ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9857 HOUSE JUDICIARY

Rokeberg C

AMENDMENT #____

OFFERED IN THE HOUSE BY: ROKEBERG

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 6, lines 4-5:

DELETE

Reletter subsequent sections

RATIONALE: This clause would mean that every time a provider contract was terminated, the entity would have to notify all covered persons. This is a cost driver as it could result in many letters being sent out to notify all covered persons.

Additionally, the language references "for cause" and putting this in a letter could create liability for the managed care entity.

Rokeberg D

AMENDMENT #_____

OFFERED IN THE HOUSE BY ROKEBERG

TO: CSHB 211 (), LS0427/N

Page 7, lines 5-10 DELETE current language and insert following:

(2) the information is disclosed for research:
(A) that is subject to federal laws and regulations protecting the rights and welfare of research participants; or
(B) using health information that protects the confidentiality of participants by coding or encryption of information that would otherwise identify the patient.

RATIONALE: Code of Federal Regulations specifically outlines the protections required and procedures to protect patients that must be used by institutional Review Boards, researchers, and clinical sites. Other federal laws given general guidance. Thus "federal laws and regulations" is the correction terminology to include all provisions followed by researchers to ensure patient protection.

Information that is coded and encrypted is not truly anonymous - the encryption code or key and be used to identify the patient in situations where the patients is in danger or when the patient's physician believes it is necessary. This amendment in (b) more clearly exempts the type of information that should be exempted, without mis-characterizing it as anonymous.

Page 7, line 14:

AFTER: "person"
INSERT: ";
(5) such disclosure is required by law.

RATIONALE: This would cover such items as court orders to disclose.

ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of ~~Washington~~ Alaska. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(6) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(7) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(8) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(9) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-5903
PHONE: (907)269-5100
FAX: (907)276-3697

April 6, 2000

VIA FACSIMILE

The Honorable Norm Rokeberg
House of Representatives
State Capitol
Juneau AK 99801-1182

Re: HB 211

Dear Representative Rokeberg:

This letter confirms my discussion with Janet Seitz regarding the authority of the director for the division of insurance over health insurance rates.

As you know, health insurers are not required to make rate filings with the division of insurance under AS 21.39, except that hospital and medical service corporations like Blue Cross are required to file all rate information before changing its rates pursuant to AS 21.87.190. The director, however, does have authority to request and ultimately review any information from health insurers to the extent it may be relevant to an investigation or examination under the insurance code.

Pursuant to AS 21.06.080, the director has the authority to conduct investigations or examinations to determine if an insurer has violated any provision of the insurance code or "to secure information useful in the lawful administration of the insurance code." Under AS 21.06.120, the director has the specific authority to review the affairs, transactions, accounts, records, and assets of each authorized insurer. Under this authority, the director conducts examination of the financial condition and market practices of insurers, which could include examination of rates. Both of these statutes represent authority upon which the director may rely to review rates of a health insurer.

For example, if a health insurer's practice with respect to rates appears to violate AS 21.36.030 relating to misrepresentation in the sale of insurance policies or AS 21.36.100 relating to rebating, the director has authority to request, or if necessary, subpoena rate information from the insurer to determine if there has been a violation. Another example and perhaps more relevant relates to AS 21.54.015, which provides that "[r]ates for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory." To determine

compliance with this provision, the director has the authority to request documents or examine the records of the insurer related to its rating plans and practices. In addition, the adequacy of rates could have a bearing on the financial solvency of an insurer, which may be another basis to examine rates under the authority of AS 21.06.120.

The director does not have express authority to routinely request rate information from health insurers. To the extent you want the director to routinely obtain and review health insurer rate information, then this is best accomplishment by a change in statute. Such a statutory change, however, may have fiscal implications to the division of insurance because it would require the division to obtain information and perform reviews that it does not do now.

Very truly yours,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Signe P. Andersen
Signe P. Andersen
Assistant Attorney General

cc: Robert A. Lohr, Director

1-LS0472\N
Ford
3/30/00

adopted
3/31/00

CS FOR HOUSE BILL NO. 211( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation of managed care insurance plans; amending Rule 602(b), Alaska Rules of Appellate Procedure; and providing for an effective date."

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

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of Rights.

*** Sec. 2.** AS 21 is amended by adding a new chapter to read:

Chapter 07. Regulation of Managed Care Insurance Plans.

Sec. 21.07.010. Patient and health care provider protection. (a) A contract between a participating health care provider and a managed care entity that offers a group managed care plan must contain a provision that

(1) clearly states or references an attachment that states the health care provider's rate of compensation;

and is not subject to public disclosure.

(b) This section does not apply to medical information that is disclosed if

(1) the individual whose identity is disclosed gives written consent to the disclosure;

(2) the information is disclosed for research purposes using

(A) medical information that is subject to federal law protecting the rights and welfare of research participants; or

(B) anonymous health information in which the confidentiality of participants is protected by coding or encryption of information that would otherwise reveal the identity of the patient;

(3) the information is disclosed for purposes of obtaining reimbursement under health insurance;

(4) the information is disclosed at the written request of the covered person.

Sec. 21.07.050. External health care appeals. (a) A managed care entity offering group health insurance coverage shall provide for an external appeal process that meets the requirements of this section in the case of an externally appealable decision for which a timely appeal is made in writing either by the managed care entity or by the enrollee.

(b) A managed care entity may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal appeal under AS 21.07.020, but only if the decision is made in a timely basis consistent with the deadlines provided under this chapter.

(c) Except as provided in this subsection, the external appeal process shall be conducted under a contract between the managed care entity and one or more external appeal agencies that have qualified under AS 21.07.060. The managed care entity shall provide

(1) that the selection process among external appeal agencies qualifying under AS 21.07.060 does not create any incentives for external appeal agencies to make a decision in a biased manner;

(2) for auditing a sample of decisions by external appeal agencies to

(2) clearly states all ways in which the contract between the health care provider and managed care entity may be terminated; a provision that provides for discretionary termination by either party must apply equitably to both parties;

(3) provides that, in the event of a dispute between the parties to the contract, a fair, prompt, and mutual dispute resolution process must be used; at a minimum, the process must provide

(A) for an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 14 working days after the plan receives written notice of the dispute or gives written notice to the provider, unless the parties otherwise agree in writing to a different schedule;

(B) that if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;

(C) that if, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law;

(D) that the parties shall agree to negotiate in good faith in the initial meeting and in mediation;

(4) states that a health care provider may not be penalized or the health care provider's contract terminated by the managed care entity because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary health care services;

(5) protects the ability of a health care provider to communicate openly with a covered person about all appropriate diagnostic testing and treatment options; and

(6) defines words in a clear and concise manner.

(b) A contract between a participating health care provider and a managed care

entity that offers a group managed care plan may not contain a provision that

(1) has as its predominant purpose the creation of direct financial incentives to the health care provider for withholding covered health care services that are medically necessary; nothing in this paragraph shall be construed to prohibit a contract between a participating health care provider and a managed care entity from containing incentives for efficient management of the utilization and cost of covered health care services;

(2) requires the provider to purchase or use all products that are currently offered or that may be offered in the future by the managed care entity; and

(3) requires the health care provider to be compensated for health care services performed at the same rate as the health care provider has contracted with another managed care entity.

(c) A managed care entity may not enter into a contract with a health care provider that requires the provider to indemnify or hold harmless the managed care entity. An indemnification or hold harmless clause entered into in violation of this subsection is void.

Sec. 21.07.020. Required contract provisions for group managed care plans. A group managed care plan must contain

(1) a provision that preauthorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the preauthorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider;

(2) a provision for emergency room services if any coverage is provided for treatment of a medical emergency;

(3) a provision that covered health care services be reasonably available in the community in which a covered person resides or that adequate referrals outside the community be available if the health care service is not available in the community;

(4) a provision that any utilization review decision

(A) must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations,

utilization review decisions for care following emergency services must be made as soon as is practicable but in any event no later than 24 hours after receiving the request for preapproval or for coverage determination; and

(B) to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by an employee or agent of the managed care entity who is a licensed health care provider;

(5) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity; except as provided under (6) of this section, this appeal mechanism must provide for a written decision from the managed care entity within 20 working days after the date written notice of an appeal is received;

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a managed care entity in any case in which delay would, in the written opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the managed care entity shall decide an appeal described in this paragraph within 72 hours after receiving the appeal;

(7) a provision that discloses the existence of the right to an external appeal of a utilization review decision made by a managed care entity; the external appeal shall be as conducted in accordance with AS 21.07.050;

(8) a provision that discloses covered benefits, optional supplemental benefits, and benefits relating to and restrictions on nonparticipating provider services;

(9) a provision that describes the preapproval requirements and whether clinical trials or experimental or investigational treatment are covered;

(10) a provision describing assignment of benefits for health care providers and health care facilities;

(11) a provision describing availability of prescription medications or a formulary guide, and its structure; if a formulary guide is made available, the guide must be updated annually; and

(12) a provision describing available translation or interpreter services,

including audiotape or braille information.

Sec. 21.07.030. Choice of health care provider. (a) If a managed care entity offers a group health plan that provides for coverage of health care services only if the services are furnished through a network of health care providers that have entered into a contract with the managed care entity, the managed care entity shall also offer a non-network option to enrollees at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible or copayment and a higher premium for the plan. This subsection does not apply to an enrollee who is offered non-network coverage through another group health plan or through another managed care entity in the group market.

(b) The amount of any additional premium charged by the managed care entity for the additional cost of the creation and maintenance of the option described in (a) of this section and the amount of any additional cost sharing imposed under this option shall be paid by the enrollee unless it is paid by the employer through agreement with the managed care entity.

(c) An enrollee may make a change to the health care coverage option provided under this section only during a time period determined by the managed care entity. The time period described in this subsection must occur at least annually.

(d) If a managed care entity that offers a group managed care plan requires or provides for a designation by an enrollee of a participating primary care provider, the managed care entity shall permit the enrollee to designate any participating primary care provider that is available to accept the enrollee.

(e) Except as provided in this subsection, a managed care entity that offers a group managed care plan shall permit an enrollee to receive medically necessary or appropriate specialty care, subject to appropriate referral procedures, from any qualified participating health care provider that is available to accept the individual for medical care. This subsection does not apply to specialty care if the managed care entity clearly informs enrollees of the limitations on choice of participating health care providers with respect to medical care. In this subsection,

(1) "appropriate referral procedures" means procedures for referring patients to other health care providers [redacted]

[redacted]

(2) "specialty care" means care provided by a health care provider with training and experience in treating a particular injury, illness, or condition.

(f) A managed care entity shall notify a covered person when a contract between a health care provider and the managed care entity is terminated for cause.

(g) If a contract between a health care provider and a managed care entity is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract between that provider and the managed care entity, the covered person may continue to receive health care services from that provider as provided in this subsection, and the contract between the managed care entity and the provider shall remain in force with respect to the continuing treatment. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the managed care entity. However, treatment is required to continue only while the group managed care plan remains in effect and

(1) for the period that is the longest of the following:

(A) the end of the current plan year;

(B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or

(C) through completion of postpartum care, if the covered person is in the second trimester of pregnancy on the date of termination; or

(2) until the end of the medically necessary treatment for the condition, disease, illness, or injury if the person has a terminal condition, disease, illness, or injury; in this paragraph, "terminal" means a life expectancy of less than one year.

(h) The requirements of this section do not apply to health care services covered by Medicaid.

Sec. 21.07.040. Confidentiality of managed care information. (a) Medical and financial information in the possession of a managed care entity regarding an applicant or a current or former person covered by a managed care plan is confidential

assure that decisions are not made in a biased manner; and

(3) that all costs of the process, except those incurred by the enrollee or treating professional in support of the appeal, shall be paid by the managed care entity and not by the enrollee.

(d) An external appeal process must include at least the following:

(1) a fair, de novo determination based on coverage provided by the plan and by applying terms as defined by the plan; however, nothing in this paragraph may be construed as providing for coverage of items and services for which benefits are excluded under the plan or coverage;

(2) an external appeal agency shall determine whether the managed care entity's decision is (A) in accordance with the medical needs of the patient involved, as determined by the managed care entity, taking into account, as of the time of the managed care entity's decision, the patient's medical needs and any relevant and reliable evidence the agency obtains under (3) of this subsection, and (B) in accordance with the scope of the covered benefits under the plan; if the agency determines the decision complies with this paragraph, the agency shall affirm the decision, and, to the extent that the agency determines the decision is not in accordance with this paragraph, the agency shall reverse or modify the decision;

(3) the external appeal agency shall include among the evidence taken into consideration

(A) the decision made by the managed care entity upon internal appeal under AS 21.07.020 and any guidelines or standards used by the managed care entity in reaching a decision;

(B) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed;

(C) the opinion of the individual's treating physician or health care provider; and

(D) the group managed care plan;

(4) the external appeal agency may also take into consideration the following evidence:

(A) the results of studies that meet professionally recognized

standards of validity and replicability or that have been published in peer-reviewed journals;

(B) the results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies;

(C) practice and treatment guidelines prepared or financed in whole or in part by government agencies;

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

(F) to the extent that the agency determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care that are directly related to the matters under appeal; and

(G) to the extent that the agency determines it to be free of any conflict of interest, the results of peer reviews conducted by the managed care entity involved;

(5) an external appeal agency shall determine

(A) whether a denial of a claim for benefits is an externally appealable decision;

(B) whether an externally appealable decision involves an expedited appeal; and

(C) for purposes of initiating an external review, whether the internal appeal process has been completed;

(6) a party to an externally appealable decision may submit evidence related to the issues in dispute;

(7) the managed care entity involved shall provide the external appeal agency with access to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the external appeal agency; and

(8) a determination by the external appeal agency on the decision must

(A) be made orally or in writing and, if it is made orally, shall

be supplied to the parties in writing as soon as possible;

(B) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the managed care entity's decision;

(C) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(D) inform the enrollee of the individual's rights, including any time limits, to seek further review by the courts of the external appeal determination.

