ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9330 HOUSE LABOR & COMMERCE

In most states, these considerations underlie differences in insurance practice and in the regulations that govern insurer behavior in the individual market. Many insurers in this market are known to underwrite medical risk aggressively, denying coverage even for minor or corrected health problems. Reluctant to underwrite as aggressively, some of the largest commercial insurers and many HMOs choose not to write coverage in the individual market at all. Because many regulators believe that insurers are more inclined to leave the individual health insurance market when faced with regulatory constraints on underwriting and pricing, regulation requiring guaranteed issue, rate restrictions, or standardized benefits is less common in the individual market. The following sections discuss measures of market structure and concentration in the individual markets in 26 states – each of the 25 states we described in the group market analysis above, plus Michigan.

A. The number of insurers in individual health insurance markets

Given the small size of the individual health insurance market compared to the group market, it includes a surprisingly large number of insurers. While the individual market is 1/15 the size of the group market (again, measured as premiums earned) it has about half as many insurers. Thus, each insurer writes proportionately less coverage compared to insurers in the group market, and these markets tend to be less concentrated.

Of the 26 state-level individual health insurance markets that we studied, Illinois has the largest number of insurers (54); Rhode Island has the fewest (4). Adjusted for population, the variation in the number of insurers across the states' health insurance markets was much less: ranging from 2 insurers per million population in California, to 15 insurers per million population in North Dakota (see Figure 8).

B. The distribution of individual health insurance markets among types of insurers

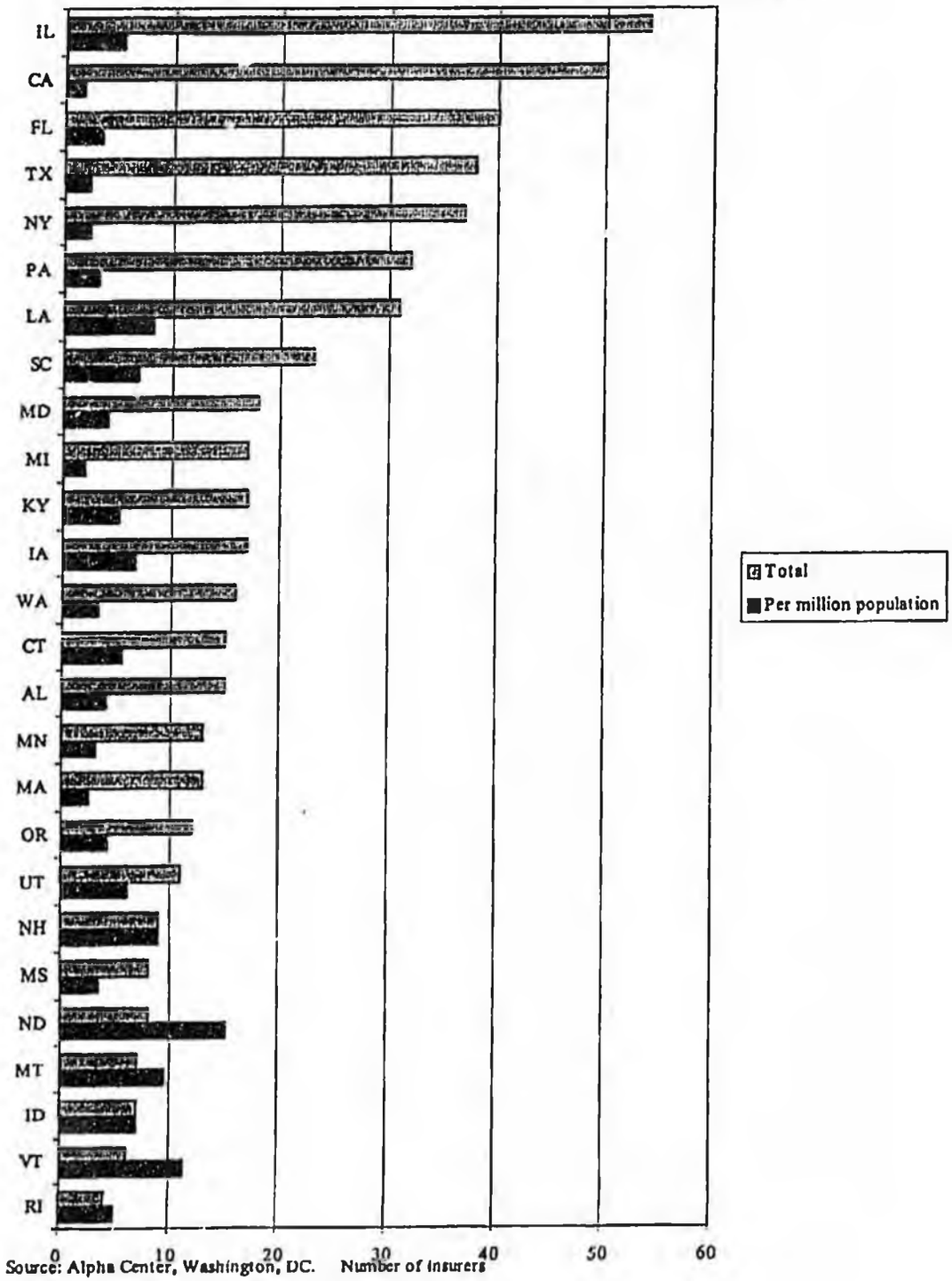
As was the case in the group health insurance market, in most states (22 of the 26 states in 1995), BCBS is the largest insurer in the individual market. But BCBS plans hold a still larger share of the individual health insurance market (56 percent in 1995, compared to 49 percent of the group market). Nevertheless, BCBS's market share varied widely across the 26 study states – from nearly 93 percent of the individual health insurance market in Idaho, to less than 1 percent of this market in Minnesota (see Figure 9). Consistent with low HMO penetration in most states' individual health insurance markets (described below), BCBS HMOs typically write very little coverage in the individual market. Notable exceptions are Kentucky (where the BCBS plan converted all of its business to an HMO in 1993), California (where the BCBS HMO competes with BCBS's smaller conventional business), and Minnesota (where BCBS's small individual market share is entirely its HMO).

Across all states, HMOs hold a much smaller share of the individual market than they do in the group market: on average, just 12 percent. HMOs hold a large share of the individual market in Kentucky (82 percent, nearly all of which is BCBS) and more than 60 percent of the market in California and Minnesota. In each of these states and also in Florida, an HMO was the largest insurer in the individual health insurance market. Nevertheless, about one-half of the 26 states that we studied have little or no HMO penetration in this market (see Figure 10).

As HMOs typically hold a much smaller share of the individual health insurance market compared to the group market, commercial insurers hold a much larger share. In 1995, commercial

Figure 8

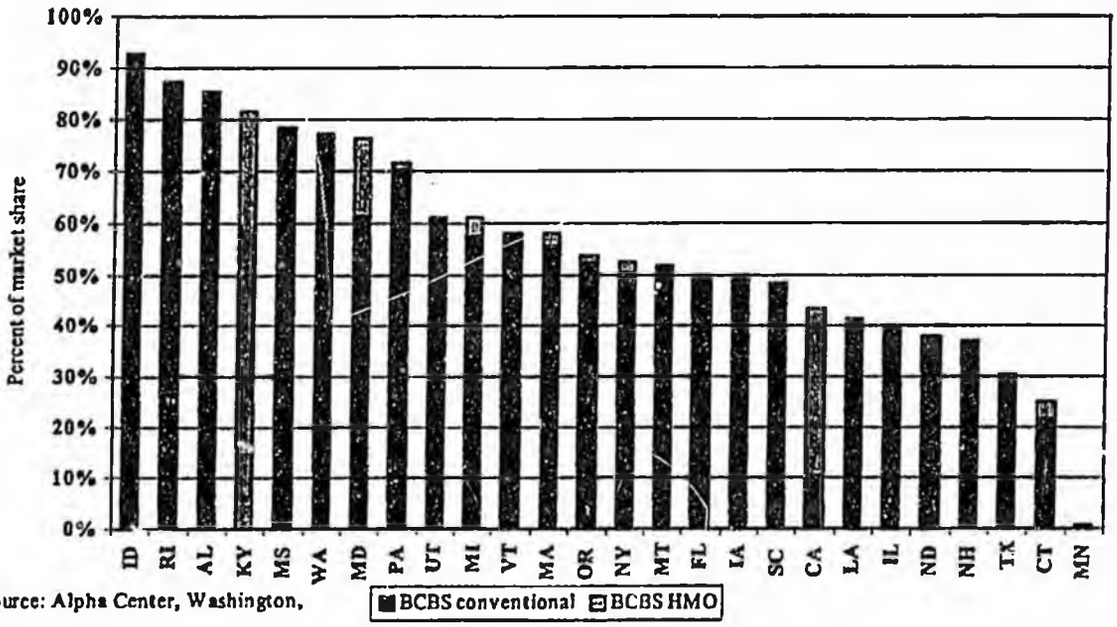
Total and Population-Adjusted Number of Insurers: The Individual Health Insurance Market in Selected States, 1995



Source: Alpha Center, Washington, DC.

Figure 9

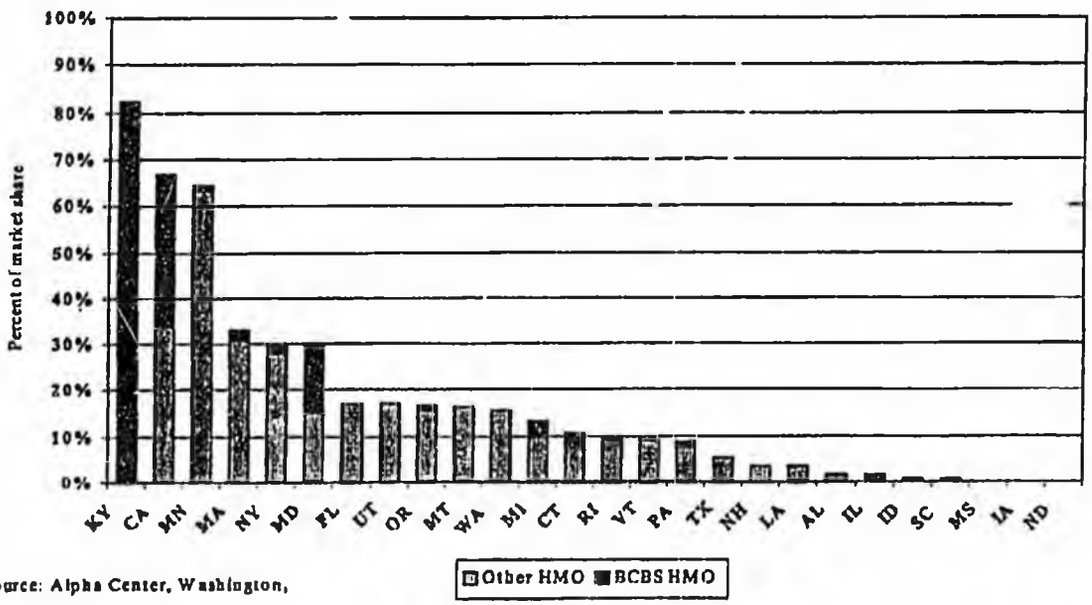
Market Share Held By Conventional and HMO Blue Cross and Blue Shield Plans: The Individual Health Insurance Market in Selected States, 1995



Source: Alpha Center, Washington,

Figure 10

HMO Market Share By BCBS Ownership: The Individual Health Insurance Market in Selected States, 1995



Source: Alpha Center, Washington,

insurers held nearly one-third (32 percent) of the individual market (compared to just 17 percent of the group market). In many states, commercial insurers dominate the individual market: commercial insurers held two-thirds of Connecticut's individual market (the only state where a commercial insurer was the largest player in this market), and more than half of the individual market in 7 of the other states that we studied. In contrast, commercial insurers' share of the group market never exceeded 50 percent in any of the 25 states that we studied.

As in group insurance markets, the average market share of commercial insurers in the individual market is usually smaller than the average market share of HMOs (see Table 4). This relationship held in 13 of the 26 states that we studied, including both states where a relatively large numbers of HMOs write coverage in the individual market (California, Florida, New York), and in states with relatively few HMOs in this market (Montana, Pennsylvania, Rhode Island and Utah). Kentucky and Idaho were unusual among the states in that only one HMO – a BCBS HMO – wrote coverage in their individual markets in 1995, and that HMO's market share was much smaller (by about half) than the average market share held by the commercial insurers in the individual market.

