ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 0072

9329 HOUSE LABOR & COMMERCE

1 (2) restricts a covered person's right to receive full information from
2 the person's health care provider regarding the care or treatment options that the health
3 care provider believes are in the best interests of the person.
4 (b) A utilization review decision to deny, reduce, or terminate a health care
5 benefit or to deny payment for a health care service because that service is not
6 medically necessary may only be made by a health care provider trained in that
7 specialty or subspecialty and licensed to practice in this state after consultation with
8 the covered person's health care provider.
9 (c) A health care insurer may not
10 (1) directly or indirectly reimburse a covered person at a different rate
11 because of the person's choice of provider;
12 (2) deny coverage, cancel a health care insurance plan or subscriber
13 contract, or otherwise take action against a covered person or a health care provider
14 because the person has asserted a right described under this section.
15 (d) A covered person may bring a civil action against a health care insurer to
16 enforce the person's rights under this section.
17 (e) In this section,
18 (1) "health care provider" means a person licensed in this state to
19 provide health care services;
20 (2) "health care services" means treatment of an individual for an
21 injury, illness, or disability and includes preventative treatment of an injury or illness.
22 * **Sec. 5.** This Act takes effect July 1, 1998.

0-LS1248\J
Ford
4/27/98

04-27-98A11:05 RCVD

* The term "health care insurance" should be used throughout the bill instead of "health insurance".

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 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. 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,

New Text Underlined [DELETED TEXT BRACKETED]

1 function, or activity was <u>negligent, reckless, or</u> motivated by malice toward the
2 affected person. <u>Except as provided in this section, a</u> [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 care Insurance Plans.**
11 **Sec. 2? 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) current usual ~~and~~ customary and reasonable reimbursement schedules and methodology
29 **Sec. 21.07.020. Required contract provisions.** A health care 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;] authorized by the attending physician;

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

5 providers;] provided Amendment No. 1

6 (3) pharmacy and dental services shall be [located] in the community in

7 which the covered person resides; and

8 (4) 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 or managed care contractor 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 services for the diagnosis, prevention, treatment,
3 cure or relief of a health condition, illness, injury or disease.

4 (3) "health care 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 insurance plan that requires a
14 covered person to use, or creates incentives, including financial incentives, for a
15 covered person to use, health care providers managed, owned, under contract with
16 or employed by the 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 necessity,
22 appropriateness, <u>efficacy, or efficiency of,</u> [QUALITY] health care services,
<u>procedures, settings</u> and supplies provided under a managed care plan using
23 specified guidelines, including preadmission certification, <u>case management,</u>
24 <u>second opinion,</u> the application of practice guidelines, <u>concurrent</u>
[CONTINUED STAY] review, discharge planning, [PREAUTHORIZATION OF]
25 ambulatory <u>review</u> [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; This paragraph does not apply to a health care insurance plan if the policyholder signs a written waiver of the provisions of this paragraph;

Amend no. 2

(2) restricts a covered person's right to receive full information from the person's health care provider regarding the care or treatment options that the health care provider believes are in the best interests of the person.

(b) A utilization review decision to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary may only be made by a health care provider trained in that specialty or subspecialty and licensed to practice in this state after consultation with the covered person's health care provider.

(c) A health care insurer may not

[(1) directly or indirectly reimburse a covered person at a different rate because of the person's choice of provider;

(2)] deny coverage, cancel a health care insurance plan or subscriber contract, or otherwise take action against a covered person or a health care provider because the person has asserted a right described under this section.

(d) A covered person may bring a civil action against a health care insurer to enforce the person's rights under this section.

(e) In this section,

(1) "health care provider" means a person licensed in this state to provide health care services;

(2) "health care services" means treatment of an individual for an injury, illness, or disability and includes preventative treatment of an injury or illness.

* Sec. 5. This Act takes effect July 1, 1998.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE MEMBERS:

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REPRESENTATIVE JOHN COWDERY, VICE CHAIRMAN
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STATE CAPITOL, ROOM 24
JUNEAU, AK 99801-1182
PHONE: (907) 465-4954
FAX: (907) 465-2040

Labor and Commerce Committee

MEMORANDUM

TO: Representative John Cowdery
Representative Bill Hudson
Representative Joe Ryan
Representative Jerry Sanders
Representative Tom Brice
Representative Gene Kubina

FROM: Shirley Armstrong, Staff
House Labor & Commerce Committee

DATE: April 21, 1998

SUBJECT: **Additional Backup For Committee Bill Packet - HB 300**

Attached is information that has come to the House Labor and Commerce Committee since our committee hearing.

Please insert in your HL&C, HB 300 committee packet.

Attachment

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

P.O. BOX 110660
JUNEAU, ALASKA [illegible]-0660
PHONE: (907) [illegible]
FAX: (907) 465-[illegible]

April 3, 1998

Representative Rokeberg
Alaska State Legislature
Alaska House of Representatives
State Capitol
Juneau, AK 99801

Re: Estimates of Uninsured Alaskans

Dear Representative Rokeberg:

We just received new estimates of the number of uninsured Alaskans from the Employee Benefits Research Institute. These estimates are derived from the March Current Population Survey which has some significant limitations as a source of data, but as I explained before, it is the best source of data that we have for estimating the number of uninsured Alaskans.

Using data collected between 1994 - 96, EBRI estimates that [illegible],000 nonelderly Alaskans have no health care coverage. Of those, EBRI estimates that [illegible],000 of the uninsured are Alaska Natives. (As you know, the Indian Health Service is not considered health insurance or health care coverage.) When using the CPS data it is important to consider its limitations and as such, I have attached a memo that EBRI sent to my staff regarding the CPS data and its limitations.

Regarding your interest in the number of Alaskans with private non-group coverage. EBRI estimates that 33,135 nonelderly Alaskans had private non-group coverage.

Thank you.

Bob Labbe, Director
Alaska Division of Medical Assistance

attachments
EBRI Memo regarding Limitations of March Current Population Survey

Sources of Health Insurance and the Number Uninsured Nonelderly, Under Age 65, Alaskans, Merged Data Years 1994-1996

	TOTAL PVT		GH breakdown			GROUP HEALTH		OTHER PVT	
ALL	na	total pvt	na	direct	indirect	na	total employer	na	total oth pvt
MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT
SUM	SUM	SUM	SUM	SUM	SUM	SUM	SUM	SUM	SUM
581,320	183,758	397,562	216,893	181,245	183,182	216,893	364,427	548,185	33,135

MEDICAID		TOTAL PUBLIC		UNINSURED	
na	medicaid	na	total public	no	yes
MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT
SUM	SUM	SUM	SUM	SUM	SUM
478,368	102,952	398,054	183,267	500,100	81,220

Source: Employee Benefit Research Institute tabulations of data from the March 1995-1997 Current Population Surveys.

[illegible]

	TOTAL PVT		GM breakdown			[illegible]		[illegible]	
ALL	na	total pvt	na	direct	indirect	na	total employer	na	total oth pvt
MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT
SUM	SUM	SUM	SUM	SUM	SUM	SUM	SUM	SUM	SUM
77,065	35,514	41,551	38,174	16,904	21,987	38,174	38,891	74,406	2,660

[illegible]		[illegible]		[illegible]	
na	medicaid	na	total public	no	yes
MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT	MARSUPWT
SUM	SUM	SUM	SUM	SUM	SUM
26,377	50,689	24,078	52,987	67,076	9,989

Source: Employee Benefit Research Institute tabulations of data from the March 1995-1997 Current Population Surveys.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR & COMMERCE COMMITTEE, CHAIRMAN
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
JUDICIARY COMMITTEE, MEMBER
CORRECTIONS BUDGET SUBCOMMITTEE, MEMBER
ADMINISTRATION BUDGET SUBCOMMITTEE, MEMBER
HESS BUDGET SUBCOMMITTEE, MEMBER

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Representative Norman Rokeberg

March 13, 1998

Marianne K. Burke, Director
Division of Insurance
PO Box 110805
Juneau, AK 99811-0805

FAX: (907) 465-3422 (Juneau office)
Salt Lake Marriott (801) 532-4127 (NAIC meeting)

Dear Marianne:

In the past before the House Labor & Commerce Committee you have presented testimony and we have had discussions on the issue of lack of availability of health insurance for Alaskan citizens, particularly for individuals and very small businesses. In addition, you have testified that because of ERISA and, if I recall, the status of self-insured groups, that the majority of legislation passed regarding health insurance issues during the last four years (i.e., psa tests, mammograms, drive through pregnancy, and the current crop of bills such as SB 197, HB 300, etc.) would only effect a minority of Alaskan citizens in the 30-35% range. I have expressed my concern that the availability of health insurance particularly as it relates to policies for individuals has been substantially reduced by a number of factors including a perception of the political climate in the state, the growth of PPO type coverage and the high cost of doing business in the state. Moreover, it is my impression that few if any companies are writing individual policies. Therefore, could you verify whether or not any underwriters are doing this except Blue Cross and Golden Rule.

The House Labor and Commerce Committee is having a hearing on HB 300 on Friday, March 20, beginning at 3:15 p.m. It is my intention to make the hearing on this particular bill a debate revolving around the availability of health insurance for all citizens of the state, and the relative costs of group versus individual policies.

The Committee previously requested information on some of these issues and your division forwarded your annual report; however, I must say that the report is difficult for the layperson to fully understand and find the needed information without the knowledge and guidance of someone such as yourself or your staff. A specific answer to these inquiries would be appreciated:

Number of health insurers licensed to do business in Alaska
Premium volume of each carrier
Any information on types of polices they are underwritten, particularly as it relates to individuals.

Additional testimony and backup information will be needed on the issue of self insurance and the federal ERISA and opinions and case law relating to state regulations of health insurance underwritten under ERISA.

I am enclosing a copy of a legislative legal opinion which while clearly incomplete seems to differ with the testimony you have given to the committee. I would appreciate your most prompt attention to this issue so we will have an opportunity to review any information before the hearing.

Also, it might be helpful for you to request a legal brief from the Department of Law on some of these issues in order that they be included as far as bill packets on this and several other pieces of legislation under consideration by the legislature.

Sincerely,

Norman Rokeberg
State Representative
Chairman, House Labor & Commerce Committee

HNR:jss
Attachment

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

<u>MEMORANDUM</u> March 18, 1998

SUBJECT: Health insurance - (CSHB 300(HES))

TO: Representative Con Bunde
Attn: Patti Swenson

FROM: Michael F. Ford
Legislative Counsel

You have asked for an explanation of the effects of CSHB 300(HES) on those employers who are self-insured. Under the Employee Income Security Act or ERISA (29 U.S.C. 1001 et seq.), the state cannot mandate health insurance benefits for those employers who provide group health insurance through self-insurance. See <u>FMC v. Holliday</u>, 498 U.S. 52 (1990). However, the state can mandate health insurance benefits for those employers who provide health care coverage by purchasing commercial insurance. See 29 U.S.C. 1144(b)(2)(A). That being said, there are exceptions to the rule that self-insured plans are exempt under ERISA from state laws mandating health insurance benefits. Under 29 U.S.C. 1003(b), ERISA does not apply to an employee benefit plan provided by a state government. Therefore for example, the preemption provisions of ERISA do not apply to the State of Alaska, even though the state provides it's health care benefits by being self-insured. Therefore CSHB 300(HES) or other mandated health care statutes do apply to the State of Alaska. Also exempted from ERISA are agencies or instrumentalities of the state, such as school districts, and state created authorities, corporations, or commissions.

If you have further questions please contact me.

MFF:glc
98-176.glc

CHAIR
HOUSE HEALTH, EDUCATION
& SOCIAL SERVICES COMMITTEE

VICE-CHAIR
HOUSE JUDICIARY COMMITTEE

MEMBER
LEGISLATIVE BUDGET & AUDIT COMMITTEE
HOUSE SPECIAL COMMITTEE ON OIL & GAS
SELECT COMMITTEE ON LEGISLATIVE ETHICS

Alaska State Legislature

REPRESENTATIVE CON BUNDE

District 18

DURING SESSION
STATE CAPITOL, ROOM 104
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DURING INTERIM
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Representative_Con_Bunde@legis.state.ak.us

SPONSOR STATEMENT

House Bill 300

"An Act relating to health insurance; and providing for an effective date."