(e) If the external appeal agency reverses or modifies the denial of a claim for benefits, the managed care entity shall

(1) upon receipt of the determination, authorize benefits in accordance with that determination;

(2) take action as may be necessary to provide benefits, including items or services, in a timely manner consistent with the determination; and

(3) submit information to the external appeal agency documenting compliance with the agency's determination.

(f) A decision of an external appeal agency is binding unless a person who is aggrieved by a final decision of an external appeal agency appeals the decision to the superior court.

(g) An appeal of a final decision of an external appeal agency must be filed within six months after the date of the decision of the external appeal agency.

(h) In this section, "externally appealable decision"

(1) means

(A) a denial of a claim for benefits that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or in which the decision as to whether a benefit is covered involves a medical judgment; or

(B) a denial that is based on a failure to meet an applicable

deadline for internal appeal under AS 21.07.020;

(2) does not include a decision based on specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment, or a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

Sec. 21.07.060. Qualifications of external appeal agencies. (a) An external appeal agency qualifies to consider external appeals if, with respect to a group health plan, the agency is certified by a qualified private standard-setting organization approved by the director or by a health insurer operating in this state as meeting the requirements imposed under (b) of this section.

(b) An external appeal agency is qualified to consider appeals of group health plan health care decisions if the agency meets the following requirements:

(1) the agency meets the independence requirements of this section;

(2) the agency conducts external appeal activities through a panel of clinical peers; and

(3) the agency has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the managed care entity on a timely basis consistent with this chapter.

(c) A clinical peer or other entity meets the independence requirements of this section if

(1) the peer or entity does not have a familial, financial, or professional relationship with a related party;

(2) compensation received by a peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(3) the plan and the issuer have no recourse against the peer or entity in connection with the external review; and

(4) the peer or entity does not otherwise have a conflict of interest with a related party.

(d) In this section, "related party" means

(1) with respect to

(A) a group health plan or health insurance coverage offered in connection with a plan, the plan or the insurer offering the coverage; or

(B) individual health insurance coverage, the insurer offering the coverage, or any plan sponsor, fiduciary, officer, director, or management employee of the plan or issuer;

(2) the health care professional that provided the health care involved in the coverage decision;

(3) the institution at which the health care involved in the coverage decision is provided;

(4) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision;

(5) the covered person; or

(6) any other party that, under the regulations that the director may prescribe, is determined by the director to have a substantial interest in the coverage decision.

Sec. 21.07.070. Limitation on liability of reviewers. An external appeal agency qualifying under AS 21.07.060 and having a contract with a managed care entity, and a person who is employed by the agency or who furnishes professional services to the agency, may not be held by reason of the performance of any duty, function, or activity required or authorized under this chapter to have violated any criminal law, or to be civilly liable if due care was exercised in the performance of the duty, function or activity and there was no actual malice or gross misconduct in the performance of the duty, function, or activity.

Sec. 21.07.080. Religious nonmedical providers. This chapter may not be construed to

(1) restrict or limit the right of a managed care entity to include health care services provided by a religious nonmedical provider as health care services covered by the managed care plan;

(2) require a managed care entity, when determining coverage for health care services provided by a religious nonmedical provider, to

(A) apply medically based eligibility standards;

(B) use health care providers to determine access by a covered person;

(C) use health care providers in making a decision on an internal or external appeal; or

(D) require a covered person to be examined by a health care provider as a condition of coverage; or

(3) require a managed care plan to exclude coverage for health care services provided by a religious nonmedical provider because the religious nonmedical provider is not providing medical or other data required from a health care provider if the medical or other data is inconsistent with the religious nonmedical treatment or nursing care being provided.

Sec. 21.07.250. Definitions. In this chapter,

(1) "clinical peer" means a health care provider who is licensed to provide the same or similar health care services and who is trained in the specialty or subspecialty applicable to the health care services that are provided;

(2) "clinical trial" means treatment, research, study, or investigation over a period of time of an injury, illness, or medical condition:

(3) "emergency room services" means health care services provided by a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in

(A) the placing of the person's health in serious jeopardy;

(B) a serious impairment to bodily functions; or

(C) a serious dysfunction of a bodily organ or part;

(4) "group managed care plan" or "plan" means a group health insurance plan operated by a managed care entity;

(5) "health care provider" means a person licensed in this state or another state of the United States to provide health care services;

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

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

(8) "managed care" means a contract given to an individual, family, or group of individuals under which a member is entitled to receive a defined set of health care benefits in exchange for defined consideration and that requires the member to comply with utilization review guide lines; "managed care" does not include Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);

(9) "managed care contractor" means a contractor who establishes, operates, or maintains a network of participating health care providers, conducts or arranges for utilization review activities, and contracts with a managed care entity;

(10) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual;

(11) "medical emergency" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in

(A) the placing of the person's health in serious jeopardy;

(B) a serious impairment to bodily functions; or

(C) a serious dysfunction of any bodily organ or part;

(12) "participating health care provider" means a health care provider who has entered into an agreement with a managed care entity to provide services or supplies to a patient covered by a group managed care plan;

(13) "primary care provider" means a health care provider who provides general health care services and does not specialize in treating a single injury, illness, or condition or who provides obstetrical, gynecological, or pediatric health care services;

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

(15) "religious nonmedical provider" means a person who does not

provide medical care, but who provides only religious nonmedical treatment or nursing care for an illness or injury;

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

(17) "working day" means a day of the week that is not a Saturday, Sunday, or a holiday.

* **Sec. 3.** AS 21.36.125 is amended by adding a new paragraph to read:

(16) violate a provision contained in AS 21.07.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by providing that an appeal from a decision of an external appeal agency must be filed within six months of the decision of the external appeal agency.

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

* **Sec. 6.** This Act takes effect July 1, 2001.

FAX TRANSMISSION COVER SHEET

Office of
Representative Pete Kott
ALASKA STATE LEGISLATURE

UO	
TO	number of pages, including cover
	269-0229
ORGANIZATION	FAX
House Judiciary	3/31/00
FROM	DATE

INTERNET: http://www.akrepublicans.org/Kott.htm
E-MAIL: Representative_Pete _Kott@Legis.state.ak.us

MESSAGE:

ALASKA STATE CAPITOL, ROOM 118 • JUNEAU, ALASKA 99801-1182
☎ (907)465-3777/(800)342-2199 • FAX: (907)465-4587

BRADY & COMPANY
INCORPORATED

Brady Building
1031 W. 4th Avenue, Suite 400
P.O. Box 107502 • Anchorage, AK 99510-7502

April 3, 2000

To: Representative Rokeberg, Chair, House Labor & Commerce Committee
Representative Kott, Chair, House Judiciary Committee

Re: HB211

Dear Representatives Rokeberg and Kott,

In my role as health care consultant for a variety of large employers and health care Trusts, I have been following HB211 very closely, as it will have an unfavorable impact on my clients' health care plans. On March 31, 2000, the Judiciary Committee heard testimony on this bill. I was present in the Anchorage Legislative Office and was prepared to testify as to the impact this bill will have on health care plan sponsors. After starting a half-hour late, the hearing was abruptly terminated at approximately 2:35 pm before all testimony was taken. The Committee had received input from the medical fraternity and the insurance companies. The concerns of the plan sponsors – the entities that actually pay health care costs – went unheard. Needless to say, I was extremely upset. It seems you are more concerned about physicians and insurance companies than those Alaskans who actually pay the cost of health care, the plan sponsors.

Therefore, I am writing to you today to express my concerns regarding HB211 as it is written (Version N). In general, we support a patient's bill of rights and appreciate the changes that have been incorporated into the bill so far. However, we still have more work to do, as this legislation will needlessly increase plan costs as well as increase the administrative burden for operating plans. In addition, it creates significant conflicts with the Employee Retirement Income Security Act of 1974 (ERISA).

First, in order to mitigate conflicts with ERISA, we suggest the following language be incorporated into the Act:

> In no event will this Act infringe upon, be in conflict with, or supercede the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), including amendments hereto and associated regulations.

Second we are concerned that the external appeals process will impose substantial administrative burdens on plan sponsors and participants. The process has the potential to require <u>three</u> claim appeal steps before proceeding to either court or arbitration. This is unacceptable for the average layman because of costs and time. We agree that an original internal appeal is necessary to determine if any errors had occurred. We suggest that after the initial internal appeal, participants should be allowed to appeal to the external review entity <u>and</u> the plan sponsor's fiduciaries jointly. The decision reached in this appeal should be based on plan provisions

(including exclusions, limitations and definitions of medical necessity) contained in the plan document. In this way, only two appeals are required in total.

In addition, we can only support this bill if it allows plan sponsors to state their definition of medical necessity in the health plan's plan document. Medical necessity should not be defined in the Act. In no event should a plan sponsor be required to pay benefits that are considered medically necessary according to the attending physician, if those benefits are excluded by the plan. A statutory definition of medical necessity is driven by the physicians' desire to extend coverage for patients so that all procedures can be reimbursed without at least very limited cost control mechanisms in place via exclusions and limitations. Physicians should not be allowed to dictate to plan sponsors what is or is not covered under the plan. Plans must be allowed to define "medical necessity" and list excluded services.

Mr. Jordan, of the Alaska Medical Association, testified that the managed care entities "make medical decisions." They do not. Managed care entities determine whether or not coverage is available under a plan according to the plan documents. It is the participant's decision whether or not to proceed with treatment, regardless of plan coverage.

After listening to the testimony Friday, it seems the AMA and Alaska Physicians and Surgeons wish to make certain coverage is granted regardless of the plan sponsors' intent in drafting plan design. If the most liberal of all approaches is taken, and no restrictions are placed upon coverage by defining medical necessity and placing exclusions upon the plan, plan sponsors will not be able to afford benefit plans in their current configuration. As it currently exists, this bill will increase the cost of health care plans, therefore depleting the funds available to pay benefits. This means the plan sponsor will have to pay more into the plan to fund the current benefits, or reduce benefits for all procedures accordingly. Worse yet, plan sponsors, who are just barely able to afford a health care plan in our already expensive state, may have to cancel it because they can't afford what physicians demand.

We find it interesting that Mr. Jordan further stated the estimates of cost increases for similar legislation were "not that high." If a health plan is required to cover procedures currently excluded or limited by the plan, health care costs will certainly increase. Furthermore, if a plan is required to pay for additional administrative appeals, administration expenses will increase as well.

This bill is intended to benefit physicians at the expense of benefit plan sponsors. Moreover, the name, "Patient's Bill of Rights" is misleading, because this bill is not intended to benefit plan participants. When asked, a member of Representative Rokeberg's staff indicated this bill was not crafted in response to constituent complaints about managed care. Rather, this bill originated from Alaska physician requests.

Lastly, legislation defines a "managed care entity" as "an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual." The definition of "an employer or employee health care organization" is totally unclear. What does it mean?

In general, this bill appears as though it is intended to mirror the Patient's Bill of Rights in Washington, D.C., which is currently under debate. The federal legislation has not yet passed and will probably still be amended. HB211 could easily end up in conflict with the final version of the federal bill, which means the Alaska legislature will have spent a significant amount of fruitless time and effort. If the intent is not to infringe upon ERISA and to mirror federal legislation, we strongly encourage defeat of this state legislation or deferral to the next legislative session to accurately assess the final version of the federal Patient's Bill of Rights.

As representatives of the State, we encourage you to contact those parties who are responsible for the payment of health care costs – the plan sponsors – to help build this legislation rather than to simply impose unworkable restrictions that will increase revenue to physicians, and by doing so, increase Alaska's high health care costs even further.

Sincerely,

Ed Burgan
Senior Vice President

cc: Associated General Contractors of Alaska
Mechanical Contractors of Anchorage
Mechanical Contractors of Fairbanks
Steel Erectors Associations
Northern Electrical Contractors
Alaska Hotel and Motel Association
Members of the Labor and Commerce and Judiciary Committees
Alaska State AFL-CIO
All Labor Organizations Sponsoring Health & Welfare Plans
Anchorage Chamber of Commerce
Brady & Company Clients
Health Care Cost Management Corporation of Alaska

Insurance Co don't want medical necessity language in. b/c ① cosmetic surgury area
② experimental surgury

- wa state excluded medical Necessity but included a version of liability. (Get copy from Sam)
- get a copy of insurance company contracts
- like bill

Jim Jorden: AK St Med Assoc → The 2 areas of medical necessity + Liability area

→ Has a problem w/ language in version "N" not only w/ 2 concepts being eliminated

House: HR2990 → allows external agency to go outside contract definition of medical necessity.

So, @ the very least external agency review.