Table 4

Number of Insurers and Average Market Share Within Major Plan Types: The Individual Health Insurance Market in Selected States, 1995

	BCBS (including BCBS HMOs)		HMOs (excluding BCBS)		Commercial insurers	
State	Number of insurers	Average market share	Number of insurers	Average market share	Number of insurers	Average market share
AL	1	85.5	2	0.8	12	1.1
CA	5	8.6	12	2.8	33	0.7
CT	2	12.6	2	3.8	11	6.1
FL	1	48.9	8	2.2	31	1.1
IA	1	48.9	0	—	16	3.2
ID	2	46.4	1	0.8	4	1.6
IL	2	19.7	3	0.3	49	1.2
KY	3	27.2	1	0.6	13	1.4
LA	1	41.5	3	1.1	27	2.0
MA	3	19.3	5	6.2	5	2.2
MD	5	15.2	5	3.1	8	1.1
MI	5	12.2	5	2.0	7	4.2
MN	1	0.9	5	12.6	7	5.1
MS	1	78.4	0	—	7	3.1
MT	1	51.92	1	16.2	5	6.4
ND	1	37.8	0	—	7	8.9
NH	1	37.1	1	3.5	7	8.5
NY	9	5.8	16	1.8	12	1.6
OR	2	26.8	3	5.2	7	4.4
PA	7	10.2	2	3.9	23	0.9
RI	1	87.4	2	4.8	1	3.0
SC	2	24.1	0	—	21	2.5
TX	1	30.6	5	1.1	32	2.0
UT	1	60.9	2	8.6	8	2.7
VT	1	57.8	1	9.2	4	8.2
WA	5	15.4	3	5.2	8	0.9

Source: Alpha Center, Washington, DC.

C. Individual health insurance market concentration

As with the group market, the number of insurers writing in the individual market is a poor indicator of market concentration. Even in states with a large number of insurers, relatively few insurers hold most of the individual market (see Figure 11). For example, in Illinois, the largest five insurers held 60 percent of the market in 1995. In Rhode Island, five insurers held all of the market; the largest single insurer held 87 percent. California is the least concentrated market of all of the states that we studied: the largest insurer in California held just 23 percent of the market.

The states' individual markets are typically less concentrated than their group markets (see Figure 12). In most states, the smallest 50 percent of insurers in the individual market (ranked by market share) hold more of the market (on average, 8.8 percent) than the smallest 50 percent of insurers in the group market (on average, 4.1 percent). By this simple measure, the individual market is less concentrated than the group market in all states except Kentucky and New York. Various other measures of market concentration for the individual market are provided in Appendix C, and correlations among alternative measures are provided in Appendix E.

4. Implications of Market Structure for State Regulation

The substantial differences among states' insurance markets reinforce the adage that to understand one state is to understand one state. The 26 states that we studied vary widely in terms of the the number of insurers in the market and the market shares of BCBS, commercial insurers, and HMOs. Some of these variations are attributable at least in part to differences in market size (estimated as the size of the population), but other factors may also contribute to differences among the states: history, employer and consumer preferences and perhaps also regulation.[7]

Press reports and discussions with state insurance departments indicate that the insurance market is changing quickly. Competition has driven some plans to merge; various plans have been acquired by competitors. Some large mergers have occurred between commercial insurers and national HMOs; in many states, BCBS plans have merged under a single for-profit parent corporation. Conversely, new entrants in the health insurance market are common. By one estimate, 120 new HMOs began operating in 1995; 68 new HMOs entered the market in 1996 (SMG Marketing Group, 1997).

State regulators of health insurance markets, and now federal regulators as well, are confronted daily with the variable and dynamic nature of these markets. Any regulation to improve employer and consumer access to health insurance markets runs the risk of unintended consequences -- in particular, driving insurers from the market and dampening competition. However, some of the structural aspects of these markets may offer important information to regulators in anticipating such unintended consequences.

One of the most outstanding structural aspects of these markets, and possibly the most relevant to regulators, is their skewness. 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. Among the 25 state-level group markets that we studied, the smallest 50 percent of insurers together held an average of only 4.1 percent of market share. In Texas – by this measure, the least concentrated group market that we studied – the smallest 50 percent of insurers held just 8.5 percent of the market; in Alabama – the most concentrated market – they held less than 2 percent of the market.

Individual markets typically have fewer insurers compared to the much larger group markets, and on average, each insurer holds less market share. In 1995, the "average" group health insurance market was 15 times the size of the average individual market (measured as premiums earned), but they had only twice the number of insurers. Like the group markets, relatively few insurers hold most of the individual health insurance market. In the least concentrated individual health insurance market – Illinois – the largest five insurers held 60 percent of the market statewide. However, the smallest insurers in the individual market collectively hold more market share than the smallest insurers in the group market. On average across all states, the smallest 50 percent of individual health insurers collectively held just 8.8 percent of the market. Thus, in many states, a significant

---

[7] An earlier *State Initiatives* monograph (Paul and Chollet, 1996) offered a review of the research literature on the determinants of insurance market structure.

number of smaller insurers might exit either the group or the individual health insurance market without substantial disruption of the market overall. That is, relatively little market share would be redistributed among the remaining insurers.

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 in the market. Considering the group markets in our study states, the presence of a dominant BCBS plan was strongly correlated with the lower presence of HMOs, a phenomenon that may be explained by managed care plans' higher fixed costs and the constraints on their geographic reach. The inability of insurers to enter a market is always a problem if competition is expected to control cost and enhance quality. But policy makers may not fully anticipate the changed structure of insurance markets that can emerge if managed care plans fail to enter markets where conventional insurers with small market share are leaving.

TELECOPY COVER SHEET
Anchorage Legislative Information Office
Office - (907) 561-7007 Fax - (907) 562-4376

TO: House Labor & Commerce

ATTN: _____ FAX: 465-2040 PHONE: _____

FROM: Anch. LIO PHONE: _____

INSTRUCTIONS: Testimony for HB300 TC# 80502

SENT: Date 3/20 Time _____

DISPOSAL OF ORIGINAL: Discard _____ Hold for Pickup _____

NUMBER OF PAGES: 11 (counting cover sheet)

TRANSMITTED BY: Anc LIO

Alaska Nurse Practitioner Association

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

Lynn Hartz, Legislative Representative
lhartz@micronnet.net
907-248-4877
fax 907-561-1257

March 20, 1998

The Honorable Con Bunde
House of Representatives
Fax 907-465-3871

Testimony to House Labor and Commerce Committee re. HB 300:

The Alaska Nurse Practitioner Association is pleased to support HB 300. This bill provides important consumer protections including the right to full disclosure regarding treatment options and assuring Alaskans continued access to their clinician of choice.

This bill also protects health care providers from discrimination. I refer to line 4 which states "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." This section has particular resonance for us because of the Blue Cross Federal Employee Program's discrimination against their own nurse practitioner preferred providers since the beginning of this year. 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.

In response to questions, Blue Cross has not explained the rationale behind this policy and to date has just forwarded complaints to their Washington DC office.

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. There are about eighteen small solo nurse practitioner practices and four nurse practitioner-owned health clinics in Anchorage and Eagle River. Insurance company policies similar to that of Blue Cross could seriously affect their business if not put them out of business.

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.

Thank-you,
Lynn Hartz, ANP
ANPA Legislative Representative

19

TESTIMONY OF J. SHELBY STASTNY
IN OPPOSITION TO
HB300
3/20/98

MY NAME IS SHELBY STASTNY. I AM THE CHIEF FINANCIAL OFFICER OF NANA REGIONAL CORPORATION.

IN A RECENT STUDY IT WAS DETERMINED THAT NANA ACCOUNTS FOR 2,000 JOBS AND $80 MILLION IN ANNUAL PAYROLL – ALL WITHIN THE STATE OF ALASKA.

IN ORDER TO STAY COMPETETIVE AND CONTINUE TO BE A STRONG POSITIVE ECONOMIC FORCE IN TIS COMMUNITY, IT IS IMPERATIVE THAT WE SEEK WAYS TO CONTROL COSTS.

NANA IS ALSO AN EMPLOYER THAT CARES ABOUT ITS EMPLOYEES. MANY OF OUR EMPLOYEES ARE IN POSITIONS THAT DO NOT REQUIRE HIGH LEVELS OF EDUCATION OR EXPERIENCE, THUS ARE NOT AT THE TOP OF THE ECONOMIC PAY SCALE. WE CONTINUALLY SEEK WAYS TO PROVIDE BENEFITS TO OUR EMPLOYEES TO IMPROVE THEIR QUALITY OF LIFE, WHILE STILL REMAINING COMPETETIVE IN OUR LOW MARGIN BUSINESSES.

AS HEALTH CARE COSTS HAVE RISEN IN THE LAST FEW YEARS, IT HAS BEEN TOUGHER AND TOUGHER TO MEET OUR DESIRE TO PROVIDE REASONABLY PRICED HEALTH COVERAGE FOR OUR EMPLOYEES.

A GROUP OF OUR MANAGERS, ALONG WITH OUR INSURANCE CONSULTANTS, HAVE WORKED FOR THE LAST SEVERAL MONTHS TO PROVIDE HEALTH COVERAGE TO THE FAMILIES OF MORE OF OUR LESS HIGHLY COMPENSATED EMPLOYEES WHILE REMANING COMPETETIVE TO OUR CUSTOMERS. EFFECTIVE APRIL 1 – IN LESS THAN TWO WEEKS – WE BEGIN OUR NEW PROGRAM. A LARGER NUMBER OF OUR EMPLOYEES' FAMILIES WILL HAVE COVERAGE BECAUSE IT WILL BE MORE AFFORDABLE.

AN INTEGRAL PART OF OUR ABILITY TO PROVIDE THIS COVERAGE HAS BEEN OUR ABILITY TO HOLD DOWN HOSPITALIZATION COSTS THROUGH THE USE OF A PREFERRED PROVIDER NETWORK OF HOSPITALS. AS A PURCHASER OF MEDICAL SERVICES, OUR COSTS WILL BE REDUCED SIGNIFICANTLY BY A VOLUME PURCHASE AGREEMENT ARRANGED THROUGH OUR INSURANCE ADMINISTRATOR. VIRTUALLY ALL HOSPITAL SERVICE PROVIDERS IN ALASKA WERE GIVEN THE OPPORTUNITY TO PARTICIPATE – NOT ALL RESPONDED.

fg2

OUR EMPLOYEES ARE NOT REQUIRED TO RECEIVE SERVICES FROM THE PREFERRED PROVIDERS. THEY ARE FREE TO CHOOSE THE PROVIDER OF THEIR CHOICE. IF, HOWEVER, THEY CHOOSE ANOTHER PROVIDER, IT IS GOING TO COST NANA MORE MONEY, SINCE WE DO NOT HAVE THE DISCOUNT ARRANGEMENT. AS AN INCENTIVE FOR THE EMPLOYEE TO UTILIZE THE SERVICE THAT WILL COST NANA THE LEAST AMOUNT OF MONEY, THE EMPLOYEE PAYS A HIGHER SHARE OF THE COST IN A NON PREFERRED HOSPITAL.

THERE IS NO CREDIBLE EVIDENCE THAT THE PREFERRED HOSPITALS PROVIDE A LOWER QUALITY OF SERVICE.

WE OBJECT TO THE PASSAGE OF HB300 SINCE IT INTERFERES WITH OUR RIGHT TO APPROPRIATELY MANAGE OUR HEALTH CARE COSTS AND PROVIDE THE HIGHEST LEVEL OF HEALTH CARE SERVICE POSSIBLE FOR OUR EMPLOYEES AT A REASONABLE COST.

T. Shelby Stastny
1001 E. Benson
Anch. Ak 99508 265-4159

THE STATE OF WYOMING

JIM GERINGER
GOVERNOR

Insurance Department
HERSCHLER BUILDING · 122 WEST 25TH STREET · CHEYENNE, WYOMING 82002

March 19, 1998

The Honorable Con Bunde
Alaska House of Representatives
Room 104
State Capitol Building
Juneau, Alaska 99801

Facsimile Number (907) 465-3871

Re: Impact of State of Wyoming **Any Willing Provider Statutes**

Dear Representative Bunde:

The State of Wyoming insurance code has "any willing provider" provisions in two separate statutes. Those are at Wyo. Stat. §§ 26-22-503 and 26-34-134. I am enclosing copies of both statutes for your review.

This agency has not seen a significant impact of either of these statutes on the insurance industry in the State of Wyoming. No administrative actions or disciplinary measures have been taken against any insurer for an alleged violation of either of these statutes over at least the past five years.

I hope this information is of assistance to you.

