 were $126,906 and $50,206 respectively. In 1996, Aetna charged or paid interest to the Association on balances held by or owing to Aetna during the year. Interest paid by Aetna was $1,949 and interest charged by Aetna was $19,100 for the year ended December 31, 1996.

(4) Line of Credit
Subsequent to December 31, 1996, the Association obtained a line of credit with a bank which allows the Association to borrow up to $1,000,000 as needed on a short-term basis.

HB
300
File 3

Blue Cross
of Washington and Alaska
An Independent Licensee of the Blue Cross and Blue Shield Association

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

ALASKA
Other Coverage Questionnaire

To avoid a delay in processing your claim(s),we need your help! We appreciate your assistance in providing this information and thank you for your cooperation. Please complete and return this form with your enrollment application.

When you or your dependents have other health coverage, the information requested below will enable Blue Cross of Washington and Alaska to coordinate payment of your claim(s) with your other carrier(s). Please refer to the back of this form for answers to the most often asked coordination of benefits questions. If you require assistance in completing this form, please contact your agent or call Customer Service at (206) 670-5900 or 1-800-345-6784.

OTHER INSURANCE INFORMATION

Do you or any family members have any of the following:

1. Blue Cross of Washington and Alaska (BCWA) coverage? ☐No ☐Yes If "Yes," please complete the following section.

SUBSCRIBER NAME	DATE OF BIRTH (MM/DD/YYYY)	SUBSCRIBER ID NUMBER	GROUP NUMBER

2. Medicare coverage? ☐No ☐Yes If "Yes":

NAME OF FAMILY MEMBER WITH MEDICARE COVERAGE

3. Other medical, dental, or vision coverage? ☐No ☐Yes If "Yes," please complete the following section and attach additional paper if more than one.
Other Insurance Company:

COMPANY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE NUMBER ( )		

NAME OF CONTRACT HOLDER	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP TO BCWA SUBSCRIBER
CONTRACT ID # (Social Security #, Member #, etc.)		GROUP NUMBER (Cert #, Union Local, etc.)
THIS COVERAGE IS FOR ☐Medical ☐Dental ☐Vision		
NAME OF EMPLOYER PROVIDING YOUR COVERAGE	ARE YOU RETIRED FROM THIS EMPLOYER? ☐No ☐Yes	

4. If parents are divorced or legally separated, the following is needed to determine which coverage will process claims first for dependent children.

CHILD'S NAME FIRST	LAST	NAME OF PERSON WITH CUSTODY	RELATIONSHIP TO CHILD LISTED	NAME OF PERSON WITH FINANCIAL RESPONSIBILITY FOR HEALTH COVERAGE ACCORDING TO DIVORCE DECREE	RELATIONSHIP TO CHILD	NAME OF OTHER COVERAGE PROVIDED*

* If this is different from the Other Insurance Company listed in Number 3 above, please list all other information (e.g. - telephone number, name of contract holder, ID Number, Group Number, etc.) on a separate sheet.

The above information is accurate and complete to the best of my knowledge.

Signature of BCWA Subscriber or Spouse	Date of Signature (MM/DD/YYYY)
X	

C20-4618 (8-1997)

Questions and Answers to Help You Understand <u>Coordination of Benefits</u>

What is Coordination of Benefits (COB)?
COB is two or more health care coverages working together to share the cost of health care expenses.

Why does Blue Cross of Washington and Alaska (BCWA) coordinate benefits?
Alaska law requires health care companies to coordinate benefits. Coordination allows us to keep your cost of health care coverage as low as possible by avoiding payment of more than the total charge of bills submitted. Coordination rules identify one plan as "primary" (the company that pays first) and the other plan as secondary (the company that pays second).