→ will send written analysis

---

* definition of medical necessity is problematic for ins. co b/c gives Drs sole discretion & they economic / & non-economic factors

Ins. cos think that pg 9 sec(8) gives enough extra protection beyond policy allowing Drs med necessity.

There needs to be a balance b/w Drs. free reign & ins. cos.

- Concerns re:
  Jorden & Hogan

pardon me for interrupting you, while I am speaking.

is not contrary to the terms of coverage under the covered person's health benefit plan;

(A) consistent with the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

NAIC external review model act

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee.

(7) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

S. Carolina language

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration; or

(b) Medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of standard services or treatments.

(d) Within forty-five (45) days after the date of receipt of the request for an external review by the health carrier, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) The covered person or his authorized representative; and

(b) The health carrier;

(2) The independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel.

BRADY & COMPANY
INCORPORATED

Brady Building
1031 W. 4th Avenue, Suite 400
P.O. Box 107502 • Anchorage, AK 99510-7502

6 April, 2000

To: Representative Rokeberg, Chair, House Labor & Commerce Committee
Representative Kott, Chair, House Judiciary Committee

Re: HB211, Version S

Dear Representatives Rokeberg and Kott,

On April 3, 2000, we faxed you a letter expressing our concerns about Version N of HB211. In that letter, we encouraged you to consider the needs of health care plan sponsors (those Alaskans who pay the cost of health care), and offered a number of recommendations on their behalf.

This morning, we received a copy of HB211, Version S. Upon first review, it seems that 100% of our recommendations were ignored. Therefore, the comments expressed in our April 3rd letter remain unchanged.

When we received Version S, we also learned a Judiciary Committee hearing is scheduled this afternoon at 2:00pm to discuss this bill. It is troubling that the Committee did not allow sufficient time between release of the work draft and the scheduled hearing so that involved parties (other than physicians) have sufficient time to review the changes and provide input. Some people may consider the short time frame your strategy to ignore constituent input. We wouldn't call it that, but we believe it is in the best interest of Alaskans to allow your constituents a few days to review amended legislation and provide comment in the future.

We contacted the following organizations to notify them of the changes made in Version S. They requested us to convey their continued opposition to HB211.

Associated General Contractors of Alaska
Alaska Steel Contractors and Erectors Association
National Electrical Contractors Association
Alaska State AFL-CIO
Alaska Teamsters Welfare Trust
Alaska UFCW Health & Welfare Trust
Health Care Cost Management Corporation of Alaska

We are also confident of similar support from other organizations, but due to the time constraints imposed by your 2:00 Committee Meeting, we have not been able to contact them.

It is likely that the above-named organizations' members and families represent 20-25% of the population of the State of Alaska. We find it interesting that this legislation is opposed by the above-named organizations and the participants they represent, but the Committee continues to follow the lead of the physicians' groups in pushing for its passage. We encourage you to consider the needs of plan sponsors and participants, as well as the desires of physicians, when you meet this afternoon.

As we stated in our letter of April 3rd, we support the concept of a patient's bill of rights and would agree to help draft such legislation. We do not believe HB211 provides any additional patient protection not currently provided under state of federal law. Rather, we believe HB211 protects the physician community, and patients and plan sponsors would be adversely affected by passage of this bill.

Sincerely,

Ed Burgan
Senior Vice President

cc: All organizations listed above
All Brady & Company clients
Governor Tony Knowles

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

INTERIM:
716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

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

Representative Norman Rokeberg

MEMORANDUM

TO: **Rep. Pete Kott, Chairman**
House Judiciary Committee

FROM: **Rep. Norman Rokeberg**

DATE: **March 20, 2000**

RE: **CSHB 211 (L&C)**

Thank you for scheduling HB 211 for hearing before the House Judiciary Committee on Friday, March 24th.

Attached are the following:

1. **CSHB 211 (L&C)**
2. **Sponsor Statement**
3. **Sectional Analysis**
4. **Zero fiscal note**
5. **Legislative Legal Counsel Memorandum dated Feb. 10, 2000, regarding emergency room services**
6. **Proposed amendment regarding confidentiality language (page 9)**
7. **Attorney General's Memorandum Opinions Concerning PPOs**
8. **February 24, 2000, letter from Alaska State Medical Association and "Economic Impacts of Managed Care Reform" study.**
9. **List of support letters received on HB 211**
10. **Brunner, Jim, "So far, Texans happy with patient-rights law", Seattle Times, March 12, 2000**
11. **Washington Office of the Governor, "Locke signs 'Patient's Bill of Rights' legislation", March 15, 2000**
12. **"Managed Care: Where Do We Go From Here", March 1999 State Legislatures.**

I would request that this meeting be teleconferenced to Anchorage as well as other LIO locations that may care to be a part of any hearing.

ALASKA STATE LEGISLATURE

House of Representatives

Committee Assignments:

Labor & Commerce Committee, Chairman
Judiciary Committee, Member
Legislative Council, Member
Special Committees:
  Utility Restructuring, Member
  Economic Development, Member
Budget Subcommittees:
  Commerce & Economic Development, Member
  Corrections, Member
  Labor, Member

Interim:
716 West 4th Avenue, Suite 440
Anchorage, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
State Capitol
Juneau, AK 99801-1182
PHONE: (907) 465-4948
FAX: (907) 465-3640

REPRESENTATIVE NORMAN ROKEBERG

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

SPONSOR STATEMENT
HB207

"An Act relating to home inspections."

HB207 will protect consumers and the home inspection industry by prohibiting certain home inspector trade practices and limiting legal actions against home inspectors. HB207 revises Title 9, Civil Actions, by limiting them; it is not a home inspector licensing bill.

Consumers deserve assurance that they can bring an action against an individual home inspector based on the contents of or omissions in a written home inspection report. HB 207 allows recourse against inspectors; it is limited to the person who contracted and paid for the report and the action must be brought within one year of the written report. HB207 further accomplishes this by making it contrary to public policy and void for any home inspection report limiting liability to the cost of the report.

A faulty inspection could have serious consequences for consumers, particularly when they are buying or selling a home. Common sense dictates that home inspectors must be held accountable for their work.

I have met with representatives from the industry who agree that home inspector accountability is a worthy goal. The goal of HB 207 is to establish a framework, within which the home inspector can operate, the home inspection profession is protected and consumers are shielded from egregious faulty inspections.

I urge you to support this legislation.

03/16/00 HB207(L&C) version T

Alaska State Legislature
HOUSE OF REPRESENTATIVES

Official Business

State Capitol
Juneau, AK 99801-1182

SUBJECT: SECTIONAL ANALYSIS: HB 207/(L&C)

HOUSE BILL 207: "A BILL RELATING TO HOME INSPECTIONS"

FROM: Representative Norman Rokeberg

DATE: March 16, 2000

SECTION 1.
Limits the legal actions against a home inspector to action brought by the person who contracted and paid for the written home inspection report; and is limited to within one year after the date of the written report. It makes any contract provision limiting the liability of a home inspector to the cost of the home inspection report as contrary to public policy and void. It defines applicable home inspection, real estate transaction and residence.

SECTION 2.
Delineates prohibited acts relating to home inspectors, including, prohibiting:
getting an extra fee to perform repairs on any structure that the individual or the company has prepared a home inspection report in the past 12 months;
inspecting for a fee any property that they have a financial interest;
offering or delivering compensation for referral of business;
disclosing information from a home inspection report, without written consent from the home inspection client or the client's representative or within one year after the date of the report , unless to a subsequent client who requests a home inspection of the same premises;
accepting compensation from more than one interested party for the same services without the written consent of all interested parties;
accepting a commission or allowance, directly or indirectly, for work for which the individual or company is responsible;
accepting a fee payable or contingent fee for a report, based on the conclusions, preestablished findings, or the close of escrow.

It defines home inspection, intentionally, real estate transaction and residence. It makes violation of this section a class A misdemeanor.

tjm/03/16/2000HB 207(L&C)sectional analysis)

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSHB 211

Revision Date/Time (Note if correction) 03/06/00
Dept. Affected Community & Economic Development
Title An Act relating to liability for providing managed care services, to regulation of managed care insurance plans . . .
BRU Insurance
Component Insurance
Sponsor Rokeberg
Requester (H) L&C
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

Sec. 21.07.020, page 7, lines 8-11 require that a managed care entity provide actuarial support to the director upon request for the increased cost of using a non-network provider. It is estimated that fewer than 15 insurers have provider network provisions in their health insurance contracts. Therefore, it is anticipated that no additional resources will be needed to request and review the increased costs of non-network provider use.

Sec. 21.07.060, page13, line 17, requires that the director approve "qualified private standard-setting organizations". It is estimated that there are currently fewer than 5 of these organizations. Therefore, it is anticipated that no additional resources will be needed for the director to certify these "qualified private standard-setting organizations". Also, it is anticipated that no additional resource will be needed to develop regulations, should they be needed, to define related party as provided on page 14, lines 20-22 of this section.

Prepared by: Robert A. Lohr
Phone 269-7900
Division Insurance
Date/Time 3-7-00 9:28 AM
Approved by Commissioner Deborah B. Sedwick
Date 3-7-00
Agency Community & Economic Development

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information, call the Governor's Legislative Office

LEGAL SERVICES

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

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

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 10, 2000

SUBJECT: Managed care - (CSHB 211(L&C))

TO: Representative Norman Rokeberg
Attn: Janet

FROM: Michael F. Ford
Legislative Counsel

You asked two questions regarding CSHB 211(L&C). First you asked if the last sentence in sec. 21.07.030(a) covers a situation when the insured has other insurance that provides non-network coverage. The answer is yes. Second, you asked if there is a conflict between a managed care plan and a statute, which prevails. While the legislature cannot change the terms of an existing managed care plan, the legislature can dictate the terms of a managed care plan entered into or renewed after the law takes effect. So if there is a conflict between the provisions of a managed care plan and statute, the statute prevails unless the contract was in existence prior to the law taking effect. See AS 21.42.265.

Please contact me if you have further questions.

MFF:pl:glc
00-048.plm

AMENDMENT #_____

OFFERED IN THE HOUSE **BY REP. ROKEBERG**

TO CSHB 211 (L&C)

Page 9, lines 5-10: DELETE

Page 9, line 4: After "public disclosure." INSERT following:

(b) Nothing in this section shall be construed to apply to the release of medical information for:

(1) Research using medical information that is subject to federal laws and regulations protecting the rights and welfare of research participants; or

(2) Research using anonymized health information in which the confidentiality of participants is protected by coding or encryption of information that reveals the identity of the patient.

Memorandum Opinion 95-0654

LEGALITY OF PREFERRED PROVIDER ORGANIZATIONS IN ALASKA

April 21, 1995

I. INTRODUCTION

This is in response to your memorandum dated April 13, 1995, by which you requested an opinion on the following question: "Are Preferred Provider Organizations (PPOs) legal in Alaska?" Our conclusion is that they are lawful, although there is no enabling legislation for

II. BACKGROUND

PPOs are a relatively recent development in the health care delivery arena. For much of this century, traditional indemnity insurance, whether through individual or group insurance policies, provided the primary means for health care reimbursement. In the last few decades, due in large part to the trend of disproportionately large increases in health care costs, alternatives to pure indemnity insurance evolved. Many of these alternatives fall under the rubric of managed care and have a primary purpose of cost containment. For instance, in the 1970s, statutory enabling laws for health maintenance organizations (HMOs) were created.[1] Alaska enacted its version of the HMO model law (AS 21.86) in 1990. However, to date there are no licensed HMOs in Alaska.

In the 1980s, PPOs developed as a managed care device.[2] PPOs are a fee-for-service alternative to traditional health insurance. Due to their dramatic growth they soon became a central feature of health care financing and delivery reform.

The PPO, also referred to as a preferred provider arrangement (PPA),[3] involves purchasers managing the cost of health care through contracting with a group of doctors or hospitals ("preferred" or "network" providers). The salient characteristics of the preferred provider arrangement are as follows. In exchange for discounted fees for services, the providers receive a guaranteed supply of patients and a commitment to quick turnaround on claims payments. Providers also typically agree to comply with utilization review procedures intended to reduce inappropriate or unnecessary care. Through a bulk purchase of medical services, purchasers have the advantage of being able to choose providers based on competitive pricing, which is expected to result in

cost savings. Patients are offered financial incentives such as reduced or eliminated copayments or deductibles if they use designated preferred providers. PPOs are formed by a wide variety of entities — purchasers as well as providers — including insurers, self insurers (employers), unions, physicians, hospitals, HMOs, service corporations, and third party administrators (often owned by insurers).[1]

At a recent hearing before the Senate Labor and Commerce Committee, a representative of the Division of Insurance was asked whether preferred provider organizations (PPOs) are legal in Alaska. The division's response that PPOs are not lawful has created some controversy. The largest group disability[5] insurer in the state (Aetna Life Insurance Co.) has been utilizing PPOs for years based in part on the division's approval of its insurance forms. The Division of Retirement and Benefits also has expressed concern regarding the use of PPOs in the state health plan. As a result, you have referred this question to the Department of Law for a legal opinion.

III. ANALYSIS

PPOs are lawful in Alaska. While there is no enabling legislation for PPOs, no provision of AS 21 on its face prohibits the formation of PPOs or contracting with such entities.

