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of defensive medicine. In the high-end scenario, Barents assumes that current utilization review and management activities have eliminated 80% of defensive medicine. The indirect effects are assumed to be an expansion in defensive medicine by plans, to the full extent practiced by physicians, and are thus estimated to be 1.8% (9% x 20%) to 7.2% (9% x 80%), respectively.

The assumption that 9% of health care spending is defensive medicine constitutes a clear and upward bias in the analysis. The Barents report applies the 9% figure for fee-for-service utilization to managed care spending broadly - ignoring capitation and withhold arrangements. Moreover, the treatment of serious heart disease among the elderly population can not be construed as being representative of variations in treatment levels in medical services generally and the analysis should be objected to on that basis alone. The level of defensive medicine assumed by Barents exceeds even high-end published estimates of the extent of defensive medicine (taken as a share of national health spending) by a factor of almost 5 (Lewin-ICF 1992). Secondly, there is no basis for the assumption that 80% (or even 20%) of defensive is eliminated by current UR/UM practices. The assumptions that current UR/UM activities have eliminated all but 20% of defensive medicine and that defensive medicine comprises 9% of current total health care spending logically indicate that 45% (5 x 9%) of total health care expenditures would be defensive medicine absent current utilization controls. Even the most extreme findings from the utilization variations literature fail to support such a number.

The failings identified in connection with the Barents analysis of indirect costs of an expansion in plan liability are damaging to claims that such legislation would be costly. Indirect costs in the Barents report comprise 67% of their low-end estimate and 84% of their high-end estimate. Their indirect cost estimates additionally feed into the cost estimates of other managed care reforms.

The estimated cost of legislation **defining UR as a practice of medicine** is based on the assumption that this type of legislation would impose medical malpractice liability on plans. The impacts of such legislation would be comparable to those identified in the discussion of more general liability provisions. The Barents study indicate that defining UR as the practice of medicine would result in slightly lower direct costs for liability insurance increases (about one percent at the high end) and that indirect costs would be

reduced by about 20%. Applying this formula would generate an estimated range of 2.3% (0.09 + 0.8 x 0.027) to 6.2% (0.01 + 0.8 x 7.2). The estimated range of costs presented in the report is actually calculated by taking 80% of the low-end and high-end values from the cost of extended managed care liability laws: 2.2% (0.8 x 0.027) to 6.9% (0.8 x 0.086). In either case, the approach taken by Barents results in estimates that are substantially biased upward. This is because the estimates depend critically on the exaggerated estimates of the costs of expanded liability.

The estimated increase in cost resulting from **medical necessity** law is based on the exaggerated figures used for UM savings. The Barents study suggests that in an extreme case, plans could lose all ability to control utilization and costs through UM activities. The study suggests that between 60% and 90% of utilization management savings would be lost if such a provision were enacted. The two scenarios considered employ additional extreme assumptions — at the high-end, slightly less than the absolute maximum savings is lost, and at the low-end, the majority of savings is lost. Such assumptions clearly rule out a broad range of potential adjustments by plans.

The cost estimates of **any willing provider** legislation are based on extreme interpretations of laws that eliminate plans' ability to reduce utilization of services and to obtain price discounts from providers. Barents refers to adopting the conservative estimate that the "due process" provision would reduce IPAs' ability to control costs to those levels currently attributable to PPOs and POS plans — a 13 percentage point loss of savings for IPAs - and that group and staff model HMOs' ability to reduce costs would also decline to the levels for PPO and POS plans — a 16 percentage point loss of savings for group and staff HMOs. It is also assumed that POS and PPO plans still receive some price discounts from providers, allowing them to maintain a five-percent cost difference from managed fee-for-service.

A review of a small number of studies is used to estimate the costs of AWP laws. The authors present no review or critique of any study cited. Two of the studies (Wyatt 1991; Atkinson & Company 1994), however, have significant shortcomings. The cost estimates from the first study are imprecise because the data used to construct the estimates are derived from a very small, unrepresentative sample of firms. Moreover, both studies assume administrative

costs per physician rise with the size of the physician network. With a large portion of those costs being fixed over a wide range of providers, economies of scale may reduce average administrative cost per provider. The Atkinson & Company cost estimates are additionally based on undocumented assumptions about physician excess capacity and changes in HMO participation brought about by AWP laws that render the estimates meaningless.

Finally, the Barents study states, without justification, that every 1% increase in managed care costs at the national level has the potential to increase the uninsured by about 315,000 individuals in 1999. This exceeds even the 1% -to- 200,000 translation that the CBO dismissed in connection with the M&R estimates.

Coopers & Lybrand

The Coopers & Lybrand (C&L) report, *Estimated Costs of Selected Consumer Protection Proposals: A Cost of the President's Advisory Commission's Consumer Bill of Rights and Responsibilities and the Patient Access to Responsible Care Act* (April 1998), was prepared for the Henry J. Kaiser Family Foundation. The C&L report focuses on the provisions of those two bills deemed to have the greatest potential effect on costs and to be reasonably precise in interpretation. On a PMPM basis, C&L report an aggregate impact of 0.61% of premium for the four provisions of the Consumer Bill of Rights and Responsibilities examined and 0.77% for the five provisions of Patient Access to Responsible Care Act costed out.

The C&L report points out that its cost estimates relate specifically to expected changes in costs for HMOs and that the cost impacts of the analyzed consumer protections, examined in the context of the entire health insurance market, would be lower than the values contained in the report.

Exhibit 7
Coopers & Lybrand Consumer Bill of Rights & Responsibilities and Patient Access to Responsible Care

Provision	
CBRR	
Information disclosure	
Emergency service access	
Access to specialists	
External appeals	
PARCA	
Information disclosure	0.08%
Emergency service access	0.19%
Access to specialists	0.02%
External appeals	0.08%
Point of service option	0.48%

The studied provisions of the two proposals, and their estimated impact on premiums, are presented in Exhibit 7.

The report discusses, but does not attempt to measure, the cost impact of changes in medical liability that would occur under PARCA.

The C&L estimates were developed using a combination of actuarial data, estimates of savings from managed care relative to fee-for-service, and key assumptions based on C&L's review of the literature. The estimates of managed care savings, which are central to the analysis, are not identified in the report. In general, however, the report appears to be solid.

The C&L report notes that the **information disclosure** requirements of the two proposals are a mix of currently collected information and new information. The CBRR report recommends extensive data collection and disclosure for health plans, facilities, and professional providers such as physicians. PARCA limits reporting requirements to health plans. C&L note that many of the information collection and dissemination requirements reflect standards already evolving in the managed care market. New information disclosure requirements in the two proposals examined relate to satisfaction, quality, quantity of services, and certain participating provider characteristics.

The cost analysis of this set of provisions is based on the Lewin Group analysis of CBRR. The C&L estimate differs from the Lewin estimate, however, because it assumes lower labor costs in collecting health plan and hospital data. In addition, it does not assume that some information would necessarily be distributed in hard copy form to all insured lives. Rather it envisions that information would be distributed on request and that centralized distribution through the Internet would emerge.

The C&L report notes that the information disclosure is likely to spur competition at all levels of the health care system and that just a 1% decrease in average HMO premiums would offset the costs of such requirements. Plans stand to benefit from the new data collection requirements as well. Analyses of enrollee satisfaction data (required under the CBRR) would enable plans to improve both individual and employer retention rates.

Both CBRR and PARCA would require that health plans use a prudent layperson standard for **access to emergency services**. C&L

indicate that the standard is generally construed to mean that plans must pay for the initial costs of emergency care of any individual who believes that emergency treatment is necessary due to potentially long term damage or to excessive pain. Neither proposal extends plans' responsibility to the coverage of ongoing treatment in an emergency facility. The CBRR would require plans to educate enrollees as to the location and appropriate use of emergency services, and would require emergency departments to contact primary care providers to discuss follow-up and post-stabilization care.

C&L use actuarial data on the rate of denials of emergency room visits by HMOs relative to the HMO utilization rate. This approach is more direct than the alternative approach of comparing HMO and fee-for-service emergency room utilization rates. Based on an average cost of $120 per visit, an average HMO utilization of emergency room services of 0.26 visits per member per year, and a 5% denial rate by HMOs, C&L calculate that the cost of this provision to be $0.10 PMPM. The report notes that most plans already comply with the prudent layperson standard.

Provisions in CBRR and PARCA also indicate specific standards for **access to specialists**. Both would require plans to use standing referrals to specialists for individuals with complex or serious medical conditions who need frequent specialty care. The Federal Employee Health Benefits Program has adopted a similar standard. Such a change is likely to significantly increase member satisfaction — especially among members with chronic, ongoing conditions. C&L note that standing referrals would entail an initial screening visit with the covered individual's primary care provider and thus the standard is distinct from direct access to all specialty care. The CBRR would additionally require plans to allow women to choose among qualified providers offered by the plan for the provision of covered routine and preventative women's health care services.

The C&L report indicates that most plans already comply with the standards considered. Actuarial data analyzed by C&L suggest that the provisions in CBRR would add 0.02% of premiums to plan costs. The provisions in PARCA, which are less extensive in scope but less specific as well, are similarly projected to add 0.02% of premiums to plan costs.

The C&L report notes a number of large health plans have recently

implemented **external appeals** processes. Plans holding Medicare or Medicaid contracts already are required to have such processes. Plans holding contracts with the Office of Personnel Management to cover federal employees are subject to external review requirements. Finally, at least fourteen states have passed legislation requiring an external appeal process.

The cost estimate for this provision is developed using the number of appeals per 1000 in Florida (reported in the Lewin Group analysis of the CBRR) as their low-end approach and a 500% increase in that number for their high-end estimate. They assume that all external appeals would be conducted by physicians, at an average cost per hour of $250 to $300, and that the average appeal would take 4 hours. They also assumed that plans have internal appeals processes sufficient to ensure that only 15% of appeals are overturned externally, at an average claims cost of $5,000 to $15,000. These figures suggest that costs from external appeals would not exceed 0.08% of premium.

PARCA would require all network-model HMOs to offer an **optional Point-of-Service** (POS) plan to all members. The C&L report indicates that POS plans typically enable members to obtain out-of-network benefits at a cost (to the member) of 20% to 30% over in-network costs. The administrative systems of such plans are potentially complex and pose the greatest challenge to staff and group model HMOs that reimburse physicians on a salary or capitated basis. Regulation of POS plans varies substantially by state. Self-funded plans are governed by ERISA.

For plans that do not offer a POS option (assumed by C&L to be half of HMOs), new administrative systems will be required. The cost to those HMOs is expected to add 0.5% to 1.0% of premiums to plan costs. Those figures translate into a best estimate of the average HMO premium increase due to new administrative requirements of 0.25%. Enrollees choosing POS will likely bear the greatest portion of the cost. Data on POS premiums relative to HMO premiums (POS premiums are indicated to be 5% to 10% higher) and an assumed 33% enrollment increase drive additional claims cost estimate of 0.23% of premium. C&L assume that out-of-network services will continue to have higher cost sharing requirements than in-network services and that members who obtain out-of-network benefits will bear those costs. Consequently, out-of-network reimbursement is estimated to have no measurable impact on plan cost.