To whom do I submit my bill(s) first?
- If the patient is a BCWA subscriber, submit to us first and the other plan second.
- If the patient is the spouse of our BCWA subscriber, submit to the other plan first and to us second.
- If the patient is a dependent child, submit to the plan of the parent whose birthday falls earliest in the calendar year. Example: Mother's birth date is May 5th and father's birth date is September 2nd, submit to the mother's plan first, regardless of year of birth.
- If the parents of the patient are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage according to the divorce decree. If not stated in the divorce decree, submit bill(s) in the following order:
  A. To the plan of the parent with custody;
  B. To the plan of the spouse of the parent with custody;
  C. To the plan of the natural parent without custody; or
  D. To the plan of the spouse of the parent without custody.
- If you have two BCWA coverages, submit each bill with both Subscriber and Group identification numbers.
- If Medicare is your primary carrier, submit your bill(s) to us with a copy of the Medicare Explanation of Benefits.
- If you are the Subscriber of more than one health care coverage, the coverage which has been effective the longest is primary. Submit your bill(s) to that carrier first.
- Retiree Plans may require any non-retiree coverage to be primary.

How does BCWA coordinate benefits?
- When we receive your bill(s), we determine which health care company will process your bill(s) first.
- If you submit your bill(s) with the amount paid by your other health care company, a copy of their denial or an Explanation of Benefits, we will use this information to process your bill(s) promptly.
- If we do not receive this information with your bill(s), we contact your other health care company to obtain the information needed to process your bill(s). We always call those companies that coordinate over the telephone. This enables us to process your bill(s) promptly.

When will I receive an "Other Coverage Questionnaire"?
- When we have conflicting, incomplete or outdated information, you will receive a questionnaire.
- When your other coverage cancels, we need new coverage information.

IMPORTANT REMINDERS

- When we request COB information, please return the form by the date indicated to ensure prompt processing of your bill(s).
- Always keep your health care providers (physician, dentist, optometrist, etc.) updated with your correct health care coverage information.

Blue Cross
of Washington and Alaska
An Independent Licensee of the Blue Cross and Blue Shield Association

Please Read This Information Before You Complete the Alaska Individual Enrollment Application 120-2535 (3-96)

In addition to the information requested in the blue Alaska Individual Enrollment Application [120-2535 (3-96)], please make certain to provide the information requested below ***if it applies to you.***

This information is used to determine eligibility for Interplan transfer and provides us other information important to your application for coverage.

If anyone applying for coverage is now or ever has been covered by a Blue Cross plan, please provide complete information below and submit this form with the enrollment application.

Subscriber Name	Group Number	Identification Number	Date Coverage Ended/Will End	City	State

0-LS1248\M
Ford
4/30/98

CS FOR HOUSE BILL NO. 300(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES BUNDE, James

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of health care insurance plans; relating to patients'**
2 **rights and prohibited practices under health care insurance; relating to health care**
3 **review organizations; and providing for an effective date."**

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

5 * **Section 1.** SHORT TITLE. Section 4 of this Act may be known as the Alaska Patients'
6 Bill of Rights.
7 * **Sec. 2.** AS 18.23.020 is amended to read:
8 **Sec. 18.23.020. <u>Liability</u> [LIMITATION ON LIABILITY] for members of**
9 **review organizations.** A person who is a member or employee of [, OR WHO ACTS
10 IN AN ADVISORY CAPACITY TO, OR WHO FURNISHES COUNSEL OR
11 SERVICES TO] a review organization is [NOT] liable for damages or other relief in
12 an action brought by another whose activities have been or are being scrutinized or
13 reviewed by a review organization, by reason of the performance of a duty, function,
14 or activity of the review organization, <u>if</u> [UNLESS] the performance of the duty,

function, or activity was **negligent, reckless, or** motivated by malice toward the affected person. **Except as provided in this section, a** [A] person is not liable for damages or other relief in an action by reason of performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

* **Sec. 3.** AS 21 is amended by adding a new chapter to read:

Chapter 07. Regulation of Health Care Insurance Plans.