By way of background, and as previously indicated in this memorandum, there is a model law developed by the National Association of Insurance Commissioners (NAIC) entitled the "Preferred Provider Arrangements Act." Currently, over half of the states (29) have adopted some version of the PPO model by legislation, regulation, or bulletin.[6] Alaska has not adopted a version of the model. Whether or not it should have is beyond the scope of this opinion.

It is noteworthy that states have been criticized for passing laws that impede the implementation of PPOs. Even before the creation of the model act, legislation was introduced in Congress in 1983 to prohibit states from restricting the operations of the already emerging PPO mechanism.[7] The existence of PPOs in the absence of enabling legislation is also evidenced by a drafting note for Section 2 of the model (Purpose), which states: "The use of the term 'allowing' in this section is not intended to indicate that health care insurers are acting unlawfully in a state which has not enacted a law allowing Preferred Provider Arrangements."[8]

Although federal law recognizes the PPO mechanism, it does not

answer the question whether PPOs are legal in Alaska. In a regulation implementing the Medicare program, the Department of Health and Human Services refers to health plans having "premium structure regulated under a State insurance statute or a State enabling statute governing health maintenance organizations or preferred provider organizations." 42 C.F.R. § 1001.952(1)(2). This regulation does not mandate the use of an enabling law for PPOs. The CHAMPUS program, which expressly authorizes federal officials to contract with PPOs, also does not require a state enabling statute. *See* 10 U.S.C. § 1095.

There are no published cases, state or federal, addressing whether PPOs are lawful in the absence of enabling legislation. One case implicitly acknowledges the validity of a state PPO enabling law. In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), the court held that ERISA's savings clause exempted from federal preemption a Virginia enabling law for establishing PPOs. However, there is no federal mandate for an enabling law. Each state may regulate PPOs as it sees fit, in the absence of congressional direction.[9]

Recognizing that there is no Alaska enabling law for PPOs, the Division of Insurance has previously taken the position that certain provisions of the insurance code prohibit the use of PPOs. We find this argument unpersuasive for the following reasons.

AS 21.54.020(a)

One of the provisions the division relies upon is a prohibition applicable to group disability insurers that provides in part: "The [group disability] policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86." AS 21.54.020(a). This law does not prohibit the use of a PPO. To begin with, HMOs, which may contract with a PPO, are exempted. *See id.*; AS 21.86.060(a). In addition, the typical health plan utilizing a PPO gives covered individuals the choice of more than one provider, and often there is an option to use a nonpreferred provider, albeit at higher cost. Only if the covered person is given no choice of provider would this provision be violated.

AS 21.36.090(b)

Another statute relied upon by the division as prohibiting PPOs is AS 21.36.090(b). It provides:

> A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same

> hazard in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

This provision prohibits only disability (health) insurers from unfairly discriminating against covered individuals. It is part of the Unfair Trade Practices Act (UTPA) in Alaska's insurance code, enacted in 1966 and based upon an NAIC model. Although the legislative history for AS 21.36.090(b) is scant and has no bearing on the PPO issue, the model act is instructive. It was adopted in 1947, well before the emergence of PPOs and the managed care concept.[10] The unfair discrimination provision at AS 21.36.090(b) is substantially the same as the corresponding provision of the model act [Section 4(G)(2)]. The legislative history for Section 4(G)(2) reveals that the primary concerns about unfair discrimination were in the contexts of race, sex, marital status, residence and national origin. More recently, redlining and blackballing underwriting practices have received attention. There is no discussion of PPOs in the legislative history of the model. Indeed, it would be illogical for the NAIC to adopt a PPO model act if PPOs were per se violative of the UTPA. It is true that a PPO could violate AS 21.36.090(b) if its conduct were unfairly discriminatory for any one of a variety of reasons. However, it is additionally possible that there would be no "unfair" discrimination if a PPO treated all individuals of the same class equally as to costs, benefits payable or other contractual terms. In conclusion, AS 21.36.090(b) does not prohibit the establishment of PPOs or contracting with them.

Hospital and Medical Service Corporation (AS 21.87)

Your memorandum also addresses hospital and medical service corporations. *E.g.*, Blue Cross. Th se entities differ significantly from disability (health) insurers and are not even considered insurers. Unlike traditional insurance companies, which are subject to the provisions of AS 21.09, service corporations are regulated by the provisions of AS 21.87. Service corporations are nonprofit, at least in theory, and pursuant to statute. *See* AS 21.87.070(2). In essence, a service corporation delivers health care coverage through the use of two contracts. In the first one, a service agreement, the service corporation and a participant provider (typically a hospital or physician) agree to exchange health care services for a set fee. *See* AS 21.87.140 — 21.87.150. The second

contract, called a subscriber contract, is between the service corporation and a recipient of care. *See* AS 21.87 160. It gives the subscriber access to health care services provided by the service contract.

Hospital and medical service corporations have statutory authority to contract with PPOs. *See, e.g.*, AS 21.87.070(3), 21.87.150 (service agreements with participant hospitals authorized); AS 21.87.070(4), 21.87.140 (service agreements with participant providers authorized); AS 21.87.120(a)(2), 21.87.130(a)(2), 21.87.160(b)(1), (2) (indemnity for services by nonparticipant providers and hospitals allowed). These statutes were enacted in 1966, well before the emergence of PPOs. They effectively allow a different benefit to be provided to a subscriber by a participant hospital or participant provider than benefits the subscriber may access on an indemnity basis. Although none of the statutes explicitly reference PPOs, their language is broad enough to allow contracting with PPOs.

Exclusive Provider Arrangements

Finally, your memorandum addresses "exclusive provider arrangements," also referred to as "exclusive provider organizations" or EPOs. These entities are a subspecies of PPOs. As previously indicated, for group disability (health) insurance, AS 21.54.020(a) prohibits the use of an EPO where the covered individual has no choice of provider. Depending on the circumstances, an EPO may also violate provisions of AS 21.36.

IV. CONCLUSION

Unlike most states, Alaska does not have an enabling law for establishing and using PPOs. For the reasons indicated in this memorandum, the Alaska insurance code nonetheless does not prohibit the creation of PPOs.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] *See generally* 42 U.S.C. § 300e *et seq.* (Federal Health Maintenance Organization Act of 1973); Health Maintenance Organization Model Act, Vol. II, NAIC Model Laws, Regulations and Guidelines, pp. 430-1 through 430-31 (adopted 1973).

[2] *See* Gabel, Ermann, Rice & de Lissovoy, *The Emergence and Future of PPOs*, Vol. 11, Journal of Health Politics, Policy and Law, 305 (1986); Preferred Provider Arrangements

Act, Vol. I, NAIC Model Laws, Regulations and Guidelines, pp. 75-1 through 75-4, (adopted 1987).

[4] A PPO is the group of providers whereas a PPA is the contractual arrangement between that group of providers and purchasers of health care. Your April 13, 1995, memorandum refers to PPOs. For the purpose of this opinion, the PPO and PPA mechanisms are interchangeable.

[5] There are myriad forms of PPOs whose description is beyond the scope of this opinion. *See generally* Combe & Krugman, *Design and Pricing of the PPO and EPO Products*, Practicing Law Institute, Commercial Law and Practice Course Handbook Series, September 25, 1986.

[6] Alaska is in the clear minority of states that uses the term "disability insurance" to refer to what is commonly known as "health insurance." *See* AS 21.12.050 (disability insurance defined); AS 21.54.060 (group disability insurance defined). "Disability insurance" includes "disability income replacement insurance."

[7] *See* Vol. I, *NAIC Model Laws, Regulations and Guidelines*, pp. 75-5 through 75-8 (1993).

[8] *See* Rolph, Ginsburg & Hosek, *The Regulation of Preferred Provider Arrangements*, 6 Health Affairs, 32, 33 (Fall 1987).

[9] *See id.* p. 75-1. *See also* Statement of Commissioner Grode (Pa.), Report of Working Group on Preferred Providers, Vol. 1, NAIC Proceedings, at 712 (1987) ("drafting note was added to clarify the possible ambiguity").

[10] *See generally* 15 U.S.C. §§ 1011-12 (McCarran-Ferguson Act delegation of insurance regulatory authority to states).

[11] *See* Vol. IV, *Model Laws, Regulations and Guidelines*, pp. 880-1 through 880-13 (1993). The NAIC's unfair trade practices model act was one of the initial efforts at developing uniform state legislation in response to the newly enacted McCarran-Ferguson Act. *See* NAIC Proceedings, at 142-43 (1946).

Memorandum Opinion 96-0291

OPINION ON CHOICE AND PAYMENT OF PROVIDERS UNDER SERVICE CORPORATION BENEFITS

November 3, 1995

I. INTRODUCTION

This is in response to your memorandum dated October 9, 1995,[1] through which you requested answers to the following two questions:

1. Whether patients have the right to receive care from a provider of their choice?

Answer: Yes.

2. Whether providers are entitled to the same fees as those received by providers who enter into contracts with a medical service corporation?

Answer: No.

II. BACKGROUND

The above questions derive from inquiries made to the Alaska Division of Insurance by the Alaska Dental Society (ADS). The attachment accompanying your memorandum indicates ADS' position that the answer to both questions is "yes." Although ADS' inquiries are made in the context of dental care, my analysis and conclusions are applicable to dentists, medical doctors, and all other properly licensed health care providers[2] rendering services within the scope of their occupational licenses. In addition, my analysis for the first question addresses traditional health insurance as well as service corporations, although a primary emphasis is placed on the latter consistent with ADS' letter to you.

It is initially useful to understand the nature of a service corporation. A significant share of group health benefits in this country are provided through "service corporations." These health care financing entities are not traditional fee-for-service insurers, who typically provide for health care through indemnifying an insured after expenses are incurred. In contrast, a service corporation generally facilitates delivery of health care through periodic *pre*payments made by subscribers (recipients of

care). *See* AS 21.87.010(a). A service corporation may, however, additionally provide subscribers with indemnity benefits. *See id.* AS 21.87.160(b)(2); AS 21.87.190(c).

There are three types of service corporations: (1) a medical service corporation principally provides medical or surgical services to subscribers; (2) a hospital service corporation principally provides hospital services to subscribers; and (3) a medical and hospital service corporation provides a combination of these services to subscribers. *See* AS 21.87.070; AS 21.87.280; and AS 21.87.330(2), (3). For the purpose of this memorandum, the term "service corporation" refers to all three of these entities. In Alaska, there are two authorized service corporations — Blue Cross of Washington & Alaska and Alaska Vision Services, Inc.

Service corporations are characterized by their use of two types of contracts. In the first one, a "service agreement," the corporation and a participant health care provider[3] (typically a hospital or physician) agree to provide health care services for a set fee. *See* AS 21.87.140; AS 21.87.150. A "nonparticipant" provider or hospital, as referenced in AS 21.87, is one that has not entered into a service agreement with the corporation. *See id.* AS 21.87.120(a)(2); AS 21.87.130(a)(2). In the second type of contract, called a "subscriber contract," a subscriber agrees to pay a set amount in exchange for certain health care benefits provided under the service agreement. *See id.* AS 21.87.160; AS 21.87.190. Another important characteristic of service corporations is that, in contrast to insurance companies, service corporations must be organized and operated in good faith as nonprofit entities. *See id.* AS 21.87.020(a); AS 21.87.070(2); AS 21.87.050(a); and AS 21.87.070(2).

Blue Cross and Blue Shield organizations are typically operated as service corporations and are the most well known types of service corporation. Historically, Blue Cross, which pioneered the hospital insurance market nearly 70 years ago, provided for hospital care, and Blue Shield provided for physicians' services (surgical and medical expenses). In 1982 the Blue Cross Association and the National Association of Blue Shield plans merged. The resulting national BlueCross BlueShield Association is currently comprised of 69 separate and locally operated companies called "plans." Blue Cross of Washington & Alaska, an affiliate of a larger holding company, is a member of the association. In the United States, more than 80 percent of hospitals and nearly 70 percent of physicians contract directly with Blue Cross and Blue Shield plans. Together, "Blues" plans in 1994 provided health care benefits for 7.6 million members, ultimately covering over 65 million people —

roughly one in four Americans. *See BlueCross BlueShield Association 1994 Fact Book*; L. Kertesz, "A blue streak for managed care," *Modern Healthcare*, p. 63 (September 12, 1994). In Alaska, the Blue Cross plan has a large market presence, insuring about 95,000 Alaskans under group and individual policies (subscriber contracts).

There is often confusion about how to categorize a service corporation. The confusion is created in part by the fact that although a service corporation is not a traditional insurer, it is regulated by the state insurance regulatory agency. In Alaska, a traditional indemnity insurer is subject to the provisions of AS 21.09 concerning its authorization and general financial and reporting requirements. In contrast, a service corporation is primarily regulated by provisions of AS 21.87. Regulatory oversight of a service corporation remains similar in many ways to oversight of a traditional insurer by the division of insurance. *See e.g.*, AS 21.87.180 (contract language must be filed with and approved by division); AS 21.87.190 (rates must be filed with division and may not be excessive or unfairly discriminatory); AS 21.87.200 (requirements for adequate reserves); AS 21.87.210 (requirements for surplus fund); AS 21.87.220 (investment requirements); AS 21.87.230 (requirements for books and accounts); AS 21.87.240 (annual statement and fees requirements); AS 12.87.250 (periodic statutory examination); and AS 21.87.260 (taxation). In addition, AS 21.87.340 makes a service corporation subject to numerous other provisions of the insurance code, including most provisions of AS 21.09, so long as the provisions do not conflict with AS 21.87. A service corporation nonetheless is exempted from some important regulatory provisions applicable to traditional insurers. *See, e.g.*, AS 21.87.340 (exemption from Holding Company Act requirements of AS 21.22; and exemption from participation in guaranty association established by AS 21.79).