Often, insurers use health care consumers as trading chips in order to obtain services for a lower price. The problem is that the patients involved don't know that they have been traded until they come to use the service, then many times, they become aware that they are not able to go to the provider of their choice.

HB 300 protects the rights of health care consumers to choose appropriate medical care. This legislation prohibits insurers from reimbursing a covered person at a different rate because of the person's choice of health care provider.

To: Nancy Cornwell, Health Policy Analyst
Alaska Division of Medical Assistance

From: Ken McDonnell, Employee Benefit Research Institute

Re: Limitations of the March Current Population Survey

Background Information
The March Current Population Survey (CPS) is an important source of information on the health insurance coverage of Americans. Administered annually by the U.S. Bureau of the Census, the survey covers a representative sample of about 60,000 households including around 150,000 people. In addition to questions about demographic characteristics, household composition, and income, the survey has included questions related to health insurance coverage since 1980. A great deal of the current discussion related to health insurance coverage and the reorganization of the U.S. health care system is framed with reference to data from the CPS.

The interpretation of survey-based data requires careful consideration of the survey itself and the comparison results to other sources of data. Such scrutiny of health insurance data from the CPS has raised a few concerns about the data.

It is important to note that at no point in the CPS are respondents asked if any members of the household were uninsured for either part or all of the previous year. Estimates of the uninsured from the CPS reflect the number of persons for whom none of the specified types of coverage are reported for the year. Therefore, if survey respondents are answering the questions as intended, a person reported as uninsured on the CPS is without insurance for the entire year. When respondents answer the questions accurately, we capture any type of coverage held for even part of the year, but only capture as uninsured those who were without insurance for the entire year.

Comparisons of CPS with Other Surveys
In addition, there is concern that persons responding to CPS may be reporting their coverage at the time of interview, rather than their status during the previous calendar year, as requested. These concerns are based on comparisons of estimates of health insurance coverage based on the CPS to other surveys of health insurance coverage. Two surveys that give a point-in-time estimate of the uninsured are the National Medical Expenditure Survey (NMES), conducted in 1987, and the Survey of Income and Program Participation (SIPP).

Data from NMES indicate that, on average 16.4 percent of the nonelderly population were uninsured during any given month. As a comparison, 11.0 percent of the nonelderly population were uninsured during all 12 months of 1987. This compares with an annual estimate of 15.9 percent from the 1988 CPS. It appears that the CPS estimates are more similar to point-in-time estimates than annual estimates.

Estimates of the total population also suggest that CPS estimates of the uninsured more likely represent point-in-time estimates. During the fourth quarter of 1991, SIPP estimates of the uninsured indicate that, on average, 13.2 percent of the total population were uninsured at a point-in-time. Annual estimates from SIPP indicate that 7.0 percent of the total population were uninsured for all of 1991. The annual 1991 CPS estimate of 14.7 percent of the total population is quite similar to the 1991 SIPP point-in-time estimates.

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This supports the argument that there is a tendency for respondents in the CPS sample to answer the health insurance questions with respect to a point in time rather than in reference to the entire year.

We believe the evidence suggests that there is at best a mix of responses among respondents to the CPS: some are reporting their current coverage while others are reporting coverage during the previous year as requested.

State-level analysis off NMES is not practical at this point in time because of the small sample size and the data is dated. NMES was conducted in 1987. State-level analysis off SIPP is problematic because of the small sample size and it is not possible to integrate separate years together due to the longitudinal nature of SIPP. Separate data for Alaska is not available off SIPP. Alaska data is grouped with Idaho, Montana, and Wyoming. Separate data for those states is not possible with SIPP.

State-Level Analysis
While the CPS is designed for national analyses of the population, it can also be used for state-level analyses. However, state-level analysis based on the CPS should be given careful consideration. In states such as Alaska, where a relatively smaller number of households are surveyed, the reliability of the state-level CPS estimates can be improved by merging three years of CPS data. To increase the reliability of our estimates in this analysis we merged data from the March 1995, 1996, and 1997, the three most recently years of the CPS available at this time. The estimates obtained using a merged sample are averages over three years. Using three years of the March CPS doubles the CPS sample size. In a given March survey, half of the households were interviewed the previous year and half of the households will be interviewed again the next year. To ensure independence of observations, households are included only once. While this merge improves the reliability of state-level estimates, it is till important to examine the standard errors and confidence intervals around estimates presented in this report.

Medicaid Reporting
The apparent under-reporting of Medicaid coverage on the CPS raises concerns about the CPS data. Participation in Medicaid and other income-related programs, such as Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI), is said to be under-reported because the number of persons on the survey file reporting participation in these programs is significantly lower than the number of program participants shown in the programs' administrative data systems.

Conclusion
In conclusion, EBRI offers the following for consideration in interpreting all CPS data provided to the Alaska Division of Medical Assistance by our firm.

Nearly all states, as well as the Health Care Financing Administration which is administering the newly-created State Children's Health Insurance Program, are relying on the CPS March Supplement data for estimates of the number of uninsured persons/children. Those few states that have collected their own data have found it to be a time consuming and expensive data collection effort.

The smaller a state's population, the greater the sampling error in the CPS March Supplement. As stated earlier, a three-year merged sample is used to improve the reliability of the estimates but Alaska's estimates are still questionable. For example, a three-year merged sample (1993 - 95) of CPS data used by HCFA to calculate Alaska's 1998 CHIP allotment reported that there were 9,000 uninsured children in Alaska in families with incomes at or below 200 percent of the FPL, with a standard error of 2,100. That means that HCFA had 90 percent confidence that the number of uninsured Alaskan children below 200 percent of the FPL was between 6,900 and 11,100 during that period. Using a merged sample for a later period (1994 - 96) EBRI reported to the Alaska Division of Medical Assistance that there were 11,600 uninsured Alaskan children at or below 200 percent of the FPL. EBRI did not provide a standard error but it is reasonable to assume a similar range.

Finally, estimates derived from the CPS on the number of Medicaid recipients are generally less reliable than the estimates of persons with other sources of since Medicaid recipients tend to have a change in

coverage status more frequently than those with private coverage. The State of Alaska should rely on its own state-generated data for estimates of the number of persons with Medicaid coverage rather than the CPS estimates. In examining the estimates we provided to the division on the size of the Medicaid population, EBRI suggests that the division look further into its own data as our estimates appear to suggest that a substantially large number of recipients have incomes much greater than the eligibility standards for at least some part of the year leading to the conclusion that there may be gross turnover in the Alaska Medicaid population.

Bill History/Action Display

```
BILL: HB 300          SHORT TITLE: ALASKA PATIENTS' BILL OF RIGHTS
BILL VERSION:
SPONSOR(S): REPRESENTATIVES(S) BUNDE, James

CURRENT STATUS: (H) L&C                  STATUS DATE:  2/25/98
```

TITLE: "An Act relating to health insurance; and providing for an effective date."

Full Text Bill/Resolution has Zero Fiscal Note(s).

Bill History

Jrn-Date	Jrn-Page		Action
1/12/98	2023	(H)	PREFILE RELEASED 1/2/98
1/12/98	2023	(H)	READ THE FIRST TIME - REFERRAL(S)
1/12/98	2023	(H)	HES, LABOR & COMMERCE
2/19/98	Text	(H)	HES AT 3:00 PM CAPITOL 106
2/19/98	Text	(H)	MINUTE(HES)
2/24/98	Text	(H)	HES AT 3:00 PM CAPITOL 106
2/24/98	Text	(H)	MINUTE(HES)
2/25/98	2423	(H)	HES RPT CS(HES) NT 1DP 2DNP 2NR
2/25/98	2423	(H)	DP: BUNDE; DNP: PORTER, VEZEY;
2/25/98	2423	(H)	NR: DYSON, GREEN
2/25/98	2423	(H)	ZERO FISCAL NOTE (DCED)
2/25/98	2423	(H)	REFERRED TO L&C
3/20/98	Text	(H)	L&C AT 3:15 PM CAPITOL 17
3/23/98	Text	(H)	L&C AT 3:15 PM CAPITOL 17

Similar Subject Match or Exact Subject Match
CLAIMS
CONSUMER AFFAIRS
INSURANCE
MEDICAL CARE

Bill Root: Display History/Action Clear Bill Root

Return to BASIS Main Menu(20th Legislature)
BASIS Last Updated 4/20/98 11:53 AM

0-LS1248\C
Ford
4/17/98

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.** **<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,

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 and termination procedures.
27 **Sec. 21.07.020. Required contract provisions.** A health insurance plan
28 offered to residents of the state must provide that
29 (1) coverage for a medical procedure that has been preapproved by the
30 insurer may not be denied;
31 (2) all emergency room services shall be covered if the person covered

1 reasonably believes the services are required;

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

3 providers;

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

5 which the covered person resides; and

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

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

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

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

10 provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

24 incurred by a subscriber who selects that option.

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

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

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

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

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

30 provide health care services;

31 (2) "health care services" means treatment of an individual for an

injury, illness, or disability and includes preventative treatment of an injury or illness;

(3) "health insurance" has the meaning given in AS 21.12.050;

(4) "managed care contractor" means a contractor who establishes, operates, or maintains a network of participating health care providers, conducts or arranges for utilization review activities, and contracts with an insurer, a hospital or medical service plan, an employer or employee health care organization, or another entity providing coverage for health care services to operate a managed care plan;

(5) "managed care entity" includes an insurer, hospital or medical service plan, health maintenance organization, an employer or employee health care organization, or a managed care contractor that operates a managed care plan;

(6) "managed care plan" means a health care plan operated by a managed care entity; "managed care plan" does not include an integrated medical group contracting with a health care plan for the direct provision of health care services to a health care plan enrollee;

(7) "participating health care provider" means a health care provider who has entered into an agreement with a managed care entity to provide services or supplies to a patient enrolled in a managed care plan;

(8) "provider" means a health care provider;

(9) "utilization review" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a managed care plan using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

*** Sec. 4.** AS 21.42 is amended by adding a new section to read:

Sec 21.42.390. Required health insurance coverage provisions. (a) A health care insurer may not include in the health care insurance plan or contract a provision that

(1) prohibits a covered [illegible]n from obtaining health care services from a health care provider of the person's choice, including a specialist;

(2) restricts a covered person's right to receive full information from the person's health care provider regarding the care or treatment options that the health

1 care provider believes are in the best interests of the person.

2 (b) A health care insurer may not deny, reduce, or terminate health care
3 benefits for a covered person unless the denial, reduction, or termination is approved
4 by a physician who is licensed to practice in this state.

5 (c) A health care insurer may not

6 (1) directly or indirectly reimburse a covered person at a different rate
7 because of the person's choice of provider;

8 (2) deny coverage, cancel a health care insurance plan or subscriber
9 contract, or otherwise take action against a covered person or a health care provider
10 because the person has asserted a right described under this section.

11 (d) A covered person may bring a civil action against a health care insurer to
12 enforce the person's rights under this section.

13 (e) In this section,

14 (1) "health care provider" means a person licensed in this state to
15 provide health care services;

16 (2) "health care services" means treatment of an individual for an
17 injury, illness, or disability and includes preventative treatment of an injury or illness.

18 * Sec. 5. This Act takes effect July 1, 1998.