Congressional Budget Office

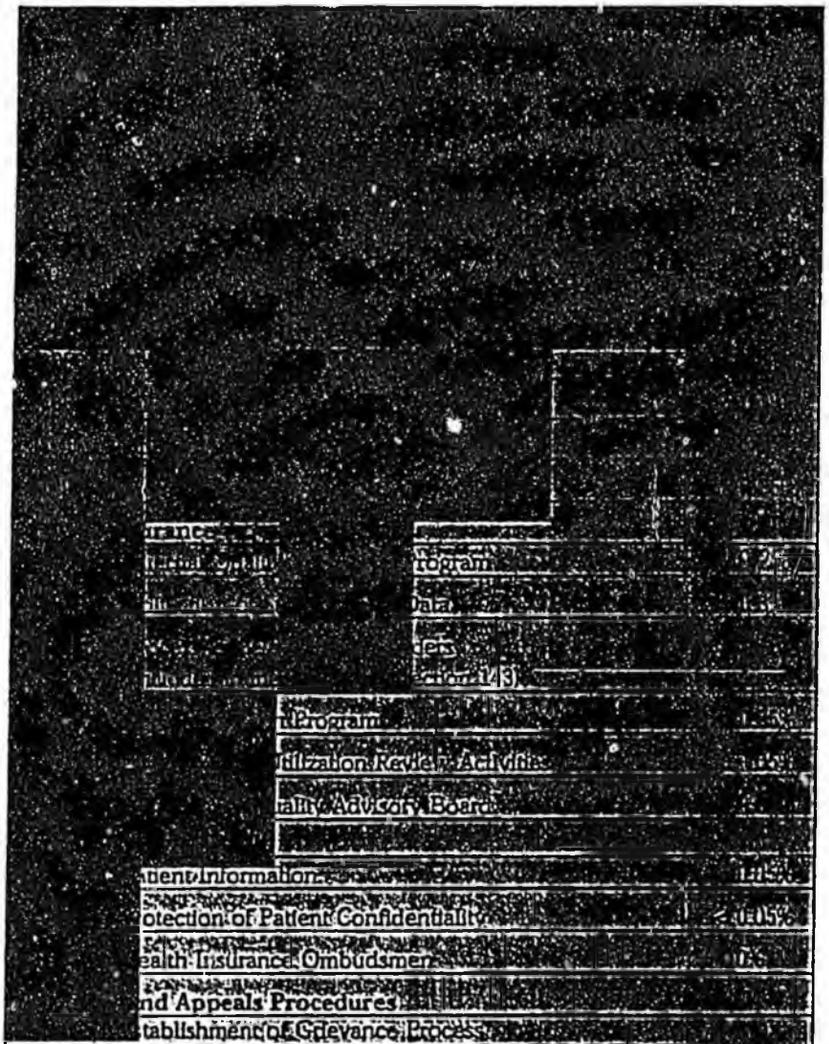
The Congressional Budget Office (CBO) prepared a cost estimate of the Patients' Bill of Rights Act of 1998 (PBR). The estimate is based on the introduced bill, the technical changes contained in Senate amendment 3063 introduced on July 7, 1998 (excluding the revenue provisions), and a change in the effective date of section 302(b) to July 1, 1999. The patient protection standards set out in the bill generally apply to group health plans, group health insurance coverage, and individual health insurance coverage. CBO estimates that the PBR would cause premiums to rise by 4.0% in the 10 years following enactment. The impact is "expressed as the expected ultimate percentage change in average health insurance premiums—that is, the change when all of the bill's provisions are fully phased in."

The report, *Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998* (July 16, 1998), contains estimates of the impact on premiums for employer-sponsored health plans of seven major provisions in the PBR covering 30 sections of the bill. The provisions, the corresponding sections of the PBR, and their estimated increase in premiums are shown in Exhibit 8.

The CBO report states that because of the extent and complexity of the changes to the health insurance system resulting from the provisions in the PBR, the estimates of their effects are subject to more than the usual amount of uncertainty. To derive the estimates, CBO consulted with a variety of experts, including representatives of managed care plans, health insurers, providers, and private industry; state regulators; practicing and academic health and ERISA lawyers; and health policy researchers. The report warns, however, that in some areas, only limited data are available to determine a cost estimate.

For several of the provisions in the PBR the report discusses potential (qualitative) sources of cost increases, but contains no methodology or empirical evidence for constructing the actual impact estimate. The report also indicates that the cost impacts may differ

Exhibit 8
Congressional Budget Office
Patients' Bill of Rights Act of 1998



132	Internal Appeals of Adverse Determinations	
133	External Appeals of Adverse Determinations	
Protecting the Doctor-Patient Relationship		
141	Prohibition of Interference	<0.05%
142	Prohibition of Improper Incentive Arrangements	<0.05%
143	Participation of Health Care Professionals	0.1%
144	Protection for Patient Advocacy	
Promoting Good Medical Practice		
151	Promoting Good Medical Practice	0.8%
152	Standards for Breast Cancer Treatment	<0.05%
153	Standards for Reconstructive Breast Surgery	
Changes to the Employee Retirement Income Security Act		
302	ERISA Preemption	1.2%

among traditional indemnity plans, indemnity plans with utilization review components, PPOs, IPAs and group- or staff-model HMOs.

Of the 30 provisions in the PBR for which CBO estimated premium impact., eight are estimated to increase premiums at least 0.2%, and of those, three are estimated to increase premiums 0.4% or more. The provisions in the PBR indicated to have the largest estimated effects on premiums are discussed in detail in the next section of this report.

The **access to emergency care** component of the PBR would require plans to pay for emergency care in any licensed hospital emergency department if the condition is serious enough to meet the "prudent layperson" standard. The bill also requires plans to pay for post-stabilization care rendered at nonparticipating institutions. Provisions requiring payments for care provided beyond the initial cost of emergency care, and for emergency care provided in any licensed hospital emergency department generally have not been part of other proposed legislation. For example, neither CBRR nor PARCA extends plans' responsibility to the coverage of ongoing treatment in an emergency facility. Consequently, other premium impact estimates of access to emergency care provisions typically have not included the costs of those requirements.

CBO assumes "that roughly half of current denials of payment for emergency room visits would meet the prudent layperson standard." The number of denials CBO used in deriving their estimate is not presented in the report. The cost estimate is also based on the assumption that payments for treating patients in nonparticipating emergency departments would be 50% higher than payments in participating hospitals. This would represent a 33% discount from out-of-plan hospital emergency departments. There is no available evidence of discounts of this magnitude.

CBO also assumes that once the prudent layperson standard became widely understood, emergency visits and the use of nonparticipating hospital emergency departments would rise, and hospitals would be encouraged to raise their charges for emergency departments. These incentives would at least be partially offset by the increase in plans' incentives to encourage and educate members to seek care in non-emergency department settings, and to provide adequate access to in-plan emergency and ambulatory care. There are generally no documented measures of the proportion of plans, accompanied with the number of

enrollees in those plans, which would comply with these provisions.

The **continuity of care** provisions in the PBR require health plans to notify enrollees on a timely basis of the termination of provider contracts, and permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period, generally of 90 days, except for pregnant or terminally ill patients. Termination includes the expiration or nonrenewal of the contract. The provider would agree to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full.

CBO argues that the major cost of this provision would be the cost of developing systems and procedures to notifying enrollees of provider contract terminations. Where such systems and procedures are already in place, however, the cost impact may be minimal. The CBO estimates are based on the assumption that plans generally gain or lose fewer than 10% of contracting physicians a year. (Data from the AMA's 1997 SMS survey indicated that in 1995, 6% of physicians were dropped from managed care contracts.)

The provisions for **coverage of clinical trials** would require plans to pay for routine patient care associated with certain clinical trials sponsored by the National Institutes of Health (NIH), Department of Veterans Affairs, Department of Defense, or NIH-sponsored cooperative groups. Trials covered by the provisions are trials for life-threatening or serious illnesses for which no standard treatment is effective. Routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved. Other proposed managed care reform legislation, and other economic impact estimates of proposed legislation generally do not contain this requirement.

In estimating impact of coverage of clinical trials, CBO assumed that patients in an NIH-sponsored trial generate cost of care 25% higher than the costs of similar patients who do not enter trials. The CBO indicates that the estimate is based on preliminary unpublished results of several small studies that found smaller incremental costs. The CBO expects the cost differential to grow because new trials will involve more expensive therapies and the number of individuals enrolled in clinical trials is predicted to triple over the next 10 years.

The number of patients, the cost of care, and whether or not the provisions of the bill cover the trial are expected to differ among phases of clinical trials. The CBO estimate however, fails to account for the phases of clinical trials, and the share of trials that would be categorized as trials for life-threatening or serious illnesses for which no standard treatment is effective. Phase I trials are considered research and generally are not paid for by insurers. Thus, the provisions in the PBR should result in little if any impact on premiums regarding Phase I trials. In Phase II and Phase III trials patient care and research are carried out jointly. But the Phase III trials which compare new therapies to existing standard treatments may not be covered by the provisions of the PBR.

The cost estimate of implementing an **internal quality assurance program** is based on assumption that all health plans except those that are federally qualified HMOs or currently accredited by the National Committee on Quality Assurance would have to develop a new quality assurance unit, or upgrade an existing one. The report does not indicate the percentage of plans that currently meet these conditions, nor does it indicate the costs of developing or upgrading quality assurance units.

Provisions in the PBR require the **collection and analysis of standardized data** on the utilization of health care services, the demographics of enrollees, disease-specific mortality and (if feasible) morbidity, satisfaction with the plan, health outcomes, and indicators of quality. The impact estimate is based on plans being required to review medical records of 2,000 patients each year. The estimate also takes into account the software development costs resulting from expected changes in the minimal dataset. Development costs and expected cost per record or per site are not presented in the report.

CBO expects the cost of this exercise to be higher for health plans with larger and more diffuse networks. Many health plans may already have information systems in place including the Health Plan Employer Data and Information Set (HEDIS) measures currently required under Medicare contracts, as well as results from consumer access and satisfaction surveys, and general health status surveys. Those plans would incur little additional costs in meeting the requirements of the PBR. Therefore, the CBO estimate that the provision would increase premiums by 0.3% on average may be overstated.

CBO estimates that the provisions **establishing a grievance process**, and **establishing the rights to internal and external appeals of adverse determinations** would jointly raise premiums by 0.3%. Clinical peers who had not previously been involved in the decision under appeal would conduct internal reviews. Only physicians would be considered clinical peers of other physicians. The bill would provide much stronger incentives for internal appeals than the Department of Labor regulations affecting internal claims procedures for ERISA health plans that will be released in response to a Presidential memorandum. Although the rate external appeals is tied to the rate of internal appeals, separate cost estimates for internal and external appeals procedures would provide useful information.

CBO assumes that although most health plans have functioning internal review systems, appeals rate will rise under the PBR because of increased consumer knowledge of the appeals process and the availability of external review. The CBO report cites a study by the General Accounting Office that indicates that data on internal appeals rates are highly unreliable and rates vary widely among HMOs — self-reported appeal rates range from 0.07 to 69.4 per 1,000 enrollees annually, with a median of 3.5. Making an adjustment for appeals related to denials of emergency services, which should be reduced under the "prudent layperson" provisions of the bill, CBO assumed a current average appeal rate of 2.5 per 1,000 enrollees. The report does not detail the adjustment methodology.

Costs per internal appeal are expected to rise due to the clinical peer review requirement and overturning a larger share of appeals in favor of enrollees to avoid cost of external review. For certain appeals, plans might apply less stringent utilization review and reduce the overall expected costs. The costs associated with overturned decisions resulting from appeals, and administrative costs are expected to increase more for health plans and issuers that do not have established systems for internal review of grievances. While the report indicates that this would be a small minority, the proportions of plans currently having and not having grievance processes in place, nor the administrative and other costs associated with having appeals overturned are presented in the CBO report.

A group health plan, and a health insurance issuer offering group health insurance coverage, must also provide for an external

appeals process for appealable decisions if the amount involved exceeds a significant threshold (undefined in the bill), or if the patient's life or health is jeopardized as a consequence of the decision. No information on the number or the share of appeals which meet these conditions is presented, however, even though that data at least partially determine the rate of external appeals.

The report indicates that 16 states require external appeals processes, but few claims reach the external appeals stage. Florida is the only state where the appeals rate is significant, about 1 per 10,000 enrollees. CBO assumes that the PBR would increase external appeals rates in all states, and that the rates would also increase through time — to about 4 per 10,000 enrollees after 5 years — as enrollees became more aware of their rights under this provision. This would represent a four-fold increase over current annual rates of external appeals in Florida, and 40% of the rate in the Medicare program where every denial is subject to appeal, and all denied appeals are automatically referred to external review. This suggests that the CBO cost impact estimate of the provisions establishing the rights to external appeals in the PBR might be overstated.