Sec. 21.07.010. Managed care provider and patient protection. A contract between a participating health care provider and an insurer that offers a managed care plan

(1) must state that the health care provider may not be penalized or the contract terminated by the insurer because the health care provider acts as an advocate for the patient in seeking appropriate, medically necessary health care services;

(2) may not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary; and

(3) must protect the ability of a health care provider to communicate openly with a patient about all appropriate diagnostic testing and treatment options;

(4) must define words in a clear and concise manner; and

(5) must clearly identify

(A) all health care services to be provided;

(B) what health care services will be provided by contractors; and

(C) provider compensation rates;

(D) termination procedures; and

(E) current, usual, customary, and reasonable reimbursement schedules, and methodology.

Sec. 21.07.020. Required contract provisions. A health care insurance plan offered to residents of the state must provide that

1 (1) coverage for a medical procedure that has been preapproved by the
2 insurer may not be denied;
3 (2) emergency room services shall be covered if authorized by the
4 attending physician;
5 (3) pharmacy and dental services shall be provided in the community
6 in which the covered person resides; and
7 (4) a utilization review decision to deny, reduce, or terminate a health
8 care benefit or to deny payment for a health care service because that service is not
9 medically necessary may only be made by a health care provider trained in that
10 specialty or subspecialty after consultation with the covered person's health care
11 provider.
12 **Sec. 21.07.030. Choice of health care provider.** (a) An insurer or managed
13 care contractor that offers a managed care plan shall offer to every contract holder a
14 point-of-service plan option that would allow a covered person to receive covered
15 services from an out-of-network health care provider without obtaining a referral or
16 prior authorization from the insurer. The point-of-service plan option may require that
17 a subscriber pay a higher deductible or copayment and higher premium for the plan
18 if the higher deductible, copayment, or premium results from increased costs caused
19 by the use of an out-of-network provider.
20 (b) An insurer shall provide each subscriber in a plan whose contract holder
21 elects the point-of-service plan option with the opportunity at the time of enrollment
22 and during the annual open enrollment period to enroll in the point-of-service plan
23 option. The insurer shall provide written notice of the point-of-service plan option to
24 each subscriber in a plan whose contract holder elects the point-of-service plan option
25 and shall include in that notice a detailed explanation of the financial costs to be
26 incurred by a subscriber who selects that option.
27 (c) The requirements of this section do not apply to an insurer contract that
28 offers a managed care plan that provides health care services to Medicaid recipients
29 or to a federally qualified, nonprofit health maintenance organization.
30 **Sec. 21.07.250. Definitions.** In this chapter,
31 (1) "health care insurance" has the meaning given in AS 21.12.050(b);

New Text Underlined [DELETED TEXT BRACKETED]

1 (2) "health care provider" means a person licensed in this state to
2 provide health care services;
3 (3) "health care services" means services for the diagnosis, prevention,
4 treatment, care, or relief of a health condition, illness, injury, or disease;
5 (4) "managed care contractor" means a contractor who establishes,
6 operates, or maintains a network of participating health care providers, conducts or
7 arranges for utilization review activities, and contracts with an insurer, a hospital or
8 medical service plan, an employer or employee health care organization, or another
9 entity providing coverage for health care services to operate a managed care plan;
10 (5) "managed care entity" includes an insurer, hospital or medical
11 service plan, health maintenance organization, an employer or employee health care
12 organization, or a managed care contractor that operates a managed care plan;
13 (6) "managed care plan" means a health care insurance plan that
14 requires a covered person to use, or creates incentives, including financial incentives,
15 for a covered person to use, a health care provider who is managed, under contract
16 with, or employed by a health care insurer;
17 (7) "participating health care provider" means a health care provider
18 who has entered into an agreement with a managed care entity to provide services or
19 supplies to a patient enrolled in a managed care plan;
20 (8) "provider" means a health care provider;
21 (9) "utilization review" means a system of reviewing the medical
22 necessity, appropriateness, efficacy, or efficiency of health care services, procedures,
23 settings, and supplies provided under a managed care plan using specified guidelines,
24 including preadmission certification, case management, second opinion, the application
25 of practice guidelines, concurrent review, discharge planning, ambulatory review, and
26 retrospective review.
27 * **Sec. 4.** AS 21.42 is amended by adding a new section to read:
28 **Sec 21.42.390. Required health care insurance coverage provisions.** (a)
29 A health care insurer may not include in the health care insurance plan or contract a
30 provision that
31 (1) prohibits a covered person from obtaining health care services from