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Fax Log Report

Apr-18-98 16:27

Identification	Result	Pages	Type	Date	Time	Duration	Diagnostic
94635515	OK	06	Sent	Apr-18	16:21	00:05:29	002584030022

7.0.0

04/27/98 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
16:52:17 PARTICIPANT LIST (ALL PARTICIPANTS) BY:ANC
TCN:80744 SCHEDULED FOR:04/27/98 15:15 TO 17:15 FOR:ANC
PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION:ANCHORAGE

HB 300	MS	KATHY	VOLZ	AK PT ASSOCI	TESTIFY
HB 300		TOM	TIERNEY	MUNI OF ANC	TESTIFY
HB 300	DR	CYNTHIA	DODGE		TESTIFY
HB 300		ROSS	BLAKER	AETNA	TESTIFY
HB 300		QUINN	MCKENNA ✓	PHSA	TESTIFY
HB 300		TOM	HIPSHER ✓		TESTIFY
HB 300		ED	BURGAN ✓	new names	TESTIFY
HB 300		MANO	FREY		TESTIFY
HB 350		ROBIN	SMITH		TESTIFY
HB 350		PATTY	GIRARD		TESTIFY
HB 350		JEFF	DAVIS	BL CROSS/SHIELD	TESTIFY
HB 350		PAULINE	UTTER		TESTIFY

NEA-ALASKA
Affiliated with the National Education Association

John Cyr
President

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FAX (907) 274-0551

04/27/98 15:21:53 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1120
MESSAGE FROM: LIOCJEN IN ANCHORAGE JNU

RE TCN: 80744 SCHEDULED FOR:04/27/98 15:15 TO 17:15
SPONSOR: HOUSE LABOR & COMMERCE PURPOSE: PUBLIC HEARING

MESSAGE TEXT: DR. ROBINSON OF WASILLA IS ON LINE TO
T ON HB 300

04/27/98 15:22:11 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1120
MESSAGE FROM: LIOCJEN IN ANCHORAGE JNU

RE TCN: 80744 SCHEDULED FOR:04/27/98 15:15 TO 17:15
SPONSOR: HOUSE LABOR & COMMERCE PURPOSE: PUBLIC HEARING

MESSAGE TEXT: OF 2, BLUE CROSS IS ON LINE TO ANSWER
QUESTIONS ON HB 350
JACK MCRAE

04/27/98 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
16:23:44 PARTICIPANT LIST (ALL PARTICIPANTS) BY:ANC
TCN:80744 SCHEDULED FOR:04/27/98 15:15 TO 17:15 FOR:ANC
PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION:ANCHORAGE

HB 300	MS	KATHY	VOLZ	AK PT ASSOCI	TESTIFY
HB 300		TOM	TIERNEY	MUNI OF ANC	TESTIFY
HB 300	DR	CYNTHIA	DODGE		TESTIFY
HB 300		ROSS	BLAKER	AETNA	TESTIFY
HB 300		QUINN	MCKENNA	PHSA	TESTIFY
HB 300		TOM	HIPSHER		TESTIFY
HB 300	WAD	ED	BURGAN — Brody & Co.		TESTIFY
HB 350		ROBIN	SMITH		TESTIFY
HB 350		PATTY	GIRARD		TESTIFY
HB 350		JEFF	DAVIS	BL CROSS/SHIELD	TESTIFY
HB 350		PAULINE	UTTER		TESTIFY

04/27/98 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
15:30:09 PARTICIPANT LIST (ALL PARTICIPANTS) BY:ANC
TCN:80744 SCHEDULED FOR:04/27/98 15:15 TO 17:15 FOR:ANC
PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION:ANCHORAGE

HB 300	MS	KATHY	Y VOLZ	AK PT ASSOCI	TESTIFY
HB 300		TOM	N TIERNEY	MUNI OF ANC	TESTIFY
HB 300	DR	CYNTHIA	Y DODGE → Psychologist		TESTIFY
HB 300		ROSS	BLAKER	AETNA	TESTIFY
HB 300		QUINN	MCKENNA	PHSA	TESTIFY
HB 300		TOM	HIPSHER		TESTIFY
HB 350		ROBIN	SMITH		TESTIFY
HB 350		PATTY	GIRARD		TESTIFY

COMMITTEE:
House Labor & Commerce Standing Committee

DATE: April 27, 1998

Subject of meeting:

HB 300 - ALASKA PATIENTS' BILL OF RIGHTS

SIGN-IN

PLEASE PRINT!

NAME	ADDRESS (MAILING / ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY ?
GORDON EVANS	211 4th St., Suite 305, Juneau	586-3210	HIAA	YES
Marianne Burke	9th Floor SOB	465-2515	Div of Insurance	Available for questions
JACQUELINE Hutchings	ANCHORAGE	345-2063	Patients	YES
DR. MICHAEL SAGE	ANCHORAGE	243-3710	Self (Former Teamster DPS.)	yes
DR. GEORGE M. HANSEN	ANCHORAGE	563-7518	SELF	YES
John Cyr	Juneau	586-3090	NEA-AK Health Trust	yes

0-LS1248\L

CS FOR HOUSE BILL NO. 300(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 2/25/98
Referred: Labor and Commerce

Sponsor(s): REPRESENTATIVES BUNDE, James

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to patients' rights under health insurance; relating to review of
2 health insurance treatment plans; prohibiting certain health insurance practices."
3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:
4 * Section 1. SHORT TITLE. This Act may be known as the Alaska Patients' Bill of
5 Rights.
6 * Sec. 2. AS 21.42 is amended by adding a new section to read:
7 Sec 21.42.390. Required health insurance coverage provisions. (a) A
8 health care insurer may not include in the health care insurance plan or contract a
9 provision that
10 (1) prohibits a covered person from obtaining health care services from
11 a health care provider of the person's choice, including a specialist;
12 (2) restricts a covered person's right to receive full information from
13 the person's health care provider regarding the care or treatment options that the health
14 care provider believes are in the best interests of the person.

no gag rule

HIAA no ...

COMMITTEE COPY

1 (b) A health care insurer may not deny, reduce, or terminate health care
2 benefits for a covered person unless the denial, reduction, or termination is approved
3 by a physician who is licensed to practice in the United States.
4 (c) A health care insurer may not
5 (1) directly or indirectly reimburse a covered person at a different rate
6 because of the person's choice of provider;
7 (2) deny coverage, cancel a health care insurance plan or subscriber
8 contract, or otherwise take action against a covered person or a health care provider
9 because the person has asserted a right described under this section.
10 (d) A covered person may bring a civil action against a health care insurer to
11 enforce the person's rights under this section.
12 (e) In this section,
13 (1) "health care provider" means a person licensed in this state to
14 provide health care services;
15 (2) "health care services" means treatment of an individual for an
16 injury, illness, or disability and includes preventative treatment of an injury or illness.

FISCAL NOTE

No: 1

Bill Version: CSHB 300 (HES)

(H) Publish Date: 2/25/98

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Revision Date (2/17/98

Dept. Affected Commerce & Economic Development

Title: An Act relating to Health Insurance

BRU: Insurance

Component: Insurance

Sponsor: Representative Bunde

Requester: House HES

Component Serial No. 354

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY98) cost: 0.0

POSITIONS

POSITIONS	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill has no fiscal impact on this component.

Prepared by: Marianne K. Burke, Director — Phone: 465-2515

Division: Insurance — Date: 2/17/98

Approved by: Commissioner Deborah B. Sedwick — Date: 2-18-98

Agency: Commerce and Economic Development

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HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: January 12, 1998 — FURTHER REFERRALS: Labor and Commerce

Date of Committee Action: 2/24/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 300

HOUSE BILL NO. 300 — HEALTH CARE INSURANCE

"An Act relating to health insurance; and providing for an effective date."

recommends it be replaced
with the following committee substitute CS HB 300 (HES)

[ ] the same title
[X] a new title

[ ] additional referral to ____________ Committee
[ ] attached amendment(s)

ADOPTS: ____________ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal note(s) ____________

[X] zero fiscal note(s) CED

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) ____________

[ ] zero fiscal note(s) ____________

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
[signature]			✓	
[signature]			✓	
Con Bunde	✓			
Brian S. Porter		✓		
[signature]		✓		

CHAIR'S SIGNATURE Con Bunde

CHANGES CONTAINED IN CSHB 300 (   )

The title is changed to reflect the emphasis of the bill, which is patient's rights.

Sect. 1 is changed, adding a new short title section that reflects the emphasis of the legislation.

Sect. 2 (b) is changed to require physician to physician contact in cases where a patients is denied care, reduced care, or terminated health care benefits.

The remainder of the bill is the same.

Alaska Nurse Practitioner Association

Alaska Nurse Practitioner Association
237 East Third Avenue
Anchorage, AK 99501

Lynn Hartz, Legislative Representative
phone 907-248-4877
fax 907-561-1257

April 28, 1998

The Honorable Norm Rokeberg
House of Representatives
Chair, House Labor and Commerce Committee
Fax 907-465-2040

Re **HB 300 Alaska Patients' Bill of Rights**

Dear Representative Rokeberg,

As the committee on Labor and Commerce considers HB 300 the Alaska Nurse Practitioner Association continues to support this bill and urges it's passage We are in favor of this bill because of it's consumer protections

This bill also protects health care providers from discrimination Section 21 07 020 (3) states "copayment requirements shall be uniform between health care providers". This section has particular resonance for us because of the Blue Cross Federal Employee Program's discrimination against their own nurse practitioner preferred providers Currently nurse practitioners with a **preferred provider agreement with** Blue Cross are not reimbursed for their services until the patient has met a $200 calendar year deductible Physicians with a preferred provider agreement with Blue Cross are paid in full after a $10 copayment for each office visit This policy has led to ridiculous situations in practitioner-physician practices in which patients are forced to decide whether to see the nurse practitioner who they may have seen for years and pay $200 before their insurance kicks in, or see the physician in the same office and pay $10 The Blue Cross Federal Employee Program in this case is actually providing financial incentives for their subscribers to see more expensive providers They are also practicing discrimination against a subgroup of their own preferred providers without warning or explanation

The Alaska Nurse Practitioner Association believes this example provides ample evidence that HB 300 is needed We need your help Providing high quality, cost-effective health care is not enough to save us from insurance company policies like that of the Blue Cross Federal Employee Program a policy that is not based on cost-savings, nor does it have anything to do with appropriate use of health care

We strongly support House Bill 300 and hope that the Labor and Commerce Committee will support it also and move it forward

Sincerely,

Lynn Hartz, MSN, ANP

cc Representative Con Bunde

TESTIMONY ON HOUSE BILL 300

BEFORE THE ALASKA HOUSE LABOR AND COMMERCE COMMITTEE

March 23, 1998

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

HIAA opposes House Bill 300 for a number of reasons, not the least of which is that its provisions include an "any willing provider" mandate, the consequence of which in the long run would be to increase the costs and reduce the efficiencies of managed care.

An integral part of managed care is the provider network. When a managed care plan enters into a contract with a particular provider -- whether a hospital, a physician, or some ancillary provider -- it seeks to accomplish several purposes.

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

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

Managed care plans attract providers by guaranteeing access to a specified pool of enrollees. If all providers in a community are required to be included in the plan, or if an enrollee is allowed to seek health care services from providers who are not participating in the plan, there is no economic incentive for any provider to enter into an alternative delivery or reimbursement system.

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

"Any willing provider" legislation also hurts consumers by hindering the ability of health insurers and PPOs (Alaska does not have any HMOs) to construct delivery systems that can guarantee specified standards of care to meet the needs of their members. To serve its enrolled population efficiently, a health care insurance plan must be allowed to establish its own credentialing standards and to decide on the optimal number (and specialty) of providers to be included.

Increasing a network of providers beyond its ideal size increases the cost of administering the network. HIAA believes that managed care systems should be able to limit their networks of providers and to alter reimbursement systems to reward efficient providers in their network. Insurers should be free to negotiate reimbursement schedules with providers to contain health care expenditures.

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

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

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

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

Finally, Mr. Chairman, with reference to proposed Sec. 21.42.390(a)(2) at the bottom of page 1, HIAA agrees that managed care plans should not limit or manage clincal discussions between physicians and their patients regarding care or treatment options, and in fact, most managed care plans do have contractual language to that effect in their agreements with providers.

We urge the committee to reject HB 300.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR & COMMERCE COMMITTEE, CHAIRMAN
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
JUDICIARY COMMITTEE, MEMBER
CORRECTIONS BUDGET SUBCOMMITTEE, MEMBER
ADMINISTRATION BUDGET SUBCOMMITTEE, MEMBER
HESS BUDGET SUBCOMMITTEE, MEMBER

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FAX: (907) 258-2916

SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

JUST THE FAX

Date: 13 mar 1998

TO: Marianne K Burke

FAX: ____________ Telephone: ____________

FROM: Representative Norman Rokeberg

FAX: (907) 465-2040 Telephone: (907) 465-4968

Number of Pages: 4 (including this page)

Comments:

Have a Nice Day

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Fax Log Report

Mar-13-98 01:17 PM

Automatic Log

Identification	Result	Pages	Type	Date	Time	Duration	Diagnostic
3422	OK	04/04	Sent	Mar-13	01:12P	00:02:25	002525030022
918015324127	OK	04/04	Sent	Mar-13	01:15P	00:01:58	002426030022

7.0.0

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STATE OF ALASKA

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FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM December 3, 1997

SUBJECT: Health insurance - (Work Order No. 0-LS1248\E) + A

TO: Representative Con Bunde
Attn: Patti

FROM: Michael F. Ford
Legislative Counsel

Enclosed are two versions of the draft you requested on health insurance. The "A" version contains changes to state law intended to protect certain patient rights. The "E" version is identical but also contains a change to the mental health benefits statute, AS 21.54.150. (See secs. 3 and 4).