The provisions in the section **promoting good medical practice** prohibits arbitrary interference with medical practices and establish a right of appeal of plans' decisions. These provisions are expected to generate a higher volume of internal and external reviews and a higher probability of decisions that would be unfavorable to plans. CBO considered plans might avoid appeals under this provision by reducing the frequency with which they challenged physicians' decisions, and the likelihood that plans would adopt defensive UR policies when those costs are lower than the expected costs of the reviews when defending those policies.

The CBO report differentiated between managed indemnity plans (fee-for-service plans with utilization review components or utilization management features), preferred provider organizations, and independent practice associations and group- or staff-model health maintenance organizations in assessing the burden of these provisions. No other cost estimates analyzed include managed fee-for-service plans in the estimates of costs of managed care reform legislation. CBO estimates that these provisions would raise premiums by 0.8%, but provides no quantitative basis for the estimate.

The provisions concerning **expanding legal liability for ERISA**

plans are estimated to increase premiums by 1.4% for ERISA plans, and by 1.2% of the premiums of all employer-sponsored plans. Section 302 of the PBR states that the bill does not authorize (i) any cause of action against an employer or other plan sponsor maintaining the group health plan, or (ii) a right of recovery or indemnity by a person against an employer or other plan sponsor for damages assessed against the person pursuant to a cause of action. This does not preclude any cause of action against an employer or other plan sponsor if (i) such action is based on the employer's or other plan sponsor's exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and (ii) the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death.

The impact estimates are driven by two assumptions, which CBO states are "estimates," but are unsubstantiated. The first is that health plans' liability costs average about 2% of their premiums (not counting defensive medicine by providers). No plan specific information on liability costs as percent of plan premiums is presented by CBO. Barents Group (1998) presents a figure of 0.5% for liability premium costs based on a small sample of insurers, but uses 2.0% as their high end estimate baseline which reflects the cost liability premiums to providers. The Barents Group cost estimate of expanded liability is generally recognized as being biased upward because of the failure to account for the ability of managed care organizations to insure against malpractice liability at significantly reduced rates relative to providers. It follows that the CBO estimates represent a high-end estimate. The second CBO assumption driving their cost estimates is that ending the ERISA preemption increase liability costs by 60% to 75%, in the case of PPOs, POS plans, and HMOs, and by a lesser percentage in the case of indemnity plans.

CBO indicates the premium increase from expanding legal liability for ERISA plans is determined by two primary sources. More than half of the increase comes about from potential suits associated with decisions on medical necessity and coverage, and unintended lawsuits involving providers and plan fiduciaries. Most of the remainder would result from more medical negligence suits against plans, reflecting the financial resources of plans and the effects of the new legal environment. No data are presented, however, to substantiate the number of additional suits or the size of the awards health plans might expect to experience due to the provisions in the PBR.

William M. Mercer

William M. Mercer, Incorporated (Mercer) was commissioned by the American Medical Association to develop an actuarial model to assess the cost impact of **managed care accountability** legislation. The report, *Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation* (August 1, 1998), presents impact estimates based on expected medical services distributions by physician subspecialty for various types of managed care organizations (MCOs), and expected MCO malpractice claim incidence and average cost of malpractice claims.

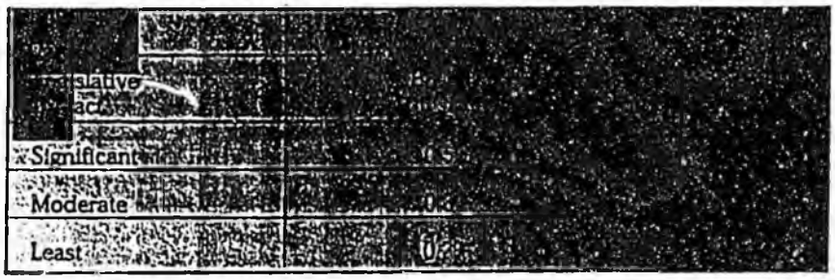
The Mercer analysis derives estimates of increases in health insurance premiums from model managed care accountability legislation which contains the following three components:

- A direct cause of action against health insurance carriers, HMOs, and managed care entities for damages caused by their failure to exercise ordinary care in making health care treatment decisions;
- A prohibition on hold harmless and indemnification clauses in provider contracts; and
- A prohibition on the use of the corporate practice of medicine defense.

The estimates also take into consideration three levels of legislative impact related to existing differences across states in use of the corporate practice of medicine defense; two constructions of ERISA preemption to capture the extent to which the actions brought by enrollees of ERISA plans could be preempted by ERISA; alternative enrollment mixes; and three types of caps on malpractice awards to account for different state tort reform laws. After considering a broad range of impact scenarios, Mercer estimates that managed care accountability legislation would increase premiums between 0.1% to 1.8%.

Exhibit 9 shows estimates for the three levels of legislative impact for broad and narrow ERISA construction presented in the Mercer report.

Exhibit 9
William M. Mercer
Increase as a Percent of MCO Premium, No Cap on Awards



The actuarial model was constructed using a general logic flow that begins with a population enrolled in an IPA or network model HMO that contracts with physicians or physician networks. The enrollment is distributed among commercial, Medicare and Medicaid managed care programs. Mercer cost models produce medical service projections by physician subspecialties. Managed care organization (MCO) malpractice claim incidence is derived from the MCO medical services by physician subspecialty. Applying an average MCO malpractice award and legal expense to the malpractice claim incidence yields the change in MCO cost per member per month.

Under the managed care accountability provisions, an MCO is liable for damages caused to an enrollee by the MCO's failure to exercise ordinary care in making health care treatment decisions. Health care treatment decisions are defined as a determination made when medical services are provided by the plan and a decision that affects the quality of the diagnosis, care or treatment provided to the enrollees. As in other negligence actions, a plaintiff must demonstrate that the MCO breached its duty to exercise ordinary care, and that such breach was the proximate cause of the plaintiff's injury. The provisions also allow for a vicarious liability cause of action, under which an MCO is liable for damages caused by the health care treatment decisions made by its employees, agents, and representatives.

The legislative impact scenarios are designed to reflect the impact of the prohibition of the corporate practice of medicine defense. States are assumed to generally fall within one of three scenarios

with respect to how the corporate practice of medicine doctrine is enforced as follows:

- The state actively enforces a complete bar against the corporate practice of medicine.
- The state actively enforces a bar against the corporate practice of medicine, but exempts from the bar certain providers, such as hospitals, HMOs, and professional corporations.
- The state has no bar against the corporate practice of medicine or has a bar that is not enforced.

The constructions of the ERISA preemption defense allow for two possible impacts. If ERISA preemption is narrowly construed to allow vicarious liability and direct negligence actions against MCOs by ERISA enrollees, the MCO liability exposure from ERISA enrollees is expanded. Alternatively, if the ERISA preemption is broadly construed, the MCO liability exposure from ERISA enrollees remains limited. The estimates are based on the assumption that 90% of the MCO enrollees are covered under an ERISA employee benefit plan. This percentage varies significantly for different states. Thus, the extent to which ERISA enrollees may bring a state law cause of action against MCOs will have a significant impact on estimates.

To account for the different mix of plan types found across the states alternative types of MCOs are considered. Managed care accountability legislation is expected to have the least impact on staff model HMOs, because they have already been subject to vicarious liability malpractice claims, based on their direct employment of physicians. IPA/network model HMOs (which include risk-bearing PPOs) are expected to experience a greater impact. It is assumed that a staff model HMO will incur 30% of the additional liability incurred by IPA/network model HMOs. The estimates are based on an enrollment mix of 96% in IPA/network model HMOs and 4% in staff model HMOs. The estimates are based on an enrollment mix by payer 90% commercial, 5% Medicaid and 5% Medicare. Mercer claim cost models are used to construct medical services distributions by physician subspecialty for each of these populations.

Three types of caps on malpractice awards are incorporated in the Mercer analysis to account for different state tort reform laws. Impact estimates are presented for (i) no cap, (ii) a cap of $250,000 on non-economic damages with no cap on economic or punitive damages, and (iii) a cap of $500,000 on non-economic damages with no cap on economic or punitive damages.

The share of a physician's practice dedicated to providing health services to MCO members are constructed for each of the three categories of enrollees. Another adjustment is made to assign hospital malpractice claims to MCO members. The estimated ratio of the total physician and hospital malpractice claims to physician malpractice claims is 1.14. Applying this factor to the annual incidence of physician malpractice claims per 1,000 members produces an estimate of the incidence of claims that includes both physician and hospital malpractice claims.

The authors of the Mercer study assume that existing claims against physicians and hospitals will remain the same. Given the relationship between existing bars to the corporate practice of medicine and the incidence of vicarious liability claims against MCOs, additional vicarious liability claims are assumed to vary with the legislative impact — 5% for low impact, 10% for moderate impact, and 20% for significant impact. Direct negligence claims are assumed to rise by 10% for all legislative impact scenarios

The average cost of an MCO malpractice claim was derived from statistics in "Civil Jury Cases and Verdicts in Large Counties," Bureau of Justice Statistics, July 1995. The malpractice awards data from the Bureau of Justice Statistics, for plaintiff awards, indicated that the median award was $201,000, the average awards was $1,484,000, 47.1% of awards were over $250,000 and the 24.8% of awards for over $1,000,000. The awards distribution was adjusted for the inclusion of hospital awards, the influence of damage caps, the recent increasing number of awards over $1 million, and the expectation that MCOs will be subject to higher malpractice awards than physicians. Because the awards distributions are based only on plaintiff awards, the average award is also adjusted to reflect the assumption that plaintiffs are successful in 25% of the cases. Average cost per MCO award is estimated to be $429,651, plus legal expenses assumed to average $125,000 over all suits.

Exhibit 10
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
Expanded Liability	4%-5% (among IPAs, PPOs, and POS plans) 2.7%-8.6%b/		0.0%-0.2%		0.1% to 0.4% (among IPAs)	uncertain	1.2%	0.5%-1.8%
Establishment and Maintenance of Health Care Provider Networks/ Due Process Provisions	5%-8% (depending on plan type)	less than 0.05%-0.1%						
Restrictions on Utilization Review	3%-5% (among HMOs)						0.1%	
Deeming Utilization Review to be Part of Practices of Medicine	2.2%-6.9%[b/]							
Prohibition of Physician Incentive Payments/No Inducement to Reduce Services (among HMOs)	3%-5%	0.0%	9.5%				less than 0.05%	
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%[v]					
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%[v]				
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).

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CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 16, 1999

S. 6
Patients' Bill of Rights Act of 1999

As modified by the sponsors

SUMMARY

The Patients' Bill of Rights Act of 1999 would impose new requirements on the structure and operation of group health plans and health insurance issuers and would provide members of health plans and insured individuals with new rights to obtain certain health care services. It would require both internal and external review processes for members to appeal decisions by health plans and insurers. It would also amend the Employee Retirement Income Security Act (ERISA) to allow individuals to sue health plans and insurers for personal injury or wrongful death under state tort laws. These provisions would have a significant effect on the costs of private insurance as well as the federal budget. Because of the extent and complexity of the changes to the health insurance system that could result from such provisions, estimates of their effects are subject to more than the usual amount of uncertainty.

The bill would affect the federal budget in three ways. First, by increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. The Congressional Budget Office (CBO) estimates that the proposal would reduce federal tax revenues by $390 million in 2000 and by $7.0 billion over the 2000-2004 period. Second, the bill would impose additional costs on the Federal Employees' Health Benefits Program, most of whose plans are classed as health insurance issuers. CBO estimates that these costs would amount to $240 million over the 2000-2004 period, of which $95 million would be mandatory. Third, it would require additional spending for administration and regulatory activities, subject to appropriation of the necessary amounts. These discretionary costs would total an estimated $315 million over the next five years. CBO recognizes that this bill could affect practice styles in fee-for-service settings, potentially raising fee-for-service expenditures under Medicare. CBO has not estimated the magnitude of such an effect.

The bill's requirements on group health plans offered by state, local, and tribal governments would be optional under the Public Health Service Act (PHSA). Consequently, those requirements would not be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

The bill would establish several private-sector mandates as defined by UMRA. Provisions imposing new functions and operating practices on private insurers and health plans would create private-sector mandates. Provisions that would indirectly raise plan costs, such as those giving plan members the right to sue plans for personal injury, would not be considered private-sector mandates. The estimated costs of the private-sector mandates would greatly exceed the annual threshold established in UMRA ($100 million in 1996, adjusted for inflation) in each of the years after enactment. CBO estimates that the cost of private-sector mandates would total about $41 billion over the 2000-2004 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the bill is shown in Table 1. The costs of this legislation fall within budget function 500 (health) and other functions.