Sincerely yours,

Donald L. Fritzen
Staff Attorney

DLF/gf
Enclosures

State of Idaho
DEPARTMENT OF INSURANCE

PHILIP E. BATT
Governor

700 West State Street, 3rd Floor
P O. Box 83720
Boise, Idaho 83720-0043
Phone (208)334-4250
FAX # (208)334-4398

JAMES M. ALCORN
Director

March 19, 1998

Via Facsimile 907-465-3871

Representative Con Bunde, Chairman
Educational and Social Service Committee
State of Alaska
State Capital Room 104
Juneau, AK 99801

RE: Any Willing Provider

Dear Representative Bunde:

The Idaho Department of Insurance is in receipt of a telephone inquiry on March 18, 1998, in regard to the "any willing provider" act within the Idaho Insurance Code. This legislation permitted any qualified provider who is willing to meet the requirements of an insurance company or a managed care organization to contract with that insurance company or managed care organization to be a participating provider. It did not require an insurer or managed care organization to contract with providers who are unqualified or who are not willing or able to meet the contract requirements.

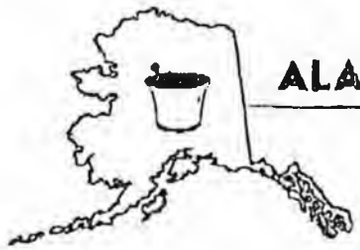
No major problems were identified during the implementation of this act. Additionally, the requirements of the act did not cause carriers or providers to discontinue the offer of health benefits or services within the state of Idaho.

Should you have further questions, please do not hesitate to contact our office.

Sincerely,

Joan A. Krosch
Health Insurance Coordinator

JAK\gcU-bunde-alaska



ALASKA PHARMACEUTICAL ASSOCIATION

Box 101185 Anchorage, Alaska 99510
(907) 563-8880

March 30, 1998

Representative Norman Rokeberg
Capitol Room #24
Juneau, AK 99801

Dear Representative Rokeberg,

Thank you for allowing our delegation to meet with you earlier this month to discuss House Bill No. 300 and related health care issues. As we stated during the meeting, our membership is very concerned about the impact of "Managed Care" on locally owned Alaskan pharmacies and the patients they serve. We appreciate your dedication to this issue and we pledge to work with you in order to maintain and improve patient care in Alaska.

We have received a copy of the committee substitute for House Bill 300. We are very much in support of the CS as it will help insure the continued viability of the smaller Alaskan owned pharmacies. This bill would not discriminate against the larger national providers, but would rather work to level the playing field for health care providers in Alaska. Without such equalization legislation, the demise of the smaller pharmacies in Alaska will become apparent. More will be forced to shut their doors because of the current practices of "Managed Care" imposed by the insurance industry.

Again, on behalf of the our Alaskan pharmacist membership, thank you for meeting with us to hear our concerns about the future of pharmacy services in Alaska. We look forward to continuing to work with you on House Bill 300 and related legislation in the future.

Sincerely,

Barry Christensen

Barry Christensen, Pharmacist
Chairman Legislative Committee

Karen Decker-Brown
2200 Shore Drive
Anchorage, Alaska 99515
Ph. 522-2254

HB 300-Testimony

The consumer should have the right to choose any health care provider (not just physicians) they need for health care coverage. It goes against all the principles our forefathers fought for to make America free to have insurance companies dictate who we can see for health care, what services we are allowed, and limiting coverage for individuals with certain problems.

In the book "Animal Farm" there is a phrase that goes something like this; "All animals are equal, it's just some are more equal than others". This is what we will have with managed care and health maintenance organizations.

Of great concern to me is that the insurance industry is no longer wholly owned by American companies. Some of the wealthiest and largest businesses in the United States are in the insurance industry. They are great companies to invest in but not at the expense of the American and Alaskan people. It is my understanding that companies such as New York Life and Equitable are owned by the Japanese if not wholly, then in part. We defeated the Japanese from taking over our land and it is of great concern that they are now buying America and dictating the quality of life and health care of the American people. It is by small bits over time, great changes take effect. It is almost imperceptible at the time, but our choices and coverage will be greatly eroded for financial gain of an overseas

conglomerate. What has that got to do with the here and now? It is looking at the larger picture of which we are a small bit.

It is for this reason I support action relating to patient's rights under health insurance and to prohibit insurance companies' restrictive treatment practices. Thank you.

HB 300 TESTIMONY TO HC&C 3/20/98

Subject: federal blue cross
Date: Wed, 18 Mar 1998 11:04:26 -0900
From: Catherine & Kevin Stange <kstange@Alaska.NET>
Organization: Stange
To: LHARTZ@MICRONET.NET

Lynn, I left a message for Annette Hewitt FNP to contact you in case she is available to testify at the legislature on Friday. Here is my bit of testimony to be read if possible. Please let me know if any changes are necessary. I'm not very experienced at such things !!Thanks

I am a nurse practitioner working in a large group pediatric pratice in Anchorage. I am directly affected in my practice by the inconsistency of benefits provided to me as a nurse practitioner and that of the pediatrician. Many of my patients I have cared for since birth and therefore have a relationship with them and their families. Presently, they are required to pay a $200.00 annual deductible to see me but for the SAME service could see the pediatrician in my office with only a $10.00 co-pay. This encouarges very poor continuity of care as well as inappropriate use of the physician in a collaborative practice, when both of the providers are Preferred Providers. Incidently, I have been a preferred provider with Federal Blue Cross for several years, in private practice, prior to joining this group practice. Financially, the discrimination against nurse practitioners does not make sense. By the inappropriate use of physicians in the practice, patients will see them instead of the nurse practitioners, and therefore, Federal Blue Cross will be paying out much more in funds for medical coverage to their clients. I also see that by this discrimination, nurse practitioners' practice is being restricted which is unconstitutional. I am convinced that this discrimination has been an oversite after many changes in the last 2 years of Benefit plans with Federal Blue Cross and hope that this issue will be addressed as soon as possible.

Thank you for your consideration in this matter.

Sincerely,

Catherine A. Stange MS ANP

Blue Cross
of Washington and Alaska

An Independent Licensee of the
Blue Cross and Blue Shield Association

P.O. Box 93932
Seattle, Washington 98133-0932
1-800-562-1011 Seattle: 425/774-3994

Federal Employee Program

FEBRUARY 24, 1998

Regarding: Nurse Practitioners

Dear Ms. [redacted].

Thank you for your recent inquiry regarding the benefits provided by the Blue Cross and Blue shield Service Benefit Plan for services performed by nurse practitioners.

Beginning on 1/1/96, preferred provider organization (PPO) benefits became available for services rendered by any covered providers with whom this Plan had a preferred provider agreement. Previously, PPO benefits were available only for preferred physicians and hospitals. This benefit change was stated on page 55 of our subscribers' 1996 Service Plan Benefit brochure.

The PPO benefit is described on page 23 of the 1996 brochure and page 26 of the 1997 brochure: After the $200 calendar year deductible, Plan pays 95% Preferred Provider Allowance (PPA). Also stated is: When preferred physicians are used for home or office visits, outpatient consultations, and second surgical opinions, they are paid in full after a $10 copayment for each outpatient office visit charge.

Benefits for services performed by a preferred provider other than a physician, such as a nurse practitioner, are paid at 95% PPA after the calendar year deductible has been satisfied.

As a courtesy to you, Ms. [redacted], I have forwarded a copy of your letter to the Subscriber Relations Department at the Blue Cross and Blue Shield Association, Federal Employee Program, at 1310 G Street, NW, Washington, DC 20005.

If you have any further questions, feel free to call our office at 1-800-562-1011 for assistance.

Sincerely,

Stephanie Kinney

Stephanie Kinney
Customer Service Advisor

[redacted]

Blue Cross of Washington and Alaska
Federal Employee Program
P.O Box 33932
Seattle, WA 98133

February 18, 1998

Dear Sir or Madam,

As a Blue Cross Blue Shield subscriber ([redacted]), I am writing to express my displeasure regarding your reimbursement practices for nurse practitioner rendered out patient services. Preferred provider nurse practitioners should be reimbursed at the same rate as preferred provider physicians. Presently, in Alaska, nurse practitioner services are not covered until patients meet their deductible, however, physician services are fully covered ($10.00 copayment only) without the need to meet a deductible.

Nurse practitioner outpatient services for uncomplicated health care is virtually identical to that of a physician and in Alaska, nurse practitioners have full prescriptive authority and independent practice. Many of the preferred provider nurse practitioners work in the same offices as preferred provider physicians and provide similar services for less cost

I believe that this current practice of Blue Cross Blue Shield is discriminatory and have contacted the Alaska State Nurse Practitioner Association with my concerns. I trust that once Blue Cross Blue Shield is made aware of this unfair practice it will be rectified. I look forward to your response in this matter.

Sincerely,

[redacted]

BLUE CROSS OF WA & AK

Prescription Drug Plan

Prescription Change Authorization Notification

Control # 06980130154620087305

A change in medication has been authorized by Dr. DONALD FUNK for: [redacted]

[redacted]

SITKA AK 99835[redacted]

Dear [redacted]

In order to keep your health and prescription drug benefits more affordable, your health plan has implemented a formulary which is a preferred list of some of the most widely prescribed medications. These medications have been reviewed by an independent Pharmacy and Therapeutics Committee for safety and efficacy, and are produced by nationally known and respected pharmaceutical companies.

As manager of your prescription drug benefit program, PAID Prescriptions, L.L.C. communicates with physicians to inform them when a formulary-preferred medication is available, which can mean more affordable benefits.

On JANUARY 30, 1998, Dr. FUNK authorized a change in your medication from PROCARDIA XL TABS to NORVASC TABS, a brand-name drug manufactured by PFIZER, which is the formulary-preferred medication.

Your co-pay will not be affected by this change. For your convenience, PAID Prescriptions, L.L.C., has prepared a Prescription Change Authorization for you to bring to your pharmacy.

Action Required:

1. Continue to take your current medication until you are ready for a refill. It is important to continue your therapy as prescribed by your physician.

2. When you are ready for a refill, tear off the "Prescription Change Authorization" form and present it at SHOPKO # 2075 or to the participating pharmacy of your choice.

3. Your pharmacist will confirm and dispense the preferred medication as authorized by your physician.

If you have any questions regarding this new medication or your doctor's instructions, please call PAID Prescriptions, L.L.C., toll-free at 1-800-671-3097, Monday through Friday, 8 am to 5 pm, Eastern time.

PAID Prescriptions, L.L.C. and Merck-Medco Managed Care, L.L.C. are subsidiaries of Merck & Co., Inc.

Please detach and give to your pharmacist when refilling your prescription. Control # 06980130154620087305

Prescription Change Authorization

TO: SHOPKO # 2075
or any Participating Pharmacy

RE: Patient [redacted]

On JANUARY 30, 1998, Dr. DONALD FUNK authorized the following change in medication:

Action Requested:

1. Call the physician's office at (907) 747-5605 to confirm this change in orders. Please speak with LINDA P. A written confirmation of this change has been sent to the physician.

2. Upon confirmation of this change, please fill the patient's prescription with the new medication.

Original Prescription:
PROCARDIA XL TABS

New Medication:
NORVASC TABS 5MG

Quantity:

Instructions:
TAKE 1 DAILY (REPLACES PROCARDIA XL)

Refills:
0

If you have any questions, please call the manager of your patient's prescription drug benefit plan at 1-800-671-3097 Monday through Friday, 8 am to 5 pm, Eastern time.

500 West Main Street
P.O. Box 1438
Louisville, KY 40201-1438
502 580 1000 Tel

HUMANA

February, 1998

Dear Pharmacy Owner/Manager:

Thank you for your interest in Humana. We appreciate your request to participate in the network of providers to service our membership in your area.

We have reviewed our network of pharmacy providers to ensure that we have provided sufficient coverage to our membership and have determined that we will not be contracting with additional pharmacies in your area at this time.

Respectfully,

Humana Pharmacy Management

Barry:
This is a real interesting "benefit" plan that has a number of employees and employers unhappy. Humana processes three PCS which we are a part of, but when we tried to do a claim, the message back was "not part of provider network" or some such message. When our bookkeeper called Humana they said we could NOT be a part of their program because they currently had K Mart, Payless-Rite Aid and Fred Meyer and that was enough!! And NO, our bookkeeper and/or owner could NOT speak to a supervisor - that's just the way it was!! One of our customers happens to be an employee in this program and he is mad and has contacted the insurance company that sold him this wonderful plan - We'll see

— Margaret [illegible]

- More Amens for the freedom of Choice -

Our vision is to improve the health of our members, and provide value to our customers, partners and shareholders.

NCSL · LEGISBRIEF

March 1998 Vol. 6, No. 13

THE "DE-SKILLING" OF AMERICAN HOSPITALS

By Brooke Davidson

To save money, many health care systems have replaced highly skilled professionals with lesser trained, lower paid workers.

Rapid changes in health care delivery and policy are moving patient safety and quality of care to the forefront of health care discussions. As health care systems place greater emphasis on cutting costs, the replacement of highly skilled professionals with lesser trained, lower paid workers has become pervasive.