You also asked for an explanation of the effects of the Employee Income Retirement Security Act of 1974 (ERISA) (29 U.S.C. 1001 - 1461) on the proposed legislation. This federal law sometimes preempts state law that regulates insurance. Generally, ERISA does not preempt statutes that specify the inclusion of certain types of benefits in insurance policies, such as mental health benefits. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1995). Therefore I would not think that ERISA poses a problem for either versions of your work draft. I would caution that this specific question has not been addressed by our state Supreme Court, therefore it is possible that a different view would be taken in Alaska.

Finally, you also asked for a copy of an A.G. opinion on preferred providers. I have checked back to 1977 and have not found an A.G. opinion on this issue. It is possible that the opinion has not been released yet. I did find a Virginia case that held that ERISA did not preempt a state statute regulating the activity of insurers in regard to preferred provider organizations. Stuart Circle Hosp. Corp. v. Aetna Health Management, 995 F.2d 500 (4th Cir. Va. 1993).

Please contact me if you have further questions.

MFF:pl
97-257.plm

Enclosures

/

HB 300

Shirley,

Norm would like you to call Mary Ann Burke, and ask her to give you a list of all Insurance Companies licensed to work in Alaska and the numbers of policies that are written a year. As well, as any other statistics that she can provide us with. He would also like her to appear before the committee to give an overview of insurance in the state.

Ryan via Norm

2/27/98 -

Called Maryann,

She is bringing over a report (annual report) that covers most of the question. She said she does not have a # of policies, but does have the $ amt that the companies write.

Told her Norm would like to know the trend are insurance companies coming or going out etc. - are there any factors that are influencing them one way or another

Mentioned that Norm wanted her to do an overview of insurance in the state. Told her we need to call it something else because they do not do [illegible] if it is an overview - She said she would help [illegible] up with a subject title - she

Facsimile Cover Sheet

To: Representative Rokeberg
Company: House of Representatives
Phone: 465-4968
Fax: 465-2040

From: Ross J. Blaker
Company: Aetna U.S. Healthcare
Phone: (907) 563-0433
Fax: (907) 561-2362

Date: March 25, 1998
Pages including this cover page: 1

Comments:

At the teleconfernce on HB300 on Friday I was asked about the number of covered members Aetna US Healthcare has in Alaska. As of the end of December 1997 we had 40,600. I do not have a breakdown between self and fully insured members.

Blue Cross
Blue Shield of Alaska
A PREMERA HEALTH PLAN

Jack C. McRae
Senior Vice President

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

April 7, 1998

The Honorable Norman Rokeberg
Chairman, House Labor & Commerce Committee
Alaska State Legislature
House of Representatives
Juneau, AK 99801-1182

Dear Chairman Rokeberg:

Thank you for the opportunity to testify during the hearing of HB 300 that you held on March 23, 1998. I am writing in response a question you raised at that time regarding the Alaska individual health insurance market. Specifically, you asked for information about Blue Cross Blue Shield of Alaska's market share and the names and market shares of other carriers offering individual coverage.

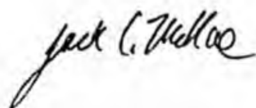
To the best of our knowledge, there has never been an thorough, independent assessment of the Alaska individual market. We understand that different regulatory requirements apply to the various carriers doing business in Alaska, with the result that Blue Cross Blue Shield of Alaska is the only carrier required to provide the Division of Insurance with detailed membership information, most of which is submitted as part of our individual rate filings. Thus the information we have available in-house at this time is for the most part anecdotal.

Given those constraints, it appears that Golden Rule, Guardian, NYL Care, Mutual of Omaha, and Principal Mutual are currently selling Alaska individual policies, in addition to Blue Cross Blue Shield of Alaska. With our own individual membership at 12,651, we estimate that we have about a 30 to 40 percent share of the commercially insured individual market.

It may very well be time to undertake a more systematic gathering of data relevant to the Alaska individual market. Such an undertaking might be most successful if direction is provided by the legislature or perhaps the Division of Insurance. In any event, we would certainly be willing to submit any needed information about our own organization or to assist in other ways.

I would be glad to discuss this matter further with you. Please do not hesitate to contact me. Once again, thank you for the opportunity to testify and for your interest in Blue Cross Blue Shield of Alaska.

Sincerely,



Jack C. McRae
Senior Vice President,
Public Affairs

cc: Marianne Burke
Jeff Davis

Municipality of Anchorage

P.O. Box 196650
Anchorage, Alaska 99519-6650
Telephone: (907) 343-4425

Rick Mystrom, Mayor

DEPARTMENT OF EMPLOYEE RELATIONS

March 24, 1998

Representative Norm Rokeberg
Chairman, Labor and Commerce Committee
Alaska State House of Representatives
State Capitol, Room 24
Juneau, Alaska 99801-1182

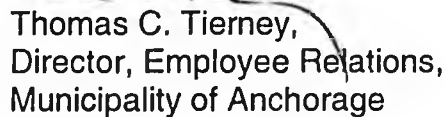
Re: House Bill No. 300

Dear Chairman Rokeburg:

Per your request I am enclosing a copy of a summary of my testimony of Friday, March 20, before the House Labor and Commerce Committee.

Please contact me if you need additional information.

Sincerely,



Thomas C. Tierney,
Director, Employee Relations,
Municipality of Anchorage

Summary of Testimony

Thomas C. Tierney

Director, Employee Relations, Municipality of Anchorage

Friday , March 20, 1998

The Municipality of Anchorage opposes this legislation. First, some information on the size of our workforce.

EMPLOYEES		
TOTAL EMPLOYEES	2,500	
PLUS: COBRA AND RETIREE ENROLEES	400	
TOTAL	2,900	
TOTAL LIVES COVERED WITH SPOUSES AND CHILDREN	APPROX	8,000

CLAIMS		
INPATIENT HOSPITALIZATION	5,700,000	35%
OUTPATIENT MEDICAL SERVICES	7,500,000	46%
PLUS: PRESCRIPTION DRUG	500,000	3%
DENTAL	2,300,000	14%
VISION	400,000	3%
TOTAL	16,400,000	

THIS PAST YEAR'S RESULT DOES NOT TELL THE WHOLE STORY. OVER THE PAST 10-15 YEARS, THE MUNICIPALITY OF ANCHORAGE, LIKE OTHER ALASKAN EMPLOYERS, HAS SEEN A STEADY INCREASE IN THE COST OF MEDICAL AND DENTAL COVERAGE FOR OUR EMPLOYEES. UNFORTUNATELY, THIS HAS BEEN A NATIONWIDE TREND.

FACED WITH THE PROBLEM, WE HAVE ATEMPTED TO MANAGE OUR COSTS IN SEVERAL WAYS, ALWAYS REMAINING MINDFUL OF THE BENEFIT/COST TRADE OFF:

- 1987 BEGAN UTILIZATION REVIEW TO HELP INSURE THAT IN PATIENT HOSPITAL ADMITS WERE PROPER
- 1990 INSTITUTED MANAGED MENTAL HEALTH CARE INVOLVING A GATEKEEPER APPROACH TO INSURE THAT TREATMENT PROTOCOLS AND PROVIDERS WERE APPROPRIATE
- 1991 INSTITUTED JOINT COST CONTAINMENT COMMITTEES WITH BARGAINING GROUPS
- 1993 APPROVED AETNA's USE OF A PREFERRED PROVIDER ORGANIZATION AS A COST CONTAINMENT TOOL

EQUALLY IMPORTANT DURING THIS PERIOD IS THAT WE HAVE HAD A CONTINUING AND INTENSIVE REVIEW OF PLAN DESIGN, INCLUDING THE LEVEL OF CO-PAYS AND DEDUCTIBLES

IN SHORT, WE'VE LEFT NO STONE UNTURNED IN OUR ATTEMPTS TO CONTROL OUR MEDICAL COSTS.

UNFORTUNATELY, EACH AND EVERY INCREASE IN COSTS FROM THE PROVIDERS OF MEDICAL AND DENTAL CARE MUST BE BORNE BY SOMEONE. EITHER OUR EMPLOYEE OR THE TAXPAYERS OF ANCHORAGE.

THEY ARE **NOT** PAID BY INSURANCE CARRIERS.

THE RESPONSIBILITY FOR THE HEALTH OF OUR EMPLOYEES IS ONE WE TAKE SERIOUSLY. IT'S A VERY PERSONAL MATTER FOR EACH OF US. BUT IT IS ALSO A BUSINESS. AND THAT BRINGS US TO THE PRESENT LEGISLATION. WE OPPOSE IT.

IT IS ESSENTIAL THAT WE CONTINUE TO HAVE THE ABILITY TO NEGOTIATE WITH THE PROVIDERS OF HEALTH CARE ON BEHALF OF OUR EMPLOYEES IN ORDER TO ACHIEVE THE MAXIMUM VALUE FOR THE EMPLOYEE AND TAXPAYER'S HEALTH CARE DOLLAR. THIS LEGISLATION WOULD SEVERELY RESTRICT OUR ABILITY TO DO SO.

THE BENEFITS OF USING ONE'S PURCHASING POWER TO NEGOTIATE FOR A BETTER DEAL ARE WELL KNOWN. FOR US TO BE RESTRICTED IN OUR ABILITY TO DO SO SHIFTS THE BALANCE OF POWER IN FAVOR OF THE MAJOR HEALTH CARE PROVIDERS AND AGAINST INDIVIDUAL USERS OF THEIR SERVICES.

THIS BILL IS CALLED THE PATIENT'S BILL OF RIGHTS. IF IT RESULTS IN INCREASED COSTS TO CONSUMERS, AS WILL SURELY BE THE CASE, THEN IT WILL BE AN EMPTY BILL OF RIGHTS.

THERE CAN BE NO QUESTION BUT THAT CERTAIN RIGHTS OF OUR EMPLOYEES HAVE BEEN RESTRICTED. LEFT UNCHECKED, MEDICAL COSTS WOULD BANKRUPT EVERY EMPLOYER AND GOVERNMENT ENTITY IN THE STATE.

INTERESTINGLY ENOUGH, OUR EMPLOYEES UNDERSTAND THIS. COMPLAINTS ABOUT OUR PPO AND OTHER CONTRACTURAL ARRANGEMENTS HAVE BEEN FEW. OUR EMPLOYEES RECOGNIZE THAT FOR THEM TO CONTINUE TO ENJOY THE COVERAGE THAT THEY HAVE, AT REASONABLE PRICES, CERTAIN CONTROLS ARE NECESSARY.

WHILE MANY OF THE COMPONENTS OF OUR HEALTH CARE DELIVERY SYSTEM IN THIS COUNTRY MAY BE IN NEED OF AN OVERHAUL, OUR UNRESTRICTED ABILITY TO NEGOTIATE ON BEHALF OF OUR EMPLOYEES TO PROVIDE THEM WITH REASONABLY PRICED HEALTH CARE IS NOT ONE OF THEM.

THANK YOU

MANAGED CARE OUTLOOK

The Insider's Business Briefing on Managed Healthcare

Volume 11, Number 12
March 27, 1998

Inside

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Page 7

Gregory Galdabini
Editor

Mass. health plans strike accord with hospitals on quality measures

Massachusetts hospitals are now supplying performance data based on a common set of reporting requirements that four of the state's leading health plans established. Key to continuing hospital-health plan cooperation will be plans not using the data to choose contract winners, participants say.

The standardization reduces the workload for hospitals under contract, which previously had to provide different measures in different formats, says David Smith, director of clinical data policy and research at the Massachusetts Hospital Association. With standardization, "we're much better off than we used to be," he says.

The single document "will help hospitals put resources toward quality improvement instead of devoting all their resources toward reporting," says Paula Griswold, director of the health institution per-

(more on page 5)

Harvard Pilgrim stems rising drug costs with flat-fee payments to pharmacies

New England HMO pioneer Harvard Pilgrim HealthCare last week rolled out a new strategy to combat rising pharmaceutical costs: contracts that pay retail pharmacies $29.70 for each prescription, regardless of the drug's cost.