TABLE 1.
ESTIMATED BUDGETARY EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
REVENUES										
Income and HI Payroll Taxes	-270	-680	-1,070	-1,320	-1,530	-1,660	-1,750	-1,850	-1,950	-2,060
Social Security Payroll Taxes	-120	-300	-470	-580	-680	-730	-770	-820	-860	-910
Total	-390	-980	-1,540	-1,900	-2,210	-2,390	-2,520	-2,670	-2,810	-2,970
DIRECT SPENDING										
FEHBP--Annuitants	5	10	20	25	35	40	45	45	50	55
AUTHORIZATIONS OF APPROPRIATIONS										
FEHBP--Active Workers	5	15	30	40	55	60	65	70	75	75
Federal Administrative Costs	25	70	70	75	75	75	80	80	80	85
Total	30	85	100	115	130	135	145	150	155	160

SOURCES: Congressional Budget Office and Joint Committee on Taxation.
NOTES: HI = Hospital Insurance; FEHBP = Federal Employees Health Benefits Program

BASIS OF ESTIMATE

The bill would significantly change the relationships between employers, health plans, health insurers, providers, and patients. These changes would be complex and would be imposed on a rapidly evolving health care system. In some areas, limited data on which to base a cost estimate are available. CBO has consulted with a variety of experts, including representatives of managed care plans, health insurers, providers, and private industry; state regulators; practicing and academic health and ERISA lawyers; and

health policy researchers. Although this cost estimate is subject to more than the usual amount of uncertainty, it represents CBO's best judgment about the likely effects of the bill. The ultimate costs could be substantially larger or smaller.

CBO estimated the impact of each provision on health plan premiums in the 10 years following enactment (which is assumed to occur by October 1, 1999). This cost impact is expressed as the expected ultimate percentage change in average health insurance premiums--that is, the change when all of the bill's provisions are fully phased in. Most of the provisions would reach their full effect within the first 3 years after enactment. CBO estimates that premiums for employer-sponsored health plans would rise by an average of 4.8 percent in the absence of any compensating changes on the part of employers. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.(1)

TABLE 2.
ESTIMATED ULTIMATE EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percent)

Provision	Increase in Premiums
Section 101--Access to Emergency Care	0.4
Section 102--Offering of Choice of Coverage Options	0.2
Section 103--Choice of Providers	a
Section 104(a)--Obstetrical and Gynecological Care	0.1
Section 104(b)--Specialty Care	a
Section 105--Continuity of Care	0.2
Section 106--Coverage for Clinical Trials	0.5
Section 107--Access to Needed Prescription Drugs	b
Section 108--Adequacy of Provider Network	0.2
Section 109--Nondiscrimination in Delivery of Services	0.1
Section 111--Internal Quality Assurance Program	0.2
Section 112--Collection of Standardized Data	0.2
Section 113--Process for Selection of Providers	b
Section 114--Drug Utilization Program	b
Section 115--Standards for Utilization Review Activities	b
Section 116--Health Care Quality Advisory Board	0
Section 121--Patient Information	b
Section 122--Protection of Patient Confidentiality	b
Section 123--Health Insurance Ombudsmen	0
Section 131--Establishment of Grievance Process	0.3
Section 132--Internal Appeals of Adverse Determinations	c
Section 133--External Appeals of Adverse Determinations	c
Section 141--Prohibition of Interference	b
Section 142--Prohibition of Improper Incentive Arrangements	b
Section 143--Participation of Health Care Professionals	0.2

Section 144--Protection for Patient Advocacy	d
Section 151--Promoting Good Medical Practice	0.8
Section 152--Standards for Breast Cancer Treatment	b
Section 302--ERISA Preemption	1.4
Total	4.8

a. Included in estimate of section 108.

b. Less than 0.05 percent.

c. Included in estimate of section 131.

d. Included in estimate of section 143.

Employers could respond to premium increases in a variety of ways to reduce their impact. They could drop health insurance entirely, reduce the generosity of the benefit package, increase cost-sharing by beneficiaries, or increase the employees's share of the premium.

CBO assumed that employers would deflect about 60 percent of the increase in premiums through these strategies. The remaining increase in premiums would be passed on to workers in the form of lower wages. These lower wages would reduce federal receipts from income and payroll taxes.

The bill would somewhat reduce the ability of managed care organizations to limit the use of health care services. The loosening of styles of practice by providers in managed care plans could spill over to other settings, raising costs to some degree in fee-for-service plans and potentially raising fee-for-service expenditures under Medicare. That conclusion is based on recent studies that found lower fee-for-service expenditures under Medicare in areas of the country with greater market penetration by HMOs. Those results suggest that providers who participate in managed care plans change their practice styles for all of their patients, not just for those enrolled in HMOs. Decreasing the restrictiveness of managed care plans could, as a result, lead to higher costs in fee-for-service plans as well. CBO has not estimated the magnitude of such an effect for either Medicare or private insurance.

Title I of the bill, comprising seven subtitles, would establish standards to protect consumers and providers in managed care plans and other health insurance plans. Title II would apply the standards to group health plans and issuers of individual health insurance coverage as defined in title XXVII of the Public Health Service Act. Title III would apply the standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act. Title IV would apply the standards to group health plans under the Internal Revenue Code. In this estimate, the costs of the patient-protection standards are assigned to the corresponding sections of title I.

In addition, title III would amend ERISA to allow enrollees in employer-sponsored health insurance plans to sue their plans under state law for damages resulting from personal injury or wrongful death. It would also require the Secretary of Labor to investigate complaints of discrimination or retaliation against health care professionals. The incremental costs of these provisions are shown separately.

Access to Care

Subtitle A would impose requirements on the structure of health plans and the access to services and providers they offer their members. These requirements would affect access to emergency and specialty care, coverage of clinical trials, and adequacy of provider networks.

Section 101--Access to Emergency Care. This section would require plans to pay for emergency care received without prior authorization in any licensed hospital emergency department when the condition is serious enough to meet the "prudent layperson" standard (as applicable to Medicare+Choice plans). Moreover, the plan could charge the patient no more than if the emergency department were in the plan's network. CBO assumes, therefore, that the plan would be responsible for paying the non-participating provider's full charge for emergency services rendered. Finally, the plan would be required to pay for post-stabilization care rendered at the nonparticipating institution consistent with regulations governing Medicare and Medicaid.

Many states have laws in place that require that health plans pay for emergency services; those laws vary widely in their definitions of emergencies and requirements for out-of-network coverage. CBO estimates that about 20 percent of the U.S. population lives in states whose laws fully meet the standard of this section and another 60 percent of the population resides in states with laws that partially conform. CBO assumed that roughly half of current denials of payment for emergency room visits would meet the prudent layperson standard and that the costs to health plans of treating patients in nonparticipating emergency departments would be 50 percent higher than they would be in participating hospitals. Once the prudent layperson standard became widely understood, members of plans would increase emergency visits and probably their use of nonparticipating hospital emergency departments. The return to fee-for-service insurance payment to nonparticipating providers would encourage hospitals to raise their charges for visits to emergency departments. CBO estimates that the new prudent layperson standard, the removal of restrictions on nonparticipating providers' payment rates, and the inducement of additional visits to emergency rooms would increase the average premium by 0.4 percent across all private employer-sponsored health plans.

Section 102--Offering of Choice of Coverage Options. This section would require health plan sponsors to offer point-of-service (POS) plans whenever their existing offerings of plans did not include a plan that pays for care received from non-network providers. CBO estimates that about 23 percent of employees currently work in organizations offering employee health plans that limit choice of provider and do not offer an alternative plan without such limits. The provision would increase the administrative cost of processing out-of-plan claims and increase the use of services by those who selected the POS option. Because the provision would not impose any requirements on the financial terms of the POS option, employers could offset some of its costs by increasing the cost-sharing requirements for beneficiaries. Based on out-of-plan use in existing preferred provider organization (PPO) and POS plans, CBO estimated that 10 percent of employees in firms newly offering the POS option would select it and that the net costs (benefit payments and administrative expenses) for those individuals would increase by 11 percent. The net effect averaged across all employer-sponsored health plans would be an increase of 0.2 percent in premiums.

Section 103--Choice of Providers. This section would require health plans to allow enrollees to choose among the participating health care providers who are available to accept patients, but it would allow health plans to restrict choice among specialists if the plan clearly informed participants of these limitations. Alone, this section would have negligible effects on health care costs because it would give plans the right to close physician practices to new patients and would also allow plans to write rules into their description of benefits that detailed limitations on access to specialists. However, this provision would be appealable under sections 132 and 133 and could interact with section 108 (requiring an adequate provider network) as it was considered by appeals bodies. For example, if only one physician in a specific subspecialty was available to see patients at the time of referral, patients might argue on the basis of both this section and section 108 that the plan was not providing a sufficient choice of providers. Because of the interaction of this section with section 108, CBO includes the cost of this section in its estimate of section 108.

Section 104(a)--Obstetrical and Gynecological Care. This subsection would grant women specific rights to designate a participating obstetrical and gynecological specialist as their primary care provider and to receive covered preventive women's health and pregnancy services from a participating obstetrical and gynecological specialist.

This provision would require an immediate change in the design and operation of some plans, but it would not affect all types of plans. Fee-for-service and PPO plans do not require referrals to specialists. In addition, fully-insured ERISA plans and self-purchased insurance products are subject to state mandates on access to obstetrical and gynecological specialists; these mandates already exist in states containing almost 70 percent of the population. CBO estimates that about 20 percent of individuals in employer-sponsored plans would be newly affected by section 104(a) to a substantial extent. CBO relied on an estimate of the effect of this provision in California made by Price Waterhouse for the Kaiser Family Foundation which found that such plans could see a 1 percent increase in physician costs or a 0.35 percent increase in overall costs.[2] Thus, across all employer-sponsored plans, section 104(a) would raise employer-sponsored premiums by about 0.1 percent.

Section 104(b)--Specialty Care. Section 104(b) would require plans to pay for referrals to specialists when such care is justified by the complexity or seriousness of the condition and the plan provides benefits for such treatment. If the referral were made to an out-of-network specialist, the patient could be charged no more than if the provider were participating in the network. The provision would also require a plan to establish a procedure for designating a specialist as the primary care provider when the plan is organized on a gatekeeper model and when the patient has a condition justifying coordination of care by a specialist. The plan would also have to establish a procedure for allowing standing referrals to a specialist when it was appropriate. Disputes arising out of this provision would be appealable under sections 132 and 133.

Although the provision does not explicitly specify that a plan would be required to refer a patient to a nonparticipating specialist, the provision would give appeal agencies the power to decide whether participating specialists had adequate expertise to treat the condition. Thus, this provision would stimulate appeals of plan decisions regarding virtually all aspects of referral management. Consequently, it would reduce the power of health plans in contract negotiations with specialists, especially sub-specialists concentrating on specific diseases or conditions. Patients and referring physicians could argue in the appeals process that certain centers of excellence or sub-specialists were uniquely qualified to treat unusual conditions. As these providers came to recognize the potential loss of plans' power to steer patients to designated specialists, they could become less willing to make fee concessions as a condition of joining the plan's network. These effects would be felt most heavily by the plans that rely heavily on provider discounts to achieve savings.

Plans would also have to establish new policies and procedures for dealing with requests for redesignation of specialists as primary care physicians in certain cases and for standing referrals. The setup and maintenance of such procedures would involve minor additional administrative costs. However, to the extent that patients with chronic conditions were assigned to specialists for primary care, the plan's pricing power with its other primary care providers could be reduced. Like section 103, this subsection would interact with section 108, which requires an adequate provider network. Therefore, CBO includes its cost in the estimate of section 108.