Many hospitals react to cost pressures in an increasingly competitive environment by cutting labor costs, in particular shifting duties performed by registered nurses (RNs) to minimally trained, unlicensed assistants. Hospital administrators argue that some tasks, such as drawing blood samples, taking vital signs, bathing and feeding patients, or inserting and removing urinary catheters can be safely handed over to unlicensed people with special training.

Nurses and consumers are worried about the changes and how they affect patient care.

Many patients, consumer advocates and RNs disagree. They say hospitals are transferring more complex procedures requiring a certain level of judgment at a time when patients are sicker, require more difficult care and have shorter hospital stays. Consumers and RNs are worried about the changes and how they affect the safety and quality of patient care.

Key findings of a study conducted by the American Hospital Association found that consumers believe health care quality has declined and will continue to fall. The report raises questions about replacing nursing staff with aides. Some patients in the study were so concerned with the quality of care that they believed they needed a family member or friend to stay with them in the hospital to act as a protector.

Hospitals don't necessarily save costs by replacing RNs. For example, Mercy Medical Center in Baltimore, Md., recently scrapped its nursing assistant and technician positions and boosted its RN staff 40 percent. Administrators expect to improve patient care and save $500,000 a year in labor costs across four medical/surgical units. A 1996 study of data bases in California, Massachusetts and New York showed that when there are more registered nurses, patients have fewer complications, shorter hospital stays and lower mortality rates.

A 1996 Institute of Medicine report ordered by Congress expresses concern about the lack of research and data to demonstrate effectiveness or the effects on patient safety of replacing RNs with lower skilled workers. The report calls for placing a high priority on collecting empirical evidence on the relationship between quality of care and staffing levels.

Federal Action

A pending congressional bill, the Patient Safety Act of 1997 (HR 1165) would require Medicare-funded hospitals to make information readily available to the public, including:

- Numbers of RNs, licensed practical nurses and unlicensed personnel providing direct care;

Amount of On-the-Job Training Provided to New Unlicensed Personnel by Hospitals

Number of Hours	*Percent of Hospitals*
Less than 40	41%
41—120	58%
201—280	1%

Source: Nursing Economics, Vol. 12, no. 2, 1994.

NATIONAL CONFERENCE OF STATE LEGISLATURES

Executive Director William T. Pound

Denver Office 1560 Broadway Suite 700 Denver, Colorado 80202 303.830.2200

Washington Office 444 N. Capitol St., N.W. Suite 515 Washington D.C. 20001 202.624.5400

- Patient injury rates;
- Hospital acquired infection rates;
- Patient satisfaction; and
- Incidence of bed sores.

State Action

State legislatures have a long history of regulating different health care professions through licensure and certification. The replacement of RNs with lower skilled workers is an emerging legislative concern.

State legislatures have a history of regulating different health care professions through licensure and certification.

The Pennsylvania House appointed a committee to study these changes; their findings, reported in November 1996, generated the following recommendations:

- Require the Health Care Cost Containment Council to collect and disseminate data on the quality of nursing care as well as the number of staff, LPNs and RNs employed by the hospital.
- Require employees working in hospitals to wear name tags that designate their status.
- Create whistle blower protection for hospital staff reporting dangerous or inadequate medical care.
- Ensure that hospitals maintain a safe environment for patients that is not excessive in price.
- Ensure that certain invasive medical procedures be performed only by licensed individuals. Others who are not licensed should be properly trained, and hospitals should be legally responsible for the care given by unlicensed workers.

A 1996 Florida law required a task force to study and report on quality assurance measures and outcomes in hospitals. A report was due December 1997. And a 1997 Rhode Island resolution created a special commission to study the impact of nurse staffing in licensed health care facilities. Their report was due by February 1998. Five states considered bills in 1997 to require hospitals and other facilities to make information on nurse staffing and patient outcomes available to the public. Bills introduced in 1997 in Pennsylvania, New York and Washington were carried over to this year. The California governor's Managed Care Improvement Task Force also recommended making this information available to the public.

Ten states considered bills in 1997 requiring health care providers to wear name badges that include their credentials. Measures passed in Georgia, Illinois, Minnesota, Missouri and New Jersey. Utah implemented the language by administrative rule. Rhode Island adopted a photo ID badge requirement. And Minnesota and New Jersey passed whistle blower legislation last year to protect providers who report unsafe or poor patient conditions in the workplace.

Selected References

Wunderlich, Gooloo S., Frank A. Sloan and Carolyne K. Davis, eds. *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* Study prepared by the Institute of Medicine Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes. Washington, D.C.: National Academy Press, 1996.

Contacts for More Information

Brooke Davidson
NCSL—Denver
(303) 830-2200
brooke.davidson@ncsl.org

Susan Whittaker
American Nurses Association
(202) 651-7111
swhittak@ana.org

Blue Cross of Washington and Alaska*
Condensed Consolidated Balance Sheets**

Blue Cross of Washington and Alaska, subsidiary and affiliate
December 31, 1996 and 1995, in thousands

	1996	1995
Assets		
Cash and investments	$ 337,721	$ 348,621
Premiums and other receivables	81,200	67,694
Property and equipment, net	41,619	43,535
Other assets	11,163	13,494
Total assets	$ 471,703	$ 473,344
Liabilities and Net Worth		
Medical claims liability	$ 176,383	$ 165,323
Unearned revenue	62,666	67,210
Accounts payable and other liabilities	89,593	77,432
Total liabilities	328,642	309,965
Net worth	143,061	163,379
Total liabilities and net worth	$ 471,703	$ 473,344

* Includes Blue Cross of Washington and Alaska and its wholly owned subsidiary, Washington-Alaska Group Services, Inc., and its affiliate, HealthPlus. The Blue Cross and Blue Shield Association licenses Blue Cross of Washington and Alaska to offer certain products under the Blue Cross® brand name. Neither the Association, nor any other organization using the "Blue Cross" or Blue Shield® brand names acts as a guarantor of Blue Cross of Washington and Alaska's obligations.

** As derived from the audited consolidated financial statements of Blue Cross of Washington and Alaska. For a complete copy of the organization's audited financial statements that were prepared in accordance with generally accepted accounting principles, please contact the Communications Department of Blue Cross of Washington and Alaska at (206) 670-4611.

Blue Cross
of Washington and Alas

1996 Annual Report

Helping You Be Healthi

PREMER
Innovation for Well Bein

PremierSM Blue Cross of Washington and Alaska, Medical Service Corporation of Eastern Washington and HealthPlus are independent licensees of the Blue Cross Blue Shield Association.

Dear Valued Member:

Each year, I look forward to the opportunity to personally update you on your health plan. It's an occasion to share with you the improvements Blue Cross of Washington and Alaska made during the last year to help you be healthier.

This year, my letter focuses on four key areas: customer service, quality, innovation and security. As a consumer, I believe that a health care company that excels in these critical areas is well prepared to meet my health care needs. By the end of this short letter, and by virtue of your experience with us, I hope you agree that BCWA is solid in every category. If not, I hope you will let us know how we can improve.

It goes without saying that you, our customer, are the most important person at Blue Cross of Washington and Alaska. Everyday, with you in mind, we strive to better our services to make it easier for you to work with us. Consider some of our work in 1996.

Last year, we piloted a new personal computer-based customer service system to more easily access customer information and respond to your inquiries faster and more efficiently. We improved our phone systems to provide you with access to claims and eligibility information 24 hours a day, 7 days a week. In addition, through continual training and development, we enhanced the ability of our customer service teams to address your needs.

Quality is something we expect in our health plan, and BCWA is constantly working to raise the quality of health care you receive. In 1996, we continued building strong relationships with providers by involving them in our operations through our Regional Advisory Physician Panels and Board of Directors. We established a set of principles to guide our partnerships with doctors and create a framework to consistently deliver outstanding care to our members. BCWA also stepped up our emphasis on preventive care through clinical quality and care management, and our HMO, HealthPlus, became only the fourth HMO in Washington to earn three year, full accreditation from the National Committee for Quality Assurance. HealthPlus was also recognized by *US News and World Report* as one of the top managed care plans in the Northwest in delivering preventive care.

Next, innovation. Last year, Blue Cross of Washington and Alaska demonstrated our dedication to constantly finding new ways to help you be healthy. For instance, we introduced several new products, including *Blue Choices* for employer groups, *Senior Partners* for Medicare enrollees, and a managed care product for individual subscribers. Also in 1996, BCWA enhanced your prescription drug benefits by establishing services such as mail order prescriptions and education programs designed to ensure drugs are used safely.

Finally, I understand the importance of knowing your health plan will be there when you need it. BCWA has been there for more than 50 years. As shown in the balance sheet included with this letter, we continue to be a strong company financially. Our ability to serve customers is reflected in the growth of our membership, which increased from 879,000 to 911,000. For a variety of reasons that have affected the health care industry generally, though, we had a difficult year financially in 1996. However, we have taken steps to address these issues.

Our security -and yours, too--is also enhanced through our holding company, PREMERA. Through PREMERA, we have worked with our affiliates Medical Service Corporation of Eastern Washington, HealthPlus and Pacific Health and Life in Oregon to find new and better ways to meet your needs. By joining forces with others we can leverage our combined resources, such as health care services and information technology, to deliver better products and services -- at lower costs - for our customers.

Customer service, quality, innovation and security: In BCWA, I believe you have the right prescription to meet your health care needs effectively and efficiently.

On behalf of Blue Cross of Washington and Alaska, thank you for the opportunity to serve you. We look forward to helping you be healthy for many years to come.

Sincerely,

Betty Woods

Betty Woods
President and Chief Executive Officer

Board of Directors

Consolidated Financial Statements

Blue Cross of Washington and Alaska and Subsidiary and Affiliate

Years Ended December 31, 1996 and 1995
with Report of Independent Auditors

Blue Cross of Washington and Alaska and Subsidiary and Affiliate

Consolidated Financial Statements

Years Ended December 31, 1996 and 1995

Contents

ERNST & YOUNG LLP

Suite 3500
999 Third Avenue
Seattle, Washington 98104

Phone: 206 621 1800

Report of Independent Auditors

Board of Directors
Blue Cross of Washington and Alaska

We have audited the accompanying consolidated balance sheets of Blue Cross of Washington and Alaska and its subsidiary and affiliate as of December 31, 1996 and 1995, and the related consolidated statements of operations, net worth, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Blue Cross of Washington and Alaska and its subsidiary and affiliate as of December 31, 1996 and 1995, and the results of their operations and their cash flows for the years then ended in conformity with generally accepted accounting principles.

February 7, 1997,
except for the second paragraph
of Note 9, as to which the date is
March 19, 1997

Ernst & Young LLP

	December 31	
	1996	1995
	(In Thousands)	
Liabilities and net worth		
Liabilities:		
Medical claims liability	$176,383	$165,323
Experience-rated refunds payable	33,747	41,551
Unearned revenue	28,919	25,659
Accounts payable	21,412	20,227
Outstanding checks in excess of bank balances	28,477	20,560
Other liabilities	38,642	36,645
Federal income taxes payable	1,062	–
Total liabilities	328,642	309,965
Commitments and contingencies		
Net worth:		
General reserves	135,419	150,253
Unrealized appreciation on available-for-sale investments, net of tax	7,642	13,126
	143,061	163,379
Total liabilities and net worth	$471,703	$473,344

See accompanying notes.

Blue Cross of Washington and Alaska and Subsidiary and Affiliate

Consolidated Statements of Operations

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Revenues:		
Premiums	$1,150,797	$1,037,229
Net investment income	17,065	15,633
Net realized gains on investments	14,445	9,862
	1,182,307	1,062,724
Expenses:		
Health care services	1,030,778	930,237
General and administrative	122,157	103,788
Commission and brokerage	24,875	27,418
Premium taxes	17,202	16,626
Other expense	1,883	4,428
	1,196,895	1,082,497
Loss before income taxes	(14,588)	(19,773)
Income tax expense (benefit)	246	(3,924)
Net loss	$ (14,834)	$ (15,849)

See accompanying notes.

Blue Cross of Washington and Alaska
and Subsidiary and Affiliate

Consolidated Statements of Net Worth

	Year Ended December 31	
	1996	1995
	(In Thousands)	
General reserves:		
Balance at beginning of year	$150,253	$166,602
Net loss	(14,834)	(15,849)
Distribution to PREMERA	–	(500)
Balance at end of year	135,419	150,253
Unrealized appreciation (depreciation) on available-for-sale investments, net of tax:		
Balance at beginning of year	13,126	(4,897)
Change in unrealized appreciation (depreciation) on available-for-sale investments	(5,484)	18,023
Balance at end of year	7,642	13,126
Total net worth	$143,061	$163,379

See accompanying notes.