Harvard Pilgrim's innovative reimbursement approach is designed to reduce rising drug costs exacerbated by the impact of a 1994 Massachusetts' "any willing pharmacy" law that was enforced in a federal court ruling last year (*MCO, Sep. 5, 1997*).

The court ruled that Harvard Pilgrim's exclusive contract with CVS Corp. violated the state's AWP law, clearing the way for any pharmacy to contract with Harvard Pilgrim as long as it accepted the HMO's reimbursement rates.

(more on next page)

Providence Health System in Alaska
Providence Alaska Medical Center
Administration Department
3200 Providence Drive
PO Box 196604
Anchorage, AK 99519-6604
PAMC Main No.: (907) 562-2211 / Administration Main No.: (907) 261-3675

FAX COVER SHEET

DATE: 4/20/98

FAX TO: Norm Rokeberg
PHONE NO.:

COMPANY: Alaska State Legislature

DEPARTMENT:

FAX NO.: 907-465-2040

FROM: Quinn McKenna

DEPARTMENT: Administration

PHONE NO.: (907) 261-3101 FAX #: (907) 261-3041

 # OF PAGES TO FOLLOW: 1 SENT BY: Laura Perry

CONFIDENTIALITY NOTICE

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MESSAGE / COMMENTS:

David G. Logan, DDS

6205 Glacier Highway
Juneau, AK 99801

Phone (907) 780-6066
Fax (907) 780-4274
Email logan@alaska.net

March 23, 1998

To: Representative Rokeberg

Re: HB300

Dear Representative Rokeberg:

Thank you for the opportunity to testify Friday before the Labor and Commerce Committee regarding HB300. I would like to clarify some of my testimony on Friday.

HB300 is not another form of "Any Willing Provider". This has no bearing on the HB300, but, unfortunately, is where the debate has centered. There is an important distinction between HB300 and "Any Willing Provider" legislation. HB300 requires insurance companies to reimburse patients the same dollar amount regardless of their choice of providers. Any Willing Provider allows any dentist, whether or not they participate in an insurance plan, to treat patients under the same provisions.

The distinction between these two concepts is important. Under Any Willing Provider there is little incentive for a health care provider to participate in a Preferred Provider Organization (PPO). The provider receives the same payment regardless of participation in the plan and agrees to accept this as payment in full. Under HB300 the patient receives the same dollar amount from the insurance company regardless of the choice of providers but would have to pay the difference, if any, between the providers fee and the payment from the insurance company.

Under HB300 there is a strong financal incentive for patients to seek providers who participate in a PPO. If patients see providers who participate in a PPO, they will have no out of pocket expenses for covered treatment. Patients who see providers who do not participate in a PPO will have to pay the difference between the between the same dollar amount the insurance company would pay to a participating provider and their regular fees. **The end result is under HB300 a patient would have no out of pocket expenses with a PPO provider and would have out of pocket expenses with an non PPO provider.**

Employers and insurance companies would not lose their ability to bargain as the financal incentives to participate in PPO's would be unchanged. The only way insurance premiums are affected is if insurance companies have factored in reduced payments to a large percentage of providers under current PPO standards. **If insurance companies have, in fact, counted on this then patients are paying the final cost as they are forced to make up the difference between what would have normally been their benefit and what the insurance company is willing to pay.**

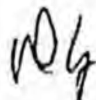
HB300 would insure the longevity of PPO's in the marketplace with employers and individuals who are comfortable with their restrictions in a health care plan. **HB300, however, insures the patient who is covered under such a plan by an employer but is not comfortable with the restrictions can go to a non participating provider without financal discrimination.**

I would like to remind all concerned what HB300 is truly about: preserving patient rights regardless of the type of insurance plan they are covered under.

- Patients should have a right to choose their provider including a specialist when they feel it is appropriate.
- Patients should have a right to have their insurance review conducted by a trained, licensed professional.
- Patients should be to choose their provider without fear of financal discrimination.

My final comment on HB300: **Employers should have the right to bargain and choose a health care plan taking into account financal considerations but patient s who often have little choice of their health care coverage should be able to choose the type of care they seek without being penalized for their choice.**

Sincerely,



David G. Logan, DDS
President-elect
Alaska Dental Society

Rx

Fax Transmission

** confidential **

Date: 3/31/98

pages faxed(including cover): 2

To: Representative Norman Rokeberg
Company:
Fax#:
907-465-2040

From: Barry Christensen
Company: Island Pharmacy
3526 Tongass Ave.
Ketchikan, AK 99901

Fax#: 907-225-6187
Voice#: 907-225-6186
E-Mail: island.pharm@juno.com

Message:

04-22-98A08:50 [illegible]

John F. Kobylarz DMD
246 N. Binkley Street, Suite B
Soldotna, Alaska 99669
TEL (907) 262-6393 Fax (907) 262-6244

Dear Representative,

Please move CSHB 300 out of the House Labor and Commerce Committee so it may be passed this session. Needless to say, we all will be patients in the future and would certainly resent some corporate beauraucrat making a fiscal decision that directly impacts our health. Everybody wins on this one, as there is no government cost to administer this one.

Sincerely,

John F. Kobylarz DMD

04-21-98P05:39 RCVD

Tue, Apr 21, 1998

I STRONGLY SUPPORT CSHB 300 AND REQUEST THAT IT BE MOVED OUT OF COMMITTEE!!!

I'M COUNTING ON YOU.

CARLA WOLF
6740 O'MALLEY
ANCHORAGE, AK 99516
346-1171

END

Dentistry for Children, Inc. 880 'N' Street, Suite 101, Anchorage, Alaska 99501

FAX

Date 4/21/98

Number of pages including cover sheet 1

To: Rep. Norman Rokeberg
Chairman
House Labor & Commerce
Committee

Phone: 465-4698

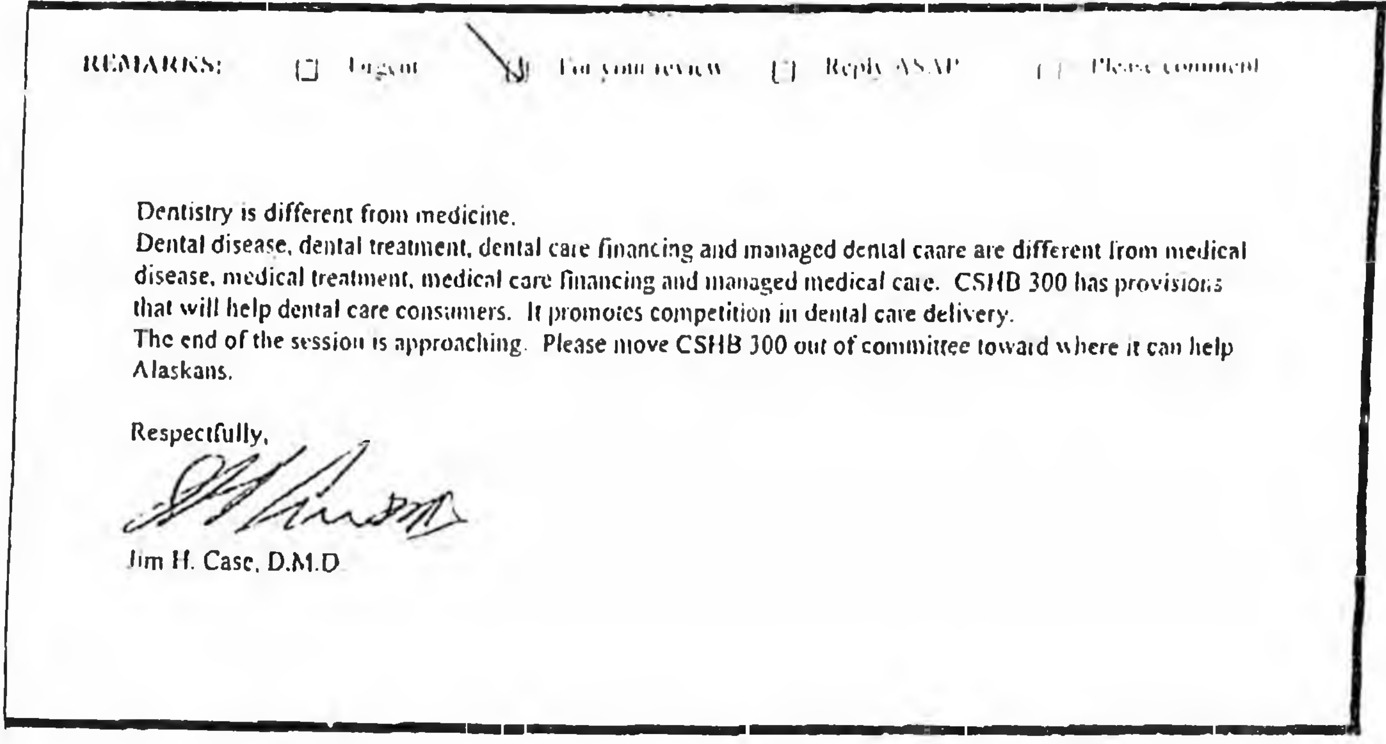
Fax phone: 465-2040

CC:

From: Jim Case D.M.D.

Phone 907-277-2525

Fax phone 907-277-4725



REMARKS: ☐ Urgent ☒ For your review ☐ Reply ASAP ☐ Please comment

Dentistry is different from medicine.
Dental disease, dental treatment, dental care financing and managed dental caare are different from medical disease, medical treatment, medical care financing and managed medical care. CSHB 300 has provisions that will help dental care consumers. It promotes competition in dental care delivery.
The end of the session is approaching. Please move CSHB 300 out of committee toward where it can help Alaskans.

Respectfully,

Jim H. Case, D.M.D

Author: jstranik@alaska.net (Gerald M. Stranik; D.D.S.) at CC2MHS1
Date: 4/21/98 3:03 PM
Priority: Normal
TO: Representative Norman Rokeberg at LAA_TRANS
CC: Representative John Cowdery at LAA_TRANS, Representative Bill Hudson at LAA_CAP, Representative Joe Ryan at LAA_TRANS, Representative Jerry Sanders at LAA_TRANS, Representative Tom Brice at LAA_TRANS, representative_gene_kubina@legis.state.ak.us at CC2MHS1
Subject: CSHB 300

Please move CSHB 300 out of committee!!

Sherree Evans
sledge@alaska.net

Author: jstranik@alaska.net (Gerald M. Stranik; D.D.S.) at CC2MHS1
Date: 4/21/98 2:53 PM
Priority: Normal
TO: Representative Norman Rokeberg at LAA_TRANS
CC: Representative John Cowdery at LAA_TRANS
Subject: CSHB300

I am requesting that CSHB300 be moved out of committee. Thank you.

Paula G. Kersbergen
2141 Lake George Drive
Anchorage, Alaska 99504
kersberg@ptialaska.net

04-21-98P04:10 RCVD

WARD A. HULBERT, D.D.S.

2700 WEST DIMOND BOULEVARD
ANCHORAGE, ALASKA 99515
TELEPHONE (907) 248-0022

4-21-98

Rep. Norman Rokenberg

CSHB 300 is good Legislation allowing people a choise in their selection of a Health provider. Please expedite its movement out of Committee.

thank you!

Ward A Hulbert D.D.S.

04-21-98 12:41 RCVD

4/21/98

Dear Rep. Rokeberg

Please pass CSHB 300 out of your committee. I have been working many years to assure the people of Alaska the right to pick any Dentist they wish — this keep the quality of Dentistry as high as possible

Thank you

Wm Fell
549 W. Fireweed
Anc AK 99503

Anchorage Midtown Dental Center
Donald E. Burk D.M.D.,P.C.
2805 Dawson St., Suite 101
Anchorage, Alaska 99503

04-21-98A09:19

FAX TRANSMITTAL

FAX # 907-562-0009

DATE 4/21/98

# of Pages including cover 1

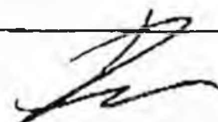
To: Rep Norm Rokeberg Fax # 907-465-2040

From: Don Burk

RE: CSHB 300

Norm: Cav Bunde's New Language Reflects special focus on Dentistry For ALASKA Patients Bill of Rights. Kindly move out of your committee.