As further evidence of the confusion regarding how to categorize a service corporation, the entity is expressly prohibited from using a corporate business name including the word "insurance" or other terms descriptive of an insurer or insurer business. *See* AS 21.87.060. And, the U.S. Supreme Court has acknowledged in a case addressing what constitutes "the business of insurance" that Blue Cross as well as some members of Congress do not consider a service corporation's product to be insurance. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 228-29 (1979). Nevertheless, service corporations are commonly referred to as insurers and as engaged in the business of insurance. They are also often included within the rubric "group medical

expense insurance." *See generally* D. Gregg, *Life and Health Insurance Handbook*, 427 (2d ed. 1964) (chapter entitled: "Group Medical Expense Insurance — Blue Cross and Blue Shield"). It is therefore not uncommon to see service corporations (*e.g.*, Blues) characterized as insurance in some contexts but not as insurance in others.

III. ANALYSIS

A. A patient has the right to receive health care services from the provider of her/his choice.

Your first question focuses on the right of a patient to choose a provider. In the broad context of traditional health insurance, the answer is that a patient (insured) has an unqualified right to seek health care services from the provider of her/his choice. The Alaska insurance code uses the term "disability insurance"[4] to refer to what is commonly known as health insurance. For individual disability insurance policies, the statutory requirement for payment of indemnity to a provider is qualified by the language: "this paragraph does not require that services be provided by a particular hospital or person." *See* AS 21.51.120. Similarly, under AS 21.54.020(a) a group disability policy "may not contain a provision requiring that services be provided by a particular hospital or person," except as applicable to an HMO. The Unfair Trade Practices Act for insurance (AS 21.36) provides additional support for a patient's freedom to choose a provider. AS 21.36.090(b) prohibits a person from unfairly discriminating in a policy or contract of disability insurance. An insurer limiting a patient's ultimate right to use the provider of her/his choice — regardless of provision for payment — violates this provision.

Provisions of AS 21.87, the chapter regulating service corporations, also acknowledge the freedom to choose. As previously addressed, in the typical situation the service corporation enters a contract with "participating" providers. *See* AS 21.87.120(a)(1) (medical and surgical services); AS 21.87.130(a)(1) (hospital services). However, this does not preclude a subscriber from obtaining services of a nonparticipating provider. AS 21.87 expressly authorizes a service corporation to provide indemnification for services provided by nonparticipant providers. *See id.* AS 21.87.120(a)(2) (indemnity for medical and surgical services); AS 21.87.130(a)(2) (indemnity for hospital services).

It is necessary to distinguish that although a service corporation has the right to offer coverage extending payment to a nonparticipant provider, the corporation is not obligated to provide for indemnity of a

nonparticipant provider. The right to provide a subscriber "indemnity in a reasonable amount" (AS 21.87.120(a)(2) and AS 21.87.130(a)(2)) is not a mandate. The following provisions support this conclusion. AS 21.87.160(b)(2) requires that a subscriber contract must include "the benefits, *if any*, to which the subscriber is entitled on an indemnity basis. . ." (emphasis added). And, it is noteworthy that the minimum service benefits which must be provided through a subscriber contract apply only to participant providers and participant hospitals. *See id.* AS 21.87.170.

As further support of a subscriber's right to choose a provider, a PPO, which allows health care recipients a choice from among a group of providers, is not prohibited by the insurance code. *See generally* 1995 Op. Att'y Gen (Apr. 21; 661-95-0654). A service corporation may contract with a PPO as a participant provider. For service corporation subscribers, this means they can choose to receive health care from among providers who have entered a service agreement, presumably at a lower (negotiated) fee. However, even if a service corporation contracts with a PPO, its subscribers still have the option to use a nonparticipant provider outside the PPO. *See* AS 21.87.120(a)(2); AS 21.87.130(a)(2).

The Unfair Trade Practices Act provides further support for the conclusion that a subscriber may seek treatment from the provider she/he chooses. AS 21.36.090(d) prohibits unfair discrimination in the group context against a provider rendering health care under a service or indemnity type contract issued by a nonprofit corporation (*e.g.*, service corporation).[5] The prohibition applies whether the provider is a participant (having entered a service agreement) or nonparticipant.

And finally, AS 21.87.160(c) provides as follows:

> A [subscriber] contract may not restrict the subscriber's right to free choice of provider or hospital, but must restrict benefits to be provided on a service basis to services rendered by participant providers and participant hospitals.

This provision, which corresponds with AS 21.87.170, reflects that a subscriber has an unqualified right to choose a provider.

B. A nonparticipant provider is not entitled to the same fees as a participant provider in the absence of a contractual provision to the contrary.

While a subscriber has the freedom to use the health care provider of

her/his choosing, *payment* for services rendered by a nonparticipant provider is subject to terms of the subscriber contract. The insurance code provides that indemnification of a nonparticipant provider must be in a "reasonable amount." *See* AS 21.87.120(a)(2) (medical and surgical services); AS 21.87.130(a)(2) (hospital services). And, as required by statute, the language used by a service corporation in a subscriber contract must be filed with and approved by the division of insurance. *See* AS 21.87.180. This filing requirement applies to contract language providing for indemnification when a subscriber uses a nonparticipant provider.[6] In practice, when the division receives a subscriber contract, it reviews the filing for compliance with applicable provisions of the insurance code, including those of AS 21.87.120(a)(2) and AS 21.87.130(a)(2) requiring that indemnity to nonparticipant providers must be "reasonable" in amount. These provisions do not require that the amount to be indemnified must be equal to the amount paid for a covered benefit under a service agreement. In light of these provisions, AS 21.87 leaves a service corporation discretion to pay a nonparticipant provider less than a participant provider for the same covered service. Payment of different amounts, depending on whether a provider is a participant or nonparticipant, is not *unfair* discrimination. *See* AS 21.36.090(d).

Please do not hesitate to contact me if you have any questions.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] I received your memo on October 25, 1995.

[2] In the context of a service corporation, "provider" is defined as "a physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner." AS 21.87.230(8).

[3] "Participant provider" and "participant hospital" mean a person (or hospital) that has entered into a service agreement with a service corporation. AS 21.87.330(5) and (6). These statutorily defined terms are not synonymous with the concept "preferred provider" as used in the context of a preferred provider organization (PPO).

[4] *See* AS 21.12.050. Disability insurance is not the same as disability income replacement insurance.

[4] This provision does not apply to individual coverages.

[5] There is an exception from the filing requirement for certain contractual language (*e.g.*, endorsements, forms of unique character). *See* AS 21.87.180(a).

§ 21.36.080 Boycott, coercion, and intimidation

A person may not enter into an agreement to commit, or by any concerted action commit, an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

History.—§ 1, ch. 120, SLA 1966.

§ 21.36.090 Unfair discrimination

(a) A person may not make or permit unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(b) A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract of health insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

(c) A person may not make or permit arbitrary or unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for a policy or contract of property, casualty, surety, marine, wet marine or transportation insurance, or in the dividends or other benefits payable on the insurance, or in the selection of it, or in any other terms and conditions of the insurance.

Text of subsection (d) effective until January 1, 1999

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a health maintenance organization or a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife.

the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

History.—§ 1, ch. 120, SLA 1966; § 68, ch. 56, SLA 1996, eff. 9-9-96.

§ 21.54.015 Rate discrimination prohibited

Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

History.—§ 58, ch. 81, SLA 1997, eff. 7-1-97.

§ 21.54.020 Direct payment to health care provider

(a) An insurer may, and upon written request of the covered person shall, within 30 working days after receiving a proof of loss statement, pay indemnities under a group health insurance policy directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86. If the insurer pays indemnities to the covered person after the covered person has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the service, the insurer shall also pay those indemnities to the provider of the service.

(b) A covered person may revoke an election of direct payment of indemnities made under (a) of this section by giving written notice of the revocation to the insurer and to the provider of the services. The written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services. Revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services.

(c) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred to a person who is not the covered person by a qualified domestic relations order. Rights under the qualified domestic relations order do not take effect until the

period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

History.—§ 1, ch. 120, SLA 1966.

§ 21.51.120 Payment of claims

(a) A health insurance policy delivered or issued for delivery must contain the following provisions:

(1) indemnity for loss of life shall be paid according to the beneficiary designation and payment provisions contained in the policy that are effective at the time of payment; if a beneficiary has not been designated, indemnity shall be paid to the estate of the insured; accrued indemnities unpaid at the insured's death shall be paid to either the beneficiary or the estate, at the option of the insurer; all other indemnities shall be paid to the insured;

(2) the insurer may, and upon written request of the insured shall, within 30 working days after receiving a proof of loss statement, pay indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services; an insurer who pays indemnities to an insured, after the insured has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the services, shall also pay indemnities to the provider of the services; this paragraph does not require that services be provided by a particular hospital or person;

(3) a covered person may revoke an election of direct payment of indemnities made under this subsection by giving written notice of the revocation to the insurer and to the provider of the services; the written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services; revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services;

(4) the right of the insured to request payment of indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services or to another person may be transferred to a person who is not the insured by a qualified domestic relations order; rights under the qualified domestic relations order do not take effect until the order is received by the insurer; in this paragraph, "qualified

Alaska State Medical Association

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

February 24, 2000

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

RE: Your Request of an "Executive Summary"

Dear Representative Rokeberg:

At our meeting on 2/22/00 you requested that I provide you with an "executive summary" of the results of the various studies that have been done in regards to the estimated cost implications of the "patient bill of rights" legislation. Attached is a chart done by the AMA. It comes from a publication called "*Economic Impacts of Managed Care Reform*" written by David W. Emmons, PhD and Gregory D. Wozniak, PhD of the AMA's Center for Health Policy Research.

You had asked specifically about the cost of the mandatory point of service option. Please note the projected premium increases range form 0.1% to 0.48%. (The Barents study lists the impact in different terms. The impact is stated such that it would reduce the premium savings realized from a closed-panel option by from 4 to 11 percentage points).

Please let me know if you would like any additional information. (Finally, the Texas Medical Association staff has reported to me that the premium costs have not increased, following the enactment of the Texas Patient Bill of Rights, at any rate different than the rest of the country.)

Thank you for your support on Alaska's Patients Bill of Rights.

Sincerely,

James J. Jordan
Executive Director

cc: ASMA Board of Trustees

JJJ/kms

Freedom of Choice Acts	9%-16% (depending on plan type)					
Elimination of Prior Authorization for Specialty Referrals/Direct Access within Network	9%	0.0%-0.2%	0.2%			
Medical Necessity Determination	4.1%-6.1%[w]					
Continuity of Care		minimal increase				0.2%
Mandatory Point-of-Service Option	4%-11% (among closed panel plans)	0.3%	0.3%		0.48% (assumes plan members incur higher cost sharing out of network)	0.1%
Any Willing Provider		6.6%-8.6%[w]				
Equivalent Reimbursement Rates In and Out of Network		less than 0.5%	5.5%			
Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	1%-3% (among managed care plans)	less than 0.05%	0.5%	less than 1%	0.11%	0.2%
Administrative Requirements			2.0%			
Elimination of Limits on Certain Benefits			5.5%			
Adverse Selection Against Rate Increases	0.1% to 0.5%	4.5%				
Access to Specialists and Standing Referrals to Specialists				0.35% choice of (OBGYNs as primary care providers)	0.02%	0.1%

Exhibit 10 (continued)
Summary Comparison of Managed Care Legislation Costs[a]

Proposals	Barents for AAHP	Muse & Associates for PARC Alliance	Milliman & Robertson for Walmart	Lewin for President's Commission	Price Waterhouse for Kaiser Family Foundation	Coopers & Lybrand for Kaiser Family Foundation	CBO	Mercer
Minimum Stays for Mastectomies					0.01% (48-hour stays)		less than 0.05%	
Expanding Drug Formularies					less than 0.6% (among HMOs)		less than 0.05%	
External Appeals				less than 0.05% (excludes administrative costs)		0.08% (includes administrative costs charged back to plans)	0.3%	
Information Reporting & Disclosure		0.3%-1.3%		0.3%-1.3%		.08%-.4% (under PARCA and CBRR, respectively)	0.3%	

Sources: Barents Group, LLC, *The Effects of Legislation Affecting Managed Care on Health Plan Costs*, (May 1997); Barents Group, LLC, *Impact of Legislation Affecting Managed Care Consumers: 1999- 2003*, (April 1998); Muse & Associates, *The Health Premium Impact of H. R. 1415/S.644, the Patient Access to Responsible Care Act (PARCA)*, (January 1998); Milliman & Robertson, Inc., *Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA)*, (November 1997); The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals*, (November 1997); Price Waterhouse, *The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals in California*, (November 1997); Coopers & Lybrand, LLP, *Estimated Costs of Selected Consumer Protection Proposals*, (April 1998); Congressional Budget Office, *Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998*, (July 1998); and William M. Mercer, Inc. and the American Medical Association, *Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation* (August 1998).

a/ Estimates of increased costs or reductions in savings rather than premium increases have been specified.
b/ Figures from Barents (1998), all other figures in the column are from Barents (1997).