Blue Cross of Washington and Alaska and Subsidiary and Affiliate

Consolidated Statements of Cash Flows

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Operating activities		
Net loss	$ (14,834)	$ (15,849)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Net realized gains on investments	(14,445)	(9,862)
Depreciation and amortization of property and equipment	6,195	6,837
Net amortization of premiums (discounts) on investment securities	(145)	(582)
Deferred federal income tax expense (benefit)	999	(1,486)
Other	666	842
Changes in certain assets and liabilities:		
Deferred benefit trust	(478)	(535)
Accounts receivable	(13,692)	(3,374)
Investment income receivable	186	(622)
Prepaid expenses and deferred charges	400	550
Federal income taxes recoverable	2,514	2,616
Federal income taxes payable	1,062	–
Medical claims liability	11,060	25,904
Experience-rated refunds payable	(7,804)	(2,705)
Unearned revenue	3,260	(5,370)
Accounts payable	1,185	5,076
Outstanding checks in excess of bank balances	7,917	3,406
Other liabilities	1,997	3,327
Total adjustments	877	24,022
Net cash (used in) provided by operating activities	(13,957)	8,173

Blue Cross of Washington and Alaska and Subsidiary and Affiliate

Consolidated Statements of Cash Flows (continued)

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Investing activities		
Proceeds from sales and maturities of available-for-sale investments	$362,165	$277,468
Purchases of available-for-sale investments	(343,076)	(254,650)
Purchases of property and equipment	(5,916)	(9,014)
Proceeds from sales of property and equipment	1,637	–
Payment for purchase of PH&L, net of cash and cash equivalents acquired	–	(746)
Net cash provided by investing activities	14,810	13,058
Financing activity – capitalization of PREMERA	–	(500)
Net cash used in financing activity	–	(500)
Net increase in cash and cash equivalents	853	20,731
Cash and cash equivalents at beginning of year	72,928	52,197
Cash and cash equivalents at end of year	$ 73,781	$ 72,928

See accompanying notes.

Blue Cross of Washington and Alaska and Subsidiary and Affiliate

Notes to Consolidated Financial Statements

December 31, 1996

1. Nature of Operations and Significant Accounting Policies

Nature of Operations

Blue Cross of Washington and Alaska (BCWA) is a Washington domiciled nonprofit corporation, licensed as a health care service contractor. BCWA is engaged in the business of providing basic medical, hospital, major medical, comprehensive, and other prepaid health care benefits for its subscribers in the states of Washington and Alaska.

BCWA owns 100% of Washington-Alaska Group Services, Inc. (WAGS), an insurance agency, which, in turn, owns 100% of States West Life Insurance Company (SWL) and Pacific Health and Life Insurance Company (PH&L). WAGS, SWL, and PH&L are for-profit organizations. SWL is domiciled in the state of Washington and underwrites group life, accident, disability, and medical contracts, while PH&L is domiciled in the state of Oregon and underwrites individual and group health insurance policies. WAGS also owns 100% of N.C.A.S. – Northwest, Inc., a for-profit entity which provides claims administrative services to self-funded plan sponsors. BCWA is also the sole voting member of its affiliate, HealthPlus, which is a nonprofit health maintenance organization licensed in the states of Washington and Idaho.

PREMERA, an upstream nonprofit holding company, is the sole voting member of BCWA and Medical Service Corporation of Eastern Washington (MSC). MSC is engaged in the business of providing basic medical, hospital, major medical, comprehensive, and other prepaid health care benefits for its subsidiaries, primarily in eastern Washington.

Principles of Consolidation

The consolidated financial statements have been prepared using generally accepted accounting principles and include the accounts of BCWA, its wholly owned subsidiary, WAGS, and its affiliate, HealthPlus (collectively hereinafter referred to as the Company). All significant intercompany balances and transactions have been eliminated in consolidation.

1. Nature of Operations and Significant Accounting Policies (continued)

Use of Estimates

Preparation of these financial statements requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

Cash Equivalents

Cash and cash equivalents consist primarily of cash balances on hand and deposited in financial institutions, and all highly liquid investments with a maturity of 90 days or less when purchased.

Investments

The Company classifies its fixed-income securities and marketable equity securities as available-for-sale. These securities are recorded at fair value with unrealized holding gains and losses, net of tax, recognized as a separate component of net worth. The fair value of investment securities is based on quoted market prices. For those securities where quoted market prices are not available, fair values were based on market prices of similar investments. Declines in fair value of securities determined to be other than temporary are recognized as a component of net income.

Premiums and discounts on fixed-income securities are recognized as adjustments to investment income, using the effective interest method, amortized over the period to maturity. Interest on fixed-income securities is recognized in income as accrued.

Gain or loss on the sale of fixed-income securities is determined using the amortized cost of the specific security sold. Gain or loss on the sale of marketable equity securities is determined using the average cost of all shares of that type of security held at the time of sale.

Included with other investments are investments held for the benefit of the Company's supplemental retirement program. Investment values are stated at fair values, which are determined based on quoted market values.

1. Nature of Operations and Significant Accounting Policies (continued)

Prepaid Expenses and Deferred Charges

Costs incurred which provide economic benefit to the Company beyond the year in which they are expended are deferred and amortized using the straight-line method over the estimated useful life of the asset.

Reinsurance

Reinsurance premiums, claims, and claims processing expenses are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Premiums and health care services expense and the related medical claims liability and unearned premium reserves are reported net of reinsurance amounts.

The Company's reinsurance contracts primarily relate to SWL. As of December 31, 1996 and 1995, the Company had reinsurance recoverables of $6.5 million and $5.5 million, respectively.

The Company remains obligated for amounts ceded in the event the reinsurers do not meet their obligations.

Property and Equipment

Property and equipment are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed on the straight-line method over the estimated useful lives of the assets which range from three to 20 years.

Medical Claims Liability

The medical claims liability represents the estimated ultimate cost of settling claims relating to insured events that have occurred on or before the balance sheet date which are unpaid at year-end. The estimated liability includes the amount that will be required for future payments of claims that have been reported, claims related to insured events that have occurred but that have not been reported, and claims processing expense. Claims processing expense is an estimate of the costs to record, process, and adjust unpaid claims.

1. Nature of Operations and Significant Accounting Policies (continued)

The medical claims liability is estimated using individual case basis valuations and statistical analyses. These estimates are subject to the effects of trends in claims severity and frequency. Although considerable variability is inherent in such estimates, management believes that the medical claims liability is adequate. The estimates are continually reviewed and adjusted, as necessary, as experience develops or new information becomes known; such adjusments are included in current operations. In 1995, the medical claims liability includes amounts related to premium deficiency reserves. For further discussion, see Note 9.

Premiums

Premiums are recognized at contractual rates and are recorded as earned during the month subscriber coverage is provided. Unearned revenue represents the portion of premiums collected that relates to future periods.

Federal Income Taxes

BCWA is subject to federal income taxation as a stock property and casualty insurance company under the provisions of the Tax Reform Act of 1986. HealthPlus, the Company's affiliate, is exempt from federal income taxes under Section 501(c)(4) of the Internal Revenue Code.

The Company files as a member of an affiliated group which includes PREMERA as the common parent. Income taxes owed by the Company are allocated in accordance with an intercompany tax-sharing agreement. Allocation is based upon separate return calculations of taxable income with current credit for losses at the consolidated tax rate. Intercompany tax balances are settled when PREMERA either makes payments to or receives refunds from the Internal Revenue Service.

The liability method is used in accounting for income taxes. Accordingly, deferred tax assets and liabilities are recognized based on differences between the financial reporting and tax bases of assets and liabilities, and are measured using the enacted tax rates and

1. Nature of Operations and Significant Accounting Policies (continued)

laws expected to be in effect when the differences are anticipated to reverse, net of any applicable valuation allowances. The effect on the deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that the change is enacted.

Reclassifications

Certain reclassifications have been made in the 1995 financial statement balances and footnotes to conform to current year classifications.

2. Investment Securities

The cost or amortized cost, gross unrealized appreciation, gross unrealized depreciation, and estimated market values of available-for-sale investment securities are as follows:

	Cost or Amortized Cost	Gross Unrealized Appreciation	Gross Unrealized Depreciation	Estimated Market Value
		(In Thousands)		
At December 31, 1996				
U.S. Treasury securities and obligations of U.S. Government corporations and agencies	$ 50,770	$ 551	$ (213)	$ 51,108
Corporate debt securities	104,211	855	(335)	104,731
Mortgage-backed securities	19,443	93	(109)	19,427
	174,424	1,499	(657)	175,266
Marketable equity securities	75,323	10,062	(1,226)	84,159
	$249,747	$11,561	$(1,883)	$259,425
At December 31, 1995				
U.S. Treasury securities and obligations of U.S. Government corporations and agencies	$ 58,813	$ 2,227	$ (86)	$ 60,954
Debt securities issued by foreign government	1,650	388	–	2,038
Corporate debt securities	123,115	3,187	(82)	126,220
Mortgage-backed securities	12,968	375	(16)	13,327
	196,546	6,177	(184)	202,539
Marketable equity securities	58,201	12,164	(1,678)	68,687
	$254,747	$18,341	$(1,862)	$271,226

The above amounts include fixed-income and marketable equity securities of approximately $2.9 million which were on deposit with various regulatory authorities at December 31, 1996. As of December 31, 1996, the Company pledged cash and eligible securities with an estimated market value of $40.1 million to meet indemnity requirements of the Insurance Department of the State of Washington.

2. Investment Securities (continued)

The cost or amortized cost and estimated market values of available-for-sale fixed-income securities at December 31, 1996, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because certain borrowers have the right to call or prepay obligations with or without call or prepayment penalties.

	Cost or Amortized Cost	Estimated Market Values
	(In Thousands)	
Due in one year or less	$ 34,845	$ 34,903
Due after one year and through five years	60,975	61,074
Due after five years and through ten years	14,877	14,941
Due after ten years	44,284	44,921
Mortgage-backed securities	19,443	19,427
	$174,424	$175,266

Proceeds from sales of available-for-sale fixed-income securities and marketable equity securities and gross realized gains and losses on those sales were as follows:

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Proceeds from sales of fixed-income securities	$229,445	$121,468
Proceeds from sales of marketable equity securities	101,802	119,409
	$331,247	$240,877
Fixed-income securities:		
Gross realized gains	$ 3,647	$ 2,035
Gross realized losses	(2,447)	(401)
	1,200	1,634
Marketable equity securities:		
Gross realized gains	17,436	12,632
Gross realized losses	(4,191)	(4,404)
	13,245	8,228
Net realized gains on investments	$ 14,445	$ 9,862

2. Investment Securities (continued)

There were no gross realized gains or losses from investment maturities in the years ended December 31, 1996 and 1995.

3. Fair Values of Financial Instruments

The following methods and assumptions were used by the Company in estimating the "fair value" disclosures for financial instruments in the accompanying financial statements and notes thereto:

Cash, Short-Term Investments, Accounts Receivable, Accounts Payable, and Other Liabilities: The carrying amounts reported in the accompanying balance sheets for these financial instruments approximate their fair values.

Investment Securities: The fair values of fixed-income securities are based on quoted market prices, where available. For fixed-income securities not actively traded, fair values are estimated using values obtained from independent pricing services or, in the case of private placements, are estimated by discounting expected future cash flows using a current market rate applicable to the yield, credit quality, and maturity of the investments. The fair values of marketable equity securities are based on quoted market prices. Fair values of investment securities are disclosed in Note 2.

All other financial instruments are specifically exempted from fair value disclosure requirements because they qualify as insurance-related products.

4. Property and Equipment

A summary of the cost and accumulated depreciation and amortization of property and equipment is set forth below:

	December 31	
	1996	1995
	(In Thousands)	
Land and land improvements	$ 7,132	$ 7,632
Buildings and improvements	33,174	33,819
Office equipment	42,458	38,294
Data processing software	11,475	9,328
	94,239	89,073
Less accumulated depreciation and amortization	52,620	45,538
	$41,619	$43,535

5. Medical Claims Liability

Activity in the medical claims liability is summarized as follows:

	1996	1995
	(In Thousands)	
Unpaid claims liability at beginning of year	$ 151,387	$127,028
Add incurred accident and health claims related to:		
Current year	1,033,109	932,247
Prior years	(7,939)	(13,926)
Total incurred	1,025,170	918,321
Deduct paid accident and health claims related to:		
Current year	876,093	789,970
Prior years	133,959	103,992
Total paid	1,010,052	893,962
Unpaid claims liability at end of year	166,505	151,387
Reinsurance recoverable	–	743
Life reserves	4,605	9,298
Unpaid claims processing	5,273	3,895
Medical claims liability at end of year	$ 176,383	$165,323

As indicated in the foregoing reconciliation, the Company's medical claims liability at December 31, 1995 and 1994 decreased in the following year by $7.9 million and $13.9 million, respectively, for claims that had occurred on or prior to those balance sheet dates. Those reductions resulted primarily from the favorable settlement of claims reported in prior years for amounts that were less than expected. No return premiums were due as a result of the deductions in the medical claims liability. Adjustments made to the medical claims liability for unpaid claims processing expense during 1996 and 1995 were immaterial.