Best ~~personal~~ Regards,



Nils P. Ersland, D.D.S.
Family Dentistry
9525 Gambell Street Suite 304
Anchorage, Alaska 99503
907 / 276 1521

04-21-95A10:25 RCVD

CSHB 300 IS VERY IMPORTANT AND VERY BENEFICIAL TO THE PEOPLE OF ALASKA WHO WILL BE ACCESSING THE HELTH CARE SYSTEM. IT PROTECTS THE FUTURE PATIENT NOT THE PROVIDER.

THOMAS G. HIPSHER, D.D.S.

04-21-98 A10:55 RCVD

April 21, 1998

To: Representative Norman Rokeberg, Chair
Representative John Cowdery
Representative Bill Hudson
Representative Joe Ryan
Representative Jerry Sanders
Representative Tom Brice
Representative Gene Kubina

RE: HB 300 - Patient's Bill of Rights

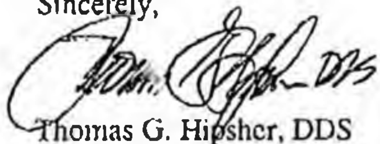
Dear Representatives:

HB 300 sits before your committee in limbo because the insurance industry and the labor lobby has successfully convinced you that passage of this bill will increase the cost of insurance premiums to purchasers of health insurance because they (the insurance industry and labor lobby) have **incorrectly interpreted this bill** as being the same as ***"Any Willing Provider"*** legislation.

Don't allow the rights of patient's to be violated under the guise of misinterpreted legislation by special interest groups. **Act now to move this bill out of your committee so that the full legislature can debate this issue rather than only the three committee members that were present as the public hearing.** You owe that to your constituencies as their representatives.

This is a public health matter and your failure to act on this legislation violates everyone's rights to equal and non-discriminatory access to health care.

Sincerely,



Thomas G. Hipsher, DDS

DIMOND CENTER TOWER 800 EAST DIMOND BOULEVARD, SUITE 3-415 ANCHORAGE, ALASKA 99515
TELEPHONE (907) 349-5585

04-21-98 ... RCVD

Fax Cover Sheet

Date 4/21/98

From T.S. REDMOND DDS.

Number of pages including this sheet 1

To REP. NORMAN ROKEBERG, CHAIR.

Company HOUSE LABOR & COMMERCE COMMITTEE Fax No. 465-2040

Regarding CSHB 300. DEAR SIR, AK. DENTAL SOCIETY HAS SUPPORTED YOU FINANCIALLY WHEN YOU NEEDED HELP. WE NOW NEED YOUR HELP WITH CSHB 300 AND ITS FOCUS ON DENTISTRY. MAY WE COUNT ON YOUR SUPPORT TO EXPEDITE THE MOVE OF CSHB 300 OUT OF COMMITTEE?

THANKING YOU IN ADVANCE, SINCERELY

THOMAS S. REDMOND DDS. PAST PRES. AK. DENTAL SOC.

NOTE: IF ANY OF THESE COPIES ARE UNREADABLE OR IF YOU DID NOT RECIEVE THE SAME NUMBER OF COPIES AS STATED ABOVE. CONTACT US IMMEDIATELY AT

1/907-346-3324

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

P.O. BOX 110660
JUNEAU, ALASKA 99811-0660
PHONE: (907) 465-3355
FAX: (907)465-2204

March 29, 1998

Representative Norman Rokeberg
Alaska State Legislature
State Capitol RM 24
Juneau, Alaska 99801-1182

Re: Estimates of Uninsured Alaskans/Individual Health Insurance

Dear Honorable Rokeberg:

The purpose of this memorandum is to describe the data sources available to state policy makers for estimating sources of health care coverage and to provide the most recent data available for Alaska. In addition, I have attached sections from a recent monograph published by the Alpha Center entitled *Mapping insurance Markets: The Group and Individual Health Insurance Markets in 26 States* that I hope will provide some insights into the individual health insurance market.

Sources for Estimating the Number of Uninsured and Other Sources of Coverage

The March Current Population Survey (CPS), conducted annually by the Bureau of the Census, is a widely accepted and in most states, the only data source for deriving state-level estimates of health care coverage. While other national surveys are available, state-level estimates are not derived from these sources (due to sampling and other considerations). While a few states have conducted their own surveys to determine sources of health care coverage, most states do not have the available resources to do.

State health policy makers routinely rely on the March Current Population Survey for estimates of coverage, openly recognizing that it has some limitations. The CPS covers a representative sample of about 60,000 households, or 150,000 individuals. The survey asks questions about demographic characteristics, household composition, and income. Since 1980, it has also included questions on health insurance. Even though the sample size is substantial, the sample size for a given state is relatively small, leading to less-reliable estimates of population characteristics at the state level. To report more reliable

Estimates of uninsured Alaskans published by the Health Resources and Access Task Force in 1993[1] and estimates of uninsured Alaskan children published by the Department of Health and Social Services in 1997[2] both used the CPS as the data source for their population estimates. The Health Resources and Access Task Force recognized that a certain number of Alaska Natives were included in (nationally-derived estimates of) the uninsured and although the task force concurred that access to care through the Indian Health Service is not health insurance, the task force in deriving their estimates eliminated all Alaska Natives since their interest was in defining the number of Alaskans who do not have access to health care, of which coverage is only one consideration. As you know, the task force reported that 76,000 non-elderly (non-Alaska Natives) Alaskans had no health care coverage in the late 1980s.

Several national organizations and firms routinely publish state-level estimates of the number of uninsured. In all of these published estimates, it is our understanding that some Alaska Natives are included. Attached is a news release from the Bureau of the Census that includes a table of state-level estimates on the percent of persons without health insurance coverage throughout the year. The Bureau of the Census using three years of data reports that 13.1 percent of Alaskans were estimated to be without health insurance coverage during one year (with a 90 percent confidence level of plus or minus 0.8 percent). It should be assumed that some Alaska Natives are included in these estimates.

I have also attached a memorandum from the Employee Benefits Research Institute, the firm our department engaged to develop estimates of the number of uninsured Alaskan children. As you know, we have reported that approximately 23,500 Alaskan children are uninsured, of which about 11,600 children are in families with incomes below 200 of the federal poverty level. The tables attached to that memorandum include estimates of the number of children with other sources of coverage. Regrettably, we do not currently have the same estimates for the entire population. However, we have hurriedly made a request for that data and expect to be able to provide it to you shortly. You will note that EBRI in its memorandum describes the limitations of the CPS as a source for estimating sources of health care coverage.

---

[1] Health Resources and Access Task Force, Alaska State Legislature. 1993. *Final Report to the Governor and Legislature*. Juneau (January).

[2] Alaska Department of Health and Social Services. 1997. *Smart Start for Alaska's Children: Children's Health Care Initiative, A Blueprint for Assuring Adequate Access to Health Care for Alaska's Uninsured Children and Pregnant Women*. Juneau (November 24).

Understanding the Individual Health Insurance Market

Since the Medicaid program is a source of health care coverage for 88,000 Alaskans, we are also interested in understanding the forces and trends in the health insurance market in the state. We also rely on data reported by the Alaska Division of Insurance including data in its annual report. It is our understanding that only a handful of insurers (including hospital and medical service corporations) are significantly active in Alaska in the individual market, most notably, Blue Cross (which reported $13 million in premiums sold in 1996).

I have attached several sections from an Alpha Center monograph on market changes in the group and individual insurance market in 26 states. Regrettably, Alaska is not one of the 26 states. However, we hope that the attached sections will provide some helpful background information as your committee seeks to better understand our individual health insurance market. I would be happy to provide you the entire report. It is also available from the Alpha Center by calling (202)296-1818.

Thank you.

Bob Labbe, Director
Division of Medical Assistance

cc: Commissioner Karen Perdue
Commissioner Deborah Sedwick

attachments
Bureau of the Census News, September 29, 1997
EBRI Memorandum regarding Limitations of the March CPS
Selected sections, *Mapping Insurance Markets: The Group and Individual Insurance Market in 26 States*

UNITED STATES DEPARTMENT OF
COMMERCE
NEWS
WASHINGTON, DC 20230

ECONOMICS AND STATISTICS ADMINISTRATION

BUREAU OF THE CENSUS

EMBARGOED UNTIL 10 A.M. EDT, SEPTEMBER 29, 1997 (MONDAY)

Public Information Office
301-457-3030/301-457-3670 (fax)
301-457-4067 (TDD)
e-mail: pio@census.gov

Income, Poverty and Health Insurance
301-763-8576

CB97-162

Income Improves, Poverty Levels Stabilize, Health Insurance Coverage Slips, Census Bureau Reports

Median household income increased in real terms between 1995 and 1996 for the second consecutive year, while the poverty rate and the number of people living in poverty remained statistically unchanged and the number of uninsured Americans, particularly children, rose, according to three reports released today by the Commerce Department's Census Bureau.

The reports, *Money Income in the United States: 1996; Poverty in the United States: 1996;* and *Health Insurance Coverage: 1996,* also include data for states. Both the income and poverty reports have additional data on the valuation of noncash benefits. The complete reports can be found on the Internet at <http://www.census.gov/prod/www/titles.html>.

Daniel Weinberg, chief of the Census Bureau's Housing and Household Economic Statistics Division, said the number of poor Americans in 1996 totaled 36.5 million, representing 13.7 percent of the nation's total population. Weinberg said, neither figure was significantly different from the previous year's estimate. In 1996, the average poverty threshold for a family of four was $16,036.

"During this same period," Weinberg said, "the real median income of households rose by 1.2 percent, increasing from $35,082 to $35,492. In addition, this was the third consecutive year in which there was no year-to-year change in overall income inequality."

On the health-care front, the number of uninsured children under 18 grew to 10.6 million (14.8 percent) in 1996; both the number and percentage were statistically higher than the 1995 figures of 9.8 million and 13.8 percent, respectively. Overall, an estimated 41.7 million, or 15.6 percent, of Americans had no health insurance during all of 1996. This number was up 1.1 million from the previous year, but the percentage was not statistically different.

(more)

Almost no group of people showed changes in its poverty rate except for the following: the rate declined significantly between 1995 and 1996 for persons living inside central cities (from 20.6 percent to 19.6 percent) and for male unrelated individuals (18.0 percent to 17.0 percent), while it increased for persons aged 60 to 64 (10.2 to 11.5 percent).

Between 1995 and 1996, there were no significant changes in poverty rates or numbers of poor among Whites, African Americans, Asians and Pacific Islanders or persons of Hispanic origin (who may be of any race).

The real median incomes of several types of households have returned to or exceeded their pre-recessionary 1989 levels. For example, the median income of married-couple households surpassed their 1989 level by 2.2 percent. Households in the Midwest and South, African American households, family households maintained by a woman with no husband present and households maintained by persons 55 to 64 years old all had incomes in 1996 comparable to their 1989 incomes (in 1996 dollars).

It was the second consecutive year that households inside metropolitan areas experienced an increase in real median income. Before 1995, the income of these households had not increased since 1989. For households inside central cities, it was the first annual increase in real median household income since 1988.

The female-to-male earnings ratio reached a new high in 1996 for persons working full time and year-round. The real median earnings for such women rose 2.4 percent to $23,710, which represented about 74 percent of the median for such men ($32,144). The last time men experienced an annual increase in median earnings was in 1991. In fact, between 1993 and 1996, men's earnings declined by 2.6 percent.

In 1996, more than one-half (53.1 percent) of the nation's 142.9 million workers had employment-based health insurance policies in their own name; this estimate did not reflect the fact that many workers are covered by an employment-based plan through another family member.

Other highlights:

Poverty

- Based on comparisons of two-year moving averages (1994-95 and 1995-96), the poverty rate dropped in five states (Indiana, Louisiana, Michigan, Missouri and Texas) and increased in three states (Arizona, Montana and Vermont).
- Using three-year averages (1994 to 1996), state poverty rates ranged from 6.5 percent in New Hampshire to 24.0 percent in New Mexico.

(more)

- Before 1994, the South had the highest regional poverty rate. Since that year the West has experienced a poverty rate not significantly different from that of the South — 15.4 percent for the West and 15.1 percent for the South in 1996.

- Neither the overall poverty rate for all children (20.5 percent), nor that for those aged 65 and over (10.8 percent), were statistically different between 1995 and 1996.

- In 1996, 14.4 million people had incomes of less than half of their poverty threshold, up from 13.9 million in 1995.

- Neither the number of poor nor the poverty rate for families showed significant change between 1995 and 1996; this was true regardless of family type or race and ethnicity.