Refe

Barents Gr
Consumers
April 1998.

Barents Gr
Care on H
May 5, 199

Chassin, M
Geographi
of Three P
Association

Congressic
Patients' R

Congressic
Medicare's
and Costs.

Congressic
Employers
May 1996.

Congressic
Managed C

Congressic
March 199

Coopers &
Protection
April 1998

Emmons, I
Health Sys
Paper 95-2
Associatio

American Medical Association

Physicians dedicated to the health of America

Economic Impacts of Managed Care Reform

Center for Health Policy Research

Economic Impacts of Managed Care Reform

David W. Emmons, PhD
Gregory D. Wozniak, PhD

Contents

List of Exhibits

Executive Summary

This report reviews nine studies of the impact of managed care reform legislation on health insurance premiums and managed care cost savings. A table at the end of the report presents a summary of the various published cost estimates of managed care reform legislation.

The studies examined are:

- a 1997 Milliman and Robertson study of the impact of eight provisions in PARCA on health insurance premiums — the composite effect of these provisions on premium increases is estimated to be 23%, and the "estimate range" of the premium impact ranges from 7% to 39%;

- a 1998 Muse & Associates study of the effects of the PARCA legislation on health insurance premiums — the enactment of PARCA is estimated to increase national premiums between 0.7% and 2.6%;

- a 1997 Lewin Group study of the costs and benefits of the information disclosure and external appeals provisions of the proposed Consumer Bill of Rights and Responsibilities — the information reporting and disclosure provisions are estimated to increase premiums between 0.3% and 1.3%, the external appeals provision is estimated to increase premiums no more than 0.05%;

- a 1997 Price Waterhouse assessment of the impact of expanded insurer liability, direct access to obstetric and gynecologic services, and lengths of stay for mastectomy patients — the impact on premiums of these provisions is fairly minimal, ranging from less than 0.1% to 1.3%;

- a 1997 Barents Group analysis of the impact of seven types of legislation or legislative elements affecting the cost saving from managed care; the analysis is general in nature rather than being carried out with respect to a specific legislative proposal — the estimated reduction in managed care savings relative to fee-for-service varies between 1 and 11 percentage points across the provisions;

- a 1998 Barents Group study of the potential cost of increasing plan exposure to malpractice liability, deeming utilization review to be the practice of medicine, prohibiting health plans from determining medical necessity and requiring plans to accept any willing provider — these types of legislation are estimated to increase managed care plans' costs by 2.2% to 8.6%;

- a 1998 Coopers & Lybrand analysis of the provisions in CBRR and PARCA dealing with information disclosure, access to emergency services, direct access to specialists, external appeals, a required point-of-service option for HMOs, and expanded health plan liability for medical decision making. Coopers & Lybrand present aggregate impact figures (excluding the effects of the expansion in plan liability proposed in PARCA) of 0.61% of premiums for the reforms in CBRR and 0.77% of premiums for the reforms contained in PARCA;

- a Congressional Budget Office analysis of the patient protection standards set out in the PBR — the provisions in the bill are estimated to increase premiums by 4% when all of the bill's provisions are fully phased in; and

- a William M. Mercer study of the cost impact of managed care accountability legislation — after considering a broad range of impact scenarios, premiums are estimated to increase between 0.1% to 1.8%.

Differences in the impact estimates between the studies are heavily dependent upon the interpretation of reform provisions and assumptions as to the extent of savings from managed care. The two studies prepared by the Barents Group for the American Association of Health Plans and the study prepared for Wal-Mart by Milliman & Robertson depict patient protection as very costly. Underlying these analyses, however, are extreme characterizations of proposed protections and exaggerated notions of cost savings.

Review of the estimates prepared by the Lewin Group, Muse & Associates, Price Waterhouse, Coopers & Lybrand, the Congressional Budget Office, and William M. Mercer all suggest that the effect of reasonable patient protection provisions on health insurance premiums is negligible. The Lewin results suggest that the additional costs of what are thought by many to be the most expensive patient protections are on the order of pennies per insured person per month.

The two most recent studies in this literature focused on the cost of expanding managed care plans' liability. The CBO estimated that expanding legal liability for ERISA plans would raise premiums among employer-sponsored plans by 1.2%. The CBO estimate may overstate the actual impact as it fails to account for the ability of managed care organizations to insure against liability claims at significantly reduced rates relative to providers. The estimate is consistent, however, with the range derived by William M. Mercer in an actuarial analysis of the impact of a model managed care accountability law. Mercer concluded that holding plans liable for damages to enrollees would add 0.1% to 1.8% to managed care organization premiums. If ERISA construction were narrow under the law, cost increases were predicted to be in the range of 0.5% to 1.8% of premiums.

Concerns about any cost increases associated with reform include potential losses of insurance coverage and reductions in the number of employed individuals. Several parties have inappropriately generalized an estimate of the impact of other reform legislation to suggest that a 1% increase in health insurance premiums is associated with a loss of insurance coverage for 200,000 individuals. The 1998 Barents study claims that each 1% increase in managed care plans' costs would result in a potential loss of insurance coverage for about 315,000 individuals. Neither of these estimates can be substantiated.

Introduction

This report reviews nine studies of the impact of managed care reform legislation on health insurance premiums and managed care savings. Two of the studies develop impact estimates of the provisions in H.R.1415/S.644, Patient Access to Responsible Care Act of 1997 (PARCA). A third examines the effect on premiums of two provisions from the proposed Consumer Bill of Rights and Responsibilities (CBRR). The fourth study assesses the impact of California managed care reform legislation on HMOs and their enrollees. The fifth analysis looks at general elements of legislative proposals that might alter the cost savings from managed care. The sixth study analyzes the effects of changes in four types of legislation on costs among managed care plans. The seventh report estimates the impact of adopting specific provisions of PARCA and CBRR on health care premiums. The next study presents cost estimates of seven major provisions of the Patients' Bill of Rights Act of 1998 (PBR). The last study assesses the cost impact of managed care accountability legislation.

The remainder of this report details the findings, methodologies, and critical assumptions underlying each of these studies.

Milliman & Robertson

Milliman and Robertson, Inc. (M&R) prepared *Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA)*, (November 7, 1997) for Wal-Mart Stores, Inc. The report estimates the impact of eight provisions of PARCA on the nationwide average health insurance premium for the non-Medicaid, non-Medicare insured population. M&R calculate the composite effect of these provisions on premium increases to be 23%. The M&R report also provides an "estimate range" of the premium impact — 7% to 39%.

Exhibit 1
Milliman & Robertson
Patient Access to Responsible Care Act

Provision	Estimated Premium Impact
No Inducement to Reduce Services	6%
Equivalent Reimbursement Rates In-and Out-Of-Network	5%
Elimination of Limits on Certain Benefits	5%
Adverse Selection Against Rate Increases	4.5%
Administrative Requirements	2.0%
Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	0.5%
Mandatory Point-Of-Service Option	0.3%
Elimination of Prior Authorization for Specialty Referrals	0.2%

The characterizations of the studied provisions of PARCA and their estimated impacts on premiums are presented in Exhibit 1.

These numbers reflect M&R's "midpoint" estimates. M&R's interpretations of several provisions of PARCA are extreme or even misrepresent actual language in PARCA. Those interpretations drive both the high-end values of the range estimates and the mid-point

estimates of premium increases. The mid-point estimates are affected because M&R's "best estimate mid-points" are merely the mid-point of ranges whose high-end values are essentially capricious.

The estimates themselves are driven by a variety of assumptions about discounts, cost sharing, and use of capitation among HMOs, PPOs, and other plans. Several of the assumptions appear to have no basis in fact, and are undocumented by M&R. The report does not test the sensitivity of the estimates to changes in any of the underlying assumptions.

The four provisions indicated to have the largest potential impacts on premiums illustrate some of the particular problems in the analysis.

M&R characterizes Section 2771(d)(1)(A) of PARCA as **no inducement to reduce services**, which they interpret as not allowing risk sharing arrangements or capitated payments. The language in the bill, however, contains no mention of capitation, capitated payments, per-member per-month (PMPM) payments, or even an implicit reference eliminating or restricting those payment methods.

M&R interpret Sections 2772(b)(3), 2772(c)(2), and 2773(a), as constraining the ability of health insurance issuers to limit the number and scope of providers in their networks. In assessing the impact of these sections, M&R overstate the savings attributable to manage care and, thereby, overstate the impact of the legislation on premiums The average discount for HMOs is taken to be 28%, a magnitude that approaches the Medicare-to-private sector payment gap. In addition, M&R assume that 50% of HMOs use discounts and capitation, when the share of enrollees in such plans (which is clearly a smaller figure) is the relevant variable.

M&R characterizes Section 2772(b)(3) of PARCA as requiring **equivalent in-network and out-of-network reimbursement rate**, suggesting that health plans can not apply different deductibles, coinsurance, and copays to enrollees who use out-of-network providers vs. enrollees using in-network providers. That interpretation is in distinct contradiction to the Section's indication that "Nothing in this paragraph shall be construed as protecting an enrollee against balance billing by a health professional or provider that is not a participating health professional or provider."

M&R characterizes Section 2773(c) of PARCA as the **elimination of limits on certain benefits.** They assert that the provision could be interpreted as requiring health plans to cover services of professionals that currently are excluded from coverage by some plans. They state that such a provision would increase premiums by 1% for plans with rich benefits, and by 10% for plans with significant barriers to accessing such providers. The endpoints of their estimate range of premium increases due to this provision are based on the assumption that all plans are rich (the lower bound) and all plans have significant barriers (the upper bound). Clearly, both assumptions are extreme and fail to reflect the fact that any estimate of the effects of this provision should reflect the actual distribution of plans measured against these characteristics.

The **adverse selection** impact reported by M&R is a secondary effect of their estimated rate increases of the provisions analyzed. The concern that the report sought to address is the fact that increases in premiums caused by PARCA could result in healthier enrollees refusing coverage, which in turn, could cause a further increase in premiums. There is no documented basis for the 4.5% figure used by M&R.

A number of parties have seized on the M&R estimates to argue that PARCA would mean a sizeable increase in the number of **uninsured.** The underlying argument is that every 1% increase in health insurance premiums results in 200,000 people losing their insurance coverage. The latter calculation is based on, but not derived from, a CBO analysis of a mental health provision in a 1996 bill. CBO has indicated that the 1% -to- 200,000 translation should not be used as a rule-of-thumb in gauging the effect of legislation on the number of uninsured in general and is inappropriate for analyzing PARCA in particular.

Muse & Associates

Muse & Associates (M&A) was commissioned by the Patient Access to Responsible Care Alliance to evaluate the private sector health care premium impact of H.R. 1415/S. 644, the Patient Access to Responsible Care Act (PARCA). The report, *The Health Premium Impact of H.R. 1415/S. 644, the Patient Access to Responsible Care Act (PARCA)*, (January 29, 1998), contains estimates of the impacts of sections of the legislation. M&A calculate the enactment of PARCA would result in a national premium increase in the managed care health insurance market between 0.7% and 2.6%. Using the example of a $160 premium, PARCA would be expected to increase the premium to between $161.12 and $164.16.

The M&A study presents the estimated premium increases for provisions in PARCA likely to impact health costs and the secondary impact of adverse selection resulting from premium increases. The descriptions of the ten sections used by M&A and the magnitude or range of their impact on premiums are presented in Exhibit 2.

Exhibit 2
Patient Access to Responsible Care Act
Muse & Associates

Section	Provision	
2771a	Enrollee Access to Care in Rural and Underserved Areas	
2771b	Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	
2771c	Access to Medically Necessary Specialty Care	
2771d	No Inducement to Reduce Medically Necessary Services	
2772b1	Choice of Point-Of-Service Option	
2772b3	Equal Reimbursement for Providers Outside of Network	
2773	Nondiscrimination Against Enrollees/Health Professionals	
2777	Due Process for Health Professionals/Providers	<0.5%-0.8%
2778	Information Reporting & Disclosure	0.3%-1.3%
4	Non-Preemption of State Law Respecting Liability of Group Health Plans	0.0%-0.2%
	Adverse Selection Against Rate Increases	0.4%-0.5%

The M&A estimates differ from the Milliman and Robertson estimates, in part, because the M&R analysis was based on draft language. The M&A analysis was developed using clarifying language for Section(s) 2771d, 2772b, 2773a, and 2773c.

The M&A analysis concludes that PARCA has only a minimal impact on utilization, and is unlikely to impact fees. Consequently, few of the provisions are expected to have substantial impacts on premiums. The M&A study also briefly discusses who will likely bear the increased premium costs due to PARCA. Based on a review of the employee benefits literature, the authors conclude that the majority of premium increases associated with PARCA would be borne by the workers — in the form of reduced wages, reduced fringe benefits, or higher health plan cost-sharing — and that employer labor costs are unlikely to increase significantly.

Because the majority of provisions are interpreted as having no effect on utilization or prices, the M&A analysis predicts a much smaller impact on premiums. The M&A impact estimates are driven by two key factors:

- Interpretation of the legislation as providing for no inducement to reduce medically necessary services, equal reimbursement for providers outside of network, and nondiscrimination against enrollees/health professionals; and

- Most provisions relating to options and services already widely available or accessible to enrollees. M&A assume that PARCA mandates no new benefits.