Section 105--Continuity of Care. This section would add about 0.2 percent to the average premium. During a transitional period, it would require employee health plans to pay for care delivered by a nonparticipating provider when the plan terminates its contract with a provider while a patient is receiving a course of care. The transition period would be 90 days, with a longer period allowed for pregnant or terminally ill patients. The termination could result either from dropping a physician from a plan's network

or from deleting an insurance product from an employer's offerings of health plans. The right to transitional care would require health plans to adopt new systems and procedures for contracting with providers and for handling transitions from one insurance plan to another. These systems would involve a one-time development cost as well as additional ongoing costs.

In the case of terminating a contract with an individual provider, the major cost to a plan would be the cost of notifying enrollees. Health plans generally gain or lose fewer than 10 percent of contracting physicians a year. Notification would involve identifying recent encounters by enrollees with terminated physicians and informing the enrollee of rights to transitional care, if the provider remained willing to accept the terms of the old contract.

In the case of terminating an insurance product, costs would increase not only because enrollees would have to be notified but also because systems and procedures would be required to administer the transition between plans. This system would require insurers to contract with willing out-of-plan providers for a limited period of time and incur costs associated with contract negotiations. The new health plan would be responsible for educating the out-of-plan provider about the plan's policies regarding quality assurance and utilization review. Although these arrangements could increase costs of health insurers and employers, they would also impose a burden on providers. Therefore, the aggregate cost of the claims exceptions process would be largely attenuated by its infrequent use.

Section 106—Coverage of Clinical Trials. This section would require health plans to pay for routine patient care associated with certain clinical trials sponsored by the National Institutes of Health (NIH), Department of Veterans Affairs (VA), Department of Defense (DoD), or NIH-sponsored cooperative groups. Only trials for life-threatening or serious illnesses for which no standard treatment is effective would qualify. The federal government's or cooperative group's contribution could be limited to in-kind contributions. The health plan would be required to pay for care at a rate no higher than it pays to participating providers, and it could require a patient to be treated by a participating provider, if such a provider was collaborating in the trial.

A high but declining portion of trial-related patient care costs is currently paid by private health plans.[3] CBO estimates that health plans currently pay at least 90 percent of these costs. NIH personnel indicated that their supported clinical trials generally cover only the research costs (for example, data collection and statistical analysis) and sometimes the experimental therapy. Medical procedures or services are paid out of the research budget infrequently (for example, when they are performed exclusively to further a research objective and have no diagnostic or therapeutic value to the patient). Private sponsors or in-kind contributions by providers may play some role, but these sources of funding are likely to be small in the aggregate.

NIH-sponsored cooperative groups typically mount studies funded by private entities as well as NIH. For example, cooperative groups sponsored by the National Cancer Institute (NCI) receive funding from NCI to support a research infrastructure and a peer review process as well as for specific NCI-sponsored trials. However, they also conduct studies on behalf of private sponsors. As with NIH-sponsored studies, the private sponsor pays for research costs and often the experimental therapy but typically relies on insurers and health plans to pay for other care provided to participants in the trial.

CBO obtained estimates from NIH, VA, and DoD of the number of individuals who entered their sponsored treatment trials each year. Most of these entrants are under age 65, and most have private insurance. The estimate assumes that virtually all such trials would meet the test of being for serious or life-threatening illness for which no existing therapy is fully effective. The estimate also assumes that the bill would not require health plans to pay for treatments that would not be covered by the plan if they were not experimental.

Because the provision would reduce the cost of clinical trials to governmental and private sponsors, it would be likely to increase the number of patients enrolled in approved trials. At least three responses would occur. First, researchers would expand the size of trials to answer more research questions and to do so with greater precision. Second, more trials would be funded. Third, researchers would seek to test more expensive treatments.

CBO assumed that today each patient in an NIH-sponsored trial has costs of care that are 10 percent higher than the costs of similar patients who do not enter trials. This estimate is based on published and unpublished results of several small studies that compare costs of cancer patients in clinical trials with similar patients who are not in trials. Those studies have found smaller incremental costs, but they did not include the relatively infrequent trials involving highly expensive therapies (such as autologous bone marrow transplantation for breast cancer). The cost differential could be expected to grow in the future as new trials involve more expensive therapies.

CBO further assumed that the provision would triple the number of individuals enrolled in clinical trials gradually over the next 5 years. Although this figure may be an underestimate of the long-term effect, constraints on the availability of trained clinical research personnel would limit the rate of increase in the near term.

The provision would limit the payment that plans would have to make to nonparticipating providers, thereby providing large managed care organizations with some bargaining power over the design and cost of trials. Specifically, plans would be required to pay those providers the rates that they would normally pay to participating providers for "comparable services." But disputes between nonparticipating providers and health plans could arise over the definition of comparable services. Those disputes could lead to suits under ERISA to enjoin violations of this provision. Depending on how the federal courts interpreted the provision, health plans might have little power to negotiate with protocol sponsors over rates of payment.

CBO estimates that this provision would ultimately increase the average premium across all kinds of employer-sponsored health plans by 0.5 percent.

Section 107--Access to Needed Drugs. Section 107(a) would require plans using restrictive drug formularies to have written policies and a process for making exceptions. CBO surveyed the evidence on current pharmaceutical benefits and concluded that virtually all drug formularies already have such processes in place.

Section 107(b) would prohibit a health plan from refusing to cover a drug or device that is approved by the Food and Drug Administration (FDA), when it is prescribed for the approved use, on the grounds that the treatment is experimental. This prohibition could create new administrative costs for health plans that currently rely on investigational technology clauses in their benefit contracts to deny payment for new treatments. These clauses allow plans to avoid conducting case-by-case reviews of medical necessity for some new technologies. CBO assumes that plans would gradually adjust to the new requirement by excluding some specific technologies from covered benefits and by using determinations of medical necessity to limit coverage for others. The additional administrative costs associated with these changes would be small, because few new technologies are excluded as investigational.

CBO estimates that this section would raise health plan costs by less than 0.05 percent.

Section 108--Adequacy of Provider Network. This section would require plans to establish networks that provide adequate and appropriate levels of availability of needed services. It provides little specific language defining what kinds of networks would be considered adequate or appropriate. CBO assumes that

the requirements for consumer choice (section 103) and access to specialists (section 104(b)) would necessitate several participating providers within specialties and subspecialties in order to assure geographic proximity and timely access. Thus, this provision would put pressure on some plans to augment their networks of providers. In conjunction with sections 103 and 104, this section would reduce the pricing power of plans when they negotiated contracts with providers. Depending on how it was interpreted by regulation, the requirement for an adequate network could require plans to become price-takers in areas with few physicians in certain key specialties and in small metropolitan areas or rural areas with few physicians in general. CBO estimates that the net effect of these potential impacts on health plan premiums is 0.2 percent for all employer-sponsored plans.

Section 109—Nondiscrimination in Delivery of Services. This section would prohibit plans from discriminating against health plan members in the delivery of health care services on the basis of race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Plans would not be prohibited from limiting health insurance coverage on the basis of pre-existing conditions or from charging higher premiums for such coverage. The boundary between a disability and a pre-existing condition is often unclear, however, and plaintiffs could sue under ERISA for injunctive relief on the grounds that determinations by health plans violated this section. CBO estimates that this provision would increase premiums by 0.1 percent.

CBO's estimate assumes that this provision would not prohibit health plans from excluding certain classes of health care services, such as prescription drugs or mental health services, from its contract benefits.

Quality Assurance

Subtitle B lays out a program for assessing and monitoring the care delivered and outcomes of care for plan members. It would require plans to set up an internal quality assurance program to oversee the collection of data on services and outcomes and to correct problems of quality; develop a set of standards and procedures for selecting participating providers, including verification of the provider's background; and, for plans with prescription drug benefits, have a quality improvement program that encourages appropriate use of prescription drugs and reduces the incidence of adverse drug interactions. It would also specify requirements for utilization review (UR), including standards of timeliness and involvement of clinical peers (that is, physicians) in the UR process.

Section 111—Internal Quality Assurance Program. This section would require each health plan or health insurer to maintain a separate office responsible for carrying out the provisions of the subtitle. The program would have a unit director and a written plan for quality assurance, with criteria for plan performance and patient outcomes. It also would have a system to receive reports of quality concerns from providers and enrollees. And, it would have the capability of producing standardized clinical data. Federally qualified health maintenance organizations (HMOs) and plans accredited by a recognized accrediting organization would be deemed to comply with this requirement.

The estimate assumes that all health plans except those that are federally qualified HMOs or currently accredited by the National Committee on Quality Assurance would have to develop a new quality assurance unit (or upgrade an existing one), with a physician director, data analysts, nurse abstracters, and clerical support personnel. CBO estimates that establishing or upgrading these units would increase costs by 0.2 percent across all employer-sponsored plans.

Section 112—Collection of Standardized Data. The bill would require the collection and analysis of standardized data on the utilization of health care services, the demographics of enrollees, disease-specific mortality and (if feasible) morbidity, satisfaction with the plan, health outcomes, and indicators of quality. The exact requirements for data collection and analysis would be specified by the Secretary of Health and

Human Services (HHS), subject to the recommendations of the Health Care Quality Advisory Board. The costs of collecting and analyzing data would depend on the data items selected and required by the Secretary. Because information systems vary widely, the costs of these reporting systems would fall unevenly on different types of plans. Some measures would be harder for tightly managed HMOs to produce, while others would be harder for broad network plans to produce.

Based on trends in data collection and quality measurement under the Medicare program, CBO assumed that the data items required by the Secretary would include all of the Health Plan Employer Data and Information Set (HEDIS) measures currently required under Medicare contracts, plus additional measures required for HEDIS accreditation in 1999, as well as new measures specifically required in the bill, such as disease-specific mortality. The Quality Improvement System for Managed Care proposed by the Health Care Financing Administration (HCFA) for all Medicare+Choice Plans would require them to produce HEDIS measures as well as other quality measures. So far, HCFA has made no separate arrangements for PPOs or other broad network plans, and the estimate assumes that the Secretary would make no special arrangements under this bill for such plans.

Some HEDIS measures could be compiled from administrative data (for example, electronic claims forms), especially if claims forms are altered to capture specific items required under HEDIS. However, most of the HEDIS measures required by Medicare involve reviewing the medical records (or charts) of a sample of beneficiaries--about 400 for each measure. Moreover, the HEDIS manual requires plans to perform chart reviews to verify some measures when administrative data are inadequate. The estimate assumes that data requirements would be expanded gradually to include severity of disease or other risk-adjustment measures that could be measured reliably only through chart reviews.

Medicare's current rules for risk plans require two direct surveys of patients: a survey of consumer access and satisfaction and a survey of general health status. HCFA requires each Medicare plan to survey 1,000 enrollees. The estimate assumes that these surveys would also be required of private insurers, only in larger numbers because of the need to cover all age groups. The need for a survey of health status would be important for adjusting outcomes for differences in risk profiles among plans, so CBO assumes that sooner or later it would be part of the information package.

The estimate takes into account the likelihood that the minimal dataset would change from year to year, requiring continual software development. It also assumes that each health plan would be required to review the medical records of 2,000 patients each year. Some of these records would be in physicians' offices. The cost of this exercise would be higher for health plans with larger and more diffuse networks. CBO estimates that the provision would increase premiums by 0.2 percent on average.

Section 113--Process for Selection of Providers. This section would require plans that selectively contract with health care professionals to develop and maintain a written process governing their selection. The plan would have to verify the provider's professional license and determine whether the license had ever been suspended or revoked. The section would prohibit plans from excluding professionals on the basis of their location in areas with high-risk patients. Plans could not exclude certain kinds of professionals from participating solely on the basis of the class of certification or licensure, as long as the services the individual would deliver were within the scope of his or her license.

This provision would entail administrative costs to verify and update the status of licensure for both potential and currently participating professionals. Most plans already verify the credentials of participating providers, at least initially. In addition, these costs would largely overlap those of section 143 (regarding the participation of health care professionals). Consequently, CBO has included them in the estimate of section 143.

Section 114—Drug Utilization Program. Although the bill would require health insurers to operate a drug utilization review program, pharmacies and pharmaceutical benefits managers are currently providing these services. Thus, the incremental costs associated with drug utilization review would be small.