- In addition to the official income and poverty data released today, the Census Bureau also released income and poverty estimates based on 17 other definitions of income.

Income

- Based on comparisons of two-year moving averages (1994-95 and 1995-96), real median household income increased significantly for nine states (Alaska, Illinois, Indiana, Kentucky, Minnesota, New York, North Carolina, Rhode Island and South Carolina) and decreased for three states (New Mexico, Vermont and Wyoming).

- Using three-year averages (1994 to 1996), the median household income for Alaska ($50,000) was higher than that of the remaining 49 states and the District of Columbia.

- The South was the only region to experience a significant year-to-year change in real median household income between 1995 and 1996. Real median household income increased there from $31,856 in 1995 to $32,422 in 1996. By comparison, the median household income in 1996 was $37,406 in the Northeast, $37,125 in the West and $36,579 in the Midwest. (The differences between the median household incomes of the Northeast, Midwest and West were not statistically significant.)

- This is the third consecutive year that family households have experienced an increase in real median income and the second consecutive year for nonfamily households. In addition, this was the third consecutive year that married-couple households experienced an increase in median income.

- Households maintained by persons of Hispanic origin experienced a 5.8 percent increase in real median household income (to $24,906) offsetting the drop observed in 1995. The percentage changes in household income of White ($37,161), African American ($23,482) and Asian and Pacific Islander households ($43,276) were not statistically different from 1995.

- Real per capita income increased significantly between 1995 and 1996, for Whites (1.8 percent to $19,181), African Americans (5.2 percent to $11,899) and Hispanics (4.9 percent to $10,048).

(more)

The 1996 per capita income of Asians and Pacific Islanders ($17,921) was statistically unchanged. (The differences between the 1995-1996 percentage changes in per capita income among the race/ethnic origin groups were not statistically significant. The differences between the per capita incomes of Whites and of Asians and Pacific Islanders, and between the total population and Asians and Pacific Islanders, were also not statistically significant.)

Health Insurance

- Based on comparisons of two-year moving averages (1994-95 and 1995-96), higher health insurance coverage rates were recorded for Alabama and Michigan. Meanwhile, coverage rates fell in six states: Arizona, Arkansas, Colorado, New Jersey, North Carolina and Tennessee.

- Using three-year averages between 1994 and 1996, the rates for the uninsured ranged from 8.2 percent in Wisconsin to 24.3 percent in Texas.

- In 1996, the percentage of persons without health insurance by income ranged from 7.6 percent (among those in households with incomes of $75,000 or more) to 24.3 percent (among those in households with incomes less than $25,000).

- In 1996, most people (70.2 percent) were covered by a private insurance plan; 25.9 percent had government coverage, i.e. Medicare (13.2 percent), Medicaid (11.8 percent), and military health care (3.3 percent). Many people had coverage by more than one plan during the year.

- About 30.8 percent of the nation's poor (11.3 million) had no health insurance of any kind in 1996.

- Among the various race and ethnic groups, persons of Hispanic origin were the most likely to be without coverage throughout 1996.

The data are from the March 1997 Current Population Survey. As in all surveys, the data are subject to sampling variability and other sources of error.

-X-

The Census Bureau — pre-eminent collector and provider of timely, relevant, and quality data about the people and economy of the United States. In over 100 surveys annually and 20 censuses a decade, evolving from the first census in 1790, the Census Bureau provides official information about America's people, businesses, industries and institutions.

Note: attached only table on Persons Without Health Insurance

-5-

Percent of Persons Without Health Insurance Coverage Throughout the Year, by State: 1994 to 1996

State	3-year average 1994-1996		2-year moving averages 1995-1996		2-year moving averages 1994-1995		Difference in 2-year moving averages 1995-96 less 1994-95	
	Percent	Standard error	Percent	Standard error	Percent	Standard error	Percent	Standard error
Alabama	15.2	0.9	13.2	1.0	16.4	1.1	*-3.2	1.0
Alaska	13.1	0.8	13.0	1.0	12.9	1.0	0.1	0.9
Arizona	21.6	1.0	22.3	1.2	20.3	1.2	*2.0	1.0
Arkansas	19.0	1.0	19.8	1.3	17.7	1.2	*2.1	1.1
California	20.6	0.4	20.4	0.5	20.9	0.5	-0.5	0.4
Colorado	14.6	0.9	15.7	1.1	13.6	1.0	*2.1	0.9
Connecticut	10.1	0.9	9.9	1.0	9.6	1.0	0.3	1.0
Delaware	14.2	1.0	14.6	1.3	14.6	1.2	-	1.0
D.C	16.2	1.1	16.1	1.3	16.9	1.3	-0.8	1.1
Florida	18.1	0.5	18.6	0.6	17.8	0.6	0.8	0.5
Georgia	17.3	0.9	17.9	1.0	17.1	1.0	0.8	0.9
Hawaii	8.9	0.8	8.8	1.0	9.1	0.9	-0.3	0.8
Idaho	14.8	0.9	15.3	1.1	14.0	1.0	1.3	0.9
Illinois	11.2	0.5	11.2	0.6	11.2	0.5	-	0.5
Indiana	11.2	0.8	11.6	1.0	11.6	1.0	-	0.8
Iowa	10.9	0.8	11.5	1.0	10.5	0.9	1.0	0.9
Kansas	12.2	0.9	11.9	1.0	12.7	1.0	-0.8	0.9
Kentucky	15.1	0.9	15.0	1.1	14.9	1.1	0.1	1.0
Louisiana	20.2	1.0	20.7	1.2	19.9	1.2	0.8	1.1
Maine	12.9	1.0	12.8	1.2	13.3	1.1	-0.5	1.0
Maryland	13.1	0.9	13.4	1.1	14.0	1.1	-0.6	0.9
Massachusetts	12.0	0.6	11.8	0.8	11.8	0.6	-	0.6
Michigan	9.8	0.5	9.3	0.6	10.3	0.5	*-1.0	0.5
Minnesota	9.2	0.8	9.1	0.9	8.8	0.9	0.3	0.8
Mississippi	18.7	1.0	19.1	1.2	18.8	1.1	0.3	1.0
Missouri	13.3	0.9	13.9	1.1	13.4	1.1	0.5	1.0
Montana	13.3	0.9	13.2	1.0	13.2	1.0	-	0.9
Nebraska	10.4	0.8	10.2	1.0	9.9	0.9	0.3	0.9
Nevada	16.7	1.0	17.2	1.3	17.2	1.1	-	1.0
New Hampshire	10.5	0.9	9.8	1.1	11.0	1.1	-1.2	1.0
New Jersey	14.6	0.6	15.5	0.8	13.6	0.6	*1.9	0.6
New Mexico	23.7	1.0	24.0	1.3	24.4	1.2	-0.4	1.0
New York	16.1	0.4	16.1	0.5	15.6	0.4	0.5	0.4
North Carolina	14.5	0.6	15.2	0.8	13.8	0.7	*1.4	0.6
North Dakota	8.8	0.8	9.1	0.9	8.4	0.8	0.7	0.8
Ohio	11.5	0.5	11.7	0.6	11.5	0.6	0.2	0.5
Oklahoma	18.0	1.0	18.1	1.2	18.5	1.2	-0.4	1.0
Oregon	13.6	1.0	13.9	1.2	12.8	1.1	1.1	1.0
Pennsylvania	10.0	0.5	9.7	0.6	10.3	0.5	-0.6	0.5
Rhode Island	11.4	0.9	11.4	1.1	12.2	1.1	-0.8	0.9
South Carolina	15.3	1.0	15.9	1.3	14.4	1.1	1.5	1.0
South Dakota	9.6	0.7	9.5	0.9	9.7	0.8	-0.2	0.7
Tennessee	13.4	0.9	15.0	1.1	12.5	1.0	*2.5	0.9
Texas	24.3	0.6	24.4	0.7	24.4	0.7	-	0.6
Utah	11.7	0.8	11.9	1.0	11.6	0.9	0.3	0.8
Vermont	11.0	0.9	12.2	1.2	10.9	1.1	1.3	0.9
Virginia	12.7	0.8	13.0	1.0	12.8	0.9	0.2	0.8
Washington	12.9	0.9	13.0	1.1	12.6	1.0	0.4	0.9
West Virginia	15.5	0.9	15.1	1.0	15.8	1.1	-0.7	1.0
Wisconsin	8.2	0.7	7.9	0.8	8.1	0.8	-0.2	0.7
Wyoming	14.9	1.0	14.7	1.1	15.7	1.2	-1.0	1.0

*Statistically significant at the 90-percent confidence level.
-Represents or rounds to zero.

SOURCE: U.S. Bureau of the Census, March 1995, 1996, and 1997 Current Population Surveys.

To: Nancy Cornwell, Health Policy Analyst
Alaska Division of Medical Assistance

From: Ken McDonnell, Employee Benefit Research Institute

Re: Limitations of the March Current Population Survey

Background Information

The March Current Population Survey (CPS) is an important source of information on the health insurance coverage of Americans. Administered annually by the U.S. Bureau of the Census, the survey covers a representative sample of about 60,000 households including around 150,000 people. In addition to questions about demographic characteristics, household composition, and income, the survey has included questions related to health insurance coverage since 1980. A great deal of the current discussion related to health insurance coverage and the reorganization of the U.S. health care system is framed with reference to data from the CPS.

The interpretation of survey-based data requires careful consideration of the survey itself and the comparison results to other sources of data. Such scrutiny of health insurance data from the CPS has raised a few concerns about the data.

It is important to note that at no point in the CPS are respondents asked if any members of the household were uninsured for either part or all of the previous year. Estimates of the uninsured from the CPS reflect the number of persons for whom none of the specified types of coverage are reported for the year. Therefore, if survey respondents are answering the questions as intended, a person reported as uninsured on the CPS is without insurance for the entire year. When respondents answer the questions accurately, we capture any type of coverage held for even part of the year, but only capture as uninsured those who were without insurance for the entire year.

Comparisons of CPS with Other Surveys

In addition, there is concern that persons responding to CPS may be reporting their coverage at the time of interview, rather than their status during the previous calendar year, as requested. These concerns are based on comparisons of estimates of health insurance coverage based on the CPS to other surveys of health insurance coverage. Two surveys that give a point-in-time estimate of the uninsured are the National Medical Expenditure Survey (NMES), conducted in 1987, and the Survey of Income and Program Participation (SIPP).

Data from NMES indicate that, on average 16.4 percent of the nonelderly population were uninsured during any given month. As a comparison, 11.0 percent of the nonelderly population were uninsured during all 12 months of 1987. This compares with an annual estimate of 15.9 percent from the 1988 CPS. It appears that the CPS estimates are more similar to point-in-time estimates than annual estimates.

Estimates of the total population also suggest that CPS estimates of the uninsured more likely represent point-in-time estimates. During the fourth quarter of 1991, SIPP estimates of the uninsured indicate that, on average, 13.2 percent of the total population were uninsured at a point-in-time. Annual estimates from SIPP indicate that 7.0 percent of the total population were uninsured for all of 1991. The annual 1991 CPS estimate of 14.7 percent of the total population is quite similar to the 1991 SIPP point-in-time estimates.

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This supports the argument that there is a tendency for respondents in the CPS sample to answer the health insurance questions with respect to a point in time rather than in reference to the entire year.

We believe the evidence suggests that there is at best a mix of responses among respondents to the CPS: some are reporting their current coverage while others are reporting coverage during the previous year as requested.

State-level analysis off NMES is not practical at this point in time because of the small sample size and the data is dated. NMES was conducted in 1987. State-level analysis on SIPP is problematic because of the small sample size and it is not possible to integrate separate years together due to the longitudinal nature of SIPP. Separate data for Alaska is not available off SIPP. Alaska data is grouped with Idaho, Montana, and Wyoming. Separate data for those states is not possible with SIPP.

State-Level Analysis
While the CPS is designed for national analyses of the population, it can also be used for state-level analyses. However, state-level analysis based on the CPS should be given careful consideration. In states such as Alaska, where a relatively smaller number of households are surveyed, the reliability of the state-level CPS estimates can be improved by merging three years of CPS data. To increase the reliability of our estimates in this analysis we merged data from the March 1995, 1996, and 1997, the three most recently years of the CPS available at this time. The estimates obtained using a merged sample are averages over three years. Using three years of the March CPS doubles the CPS sample size. In a given March survey, half of the households were interviewed the previous year and half of the households will be interviewed again the next year. To ensure independence of observations, households are included only once. While this merge improves the reliability of state-level estimates, it is till important to examine the standard errors and confidence intervals around estimates presented in this report.