For those provisions estimated to have an increase on premiums, there is little description of the methods used to produce the estimates or discussion of the rationale for the assumptions used in those calculations. Much like the criticism of the M&R analysis of PARCA, it is impossible to assess the sensitivity of the M&A estimates to changes in the assumptions.

The key factor determining the M&A impact estimates, and consequently explaining a large share of the difference between their estimates and those presented by M&R, is the interpretation of three sections of the PARCA legislation. The three sections (provisions) — **no inducement to reduce medically necessary services, equal reimbursement for providers outside of**

network, and nondiscrimination against enrollees/health professionals — in the M&R analysis account for most of the estimated 23% increase in premiums. M&A assert that the M&R interpretation of these provisions as eliminating risk sharing, capitation, and provider discounts is unwarranted and assume that managed care organizations will continue to receive discounts. Consequently, the legislation is expected to have little or no effect on health care prices. M&A estimate those three provisions have a minimal (<0.05%) effect on premiums.

A second factor, in the form of either "almost all" or "most" managed care plans already provide the mandated services or plan options to enrollees, or restriction are not "...a widespread practice," is used to explain why **the provision of emergency room and urgent care services with limits on prior authorization, access to medically necessary specialized treatment**, and several other sections are found to have "minimal premium increase effect." There are generally no documented measures of the proportion of plans, accompanied with the number of enrollees in those plans, which would comply with the provisions in PARCA.

The **adverse selection** impact reported by M&A (0.1% - 0.5%) is derived from the M&R estimate. This impact captures the effect of increased premiums caused by PARCA resulting in healthier enrollees refusing coverage, which in turn could cause a further increase in premiums. The estimated range, 0.1% to 0.5%, for the impact of adverse selection on premiums is derived as a proportion of the total impact based on the midpoint estimate of M&R, 4.5%/23%. There is no documented basis for the 4.5% impact assumed by M&R.

M&A rely on the M&R estimate for the effect on premiums of the **point-of-service** option provision (0.3%) and argue that M&R's use of actual claims data are a valid data source for estimating the impact on premiums of this section of the legislation.

The M&A estimated impacts of the **information reporting and disclosure provisions** (0.3% - 1.3%) are taken from the Lewin Group study "Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals," Presidential Advisory Commission on Consumer Protection and Quality in Health Care Industry, Final Report, November 1997.

The estimated costs of information disclosure ranges between $0.59 and $2.17 per insured person per month. Based on a $170 per month managed care premium, M&A estimate that information reporting and disclosure provisions would increase the premium between 0.3% and 1.3% ($0.59/$170 or 0.3%, and $2.17/$170 or 1.3%). (In other parts of report, M&A uses a $160 premium.) In the Lewin Group study, the low-end estimate represents a three to five year phase-in period, which assumes that the cost of information acquisition and distribution will fall substantially over time.

Finally, M&A estimate the impact on premiums of **the non-preemption of state law respecting liability of group health plans** section of PARCA (0.0% - 0.2%). The authors of the study derive the impact estimate using a 1992 Congressional Budget Office estimate of 1998 national medical injury and litigation costs ($36 billion); an unspecified estimated ratio of the managed care sector of the health insurance market; and an assumed four percent increase in medical injury premiums.

Lewin Group

The Lewin Group report *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals, Final Report* (November 18, 1997) was commissioned by the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The report contains estimates of the impact of the information disclosure and external appeals provisions of the proposed Consumer Bill of Rights and Responsibilities. These are two of the seven areas of consumer rights under consideration by the Commission. The analysis was limited to administrative costs and did not examine the effects of information and external appeals on utilization. The Lewin study also describes the nature of possible benefits of those provisions, but does not quantify the dollar value of the benefits.

The per-person, per-month cost of information disclosure is estimated to range between $0.80 and $2.17 for one year, and between $0.59 and $1.10 for a three to five year phase-in period. Based on a $170 per month managed care premium, the information reporting and disclosure provisions would increase premiums between 0.3% and 1.3%. The cost estimates for external appeals (excluding states with mandated external appeals systems) ranged from $0.003 to $0.07 per person per month. Based on the $170 per month managed care premium, the effect of the external appeals provisions on premiums would be less than 0.05%.

The information disclosure provisions of the Consumer Bill of Rights Responsibilities (CBRR) recommend that consumers have access to a broad range of information on the characteristics, policies, procedures, experience, and performance of physicians, facilities, and plans. This information should include:

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

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

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

The provisions related to appeals recommend that consumers have the right to a fair and efficient process for resolving differences with their health plan, health care providers, and institutions that serve them; and that consumers have access to a rigorous system of internal review and an independent system of external review of plan decisions. The CBRR posits that an external appeals systems should:

- Be available only after consumers have exhausted all internal processes (except in cases of urgently needed care).

- Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized.

- Be conducted by health care professionals who are appropriately credentialed with respect to the treatment involved and subject to conflict-of-interest prohibitions. Reviews should be conducted by individuals who were not involved in the initial decision.

- Follow a standard of review that promotes evidence-based decisionmaking and relies on objective evidence.

- Resolve all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (ie, 72 hours).

The Lewin report noted that no definitive studies have been conducted in these areas because information disclosure and external

appeals processes are just now being developed. Consequently, the authors relied on a literature review for context and a series of interviews to provide cost information as it relates to current and on-going information and appeals efforts.

Actual cost data from a variety of projects are used to estimate the costs of several aspects of information disclosure and external appeals. While the estimates are derived from cost figures of ongoing activities, the end-points of the range of these "estimates" are still based on sample sizes of one. The report does, however, provide detailed information on the sources of data, the specific calculations, assumptions, and other elements which would allow for testing the sensitivity of the estimates.

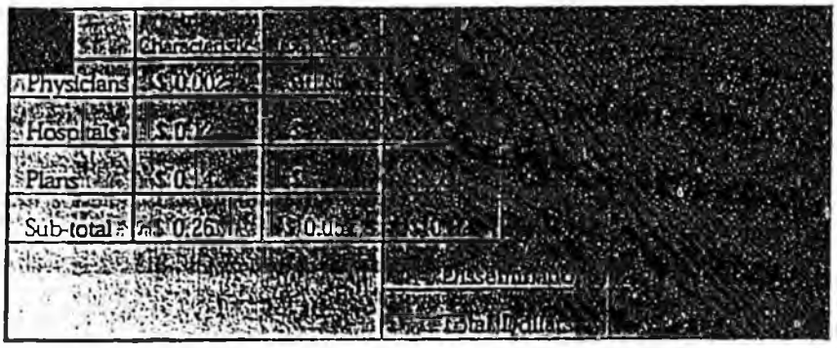
The cost estimates for the **information disclosure** provisions constructed by Lewin are intended to be incremental; they measure costs of efforts beyond the current state and private activities. See Exhibit 3. The low-end estimate assumes a three to five year phase-in implementation period and that as information becomes more widely available and information technology advances, the cost of information will fall substantially.

Exhibit 3
Lewin Group Information Disclosure Cost per Insured Person per Month

	[illegible]
	[illegible] Year
Low Estimate	$0.80
Mid-Point Estimate	$1.49
High Estimate	[illegible]

Estimates are also presented on a category by category basis for physicians, hospitals, and plans separately. The categories include characteristics, experience, customer satisfaction, and quality. See Exhibit 4.

Exhibit 4
Lewin Group Midpoint Estimates for Information Disclosure
3-5 Year Phase-In



The incremental cost of providing the information required by CBRR is estimated to be relatively small. Behind these calculations, however, several assumptions are questionable:

- the average survey cost per enrollee for plan customer (patient) satisfaction information, between $0.045 and $0.14 — which is less than a first-class stamp, and

- the costs to physicians to collect quality data based on medical records, $160 per physicians per year provisions.

Consequently, the Lewin estimates may be low-end estimates of the costs of implementing CBRR information disclosure.

The estimated costs of external appeals presented range between $0.003 to $0.07 per person per month. The range of estimates was driven by assumptions concerning appeals rates per 1000 persons and how external appeals are processed. In Florida, the appeals rate is 0.000093 per enrollee. Whereas for the Medicare population, the rate is 0.001 per enrollee. The actual costs of appeal also vary considerably across states. In Florida, the state panel has an average cost of $867 per appeal. The cost among appeals in Texas, Rhode Island, and New Jersey, which use independent review contractors, ranges from $288 to $600 per appeal. Lewin uses an "average" cost from those states of $450 per appeal, the $867 per appeal from Florida, and the appeals rates from Florida and Medicare to construct their range of estimates. If these figures are not representative of national ranges of costs and appeal rate, however, external appeal costs could be outside of the range presented by Lewin.

Price Waterhouse

Price Waterhouse (PW) was commissioned by the Henry J. Kaiser Family Foundation to assess the impact of managed care reform legislation on HMOs and their enrollees. The report, *The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals in California*, analyzes insurer liability, use of drug formularies, mental health parity, direct access to obstetric and gynecologic services, and lengths of stay for mastectomy patients. The impact estimates of the first and last two legislative areas are reviewed in this report.

PW examines the specifics of the legislative bills in California, the likely impact of the legislation on HMOs by organizational type, and the corresponding effects for consumers. The estimated impacts are broken out by type of HMO plan, i.e., staff model, group model, network model, and independent practice/physician association (IPA) model. Other forms of managed care plans — preferred provider organizations (PPOs) and point-of-service plans (POSs)— are excluded from the analysis.

The authors of the PW study present a relatively detailed description of the methodology utilized to derive the impact estimates. In places, the methodology relies upon unsubstantiated assumptions and national (rather than California-specific) utilization and spending data. The data used are taken from aggregated categories of services, rather than the specific services targeted in the legislation. Of particular concern is the failure to account for differences between the structure of the national health care delivery and financing system and the structure of that system in California. National data will be partially driven by the nationwide mix of plans — indemnity, staff model HMO, group model HMO, network model HMO, independent practice/physician association (IPA) model, preferred provider organizations (PPOs) and point-of-service plans (POSs) — and hence, may not be appropriate for constructing state-level estimates. Finally, the authors of the PW study base their expectations regarding service utilization differentials across plans on relative "incentives" across plans. But the specific incentives and payment mechanisms are unspecified.

Expanded liability is expected to have a minimal impact on premiums. Theoretically, the non-preemption of state law regarding liability of group health plans mandate should not change the amount of liability or risk in the system. The burden of risk, however, would be redistributed from providers to plans. As risk is shifted to plans, and away from providers, the part of the health insurance premium paid to providers and others to compensate them to bear risk (the "risk premium" in economic terms) would also be shifted to plans to cover their cost of increased liability. Overall, the change in the premium would be minimal. Price Waterhouse estimates the impact on IPA model HMO premiums to be between 0.1% to 0.4%.

The effect of California legislation, AB 1354, providing women **direct access to obstetricians and gynecologist services**, on premiums is expected to be minimal. This is partially due to the fact that in 1994 California enacted legislation enabling women to choose an obstetrician and gynecologist (OB/GYN) as their primary care physician. The legislation, AB 1354, expands upon the 1994 legislation by requiring health plans to provide women with direct access to obstetrical and gynecological services. PW estimate that direct access would increase premiums and out-of-pocket costs 0.35% for (staff model) HMO, IPA model, and group model HMO enrollees.

The PW estimate of the cost of those provisions is problematic because the data on spending, utilization, and physician fees used in developing the estimates are national measures, not California specific. Since women in California could already choose a specialist in OB/GYN as their primary care physician, some measure of the extent to which women nationwide have that choice and how it impacts the number of visits per year should be accounted for in constructing the estimates. This effect may have caused PW to overstate the costs of AB 1354. In addition, a measure of the relative cost of OB/GYN versus FP/GP services comes from AMA data on the average fee for an office visit of an established patient. In addition to being a national average, the data refer to a series of CPT codes which have a fairly wide variation in the level of complexity. Consequently, differences in fees across specialties are at least partially determined by differences in the mix of services provided by those specialties.

The enactment of a **48-hour minimum stay for mastectomies** is estimated to result in a 0.01% increase in premiums, for both IPA

model and group model HMOs. That estimate is based on national data and assumptions which are not substantiated. For example, while no source is given, the average per day cost for hospital stays ($1,025) appears to be a national average, over all inpatient procedures. National measures of the relative utilization rates across plan types are drawn from MEDSTAT data. Yet plan type on the MEDSTAT files are often missing or recoded to "other."

Finally, there is no stated basis for the assumption that between 25% and 30% of short-stay patients (those who would have previously stayed less than 48 hours) would elect to stay the full 48 hours. Nonetheless, even if that share of patients were to double, the low-end estimate of the premium impact of mandating minimum LOS for mastectomies would still be less than a 0.05%.

Barents Group (1997)

Barents Group, LLC has published two reports that discuss cost implications of managed care reform legislation. *The Effects of Legislation Affecting Managed Care on Health Plan Costs* (May 5, 1997), was prepared for the American Association of Health Plans. The report identifies seven types of legislation or legislative elements that would alter the way managed care firms do business. The analysis is general in nature rather than being carried out with respect to a specific legislative proposal.

The legislative provisions analyzed in the report and their estimated reduction on savings from managed care relative to fee-for-service are as follows:

- **Mandated Point-of-Service Option (MPOS)**, characterized as requiring either that health care plans that offer a closed-panel option also offer a point-of-service (POS) option or that employers that offer employees a closed-panel health plan also offer a POS option. Barents estimates that this type of act could reduce premium savings by 4 to 11 percentage points for those employers who do not currently offer a point-of-service option.