1 (1) prohibits a covered person from obtaining health care services from
2 a health care provider of the person's choice, including a specialist; this paragraph does
3 not apply to a health care insurance plan or contract if the covered person signs a
4 written waiver of the provisions of this paragraph;
5 (2) restricts a covered person's right to receive full information from
6 the person's health care provider regarding the care or treatment options that the health
7 care provider believes are in the best interests of the person.
8 (b) A utilization review decision to deny, reduce, or terminate a health care
9 benefit or to deny payment for a health care service because that service is not
10 medically necessary may only be made by a health care provider trained in that
11 specialty or subspecialty and licensed to practice in this state after consultation with
12 the covered person's health care provider.
13 (c) A health care insurer may not deny coverage, cancel a health care
14 insurance plan or subscriber contract, or otherwise take action against a covered person
15 or a health care provider because the person has asserted a right described under this
16 section.
17 (d) A covered person may bring a civil action against a health care insurer to
18 enforce the person's rights under this section.
19 (e) In this section,
20 (1) "health care provider" means a person licensed in this state to
21 provide health care services;
22 (2) "health care services" means treatment of an individual for an
23 injury, illness, or disability and includes preventative treatment of an injury or illness.
24 * **Sec. 5.** This Act takes effect January 1, 1999.

0-LS1248\J
Ford
4/27/98

CS FOR HOUSE BILL NO. 300( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s) **REPRESENTATIVES BUNDE, James**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of health insurance plans; relating to patients'**
2 **rights and prohibited practices under health insurance; relating to health care**
3 **review organizations; and providing for an effective date."**

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

5 * **Section 1.** SHORT TITLE. Section 4 of this Act may be known as the Alaska Patients'
6 Bill of Rights.
7 * **Sec. 2.** AS 18.23.020 is amended to read:
8 **Sec. 18.23.020. Liability [LIMITATION ON LIABILITY] for members of**
9 **review organizations.** A person who is a member or employee of [, OR WHO ACTS
10 IN AN ADVISORY CAPACITY TO, OR WHO FURNISHES COUNSEL OR
11 SERVICES TO] a review organization is [NOT] liable for damages or other relief in
12 an action brought by another whose activities have been or are being scrutinized or
13 reviewed by a review organization, by reason of the performance of a duty, function,
14 or activity of the review organization, **if** [UNLESS] the performance of the duty,

1 function, or activity was **negligent, reckless, or** motivated by malice toward the
2 affected person. **Except as provided in this section, a** [A] person is not liable for
3 damages or other relief in an action by reason of performance of a duty, function, or
4 activity as a member of a review organization or by reason of a recommendation or
5 action of the review organization when the person acts in the reasonable belief that the
6 action or recommendation is warranted by facts known to the person or to the review
7 organization after reasonable efforts to ascertain the facts upon which the review
8 organization's action or recommendation is made.
9 * **Sec. 3.** AS 21 is amended by adding a new chapter to read:
10 **Chapter 07. Regulation of Health Insurance Plans.**
11 **Sec. 21.07.010. Managed care provider and patient protection.** A contract
12 between a participating health care provider and an insurer that offers a managed care
13 plan
14 (1) must state that the health care provider may not be penalized or the
15 contract terminated by the insurer because the health care provider acts as an advocate
16 for the patient in seeking appropriate, medically necessary health care services;
17 (2) may not provide financial incentives to the health care provider for
18 withholding covered health care services that are medically necessary; and
19 (3) must protect the ability of a health care provider to communicate
20 openly with a patient about all appropriate diagnostic testing and treatment options;
21 (4) must define words in a clear and concise manner; and
22 (5) must clearly identify
23 (A) all health care services to be provided;
24 (B) what health care services will be provided by contractors;
25 and
26 (C) provider compensation rates;
27 (D) termination procedures; and
28 (E) usual and customary reimbursement schedules.
29 **Sec. 21.07.020. Required contract provisions.** A health insurance plan
30 offered to residents of the state must provide that
31 (1) coverage for a medical procedure that has been preapproved by the