Unpaid claims liability has been reduced for subrogation of $8.2 million and $9.1 million as of December 31, 1996 and 1995, respectively.

6. Federal Income Taxes

The provision for income tax expense (benefit) from operations consists of the following:

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Current:		
Federal	$(822)	$(2,589)
State	69	151
	(753)	(2,438)
Deferred:		
Federal	968	(1,467)
State	31	(19)
	999	(1,486)
	$ 246	$(3,924)

The tax provision for income tax differs from the amount of tax determined by applying the federal statutory rate of 35% due to the following:

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Tax provision at statutory rate	$(5,106)	$(6,920)
Nontaxable affiliate	4,649	(1,210)
Alternative minimum tax rate adjustment	529	3,726
Other	174	480
	$ 246	$(3,924)

6. Federal Income Taxes (continued)

At December 31, 1996, the Company had net operating loss carryforwards of $93.5 million available to offset future regular taxable income, if any, through the year 2003. Also, the Company has alternative minimum tax credit carryforwards of $11.3 million available indefinitely to reduce regular federal income taxes. The Company received refunds of federal income taxes of $4.3 million and $5.2 million during the years ended December 31, 1996 and 1995, respectively.

Deferred federal income taxes consist of the following:

	December 31	
	1996	1995
	(In Thousands)	
Deferred tax assets:		
Net operating loss carryforwards	$32,736	$32,801
Minimum tax credit	11,312	10,949
Deferred compensation	3,584	3,588
Postretirement benefits	5,987	5,525
Medical claims liability	2,095	4,245
Other assets	1,920	2,645
Total deferred federal income tax assets	57,634	59,753
Less valuation allowance	49,904	50,548
Deferred federal income tax assets, net	7,730	9,205
Deferred tax liabilities:		
Net unrealized gain on available-for-sale investments	(1,743)	(3,261)
Other	(387)	(927)
Total deferred federal income tax liabilities	(2,130)	(4,188)
Net deferred federal income tax assets	$ 5,600	$ 5,017

7. Employee Benefits

Defined Benefit Retirement Program

The Company has a defined benefit retirement program covering substantially all of its employees. The assets are part of the Blue Cross and Blue Shield National Retirement Trust which invests primarily in listed equity securities, U.S. Treasury Bonds and Notes, U.S. Government agency securities, domestic corporate bonds, commingled real estate funds, and short-term investments. Benefits are based on years of service and an employee's base salary at the beginning of the year. The Company's funding policy is to meet the minimum funding requirement of the Employee Retirement Income Security Act of 1974 (ERISA). Contributions are intended to provide not only for benefits attributed to service-to-date, but also for benefits expected to be earned in the future.

The following summary sets forth the funded status of the Company's defined benefit plan and amounts recognized in the Company's consolidated financial statements:

	December 31	
	1996	1995
	(In Thousands)	
Actuarial present value of benefit obligation:		
Accumulated benefit obligation, including vested benefits of $28,297 in 1996 and $27,880 in 1995	$29,432	$29,030
Projected benefit obligation for service rendered to date	$37,639	$38,421
Less plan assets at fair value, primarily listed fixed-income and marketable equity securities	39,346	32,849
Projected obligation (less than) in excess of plan assets	(1,707)	5,572
Unrecognized net transition asset at December 31	1,747	2,048
Unrecognized prior service cost	151	154
Unrecognized net gain (loss) from past experience different from assumed experience	6,371	(1,490)
Accrued pension cost included in other liabilities	$ 6,562	$ 6,284

7. Employee Benefits (continued)

The net pension cost of the Company's defined benefit plan included the following amounts which were recognized in the Company's consolidated financial statements:

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Service cost of benefit earned	$ 2,028	$ 1,515
Interest cost on projected benefit obligation	2,721	2,271
Actual return on plan assets	(5,524)	(6,421)
Net amortization and deferral	2,498	3,473
Net periodic pension cost	$ 1,723	$ 838

At December 31, 1996 and 1995, the weighted average discount rate was 7.25%, and the expected long-term rate of return on plan assets was 9%. At December 31, 1996 and 1995, the rate of increase in future compensation levels used in determining the actuarial present value of the projected benefit obligation ranged from 3.5% to 7%.

Supplemental Retirement Program

The Company has a nonqualified defined contribution retirement program covering executive management employees. Participants must have been employed by the Company for at least one year and hold a position approved by the President and the Board of Directors as having a significant corporatewide impact on accomplishing the Company's strategic goals and objectives. Company contributions are made to individual participant accounts based upon percentages of an individual participant's base salary as approved by the Board of Directors. The expense related to this program was $291,000 and $167,000 for the years ended December 31, 1996 and 1995, respectively. Deferred benefits relating to this program, which have been included in other liabilities, were $4.1 million and $3.6 million at December 31, 1996 and 1995, respectively.

7. Employee Benefits (continued)

The Company funds the deferred benefits of this program through the establishment of a separate deferred benefit trust. The fair value of the trust assets, which have been included in other investments, was $3.8 million and $3.3 million at December 31, 1996 and 1995, respectively. Realized and unrealized gains and losses from the assets included in the trust accrue to the participants. However, participants only have an unsecured interest in trust assets. In the event of the Company's insolvency, trust assets can be used to satisfy the claims of general creditors.

Savings Plan

The Company has a defined contribution retirement savings plan, pursuant to Section 401(k) of the Internal Revenue Code, for employees who have one year of service with the Company or another Blue Cross or Blue Shield plan. Participants may contribute up to 15% of their compensation, as defined by the plan, with the Company providing a matching contribution of the lesser of 50% of a participant's contribution or 3% of a participant's compensation, as defined under the plan. The Company made total contributions of approximately $969,000 and $693,000 to the plan for the years ended December 31, 1996 and 1995, respectively.

Other Postretirement Benefits

The Company provides certain health care benefits for eligible retired employees. Substantially all employees may become eligible for these benefits if they reach retirement age while working for the Company. The costs of these benefits are shared by the Company and the retiree. The Company's policy is to fund the cost of these benefits in amounts determined at the discretion of management.

7. Employee Benefits (continued)

The following table reconciles the plan's status with amounts recognized in the Company's consolidated financial statements:

	December 31	
	1996	1995
	(In Thousands)	
Accumulated postretirement benefit obligation:		
Retirees	$12,362	$13,102
Fully eligible active plan participants	395	315
Other active plan participants	2,339	2,132
Accumulated postretirement benefit obligation	15,096	15,549
Unrecognized net gain	1,480	237
Accumulated postretirement benefit obligation included in other liabilities	$16,576	$15,786

Net other postretirement benefit cost included the following:

	Year Ended December 31	
	1996	1995
	(In Thousands)	
Net other postretirement benefit cost:		
Service cost	$ 256	$ 386
Interest cost	1,063	1,092
Payments during the year	(529)	(595)
Net other postretirement benefit cost	$ 790	$ 883

Actuarial assumptions used to determine costs and benefit obligations at December 31, 1996 and 1995 include discount rates of 7.5% and 7% and health care cost trend rates of 8.6% and 8.8%, respectively, decreasing to 6% after 13 years. A 1% increase in the assumed health care cost trend rate for each year would increase the accumulated other postretirement benefit obligation as of December 31, 1996 by $2,683,000 and the net other postretirement benefit cost for the year then ended by $358,000.

8. Leases

The Company's rental expense for 1996 and 1995 was $2.7 million and $3.4 million, respectively. The principal leases, all of which are operating leases, are for data processing equipment, office equipment, and office space. The leases contain various provisions for renewal options, sublease agreements, and lease cancellations with nominal penalties.

Future minimum lease payments under noncancelable operating leases at December 31, 1996 are as follows (in thousands): 1997 – $1,149; 1998 – $826; 1999 – $492; and 2000 and thereafter – $532.

9. Commitments and Contingencies

In November 1995, the Company filed with the State of Washington Office of Insurance Commissioner (OIC) individual rate forms with January 1, 1996 effective dates (1996 Contracts). On December 5, 1995, the OIC disapproved the individual rate filings and issued cease and desist orders (Cease and Desist Orders) to prevent the Company from implementing the 1996 Contracts.

The Company appealed the rate disapproval, as well as the Cease and Desist Orders in administrative appeals. In an action in Thurston County Superior Court (Washington), an order was issued permitting the Company to charge the approximate 12.5% rate increases on the contracts at issue in that proceeding pending the Company's appeal of the disapproval of the rate increases. Effective October 1996, the Company implemented its 12.5% rate increases. The entire portion of premiums relating to the 12.5% rate increases for 1996 was recorded as unearned revenue at December 31, 1996 ($3.3 million) pending the outcome of the proceedings. In March 1997, the OIC settled with the Company allowing for the Company to implement the disputed rate increase.

As of December 31, 1995, without adequate rate relief, management had estimated the Company would incur losses on various contract forms for individual health care policies entered into with the Company's insureds for which premiums were not sufficient to cover estimated loss and policy maintenance costs using assumptions considered indicative of future loss experience. The Company's premium deficiency reserve was $7.8 million as of December 31, 1995. As a result of the above-mentioned rate increase, no premium deficiency reserve was required at December 31, 1996.

9. Commitments and Contingencies (continued)

Various lawsuits against the Company have arisen in the course of the Company's business. Contingent liabilities arising from litigation, income taxes, and other matters are not considered material in relation to the financial position of the Company.

10. Agency Contracts

BCWA acts as a fiscal intermediary and subcontractor in administering certain health care programs, including Medicare. Claim payments processed by BCWA for Medicare, which are not included in the financial statements, were $1.2 billion for the years ended December 31, 1996 and 1995. Revenue resulting from administering these programs, of $4.6 million for 1996 and $4.4 million for 1995, has been offset against general and administrative expenses. The revenue received from the Medicare program is subject to final federal government approval, and any resulting adjustments are recognized in current operations.

Medicare regulations require BCWA to use the checks-paid method for the Medicare bank account. Under this method, the bank holds an irrevocable letter of credit from the U.S. Department of Health and Human Services and draws funds to cover Medicare program checks as they are presented for payment. This method of payment results in technical overdrafts of $30.8 million and $23.3 million at December 31, 1996 and 1995, respectively. The technical overdrafts for Medicare are netted against the corresponding receivables, which represent claim payments made by BCWA on the program's behalf.

11. Statutory Reserves and Net Income from Operations

BCWA, SWL, PH&L, and HealthPlus file regulatory reports and financial statements with various state insurance commissioners in accordance with statutory accounting practices prescribed or permitted by the respective state insurance departments. Prescribed statutory accounting practices include a variety of publications of the National Association of Insurance Commissioners, as well as state laws, regulations, and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so prescribed. The Company has no significant permitted statutory accounting practices.

11. Statutory Reserves and Net Income from Operations (continued)

Differences between statutory reserves and unassigned surplus, and statutory net income and net worth and net income as determined on a generally accepted accounting principles basis primarily relate to differences in accounting for postretirement benefits, net income of subsidiary and affiliate, deferred taxes, unrealized gains or losses on fixed-income securities available-for-sale, and nonadmitted assets such as prepaid expenses and certain furniture and equipment.

A summary of statutory reserves and unassigned surplus and statutory net loss for the Company is as follows:

	1996	1995
	(In Thousands)	
Statutory reserves and unassigned surplus	$128,089	$144,760
Statutory net loss	(3,671)	(25,749)

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

3/20/98

HB 300

The Alaska State Hospital and Nursing Home Association represents all of the community hospitals in the state. The Association wishes to state our strong opposition to HB 300, specifically Sec 21.42.390. (a) (1) (line 07 and 08) and (c)(1) (line 04 and 05).

This bill would take away one of the few options Alaska businesses have for managing the cost of offering health insurance benefits to their employees--contracting with hospitals for volume discounts.

The bill interferes with the right of a business to fully define the benefit package it will offer. It also interferes in the contracting relationship between purchasers and providers.

Instead of providing choice we believe it will reduce the variety of health plan options on the market.

The Association believes the net result will be higher health costs for everyone in Alaska and more people losing health insurance.

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

THOMAS G. HIPSHER, D.D.S.