Section 115—Standards for Utilization Review Activities. This section sets out requirements for the conduct of utilization review activities. It would require plans to specify clinical review criteria developed with input from appropriate physicians and based on outcomes of care to the extent feasible. The requirements of the section are largely consistent with current practice in health plans that rely on utilization review. Therefore, CBO estimates this provision would increase health plan costs by less than 0.05 percent.

Section 116—Health Care Quality Advisory Board. This section would establish an appointed health care quality advisory board to identify, update, and distribute quality measures for health plans; advise the Secretary of HHS on the minimum data set; and advise the Secretary on standardized formats for this information. CBO estimates that the operations of the Heath Care Quality Board would cost $15 million over the 2000-2004 period, assuming appropriation of the necessary amounts.

Patient Information

Subtitle C would require health plans to provide information about policies governing their operations, as well as the quality-assurance data called for in subtitle B. It also requires health plans to protect the confidentiality of individually identifiable information. Finally, it calls for federal grants to states or nonprofit entities for new health insurance ombudsmen, whose job would be to assist consumers in their interactions with group health plans.

Section 121—Patient Information. The section contains a long list of information that plans would be required to provide to enrollees annually or to make available upon request. Much of the required information is typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although a plan's documents would have to be amended to meet the requirements of this provision, such documents are continually updated in any event. The provision of this information as part of the plan document would not appreciably raise health care costs. Although the requirement that the plan provide information on all participating providers (for example, name, address, telephone number, availability, and credentials) might represent a new operation for many plans, the costs of this requirement should also be modest.[4]

Section 122—Protection of Patient Confidentiality. The provision requiring plans to safeguard enrollee information may impose a small additional cost on those employee health plans that do not have formal policies on data confidentiality, but discussions with health insurance and managed care plan executives indicate that the requirements of this provision are general practice in the insurance business today. Moreover, the Health Insurance Portability and Accountability Act of 1996 requires the Secretary of HHS to promulgate regulations by February 2000, protecting the confidentiality of certain patient information (if the Congress fails to enact legislation by August 1999). Thus, this provision would not have a significant effect on premiums.

Section 123—Health Insurance Ombudsmen. This section would authorize the appropriation of such amounts as are necessary to provide grants to states to establish a health insurance ombudsman program. The ombudsman would be directed to assist consumers in choosing health insurance coverage and to help dissatisfied enrollees with appeals and grievances. If a state did not provide an ombudsman, the Secretary of HHS would provide one. CBO estimates that outlays for these grants would total $55 million during the 2000-2004 period.

Grievance and Appeals Procedures

Subtitle D would require all group health plans and health insurance issuers to establish a system for handling enrollees' grievances, which would include a two-tier process for reviewing appeals of plans' decisions. The first stage would involve appeals to professionals within the plan. Enrollees who were not satisfied with that internal decision could then appeal certain grievances to an external appeals board.

CBO estimates that these provisions, which are highly interrelated, would jointly raise premiums by 0.3 percent. Because plans could require enrollees to exhaust all internal appeals before taking a grievance to the external review board, the number and type of claims that the external review board would consider would depend on the stringency of the internal appeals process. Conversely, having an external appeals process with binding authority over plans would affect both the number of internal appeals and the likelihood that the plan would decide in favor of the beneficiary.

Section 131—Establishment of Grievance Process. The bill would require group health plans and health insurance issuers to establish a system to provide for the presentation and resolution of grievances brought by enrollees or their representatives, including their health care providers, regarding any aspect of the plan's services. Plans would have to provide written notification to enrollees of whom to contact in the event of a grievance or appeal, establish systems to record and document all grievances and appeals and their status, develop a process for timely processing and resolution of grievances and for follow-up actions, and ensure that the continuous quality improvement program would be informed of any grievances relating to the quality of care.

Section 132—Internal Appeals of Adverse Determinations. This section would establish an enrollee's right to appeal a wide range of decisions by their health plan, including denial, reduction, or failure to provide or pay for a benefit; failure to provide emergency coverage, choice of providers, qualified providers, access to specialty care, continuation of care if an enrollee's provider was terminated, access to necessary prescription drugs, or coverage of clinical trials; adverse utilization review decisions; and arbitrary interference with the physician's decision on the manner or setting of care, when the care was medically necessary or appropriate.

The bill would require individuals conducting internal reviews to include clinical peers who had not previously been involved in the decision under appeal. Clinical peers would be physicians or other health professionals with qualifications in the specialty that typically managed the condition or treatment involved in the appeal, but only a physician would be considered the clinical peer of another physician.

Group health plans and health insurance issuers would face limits on the time for resolving an appeal, which would vary according to the urgency of the situation. They would have to resolve expedited appeals within 72 hours of receiving them and all other appeals within 30 working days.

CBO's estimate assumes that although most health plans have functioning internal review systems, they would experience an increase in the rate of internal appeals per enrollee, as a result of greater consumer knowledge of the appeals process and the availability of external review. A recent study by the General Accounting Office suggests that data on internal appeals rates are highly unreliable and vary widely among HMOs.[5] The range of self-reported appeal rates was 0.07 to 69.4 per 1,000 enrollees, with a median of 3.5. Those rates, however, included appeals for the denial of emergency services, which might occur less frequently under the bill because of the "prudent layperson" provisions. CBO's estimate, therefore, assumes a current average appeal rate, excluding appeals relating to emergency services, of 2.5 per thousand enrollees.

Health plans and health insurance issuers with internal appeals processes in place would still incur cost

increases under the bill because of higher rates of appeal and higher costs per appeal. But appeal rates and costs will rise somewhat even without the legislation. Increases will occur under current law if proposed regulations affecting internal claims procedures for ERISA health plans proposed by Department of Labor (DoL) are adopted.(6) The regulations will require ERISA plans to provide enrollees whose claims are denied with information on their appeal rights and will require plans to meet tighter timeframes both for the initial review of claims and for subsequent appeals.

Nonetheless, CBO assumes that the enactment of this bill would raise internal appeals rates among ERISA plans, as well as among the non-ERISA plans that would be required to comply. Because of the provisions for external review of denied appeals and the penalties for health plans that did not comply with the legislation, the bill would provide much stronger incentives for internal appeals than the DoL regulations alone.

Costs per appeal would also rise for ERISA and non-ERISA plans as a result of the legislation. Factors contributing to higher costs include:

- The requirement for review by a clinical peer, which will result in higher professional costs for internal appeals and
- Higher rates of appeals being overturned in favor of enrollees, reflecting plans' desire to avoid external review.

Plans would attempt to reduce the cost of appeals by applying less stringent utilization review standards to appealable decisions, provided that such responses would lower their overall expected costs.

Cost increases would be larger for the small minority of health plans and issuers that do not currently have systems for internal review of grievances in place. They would experience a significant increase in administrative costs as well as the costs associated with overturned decisions resulting from appeals.

Section 133--External Appeals of Adverse Determinations. This section would require all health plans and health insurance issuers to establish a process whereby enrollees could appeal plans' decisions to an external review organization, which would provide a *de novo* determination of the merits of the claim. Decisions in any of the internal appeal categories would be eligible for further appeal if the costs at issue exceeded a significant threshold, or if the patient's life or health would be jeopardized. The plan or issuer could require the appellant to exhaust the internal appeals process first before taking a claim to external review. But enrollees could take a claim directly to external review if the plan failed to comply with the deadlines for internal appeals in the law. The decision of the external review organization would be binding on the plan or issuer but would not affect the enrollee's right to seek judicial remedies in the courts. Decisions would have to be made within 60 days of filing notice of appeal or 72 hours in the case of expedited appeals.

Plans and issuers would have to contract with qualified external appeals entities. States could designate such entities for health insurance issuers and the appropriate Secretary for group health plans. External review organizations would have to meet certification and recertification requirements imposed by the states or the Secretary of Labor. But if a state did not establish an adequate certification and recertification process, the Secretary of Health and Human Services would fulfil that function.

Although about half of the states already require external appeals processes, few claims are appealed. Various factors appear to have contributed to that outcome, including:

- Lack of awareness by enrollees of their external appeal rights because programs are new or not

widely promoted;

- Coverage of certain functions only, such as experimental procedures;
- Uncertainty about whether the state's requirements are preempted by ERISA; and
- Sentinel effects of having an external review program, which causes plans to modify their internal review procedures.

Florida is one of the few states that appears to have a program that is functioning at much more than a minimal level. And even Florida's rate of external appeals, about 1 per 10,000 enrollees, is only about one-tenth of the external appeals rate in the Medicare program.[7] The Medicare rate, however, is higher than would be expected under the bill because every form of denial in Medicare is subject to appeal, and all appeals that plans deny are automatically referred to external review.

For the purposes of this estimate, CBO assumed that the legislation would significantly increase external appeals rates, even in those states that nominally have external review requirements. Moreover, those rates would rise over time as enrollees became more aware of their rights to such reviews. Nonetheless, external review rates would remain relatively low when compared to internal appeals rates (which plans would be more likely to resolve in favor of the enrollee if an external review option was available). Specifically, CBO estimated that external appeals rates would rise to about 4 per 10,000 enrollees after 5 years.

Protecting the Doctor-Patient Relationship

Subtitle E contains four provisions governing plans' contracts with providers.

Section 141—Prohibition of Interference. This section, an anti-gag-rule provision, would void any provision of a contract that limited a provider's freedom to discuss or communicate with a patient about aspects of his or her care. Several studies have shown that few plans impose such restrictions today. For those that do, their costs associated with this provision would be minimal.

Section 142—Prohibition of Improper Incentive Arrangements. This section would prohibit provisions in contracts between health plans and providers that transferred liability for decisions of the plan to the provider or rewarded the provider for decisions regarding specific patients. Although health plans might seek to reduce their own potential liability for medical negligence under the bill by transferring that liability to providers, their costs would not be affected because they would have to pay more to providers to cover the transferred costs of liability. The prohibition of physician incentive plans that financially reward or penalize physicians for decisions involving specific patients would follow guidelines promulgated for Medicare HMOs. Those guidelines require physicians who take substantial financial risks to have stop-loss insurance covering the risk of high-cost patients. The section would have a small impact on premiums overall.

Section 143—Participation of Health Care Professionals and Section 144--Protection for Patient Advocacy. These sections would establish protections for providers that generally do not exist in health plans today. Section 143 would specify due process standards for selective contracting between plans and health care professionals. Section 144 would protect providers (and enrollees) from retaliation for participating in the appeals and grievance process or for disclosing information on the quality of care to a plan or regulatory agency. Under title III, physicians and other professionals could appeal adverse contractual decisions by ERISA health plans to the Secretary of Labor on the basis of this provision. Title III also would prohibit retaliation against professionals by institutional health care providers.

Although these protections would be largely procedural (for example, requiring written rules on participation but not dictating the content of those rules), they would require plans to establish regulatory compliance operations for their contractual interactions with providers. Plans would not only need to establish compliance with sections 113, 143, and 144, but they would also have to defend against the threat of appeal through careful documentation of all contract actions. Thus, although these sections fall well short of constituting any-willing-provider provisions, they would entail some administrative costs.

The provisions would fall most heavily on managed care plans with broader networks, such as preferred provider organizations and independent practice associations, which do not typically have exclusive arrangements with physicians and hospitals. CBO estimates that the incremental costs of these provisions would be 0.2 percent of premiums.

Promoting Good Medical Practice

Subtitle F contains a specific benefit mandate and a more general provision prohibiting arbitrary interference with medical practices. The benefit mandate relates to treatment of breast cancer.

Section 151—Promoting Good Medical Practice. This section would prohibit plans from arbitrarily interfering with or arbitrarily altering the manner or setting of care when that care is medically necessary or appropriate. Manner or setting would be defined as the location of treatment and the duration of service but would exclude decisions on the plan's coverage of particular services or treatments. The section defines medically necessary or appropriate care as care that is "consistent with generally accepted principles of professional medical practice." Grievances regarding the plan's conformance with this section could be appealed under subtitle D. Members of ERISA plans could also sue in federal court to seek remedies under this provision.