- **Direct Access and Freedom of Choice**, characterized as giving plan members the opportunity to obtain services without referral from their primary care provider. Direct access is used to refer to legislative provisions that cover treatment within the plan's provider network while freedom of choice is used to refer to provisions that would allow plan enrollees to seek treatment outside of plans' provider networks. Barents estimates that direct access provisions would reduce cost savings to group and staff model HMOs by 9 percentage points and that freedom of choice provisions would reduce savings for HMOs by 16 percentage points and by 9 percentage points for IPAs.

- **Establishment and Maintenance of Health Care Provider Networks**, often characterized as due process provisions, would require appeal mechanisms for denied medical treatment and would regulate the nature of contracts between plans and providers by requiring, for example, written processes for termi-

nation of a provider's contract. Barents suggests that HMO savings would be reduced by 8 percentage points; PPO/POS savings by 5 percentage points.

- **Prohibition of Physician Incentive Payments**, eliminating the use of financial incentives such as bonuses and withholds by managed care plans, is estimated to reduce HMO savings by 3 to 5 percentage points.

- **Restrictions on Utilization Review (UR)**, imposing restrictions on how managed care organizations design and implement utilization review, such as requiring that only a health care professional of the same specialty as the practitioner and who resides in the same state could refuse to certify payment for a service. Barents estimates that such restrictions would reduce HMO savings by 3 to 5 percentage points.

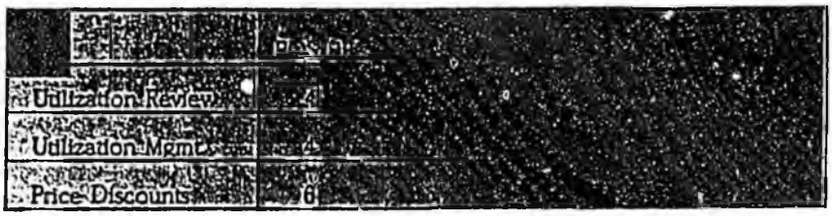
- **Care Delivered in Emergency Rooms**, characterized as requiring that plans cover and reimburse expenses for any emergency room or urgent care obtained, without prior authorization and without limits on the provision of these services. Barents estimates that costs in managed care plans would rise by 1 - 3%, excluding post-stabilization care.

- **Expanded Health Plan Liability** legislation would make managed care plans liable for failure to provide a covered service and for the actions of providers and other agents of the plan. Barents estimates a 4 - 5% increase in costs for IPA and PPO/POS plans.

The estimates in the Barents Group (1997) report are driven by assumptions as to the savings in managed care plans that accrue through utilization review, utilization management and price discounting. Barents assumes that these tools enable staff and group model HMOs, IPAs, and POS/PPO plans to reduce costs by 30, 23, and 14%, respectively, relative to traditional indemnity.

Understanding the composition of each of these three managed care savings assumptions provides a critical perspective on the Barents estimates. Exhibit 5 contains the managed care health plan savings relative to fee-for-service plans used in the Barents (1997) study.

Exhibit 5
Barents (1997) Percent Savings Relative to Traditional Indemnity



Utilization Review	4
Utilization Mgmt	6
Price Discounts	6

The fourth column of numbers (All HMOs) reflects the current mix of HMOs in the market and is calculated as the market share weighted average of the IPA (70%) and Group/Staff model HMO (30%) figures. All of the plan types considered in the Barents report, including managed fee for service, achieve a 4% savings relative to traditional indemnity. Traditional indemnity, of course, is a bit of a strawman in the Barents analysis since currently such coverage is the rare exception, not the rule.

The figures used for utilization management savings are high relative to careful review of the literature. Barents notes that the February 1995 CBO report generally credited forms of managed care other than group and staff model HMOs with very low utilization effects. The Barents report cites two works (which had been reviewed as part of the CBO analysis) and suggests that those works provide a sense of the true effects of utilization management in such plans. It ignores the broader range of studies reviewed by CBO and rejects the conclusion by CBO that IPAs reduce utilization by less than one percent.

The Barents report also suggests that IPA efficiency has improved over time. It attempts to support the notion by appealing to a March 1997 CBO study, Predicting How Changes in Medicare's Payment Rates Would Affect Risk-Sector Enrollment and Costs, which found greater IPA utilization impacts for the Medicare population than past CBO analyses. However, as that CBO report noted, improved IPA efficiency is only one explanation for the expenditure differentials in that report. Another explanation offered by the CBO is increased favorable selection and statistical models that inadequately identify the selection.

In the CBO's March 1994 report, it was noted that PPOs have a mixed score card on utilization reduction because of generally

low cost sharing. CBO estimated that PPOs achieve a 2% savings relative to unmanaged fee for service arrangements. Finally, although the Barents report based its utilization savings figure for group and staff model HMOs on the 1995 CBO report estimate, the latter likely overstates the true effect due to an econometric error in the treatment of self-selection in the CBO analysis. Sensitivity tests reported by CBO suggest that the utilization savings attributable to all HMOs is probably on the order of the 3.9% found in their March 1994 analysis. The latter analysis also contains errors, but they partially offset one another.

The savings estimates used for price discounts accruing to HMOs have no scientific basis. The Barents report indicates that there is no available evidence of the extent of discounting realized by staff/group model HMOs, and that it arbitrarily uses half the IPA savings figure. The 15% figure for IPAs is derived from an analysis by Lewin-VHI that was based exclusively on data (for a small number of markets) provided by Aetna. It's unlikely that typical IPAs can extract provider discounts as large as a major insurer such as Aetna. In any event, the data used in the analysis were actuarial projections, not actual claims or premium data. The 13% figure for the all HMO category is the weighted average of the other two figures.

Finally, it should be noted that the design of the Barents analysis prohibits its usefulness in examining particular pieces of legislation. That is because many of the effects analyzed would be overlapping and aggregating the individual estimates would constitute double counting.

Barents Group (1998)

The second report by the Barents Group, *Impacts of Four Legislative Provisions On Managed Care Consumers: 1999 - 2003* (April 22, 1998), was also prepared for the American Association of Health Plans. The report estimates the potential costs of four types of legislation that are either under consideration or have been adopted into law at some level. Estimated changes in health insurance costs are calculated in terms of percent increases in plan premiums and are used to project changes in spending on coverage for the 1999 to 2003 period. Baseline estimates of spending on managed care premiums by employers, households, and governments from 1999 through 2003 were developed in a separate Barents Group report.

The four types of provisions examined in the Barents Group (1998) study and their estimated impacts are as follows:

- **Increasing exposure of health plans to malpractice liability** - H.R. 1415 proposed by Representative Norwood (R-GA) and H.R. 3605 proposed by Representative Dingell (D-MI) are identified as examples of legislation that would eliminate Employee Retirement Income Security Act (ERISA) preemption of state law causes of action against health plans sponsored by private employers. Barents estimates that this type of legislation would increase managed care plans' costs by between 2.7% and 8.6%.

- **Deeming utilization review to be part of the practice of medicine** - Barents cites New Mexico Senate Bill (SB 862; enacted in 1994) as an example of this type of legislation. This provision is estimated to increase managed care plans' costs by between 2.2% and 6.9%.

- **Prohibiting health plans from playing any role in making medical necessity determinations when making coverage decisions** - The medical necessity law contained in the proposed Federal Health Insurance Bill of Rights Act of 1997 (S. 373), sponsored by Senator Kennedy (D-MA) was analyzed by Barents. Restricting plans from making medical necessity determinations for purpose of coverage decisions is estimated to increase managed care plans' costs by between 4.1% and 6.1%.

- **Requiring plans to allow any willing provider (AWP) in their network if the provider meets certain qualifications and is willing to abide by plan requirements** – Barents examines the AWP provisions of Tennessee's "Patient Advocacy Act of 1997" (SB 1767). The adoption of any willing provider laws is estimated to increase managed care costs by between 6.6% and 8.6%.

The managed care savings assumptions employed in the Barents (1998) analysis are presented in Exhibit 6. Those assumptions, which are central to the Barents analysis, are based on the managed care savings estimates used in the Barents (1997) analysis and an assumed 4 percentage point increase in savings attributable to IPAs. Our discussion of the Barents (1997) savings estimates indicates that there is substantial upward bias in those numbers and a report from the Medicare Payment Advisory Commission (Greene 1998) indicates that new IPA cost savings may be attributable to increases in favorable selection experienced by Medicare HMOs. That report found that disabled and chronically ill Medicare beneficiaries have lower rates of enrollment in Medicare managed care than other groups of beneficiaries.

Exhibit 6
Barents (1998)
Percent Savings Relative to Traditional Indemnity

	POS/PPO	
Utilization Review	4	
Utilization Mgmt.	4	8
Price Discounts	6	15

As with the initial Barents analysis, many of the effects analyzed in the 1998 Barents study overlap. In other instances, the report aggregates the cost of mutually exclusive outcomes. For example, adding the cost impact of an expansion in plan liability absent any change in utilization review to the cost of a change in utilization as a result of plan "defensive medicine" constitutes clear exaggeration of the true cost impacts of expanded liability.

The legislative proposals cited in the Barents (1998) study remove the ERISA preemption provision by varying degrees. The analysis presumes, however, that in expanding managed care organizations' malpractice liability, the ERISA preemption would be eliminated.

Obviously, some reform bills (e.g., H.R. 3605) have more limited or targeted removal of ERISA preemptions. A broader ERISA preemption of actions against managed care organizations would generate small increases in the direct cost of liability insurance.

The Barents (1998) study classifies the effects of **legislation that expands managed care organizations' exposure to malpractice liability** as direct costs (malpractice insurance premiums, contributions to liability self-insurance funds, and uninsured losses from malpractice claims) and indirect costs (defensive medicine). Direct effects are estimated to range between 0.9% and 1.4%. Indirect effects are estimated to range from 1.8% to 7.2%. These figures combine to a total cost estimate of between 2.7% and 8.6% of premiums.

Direct effects are based on the costs of health plan liability insurance, the number of plans that will have to obtain liability insurance, and the average increase in premium costs because of the increased probability of being subject to malpractice suits. The study uses two baseline scenarios and two different assumptions about the number of managed care plans that would need to purchase medical liability coverage if such legislation were passed. The analysis assumes that the number of claims filed will increase due to the presence of new (and deep) pockets, that the number of successful malpractice suits will increase, and that the average value of awards will increase.

For the low-end estimate, all plans are assumed to have liability insurance and the baseline liability costs are assumed to be 0.5% of plan premiums. The latter figure is based on a small sample of insurers' liability premium costs. Total direct effects for the low-end estimate are driven entirely by the assumption that plan liability costs expressed as a percentage of plan premiums increase to the level of hospital liability costs expressed as a percentage of revenues, after the expansion in plan liability. For the high-end estimate, Barents assumes that 34% of plans will need to obtain liability coverage that they do not already have and that baseline liability costs are 2.0% of plan premiums. The baseline figure of 2.0% was chosen to be greater than the level of hospital liability expenses, yet below the level of physician liability expenses. The analysis then assumes that liability increase to a "weighted average of physician and hospital premium costs," or 2.5%. The resulting estimated range of direct cost increases is between 0.9% and 1.4%.

The use of hospital and physician liability costs as baseline for Barents's high-end estimate scenario and the use of such costs, in both scenarios, in gauging the increase in direct liability costs clearly introduces significant upward bias into the analysis. The only plan specific information on liability costs as percent of plan premiums presented by Barents was 0.5%. Yet the high-end estimate baseline, 2.0% of plan premiums, is 4 times that figure and factors into Barents's estimate of a 0.9% addition to costs due to plans obtaining coverage that they are presumed to currently be without. The only other figure in the high-end scenario estimate of direct costs, the 0.5% increase in liability insurance premiums, is driven by Barents use of hospital and physician liability costs. Managed care organizations, however, enjoy an obvious advantage relative to providers in obtaining liability coverage - they deal with insured populations large enough to take full advantage of the law of large numbers. In other words, and as the data presented by Barents suggest, managed care organizations should be able to insure against malpractice liability at significantly reduced rates relative to providers.

The Barents report proposes that managed care liability provisions create incentives for plans to loosen utilization review restraints, i.e., to practice defensive medicine. Considerable care needs to be taken in analyzing this potential effect. In the Barents analysis, any resultant increase in services delivered should be measured in lieu of, rather than in addition to, the direct effects of increased exposure to malpractice liability. The Barents analysis fails to account for the reduction in liability exposure which defensive medicine is intended to offset. Consequently, a form of double counting exists in the Barents cost estimates.

The double counting aside, the Barents estimate of the indirect effects is overstated because of its assumption that defensive medicine currently comprises 9% of fee-for-service spending and, at least in the case of its high-end estimate scenario, an unrealistically high assumption as to the potential extent of defensive medicine in the U.S. absent utilization management by plans. The estimate that 9% of fee-for-service spending is defensive medicine is drawn from a study of defensive medicine associated with hospital expenditures in treating serious heart disease among elderly Medicare beneficiaries. It is used in both the high-end estimate and low-end estimate scenarios. Under the low-end scenario, Barents assumes that current UR/UM activities have eliminated 20%