March 24, 1998

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

RE: HB 300

I appreciate having had the opportunity to testify before the House Labor and Commerce Committee on March 20, 1998. After listening to the testimonies of both the insurance industry and organized labor, **it appears that HB 300 will go down in history as the most misunderstood bill in its time.** Everyone interpreted this bill as "Any Willing Provider" legislation. If this were the case, then all of their arguments are absolutely correct and I agree 100% that insurance premiums would have to rise because of the likely outflow of patients from closed panels of providers. Their argument would also be correct that labor would not retain the power to bargain effectively with closed panels of providers

However, this is <u>not</u> "Any Willing Provider" legislation. HB 300, in fact, does just the opposite. Labor absolutely retains their bargaining power with closed panels of providers because there is a significant financial disincentive for people to leave Preferred Provider Organizations and because of this, insurance premiums will not rise. What this legislation does provide to the patient is a non-discriminatory outlet in the event that they feel they are being mistreated by any means by doctors within a closed panel or by their insurance carrier. It guarantees that if the patient has been harmed by virtue of decisions made by the insurance industry or the treating doctor, that patient has legal recourse against the party that made the decision. It also guarantees that for a procedure, that if the patient elects to go outside the closed panel, the reimbursement for that procedure will be the same as if treatment was completed by doctors within the closed panel.

It further guarantees that if claims are reviewed by a consultant within the insurance industry, that consultant must be licensed to practice in the State of Alaska. In this way, legal recourse for inappropriate decisions made by third parties can be handled through the Attorney General's office.

I as a provider am not concerned about patients that elect to go to doctors within a closed panel. In fact, I respect their decisions based on their needs at that time. However, I am concerned that if a patient becomes disgruntled with the care that they are receiving, that they be able to go to the provider of their choice and have the care they need without any type of discrimination.

Sincerely,

Thomas G. Hipsher, P.E., D.D.S.

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

FACSIMILE COVER PAGE

DATE: March 20, 1998

TO: Rep. Norman Rokeberg
House Labor and Commerce, Chair
FAX (907) 465-2040

FROM: Rena Anderson, RDH
President, Alaska State Dental Hygienists' Assoc.
P.O. Box 240247
Anchorage, AK 99524
FAX 909-248-6426

RE: HB 300

PAGES: 1 including this cover page

****

Dear Rep. Rokeberg,

The Alaska State Dental Hygienists' Association would like to express support for HB 300.

We feel HB 300 will benefit all Alaskans as it will allow patients to continue to appoint with established and trusted health care providers without the penalty of decreased payment benefits from insurance providers.

Sincerely,

Rena Anderson

Rena Anderson, RDH

Wm. MARSHALL DOTSON, JR., D.D.S., PC
Practice Limited to Orthodontics
P.O. Box 3693
Soldotna, Alaska 99669
(907) 262-3125

March 20, 1998

Dear Rep Norman Rokeberg

Please support CSHB 300 and move it out of committee. This bill is in the best interest of the public in that it supports:

Patients free choice of provider; the right to receive full information about treatment options; the right not to have treatment reduced; denied or terminated without approval of provider licensed in the state; and the right not to be penalized for their choice of provider.

Sincerely,

Wm Marshall Dotson DDS

Mark and Rena Anderson
7502 Setter Drive
Anchorage, AK 99502
FAX (907) 248-6200

Rep. Norman Rokeberg
Alaska State Capital
Juneau, Ak 99801-1182
FAX (907) 465-2040

RE: HB 300

Dear Rep. Rokeberg,

We would like to express our support and urge you to pass HB 300.

We feel HB 300 would be a benefit for all Alaskans. It will allow all Alaskans to continue to have a choice in their health care providers and will, most importantly, allow patients to continue seeing trusted and established health care providers without a penalty of decreased insurance payment benefit..

Insurance providers have said that they will have to raise premiums to cover this additional payment to non-members of their group. It is our understanding that this percentage of non-members is about 5%. If insurance companies decreased the amount payable on the usual and customary fee by only $1.00, we believe that there would be no need to raise premiums. Preferred providers will not loose any income or benefit because they will continue to have increased volume.

We appreciate your time and interest in this bill.

Sincerely,

Mark & Rena Anderson

Mark and Rena Anderson

the hotel Captain Cook

WALTER J. HICKEL, JR.
PRESIDENT

P.O. Box 102200, Anchorage, Alaska 99510-2200
Phone (907) 276-6000
Executive Fax (907) 330-4057

March 20, 1998

03-27-98P02:35 RCVD

VIA FACSIMILE
(907) 465-2040

Representative Norm Rokeburg
House Labor and Commerce Committee

RE: HB 300

Dear Representative Rokeburg:

As an employer, I wish to express my opposition to HB 300. This makes absolutely no business sense.

There are not many options for Alaska Businesses to adequately manage the cost of health insurance benefits for their employees. Why would this legislature, so committed to reducing our State budget, want to take away the same ability from those of us in business who must work so hard to manage our own bottom line?

Please do not pass HB 300.

Sincerely,
THE HOTEL CAPTAIN COOK

Walter J. Hickel, Jr.
President and General Manager

Alaska Dental Society
3305 Arctic Blvd . Suite 102
Anchorage, Alaska 99503-4975
(907) 563-3003 • FAX: 563-3009

FAX MESSAGE

DATE: Thursday, March 12, 1998

SENT TO: Representative Norm Rokeberg, Chairman
House Labor and Commerce Committee

FROM: Martha A. Reinbold, Executive Director

FAX NUMBER: (907) 465-2040

TOTAL PAGES: One

Representative Rokeberg:

It has come to our attention that there is question regarding language in HB 300 - the Patients' Rights bill. Please know that the Alaska Dental Society is in total support of the language in this bill as reported out of House HESS.

> "An Act relating to patients' rights under health insurance; relating to review of health insurance treatment plans; prohibiting certain health insurance practices."

Thank you for all your continued efforts on behalf of this legislation.

Tim Woller, DDS, President, Alaska Dental Society

Robert W. Robinson II, DMD, Legislative Chairman, Alaska Dental Society

Martha A. Reinbold, Executive Director, Alaska Dental Society

PHONE MESSAGE DATE 3/12/98 TIME 4:00 A.M. P.M.

FOR Brett Sh:
M Dr Gardner
OF
PHONE ( ) 907 337-5419 EXT.
☐ FAX ☐ MOBILE ☐ PAGER ( )
MESSAGE
HB 300.
Supports A

☐ URGENT
☒ PHONED
☐ RETURNED YOUR CALL
☐ PLEASE CALL BACK
☐ WILL CALL AGAIN
☐ WAS IN
☐ WANTS TO SEE YOU

AVERY'

SIGNED

PHONE MESSAGE DATE 3/11/98 TIME 12:50 A.M. P.M.

FOR Nora / Shirley
M Ms. McHaffie
OF
PHONE (907) 277-2943. EXT.
☐ FAX ☐ MOBILE ☐ PAGER ( )
MESSAGE
He "HB 300"
Supports it and wants you
To Juneau. Pass.

☐ URGENT
☒ PHONED
☐ RETURNED YOUR CALL
☐ PLEASE CALL BACK
☐ WILL CALL AGAIN
☐ WAS IN
☐ WANTS TO SEE YOU

AVERY'

SIGNED

National Bank of Alaska

Kathleen Soderberg
Executive Vice President

Corporate Headquarters
P.O. Box 100600
Anchorage, AK 99510-0600
Phone (907) 522-8888

March 12, 1998

Representative Con Bunde
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Representative Bunde,

As one of the largest employers in Alaska, National Bank of Alaska opposes CS FOR HOUSE BILL NO. 300(HES), Alaska Patients' Bill of Rights. We, like many companies our size, are self insured and we share the cost of health insurance with our employees. We work together with the employees to control costs so that our employees are able to afford health insurance. As proposed, Sec.2. AS 21.42.390 (2) (c) (1) would prohibit us from negotiating price concessions with various health care providers through preferred provider networks and would in turn drive our health care costs and premiums up.

On the surface patients' rights seem very desirable. However, these benefits must be funded and in most cases they will be funded through higher premiums paid by the employee.

Very truly yours,

Kathleen Soderberg

Kathleen Soderberg
Executive Vice President

Facsimile Cover Sheet

To: Rep. Norm Rokeberg
Company: Alaska State Legislature
Phone:
Fax: 1-907-465-2040

From: Jerry Weaver - Alaska Bankers
Company: National Bank of Alaska
Phone: (907) 265-2920
Fax: (907)265-2141

Date: 3-13-98
Pages including this cover page: 2

Comments:

Anchorage Midtown Dental Center

Donald E. Burk DMD P.C.

The Leslie Building
2805 Dawson St., Suite 101
Anchorage, Alaska 99503

Telephone (907) 562-6456
Fax (907) 562-0009

03-13-98 01:12 RCVD

Rep. Norman Rokeberg
Chairman
Labor and Commerce Committee

3/13/98

Dear Norm,

It is very important to move CSHB 300 out of committee. The main provisions of the Bill give patients free choice of health care providers. The Patients treatment should not be reduced, denied or terminated, because the patient did not get approval of a licensed provider the State of Alaska.

Patients do not want Washington D.C. or other large insurance companies telling Alaskans how they may be treated. Also, patients should not be penalized for his or her choice of Health Care Providers.

Sincerely,

Don E. Burk DMD

RALPH B. FERIANI, D.D.S.

A Professional Corporation

3340 Arctic Boulevard, Suite 104
Anchorage, Alaska 99503
Phone 907/561-5154

Dear Representative

Please move CSHB 300 out of Committee: It's a good bill and the right thing to do.

Thank-you.

Ralph B Feriani

Ralph B. Feriani, D D.S.

1. patients' free choice of health care provider - including specialists
2. patients' right to receive full information about treatment options
3. patients' right not to have treatment reduced, denied or terminated without approval of a "provider licensed in this state" (can suggest this wording)
4. patients right not to be penalized for his/her choice of provider

03-15-98A08:03 RCVD

Fax Cover Sheet

Date 3/15/98

From T.S. REDMOND DDS. 1(907) 522-8816 FAX.

Number of pages including this sheet 1

To REP. NORMAN ROKEBERG. CHAIR.

Company LABOR & COMMERCE COMMITTEE Fax No. 1(907) 465-2040

Regarding (CS) FOR HB 300 - PATIENTS' RIGHTS BILL

PLEASE PRESERVE: ① PATIENTS' FREE CHOICE of HEALTH CARE PROVIDER.

② PATIENTS' RIGHT TO RECIEVE full INFORMATION re TREATMENT OPTIONS.

③ PATIENT'S' RIGHT NOT TO HAVE TREATMENT REDUCED, DENIED, OR TERMINATED W/O APPROVAL of a PROVIDER LICENSED IN THIS STATE MAKING THE DETERMINATION - FOR 3RD PARTY PAYORS. ④ PATIENT'S RIGHT NOT TO BE PENALIZED FOR HIS/HER CHOICE of PROVIDER.

⑤ MANY 3RD PARTY PAYORS/INSURERS HAVE UNQUALIFIED PERSONS MAKING TREATMENT DECISIONS.

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.

John E. Miller, D.D.S.
Ten Twenty West Fireweed
Anchorage, Alaska 99503

Representative
Norman Rokeberg
State of Alaska Bldg
Juneau, Alaska

Dear Sir,

I have practiced Dentistry for 48 years in Alaska. I have always been proud of the fact there were no rules limiting free choice of our citizens, to any health care provider here.

This bill would hurt all citizens. They are the ones that are important & are need to be considered & Protected. I am (C.S.) H.B. 300 - Please

John E. Miller D.D.S.

Author: Forest@alaska.net (Moeller And Bedore) at CC2MHS1
Date: 3/15/98 8:33 PM
Priority: Normal
TO: Representative Norman Rokeberg at LAA_TRANS
Subject: HB 300

Dear Representative Rokeberg:

I am concerned that the people of Alaska not be subject to the 'cost containment' measures which have reduced the quality of services available to so many people in the rest of the US. We should not buckle under to the pressures of insurance companies which do not have the patient's best health at the top of their ledger sheets. Patients should not be penalized for seeking out providers they trust and with whom they can develop lifelong relationships. HB 300 will guarantee patients' choice of provider and not force them to accept substandard treatment for purely insurance profit motives.

Please support this critical health Bill.

Respectfully,

Gary A Moeller, DDS
Juneau, Ak.

Dear Representative Rokeberg,

As President of the Anchorage Dental Society along with my partner and past President of the Anchorage Dental Society, we would like to encourage you to take action on HB 300. This "Patients' Bill of Rights" is important legislation that will provide for protection of the basic rights of patients.

The main points of this bill are that the patients are able to maintain their freedom of choice in choosing their health care provider. This bill would also enable all patients to receive full information about their care including all treatment options. A provision would also prevent an insurance administrator out of state from altering or denying treatment. It is vital that a treament plan agreed upon by both the patient and provider not be altered without the approval of provider licensed in the state.

It is important to understand that this is a **Patients Rights Bill**. It is does not pertain to fees or payment. It is to ensure that a patient not be penalized for their choice of provider.

We encourage you to take action on this bill and move it out of committee. We would like to see the rights of all patients protected!

Sincerely,

Douglas J. L[illegible]ten, D.M.D.