This section could affect plans in two ways. First, it would increase the expected costs of utilization review and reduce the potential savings from such activities. Second, it could restrict plans' ability to use more indirect methods of influencing utilization, such as financial incentives for education of providers.

The section would establish the right to appeal plans' utilization review decisions about the appropriateness of inpatient, outpatient or home care for procedures or treatments, monitoring of high risk patients, and administration of medications, as well as all decisions about lengths of inpatient stays. Any decisions regarding those categories of care would be subject to the provision's definition of medical necessity.

Because the provision would put the burden on the plan to prove that a given practice was not "consistent with generally accepted principles of professional medical practice" any appeal would require the plan to develop substantial evidence that the physician's decision was unreasonable. This provision would increase the volume of internal and external appeals above and beyond the volume expected from other provisions. Not only would the provision provide additional incentives to appeal decisions by plans, but it would probably also lead to a higher rate of reversal on appeal. Although the external appeals bodies might eventually settle on uniform and easily interpreted standards of medical necessity, the variability of medical practice styles across the country would ensure continuing challenges to decisions by plans over the 10-year estimating period.

One way for plans to avoid appeals under this provision would be to reduce the frequency with which they challenged physicians' decisions. CBO took account of the likelihood that plans would adopt defensive utilization review practices when the costs of such changes to the plan were lower than the expected costs of the internal and external review actions required to defend the UR policies. The burden of this provision would fall more heavily on those health plans with broader networks which rely on utilization review to influence patterns of care. Traditional indemnity plans with utilization review components, preferred

provider organizations, and non-capitated independent practice association-model HMOs would face more appeals than would group- or staff-model health maintenance organizations. CBO estimates that the higher volume of internal and external appeals and the higher probability of decisions unfavorable to plans would raise premiums by 0.8 percent overall.

Section 152--Standards for Breast Cancer Treatment. Section 152 would prohibit health plans from limiting hospital lengths of stay for mastectomies to less than 48 hours and for lymph node dissections for breast cancer to less than 24 hours. The provider would not have to obtain prior authorization for any length of stay for those conditions. CBO estimated that these two provisions would add less than 0.05 percent to health plan premiums.

Changes to the Employee Retirement Income Security Act

Title III of the bill would apply the patient protection standards of title I to group health plans and group health insurance coverage under ERISA. The estimated costs of these standards were discussed above. In addition, title III would impose additional regulatory costs on the Department of Labor and would alter the legal liability of health insurance plans under ERISA.

Enforcement by the Department of Labor. Section 301 would permit any health care professional who has been discriminated against or retaliated against to file a complaint with the Secretary of Labor. The Secretary would be required to investigate these complaints to determine if a violation had occurred. If a violation occurred, the Secretary would issue an order to ensure that the health professional did not suffer any loss of position, pay or benefits from the plan. Costs associated with this enforcement include the expenses associated with tracking and investigating complaints by providers. CBO estimates that these costs would total $190 million over the 2000-2004 period, assuming appropriation of the necessary amounts.

Legal Liability for ERISA Plans. As a result of ERISA, enrollees in employer-sponsored health plans are generally unable to seek legal remedies under state law for damages resulting from the actions or decisions of their health plans. They may seek redress only in federal court under the provisions of ERISA, which limits any damages to the cost of the plan benefits under dispute and, in some cases, attorneys' fees and court costs. In recent years, ERISA case law has evolved, with some federal courts ruling that enrollees can sue their plans in state courts for vicarious liability for the medical negligence of the plan's providers. But disputes over benefits and administration have largely been preempted by ERISA.

The bill would amend ERISA to allow enrollees in employer-sponsored plans (or their estates), under certain circumstances, to sue their health plans under state law for damages resulting from personal injury or wrongful death. Specifically, enrollees could sue a person if personal injury or wrongful death resulted from that person's provision of insurance, administrative, or medical services to or for a group health plan, or arose out of their arrangement for the provision of insurance, administrative, or medical services by others. The bill would protect employers and other plan sponsors from suits as long as the action that led to the suit did not reflect the exercise of discretionary authority by the employer or sponsor. The cost of this provision depends on assumptions for which the supporting data are extremely limited or nonexistent. CBO therefore consulted with many experts nationwide on the likely outcomes of this provision and received a broad range of opinions.

Some experts believe that ending the ERISA preemption for health plan liability would increase costs only slightly. They maintain that the bill would do little more than speed up trends that are already underway in the courts of holding ERISA plans accountable for the medical negligence of their providers and treating adverse outcomes resulting from decisions on medical necessity by health plans as medical negligence. Health plans could limit their liability for decisions on medical necessity by including more explicit

coverage statements in their contracts and by using binding arbitration or other alternative dispute resolution techniques. Moreover, the external review requirements in the bill would limit the number of cases that would be litigated, and the caps on tort liability that exist in more than half of the states would limit the size of awards. These experts also argue that the experience of state and local government health plans and among plans in the individual insurance market, all of which are exempt from ERISA and potentially subject to litigation, suggests that litigation over issues relating to denial of coverage is likely to be small.

Others believe that ending the ERISA preemption would fundamentally change the environment in which private employer-sponsored plans operate and increase their costs considerably, not only as a result of litigation but also because of the defensive utilization review strategies that plans would adopt. They predict that health plans would be sued along with providers for medical malpractice much more frequently when patients were injured, because of the plans' "deep pockets" and because lawyers would not have to deal with potential issues of ERISA preemption and would be attracted by the large damages that juries might award. A big increase in suits over decisions on medical necessity and denial of coverage would probably occur, they contend, with providers as well as beneficiaries seeking damages. Health plans' attempts to limit coverage contractually could be thwarted by arguments that such contractual restrictions were another form of practicing medicine and, hence, subject to suit. Whether state tort liability caps would apply to health plans is uncertain and would probably vary among the states. In addition, the language in the bill protecting employers and sponsors who were not exercising discretionary authority would not protect the fiduciaries of ERISA plans who, by definition under the law, exercise such authority. Proponents of these views also argue that the experience of non-ERISA plans does not throw much light on what would probably happen in the ERISA market because of differences in the covered populations (including the degree of unionization), appeals processes, plan generosity, and choice of plan, as well as states' ability to limit their legal liability. They envision the emergence of an aggressive plaintiffs' bar that would declare open season on health plans.

The bill includes several provisions designed to address some of those concerns:

- Only plan participants and beneficiaries (or their estates) would have standing to file suit;
- The term "personal injury" is defined to mean physical injury, including an injury arising out of the treatment, or failure to treat, a mental illness or disease;
- The limitation on suits against employers and plan sponsors also includes their employees when acting within the scope of their employment; and
- A construction clause establishes that nothing in section 302 should be construed as permitting a cause of action under state law for the failure to provide an item or service that the group health plan did not cover.

Regardless of the extent to which they are subject to suit under current law, all health plans are already, directly or indirectly, incurring significant liability costs. Most of those costs relate to medical negligence, as litigation over coverage questions has been relatively rare (in part, because of the ERISA preemption). Tightly managed plans are at risk for being held vicariously liable for the medical negligence of their providers. To offset that risk, they may purchase liability insurance, establish mandatory arbitration procedures, or increase their oversight and monitoring of providers. Loosely managed and indemnity plans pay liability costs indirectly through the rates that they pay to providers, which include those providers' liability insurance costs. Those types of plans also pay for additional services that result from physicians' defensive practices. CBO estimates that health plans' liability costs average about 2 percent of their premiums (not counting defensive medicine by providers).

Several factors could cause plans' expected liability costs to rise.

- More medical negligence suits would be filed against ERISA plans, and the amount of damages awarded would rise, as plaintiffs would have another party to sue in addition to the provider. Although some of those suits are occurring now, dealing with the issue of ERISA preemption is a disincentive for many medical malpractice lawyers and reduces the number of suits that are filed.

- Expected liability costs associated with decisions on medical necessity and coverage would increase significantly. At present, there are few coverage suits against ERISA plans as a result of the preemption, and the associated liability costs are low. Ending the ERISA preemption would mean not only that more plans would be successfully sued but, more importantly from a cost perspective, every judicial decision awarding damages to a plaintiff for a plan's coverage decision would increase the risk of suit for all other plans with similar coverage policies. Several of the experts whom CBO consulted mentioned the *Fox v. Health Net* suit as an example of that phenomenon.(8) The jury in *Fox* awarded the plaintiff, a breast cancer patient, $89 million for denial of coverage of autologous bone marrow transplantation (ABMT). Although the case was subsequently settled for a much lower amount, expected liability costs rose for all health plans with similar coverage standards for ABMT. Consequently, many plans apparently took action to reduce their risks from such suits, changing their utilization review criteria for ABMT so that the treatment became much more widely utilized. (Plans could have handled the increased risk in a variety of ways, of which loosening their utilization review criteria was just one. Alternatively, they might have increased their liability insurance or changed the coverage standards written into their contracts with enrollees.) Two recent suits (*Johnson v. Humana and Goodrich v. Aetna U.S. Healthcare of California, Inc.*) provide further indications of the potential for juries in state courts to award large punitive damages to enrollees who argue that they have been injured by their plans. Such awards serve as sentinel events that can have far-reaching effects on the behavior of all health plans, not just those that are sued.

- The bill is likely to result in a variety of unforeseen lawsuits against health plans--including suits instigated by providers and suits against plan fiduciaries. Section 302 would raise new issues regarding the extent of the ERISA preemption that could take the courts a long time to address.

- In addition to the increase in direct liability costs that plans would face, plans would also have to consider the indirect costs associated with the adverse publicity that litigation engenders. Adverse publicity could result in loss of market share, adding to plans' expected liability costs.

Taking all of those factors into account, CBO estimates that ending the ERISA preemption of legal liability for private employer-sponsored plans would increase liability costs by 70 to 90 percent, in the case of PPOs, POS plans, and HMOs, and by a lesser percentage in the case of indemnity plans. Those increases represent, on average, about 1.4 percent of the premiums of all employer-sponsored plans. Those estimates take into account all of the actions that plans take to lessen their liability costs, including the purchase of liability insurance and changes in utilization review criteria and coverage standards intended to reduce the probability of lawsuits.

Under CBO's assumptions, more than half of the increase would arise from potential suits associated with decisions on medical necessity and coverage (and the associated behavioral responses by plans), as well as lawsuits involving providers and plan fiduciaries. Most of the remainder would result from more medical negligence suits against plans, reflecting the financial resources of health plans and the effects of the new legal environment. The estimate also assumes that a further loosening of review criteria and standards of medical necessity (with a corresponding increase in costs) would result from the desire of plans to avoid the adverse publicity of litigation.

Questions have been raised about the impact of the health plan liability provisions on small self-insured firms. Advocates for small businesses argue that liability insurance is not currently available for such firms, and they would be unlikely to remain self-insured without liability coverage if the ERISA preemption was lifted. Purchasing a fully-insured plan from an insurer or an HMO, which the firms might feel compelled to do, would increase their insurance costs because they would have to pay for benefits mandated by the state as well as state premium taxes. In addition, they could face a one-time cash flow problem because they would have to start making premium payments to an insurer while they were still paying off the tail of claims from their own plan.

Although temporary dislocations might occur when these provisions first came into effect, insurance markets would almost certainly respond to the demand for liability coverage for health plans. Third-party administrators that service small self-insured plans, and insurers that offer risk-sharing arrangements to such plans, would have a strong incentive to develop the means for self-insured plans to obtain liability coverage. In order for liability insurers to be willing to provide such coverage at a reasonable premium, however, the plans might have to accept more oversight and standardization of their coverage policies, which could increase their costs. In addition, obtaining liability coverage for punitive (as opposed to compensatory) damages might be a problem in the 15 or so states in which the courts have ruled that punitive damages are not insurable. But punitive damage awards are capped in at least some of those states, which would limit the risk for a firm without coverage for punitive damages.

The transition period until liability coverage was more generally available could be difficult for some self-insured firms, with some of them opting to purchase fully insured products rather than face an uncertain risk of liability. To the extent that response occurred, average premium costs would be higher than they otherwise would be, but the effects would diminish over time as markets for liability insurance developed. Offsetting any subsequent decline in premiums, however, would be rising costs resulting from the growth in liability suits as more consumers (and their lawyers) became aware of their rights to sue health plans.