1 insurer may not be denied;

2 (2) all emergency room services shall be covered if the person covered

3 reasonably believes the services are required;

4 (3) copayment requirements shall be uniform between health care

5 providers;

6 (4) pharmacy and dental services shall be located in the community in

7 which the covered person resides; and

8 (5) a utilization review decision to deny, reduce, or terminate a health

9 care benefit or to deny payment for a health care service because that service is not

10 medically necessary may only be made by a health care provider trained in that

11 specialty or subspecialty after consultation with the covered person's health care

12 provider.

13 **Sec. 21.07.030. Choice of health care provider.** (a) An insurer that offers

14 a managed care plan shall offer to every contract holder a point-of-service plan option

15 that would allow a covered person to receive covered services from an out-of-network

16 health care provider without obtaining a referral or prior authorization from the insurer.

17 The point-of-service plan option may require that a subscriber pay a higher deductible

18 or copayment and higher premium for the plan if the higher deductible, copayment, or

19 premium results from increased costs caused by the use of an out-of-network provider.

20 (b) An insurer shall provide each subscriber in a plan whose contract holder

21 elects the point-of-service plan option with the opportunity at the time of enrollment

22 and during the annual open enrollment period to enroll in the point-of-service plan

23 option. The insurer shall provide written notice of the point-of-service plan option to

24 each subscriber in a plan whose contract holder elects the point-of-service plan option

25 and shall include in that notice a detailed explanation of the financial costs to be

26 incurred by a subscriber who selects that option.

27 (c) The requirements of this section do not apply to an insurer contract that

28 offers a managed care plan that provides health care services to Medicaid recipients

29 or to a federally qualified, nonprofit health maintenance organization.

30 **Sec. 21.07.250. Definitions.** In this chapter,

31 (1) "health care provider" means a person licensed in this state to

1 provide health care services;
2 (2) "health care services" means treatment of an individual for an
3 injury, illness, or disability and includes preventative treatment of an injury or illness;
4 (3) "health insurance" has the meaning given in AS 21.12.050;
5 (4) "managed care contractor" means a contractor who establishes,
6 operates, or maintains a network of participating health care providers, conducts or
7 arranges for utilization review activities, and contracts with an insurer, a hospital or
8 medical service plan, an employer or employee health care organization, or another
9 entity providing coverage for health care services to operate a managed care plan;
10 (5) "managed care entity" includes an insurer, hospital or medical
11 service plan, health maintenance organization, an employer or employee health care
12 organization, or a managed care contractor that operates a managed care plan;
13 (6) "managed care plan" means a health care plan operated by a
14 managed care entity; "managed care plan" does not include an integrated medical
15 group contracting with a health care plan for the direct provision of health care
16 services to a health care plan enrollee;
17 (7) "participating health care provider" means a health care provider
18 who has entered into an agreement with a managed care entity to provide services or
19 supplies to a patient enrolled in a managed care plan;
20 (8) "provider" means a health care provider;
21 (9) "utilization review" means a system of reviewing the medical
22 necessity, appropriateness, or quality of health care services and supplies provided
23 under a managed care plan using specified guidelines, including preadmission
24 certification, the application of practice guidelines, continued stay review, discharge
25 planning, preauthorization of ambulatory procedures, and retrospective review.
26 * **Sec. 4.** AS 21.42 is amended by adding a new section to read:
27 **Sec 21.42.390. Required health insurance coverage provisions.** (a) A
28 health care insurer may not include in the health care insurance plan or contract a
29 provision that
30 (1) prohibits a covered person from obtaining health care services from
31 a health care provider of the person's choice, including a specialist;

New Text Underlined [DELETED TEXT BRACKETED]