March 17, 1998

House Labor and Commerce Committee
Juneau, AK

re: CS for HB 300
SB 122

Dear Rep. Rokeberg,

I urge you to pass on to the next committee assignment CS for HB 300. This legislation is not about my fees or insurance companies or health care costs. It is about patient's rights. It is about **you** and **your families'** right to choose a doctor (I'm a doctor-not a provider) that you are comfortable with. A doctor that practices in this state and doesn't micro-manage your care from Seattle or Little Rock. It is about **you** and **your families'** right to hear about all the options for treatment, not just the ones your HMO can use to minimize their costs (and maximize shareholders profits). I'm a GP. I should be able to send **you** or **members of your family** to a specialist without penalty if that is what we (**you and I**) deem necessary.

Please also pass SB 122 as written (without Blue Cross' amendment that exempts insurance companies from claims of Unfair Discrimination).

Sincerely,

Michale L. Boothe, DDS
19961 Birchwood Loop
Chugiak, AK 99567

Author: ScullyMJ@alyeska-pipeline.com (Scully; Matthew J.) at CC2MHS1
Date: 3/17/98 3:29 PM
Priority: Normal
TO: Representative Norman Rokeberg at LAA_TRANS, Representative Vic Kohring at LAA_TRANS, Representative Con Bunde at LAA_HBUN
Subject: FW: HB 457

Matt

"Challenge Conventional Wisdom .....if it's the former, it's often not the latter."
Edgar Freemount III

> ----------
> From: Scully, Matthew J.
> Sent: Tuesday, March 17, 1998 3:23 PM
> To: 'Con Bunde'; 'Norm Rokeberg'; 'Vic Kohring'
> Subject: HB 457
>
> Just a short note of my strong support for this bill regarding project
> labor agreements. If I understand it correctly, it would simply
> provide for more competition for state construction contracts and very
> likely save us many millions (perhaps 25%) in construction costs. We
> can't afford to continue to be spending more money than we have to
> just to satisfy some special interest groups.
> It seems to me it would also fulfill our constitutional requirements
> of " equal opportunity and equal protection under the law". It would
> eliminate what I consider to be a flagrant form of discrimination!
> Please support this bill and get it on its way to the Governor.
>
> As a separate issue, I also support efforts to eliminate the totally
> unnecessary 1% for arts program.
>
> Thanks.
> Matt
>
> "Challenge Conventional Wisdom .....if it's the former, it's
> often not the latter."
> Edgar Freemount III
>

Author: simsa@alaska.net (Thomas Hipsher) at CC2MHS1
Date: 3/17/98 5:31 PM
Priority: Normal
TO: Representative Norman Rokeberg at LAA_TRANS, 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: House Bill 300-Patient's Bill of Rights

I urge you to support HB 300. This bill is not about protecting an insurance compan/Æs control over patients and doctors in their profiteering methods of controlling costs at the patient level by denying treatment and the coverage for such treatment. ItÆs not about protecting doctors from the insurance companies whose mission it is to involve the world in managed care. ItÆs not about trying to undermine the contractual relationships that various companies, hospitals and insurance companies have with patients, providers and businesses that buy and sell standard indemnity and managed care products.

With healthcare becoming a Wall Street commodity, this bill is about protecting the basic rights of individuals and forever eliminating the financial and medical discrimination that goes on every day with regards to obtaining dental and medical care in this state. Everyone that is covered by any type of health benefit plan should have the absolute right to seek treatment from any provider that they choose and seek the type of treatment that is most appropriate to their needs based on a full disclosure of all treatments available for their particular situation. In doing so, if the treatment selected is covered by the benefit plan, then the patient should be able to seek reimbursement for that treatment regardless of who they see as a provider. Also, reimbursement should be at the same level regardless of the provider that rendered the treatment. Anything less is financial discrimination.

If a patient has treatment denied by an insurance company for any reason, it is imperative that the review be conducted in a timely manner by a doctor licensed in this state due to variations in treatment philosophies depending on the area where the treatment was conducted versus where the reviewing doctor resides and who they work for. In many cases, treatment is routinely denied as a means of delaying payment. If such practices occur, the patient should have the right to seek legal recourse against the insuran company or plan administrator.

America was built on the concept of freedom. HB 300 is a bill to protect our freedoms as healthcare consumers.

Respectfully submitted,

Thomas G. Hipsher, P.E., D.D.S.

GREGORY T. GRUBBA, D.D.S.
General Dentistry
4200 Lake Otis Parkway, Suite 301 • Anchorage, Alaska 99508
(907) 562-1958

March 19, 1998

Dear Mr. Roheberg:

As both a health care consumer and health care provider I have valuable insight regarding many emerging trends which affect the quality of life for all who utilize the health care system.

I urge you to aid myself and others who have come to expect high quality health care by moving CSHB 300 out of committee.

This bill ensures the patients free choice of any health care provider and more importantly ensures patients rights to receive full information regarding treatment options.

This bill attempts to curtail "denial of treatment by "paper pushers" in far away places" by requiring any denied or terminated treatment be OK'd by a state licensed provider.

Lastly, this bill stressed that patients not be penalized for their choice of provider.

Again, I urge you to move this bill out of committee

Sincerely,

Greg Grubba DDS

Greg T. Grubba, DDS

03-19-98A10:52 RCVD

ROBERT J. BAUDER, D.M.D.

36275 Kenai Spur Highway
Soldotna, Alaska 99669
Telephone: (907) 262-8404

March 19, 1998

Representative Norman Rokeberg
Chairman
Fax: 907-465-2040

Re: HB 300 "Patients' Rights Bill"

Dear Representative Rokeberg:

I would ask that you give serious consideration to supporting HB 300 "Patients' Rights Bill."

I feel that without your support every person in Alaska who has dental benefit coverage will be in a potentially compromised situation.

This bill should establish the rights of patients in Alaska to:

1) choose the health care provider of their choice

2) receive professional advice with full and comprehensive consultations, not limiting dentists disclosure to those options dictated by third party payers

3) review of insurance treatment claims by an Alaskan licensed dentist, not an insurance trainee

4) receive their full insurance benefit without being discriminated against because of their choice of providers.

Sincerely,

Dr Bauder

Robert J. Bauder, D.M.D., A.P.C.
Past President
Kenai-Kodiak Dental Society

MAR-23-98 MON 03:51 PM ANC LEGIS INFO OFC FAX NO. 907 258 1261 P. 01

TELECOPY COVER

Anchorage Legislative Information Office
Office - (907) 561-7007 Fax - (907) 562-4376

TO: Rep Rokeberg - Chair - (H) L & C Comte

ATTN: _____ FAX: 465-2040 PHONE: _____

FROM: _____ PHONE: _____

INSTRUCTIONS: Written (T) from yesterday 3/23 tele conference

SENT: Date 3/23 Time _____

DISPOSAL OF ORIGINAL: Discard _____ Hold for Pickup _____

NUMBER OF PAGES: 5 (counting cover sheet)

TRANSMITTED BY: Jlw

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907 562 2211

03-11-98P01:10 RCVD

PROVIDENCE HEALTH SYSTEM
Position Regarding HB 300

"Managing" or coordinating health care is no different than the process this Legislature is following to balance the State budget:

> The *choice* of your constituents is to have all their wishes funded, but you must work hard to carefully prioritize according to greatest need versus funds available *and* reach agreement between all the players.

In the same way, purchasers of health care (usually employers) can no longer offer carte blanche health care coverage. With limited resources they are attempting to use their dollars wisely.

- This means more careful decisions in purchasing.
- It means more oversight of the process when care is needed.
- It means that in some cases choices become limited in order to live within budget restraints--just as the Legislature sets its own limits.

HB 300 could severely handicap efforts to contain health care costs.

Here's the language that concerns us:

Sec. 231.42.390(a) "A health care insurer may not include in the health care insurance plan or contract a provision that

(1)prohibits a covered person from obtaining health care services from a health care provider of the person's choice, including a specialist; . . ."

and

(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."

Basically this bill ends to our ability to offer employers "preferred provider" discounts in return for patient volume from their employee base.

We do understand the public's concern for *choice*, but believe they forget the choice begins with the primary purchaser--*the employer* who pays the greatest share of the premium cost. And like you, in the Legislature, they are in the

position of having to live within their budgets--including selection of employee health benefits that meet those constraints.

THE PROVIDENCE PERSPECTIVE:
It has been pointed out by some that Providence and all health care providers will benefit if these pieces of legislation passed--we wouldn't have to offer discounts! But this a) goes against our historic commitment to provide affordable, accessible health care to Alaskans and b) undermines and interferes with our relationships with our customers.

To date we estimate **at least 138,453 Alaskans** benefit from such discounting provided by Providence owned or affiliated hospitals in this state. (And we're still counting.)

Additional comments:
Sec. 21.42.390 (a) (1), line 7.

1. This obviously limits a health plan from fully defining the benefit package it will offer--including which providers will be included in its network thus impacting utilization management and referral authorization procedures. **This will only lead to increased health care costs.**

2. For good or bad, managed care organizations have dramatically reduced health care expenditures in this country. In 1996, health care inflation was only 1.9 percent, down from double digit inflation just a few years ago.

3. Health plans have been able to do this through a variety of means such as
   (a) price competition - discounts given in return for volume
   (b) benefit plans that encourage good health and appropriate utilization
   (c) utilization management when subscribers are receiving medical care
   (d) referral authorization (for specialists) based upon predefined clinical protocols.

4. Currently, the market provides people with a choice. They can select an insurance plan that provides them with open access to all providers and benefits or they can choose a managed care plan with its related limitations. **The primary difference is usually cost.**

5. As noted previously, both (a) (1), line 7 and (c) (1) line 3 and 4 of page 2 eliminate key components of managed care and will return us to the traditional indemnity plans. The only things we will accomplish are limited insurance plan choices in the market and higher prices in exchange for unrestricted personal choice.

We have few problems with other portions of this bill and in fact agree wholeheartedly with (a) (2) enabling "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".

However, because HB 300 undermines all proven measures to contain health care costs, we urge you not to pass this bill.

Janet Oates
Director of Marketing &
Government Relations
907 261-4947

THE PROVIDENCE PERSPECTIVE:
It has been pointed out by some that Providence and all health care providers will benefit if these pieces of legislation passed--we wouldn't have to offer discounts! But this a) undermines our relationships with you our valued customers and b) goes against our historic commitment to provide affordable, accessible health care to Alaskans.

The Providence response to this bill given in testimony to the House Health, Education and Social Services Committee is attached. So far we have been the only organization to testify against it. The bill has been passed on to the Labor and Commerce Committee.

Contact House Labor and Commerce Committee regarding HB 300.
No doubt you are following other key pieces of legislation through the Session, but **it is extremely important that legislators understand the magnitude of this particular issue.** To date Providence estimates **at least 138,453 Alaskans** would be negatively impacted by this legislation (and we're still counting). Please contact legislators and let them know this bill will affect your business by undermining proven measures to contain your health care costs.

Fax or call members of the House Labor and Commerce Committee giving them the number of employees and subscribers covered now under your health plan. Many of you have good numbers on cost containment you have achieved through negotiated health care coverage discounts. This would be excellent information to give as well.

We will also keep you posted on scheduled hearings. We need folks down at the Legislative Information Office to testify.

House Labor and Commerce Committee Members:
Norm Rokeberg, Chair 465-4954, FAX 465-2040 ← Need to reach him ASAP
John Cowdery, 465-3879, FAX 465-2069
Bill Hudson, 465-3744, FAX 465-2273
Joe Ryan, 465-3875, FAX 465-4588
Jerry Sanders, 465-4945, FAX 465-3476
Tom Brice, 465-3466, FAX 465-2937
Gene Kubina, 465-4859, FAX 465-3799

SB 197:
SB 197 has similar intent although dealing in hypotheticals since the language specifically addresses HMOs (which as yet don't exist in Alaska). You will be interested in the chiropractic section which essentially allows chiropractors to be

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, MT 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

---

[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] 15 U.S.C. § 41 et seq.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these

---

[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). See also Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

[4] See, e.g., Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital of Price George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991); see also American Society of Anesthesiologists, 93 F.T.C. 101 (1979); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. See, e.g., Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

comments have addressed "any willing provider" requirements for health care service contracts.[6]

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action,

---

[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

[8] Mont. Code Ann. §33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how providers and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10] In

---

[9] Mont. Code Ann. §33-22-1704(3).

[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. See, e.g., J. C. Robinson and C. S. Phibbs, An Evaluation of Medicaid Selective Contracting in California, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study

(continued...)

addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for

---

[10](...continued)
concentrated on Medicaid experience; however, further studies based on private health insurance experiences confirm these findings. See, e.g., D. Dranove et al., Is hospital competition wasteful? Rand J. Econ., Summer 1992; see also G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).