Medicaid Reporting
The apparent under-reporting of Medicaid coverage on the CPS raises concerns about the CPS data. Participation in Medicaid and other income-related programs, such as Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI), is said to be under-reported because the number of persons on the survey file reporting participation in these programs is significantly lower then the number of program participants shown in the programs' administrative data systems.

Conclusion
In conclusion, EBRI offers the following for consideration in interpreting all CPS data provided to the Alaska Division of Medical Assistance by our firm.

Nearly all states, as well as the Health Care Financing Administration which is administering the newly-created State Children's Health Insurance Program, are relying on the CPS March Supplement data for estimates of the number of uninsured persons/children. Those few states that have collected their own data have found it to be a time consuming and expensive data collection effort.

The smaller a state's population, the greater the sampling error in the CPS March Supplement. As stated earlier, a three-year merged sample is used to improve the reliability of the estimates but Alaska's estimates are still questionable. For example, a three-year merged sample (1993 - 95) of CPS data used by HCFA to calculate Alaska's 1998 CHIP allotment reported that there were 9,000 uninsured children in Alaska in families with incomes at or below 200 percent of the FPL, with a standard error of 2,100. That means that HCFA had 90 percent confidence that the number of uninsured Alaskan children below 200 percent of the FPL was between 6,900 and 11,100 during that period. Using a merged sample for a later period (1994 - 96) EBRI reported to the Alaska Division of Medical Assistance that there were 11,600 uninsured Alaskan children at or below 200 percent of the FPL. EBRI did not provide a standard error but it is reasonable to assume a similar range.

Finally, estimates derived from the CPS on the number of Medicaid recipients are generally less reliable than the estimates of persons with other sources of since Medicaid recipients tend to have a change in

coverage status more frequently than those with private coverage. The State of Alaska should rely on its own state-generated data for estimates of the number of persons with Medicaid coverage rather than the CPS estimates. In examining the estimates we provided to the division on the size of the Medicaid population, EBRI suggests that the division look further into its own data as our estimates appear to suggest that a substantially large number of recipients have incomes much greater than the eligibility standards for at least some part of the year leading to the conclusion that there may be gross turnover in the Alaska Medicaid population.

Attachment 1
(All Children)

Sources of Health Insurance for Children Age 0-18, by Poverty, Alaska, Merged Data Years 1994-1996

		TOTAL PVT		GROUP HEALTH		OTHER PRIVATE		TOTAL PUBLIC
	ALL	na	total pvt	na	total employer	na	total oth pvt	na
ALL	215,405	76,172	139,233	88,803	126,602	202,773	12,631	124,630
POVERTY RATE								
0-99%	24,286	20,373	3,913	21,852	2,434	22,807	1,479	6,481
100%-149%	17,253	13,575	3,677	15,079	2,173	15,748	1,504	5,575
150%-199%	22,023	10,055	11,968	12,809	9,214	19,269	2,754	10,306
200%-249%	21,311	7,952	13,359	8,702	12,609	20,561	750	13,347
250%-299%	20,061	7,104	12,957	8,639	11,422	18,527	1,534	11,797
300%-349%	17,818	3,780	14,038	4,503	13,316	17,096	722	10,666
350%-399%	18,394	4,356	14,039	5,573	12,822	17,177	1,217	10,494
400% or more	74,258	8,977	65,282	11,647	62,612	71,589	2,670	55,964

(CONTINUED)

cont, All Children

	TOTAL PUBLIC	MEDICAID		UNINSURED?	
	total public	na	medicaid	no	yes
ALL	90,775	160,493	54,911	191,914	23,491
POVERTY RATE					
0-99%	17,805	8,297	15,989	18,733	5,553
100%-149%	11,677	10,365	6,887	13,574	3,679
150%-199%	11,717	14,377	7,646	19,666	2,357
200%-249%	7,964	17,691	3,620	18,291	3,020
250%-299%	8,264	15,068	4,993	17,464	2,597
300%-349%	7,153	14,673	3,145	16,633	1,185
350%-399%	7,900	14,767	3,627	16,865	1,529
400% or more	18,294	65,255	9,004	70,480	3,571

11,589

11,902

23,491

Source: Employee Benefit Research Institute tabulations of data from the March 1995, 1996, and 1997 Current Population Surveys.

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STATE INITIATIVES

IN HEALTH CARE REFORM

Mapping Insurance Markets: The Group and Individual Health Insurance Markets in 26 States

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October 1997

ALPHA CENTER

Executive Summary

The states' and the federal government's need to understand insurance markets may be greater now than ever before. In many states, insurance regulation is reaching into new areas of insurer practice: requiring insurers to guarantee issue and renewal, limiting insurance price variation, and standardizing insurance benefits. Having already defined a new federal role in the regulation of insurance, Congressional interest in additional regulation restricting the practices of managed care plans is apparent.

Although knowledge of the group and individual health insurance markets is critical to successful regulation, these markets have largely gone unmapped. Thus, some of the most fundamental questions about health insurance markets remain unanswered: How many insurers offer major medical products? How is market share distributed among insurers, and is the distribution of market share changing? If some insurers leave a state, what impact might it have on the health insurance market? If a not-for-profit insurer converts to for-profit, how much of the total market does it convert?

This monograph offers an overview of the group major medical health insurance markets in 25 states and the individual (nongroup) markets in 26 states in 1995. The information provided here was compiled from the financial reports that HMOs, commercial insurers, and Blue Cross and Blue Shield (BCBS) plans file with each state. We compare some basic features of these markets across all of the study states. For the group and individual markets in each state, we present measures of market share held by three major types of insurers – HMOs, commercial insurers, and BCBS plans and HMOs; and we examine the distribution of the HMO market between BCBS HMOs and other HMOs. Market share is defined as an insurer's earned premiums during calendar year 1995, as a percent of the total earned premiums of all insurers in the state.

The structure of the states' health insurance markets varies substantially in terms of the number of insurers; the relative roles of HMOs, commercial insurers and BCBS plans; and the share of the market held by a few large insurers. Despite this diversity, some general observations can be made:

- The average insurer in the individual market is much smaller than the average insurer in the group market, both in terms of premium volume and in terms of average market share. On average, the states' group health insurance markets are 15 times the size of their individual markets, measured as premiums earned; but only about twice as many insurers write business in the group market as in the individual market.

- In most states, BCBS is the largest insurer in both the group and the individual health insurance markets. Averaged across all of the study states, BCBS plans (including both conventional BCBS and BCBS HMOs) hold about half of both the group and individual markets.

- In the group market, the average HMO holds much greater market share than the average commercial insurer. Moreover, HMOs are typically among the largest insurers in the group market, even in states with low HMO penetration.

- Where BCBS dominates the market, HMOs' group share is lower. This inverse relationship is especially strong in the group market (where HMO penetration is significant), but less evident in the individual market (where HMOs typically have much smaller market presence).

- Commercial insurers play a much greater role in the individual market than in the group market. In 8 of the study states, commercial insurers held more than half of the individual market; in no state did commercial insurers hold such a large share of the group market.

- Both the group and individual markets are heavily dominated by relatively few large insurers, even when there are many insurers writing business. In the group market, the smallest insurers hold very little market share (on average, 4.1 percent).

- The individual market is less concentrated than the group market, by most standard measures of concentration. In the individual market, the smallest 50 percent of insurers collectively play a greater role than the smallest insurers in group markets – on average, holding 8.8 percent of the market.

Regulation to improve employer and consumer access to health insurance markets always runs the risk of unintended consequences – in particular, driving insurers from the market and dampening competition. However, in insurance markets where most of the business is concentrated among relatively few insurers, the exit of smaller insurers from a state may not substantially redistribute market share and, therefore, may have little impact on the prices of either health insurance or health care services. This may be particularly true in the individual health insurance market, where on average each insurer holds less market share compared to the group market.

Nevertheless, regulators probably should regard the exit of smaller insurers and the potential for growing concentration in insurance markets with some caution – especially if departing insurers are yielding market share to an already dominant insurer. Policy makers may not fully anticipate the changes in insurance market structure that can emerge if managed care plans fail to enter markets where conventional insurers with small market share are leaving.

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2. Overview: The Group and Individual Health Insurance Markets

Nearly two-thirds of the nonelderly population has coverage from an employer-sponsored group plan, while only about 7 percent report coverage from any other type of private insurance plan.[3] Thus, it is not surprising that the group health insurance market in all states is substantially larger than the individual market. On average, the states' group health insurance markets (measured as total earned premiums) were 15 times the size of their individual health insurance markets in 1995 (see Table 1).

Table 1
Total and Population-Adjusted Number of Insurers per State and Average Total Premiums: Selected States, 1995

	Group market	Individual market
Number of insurers per state:		
Average	40.9	19.9
Minimum	8	4
Maximum	96	54
Median	36	15.5
Number of insurers per million state population under age 65:		
Average	13.6	5.4
Minimum	2.9	1.7
Maximum	35.3	15.1
Median	10.0	4.6
Average total premiums per state (in millions):	$3366.3	$232.9
Average total premiums per state, per million state population under age 65 (in millions):	$565.0	$46.7

Source: Alpha Center, Washington, DC

For most products, the number of sellers in the market and the distribution of market share among sellers are important indicators of competitiveness. In turn, more competitive markets are presumed to yield lower prices and greater quality and innovation, as sellers strive for greater market share and competition drives profits to minimum sustainable levels. Conversely, a strongly dominant company in any market can discourage the entry of new firms and may exercise substantial

[3]Alpha Center tabulations of the March 1996 Current Population Survey (Bureau of the Census, U.S. Department of Commerce).

control over prices in both its input and output markets. In health insurance markets, dominant insurers may affect both the price of health care services and the price of health insurance. In theory, such insurers also extract higher profits than they would if they were unable to affect price levels unilaterally.

On average, about twice as many insurers write major medical coverage in the group market as in the individual market, although in both markets the number of insurers writing major medical coverage varied substantially among the states. Adjusted for the size of the state's population under age 65 – a proxy for market size – the disparity among states in both markets was substantially less but nevertheless significant: from 3 insurers to 35 insurers in the group market, and from 2 to 15 insurers in the individual market.

Not only does the number of insurers differ between the group and individual health insurance markets, but in each state the two markets typically are dominated by different specific insurers, and the business is distributed differently among broad types of insurers. Aggregated across the study states, BCBS plans held nearly half of the group health insurance market and about 56 percent of the individual health insurance market in 1995 (see Figure 2). However, HMOs typically held a much greater share of the group market than the individual market in all states where they had a significant presence. In 1995, HMOs held more than one-third of the group health insurance market (34 percent, aggregated across the study states), but just 12 percent of the individual insurance market. In the individual market, commercial insurers held the largest block of business after BCBS plans (32 percent).

The following sections examine the structure of the group health insurance market in each of 25 states, and individual health insurance market in 26 states. We consider differences among states in the shares of each market held by BCBS plans, commercial insurers, and HMOs; and we present measures of market concentration for each state. While the text illustrations in each section are in graph form, much of the underlying data for these graphs is provided as tables in Appendices B and C.

Table 3
HMO Market Share and Number of HMOs Among the Largest 5 Insurers: The Group Health Insurance Market in Selected States, 1995

State	HMO market share[a]	Number of HMOs Among the Largest 5 Insurers
AL	12.6	4
CA	86.5	5
CT	39.1	4
FL	49.7	4
IA	19.8	2
ID	2.7	1
IL	39.6	4
KY	87.6	5
LA	62.8	4
MA	68.4	4
MD	49.3	3
MN	74.3	4
MS	6.0	1
MT	11.3	1
ND	2.6	2
NH	53.2	2
NY	52.5	4
OR	61.0	4
PA	37.6	2
RI	30.0	4
SC	28.4	3
TX	40.4	3
UT	53.1	2
VT	43.3	1
WA	32.4	1

Source: Alpha Center, Washington, DC.
[a]Includes BCBS HMOs.

4. Individual Health Insurance Markets

Several characteristics of the individual health insurance market make it a different and perhaps more difficult market for insurers. The individual market is much smaller than the group market, and it is typically the market of second resort – few people choose to buy individual coverage if they have access to group coverage. Thus, insurers' risk of adverse selection is higher in the individual market.