Two other factors would have offsetting effects on the costs of ending the ERISA preemption for health plan liability. On the one hand, some experts believe that the courts will continue on their current path of limiting the extent of the ERISA preemption, not only for medical negligence but also for decisions on medical necessity and coverage. Insofar as that occurred, then the additional costs resulting from this legislation would be lower, although there is considerable doubt about how long it would take to establish this expanded body of ERISA case law. On the other hand, ending the preemption could have long-term consequences for the development and adoption of costly new technologies. Research suggests that the spread of managed care may have slowed the rate of adoption of new medical technologies, helping to contain the rate of growth of health spending.[9] Because the bill would allow enrollees to sue plans for their decisions on medical necessity and coverage, the dissemination of new technologies would speed up, encouraging further technological development and raising costs.

Other Federal Administrative Costs

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the Secretary of HHS to enforce provisions of HIPAA that apply to group or individual health insurance if she determines they not being enforced by a state. The Secretary currently enforces provisions of HIPAA in four states.

The Secretary would also be required to enforce the provisions of this bill, as they apply to group and individual health insurance, if she determines they are not being enforced by a state. CBO assumes that enactment of those provisions would increase to five the number of states subject to Federal enforcement. Over ten years, however, the number of states subject to Federal enforcement would decline to one. The

estimate assumes that the average cost per state of enforcing S.6 would be the same as the average cost of enforcing HIPAA. Assuming appropriation of the necessary amounts, federal discretionary spending would increase by $5 million in 2000, and by $55 million in 2000-2004.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the Table 3. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted. As noted earlier, this bill could reduce some of the savings associated with the spillover effect of managed care. Due to uncertainty about the existence or magnitude of the change, CBO has not included an estimate of Medicare costs.

TABLE 3.
ESTIMATED PAY-AS-YOU-GO EFFECTS OF THE PATIENTS' BILL OF RIGHTS ACT

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in Revenues	-270	-680	-1,070	-1,320	-1,530	-1,660	-1,750	-1,850	-1,950	-2,060
Change in Outlays	5	10	20	25	35	40	45	45	50	55

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The PHSA allows state, local, and tribal governments to elect not to have certain federal requirements apply to their own group health plans. The requirements for state, local, and tribal governments in this bill would also be optional under the provisions of the act. Consequently, the bill does not contain intergovernmental mandates as defined in UMRA. The bill would affect the budgets of state, local, or tribal governments only if they chose to comply with the requirements on group health plans. If they chose to apply the bill's requirements to their own health plans, the budgetary impact on state, local and tribal governments could be significant. Because the bill imposes a number of new requirements on insurance issuers, state and local governments also may face increased costs if they offer fully insured products as part of their employee benefits plans. The bill would provide grants to states to establish a health insurance ombudsman, but in the absence of state activity, the federal government would assume responsibility for the office.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains several private-sector mandates as defined in the Unfunded Mandates Reform Act. CBO

estimates that the direct cost of those requirements to private sector entities would significantly exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) in every year following enactment (see Table 4).

TABLE 4.
ESTIMATED DIRECT COST OF THE PRIVATE-SECTOR MANDATES IN THE PATIENTS' BILL OF RIGHTS ACT

	By Fiscal Year, in Millions of Dollars				
	2000	2001	2002	2003	2004
Provisions in Title I[a]	2,900	6,200	8,700	10,700	12,900

SOURCE: Congressional Budget Office.

a. Includes the items listed in Table 2, with the exception of sections 116, 123, and 302.

Most of the provisions of title I would impose requirements on both group and employer-sponsored health plans and on health insurance issuers. The mandatory point-of-service requirement in section 102 would affect only group and employer-sponsored plans, however, and the continuity of care requirement in section 105 would have almost all of its effect on that market as well. The provisions establishing the Health Care Quality Advisory Board (section 116) and the Health Insurance Ombudsman (section 123) would not impose mandates on private sector entities. CBO estimates that the total direct costs of the mandates in title I would be about $3 billion in 2000 and would reach about $13 billion in 2004. The costs in 2004 would represent about 3.4 percent of total private-sector health insurance expenditures, although their distribution among health insurance plans would be uneven.

Section 302 would amend ERISA to allow enrollees in employer-sponsored plans to sue their health plans under state law for damages resulting from personal injury or wrongful death. That provision would not constitute a mandate on private health plans. Rather, it would convey a new right that members of ERISA plans could exercise at their discretion.

COMPARISON WITH PREVIOUS ESTIMATES

On April 23, 1999, CBO provided an estimate of S. 6, as introduced. This estimate reflects two modifications offered by the sponsors.

The first modification deletes subparagraph 132(c)(2)(C) of the introduced bill, which required appeals to be expedited at the request of a physician. This change reduces the estimated increase in premiums for employer-sponsored health insurance by about 0.3 percentage points.

The second modification adds a new section 502(n) of ERISA, which would limit the ability of participants in health plans to bring legal actions to enforce certain provisions of S. 6 under subsections 502(a)(1)(B), 502(a)(2), and 502(a)(3) of ERISA. Under the bill as modified, participants could not initiate class actions or sue to obtain plan-wide injunctive relief under these provisions of ERISA. Legal relief would be limited to the provision of or payment for benefits or services denied to the individual participant. The limitation

would not apply to complaints of discrimination in the delivery of services under section 109 of S. 6. This change reduces the estimated increase in premiums for employer-sponsored health insurance by 1.0 percentage point.

ESTIMATE PREPARED BY:

Federal Cost Estimate: Linda Bilheimer, Tom Bradley, Cyndi Dudzinski, and Judith Wagner
Impact on State, Local and Tribal Governments: Leo Lex
Impact on the Private Sector: Judith Wagner

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis

---

1. Most of the provisions of the bill were extended to the Federal Employees Health Benefits Program under a Presidential memorandum of February 20, 1998. On April 9, 1999, the President announced that two additional provisions would be included. This estimate includes the costs of the provisions of the bill that cannot be implemented administratively.

2. Health Policy Economics Group, Price Waterhouse, LLP, "The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals from California" (November 1997).

3. Robert E. Mechanic and Allen Dobson, "The Impact of Managed Care on Clinical Research: A Preliminary Investigation," *Health Affairs*, Fall 1996, vol. 15, no. 3, pp. 72-89.

4. U.S. General Accounting Office, *Consumer Health Care Information: Many Quality Commission Disclosure Recommendations are Not Current Practice*, April 1998 (GAO/HEHS-98-137).

5. U.S. General Accounting Office, *HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent*, GAO/HEHS-98-119 (May 1998).

6. Federal Register, Wednesday, September 6, 1998, Department of Labor, Employee Retirement Income Security Act of 1994; Rules and Regulations for Administration and Enforcement; Claims Procedure; Proposed Rule.

7. Allen Dobson and others, "Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals" (report submitted by The Lewin Group, Inc., to the Presidential Commission on Consumer Protection and Quality in the Health Care Industry, November 1997).

8. *Fox v. Health Net*, Riverside Superior Court, March 26, 1994.

9. David M. Cutler and Louise Sheiner, *Managed Care and the Growth of Medical Expenditures*, (NBER Working Paper No. 6140, Cambridge, MA: National Bureau of Economic Research, August 1997).

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8. *Fox v. Health Net*, Riverside Superior Court, March 26, 1994.

9. David M. Cutler and Louise Sheiner, *Managed Care and the Growth of Medical Expenditures*, (NBER Working Paper No. 6140, Cambridge, MA: National Bureau of Economic Research, August 1997).

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CBO TESTIMONY

Statement of
Dan L. Crippen
Director
Congressional Budget Office

on
Health Care Costs and Insurance Coverage

before the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives

June 11, 1999

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the relationship between health care costs and insurance coverage. Despite several factors that might boost health insurance coverage--such as the booming economy, expansions in Medicaid eligibility, state insurance reforms, federal legislation to improve the portability of health insurance, and several years of slow growth in health insurance premiums--the percentage of Americans who lack health insurance has grown. The number of people without insurance is likely to continue to increase, although that growth will be moderated by federal and state initiatives to expand coverage (such as the State Children's Health Insurance Program). Health insurance premiums will grow more rapidly than in the recent past, and more low-income families will move off the welfare rolls and Medicaid into entry-level jobs that do not offer coverage. Policies that further increase health care costs and premiums could result in larger reductions in insurance coverage than might otherwise occur.

My testimony today will outline what we know about the characteristics of the uninsured population and describe recent trends in health care costs and insurance coverage. Most of my remarks will focus on how policies that mandate benefits or impose other standards on health plans may contribute to higher premiums and lower coverage rates.

CHARACTERISTICS OF THE UNINSURED POPULATION

According to the Current Population Survey (CPS), about 43 million people under age 65 lacked insurance coverage in 1997.[1] That estimate represented 18.3 percent of the nonelderly population and compares with 14.8 percent who lacked coverage a decade earlier. Most uninsured people were in working families, and one-quarter of them were children. More than half of them were in families with income below 200 percent of the poverty level.

Low-wage workers and those in small firms are much more likely to lack coverage than other workers. Most low-wage workers with access to employer-sponsored coverage--either through their own employer or that of a family member--enroll in employer-sponsored plans. But they are much less likely than other workers to have access to employer-sponsored coverage from any source. In 1996, for example, 55 percent of workers earning up to $7.00 an hour had access to employer-sponsored coverage from any source

compared with 96 percent of workers earning more than $15.00 an hour. Similarly, 63 percent of workers in firms with fewer than 10 employees had access to such coverage compared with 93 percent of workers in firms with more than 100 employees.(2)

The percentage of the population that is uninsured varies widely among the states, ranging from less than 15 percent in most midwestern and New England states to more than 20 percent in California and some of the southwestern states. That variation reflects differences in population characteristics, such as per capita income and the proportion of recent immigrants, and in labor force characteristics, such as the distribution of workers among different industries and the extent of unionization. States also differ in their policies regarding Medicaid eligibility, rules relating to the accessibility and affordability of coverage in the small-group market, and the extent to which they impose benefit mandates and other requirements on health insurance.

TRENDS IN HEALTH CARE COSTS AND INSURANCE COVERAGE

Competition among health plans, and the associated shift from indemnity to managed care plans, contributed to a dramatic slowdown in the growth of health insurance premiums in the 1990s. On average, the annual rate of increase in premiums fell from double-digit levels in the late 1980s and early 1990s to 2 percent or less in 1995 through 1997. Over the past year, however, premiums have begun to grow more rapidly again as health plans that had held down premiums to capture a larger market share seek to improve their profit margins. Some analysts and health plans are predicting increases in the range of 6 percent to 10 percent in both 1999 and 2000. Others are predicting even larger hikes.

Rates of insurance coverage for both adults and children declined over the 1987-1997 period, and that decline appears to be continuing. Data from the CPS indicate that coverage of nonelderly adults fell fairly steadily until 1992 and then remained relatively stable before declining again in 1997. The percentage of nonelderly adults who were uninsured rose from 15.6 percent to 19.7 percent during the period. Coverage of children increased slightly from 1987 to 1992 and then started to fall. In 1997, 15 percent of children were uninsured.

Analysis based on the CPS suggests that the reductions in coverage rates that occurred between 1987 and 1992--a period in which premiums were growing rapidly--were attributable primarily to lower rates of employer-sponsored insurance.(3) One cannot, however, infer causality solely on the basis of that apparent association. Subsequent declines appeared to be attributable mainly to falling rates of Medicaid coverage, with the proportion of the population with employer-sponsored insurance remaining relatively steady through 1997.

Another recent study, which was based on data from other surveys taken in 1987 and 1996, found that the proportion of workers with employment-based coverage from any source fell from 76.2 percent to 73.2 percent over that period.(4) The study suggested that the decline generally resulted from lower rates of participation in employer-sponsored plans rather than reductions in the rate at which employers offer coverage. For low-wage and young (under age 25) workers, however, the proportion with access to employer-sponsored coverage (through their own job or that of another worker in the family) fell, as did their participation rates.

IMPACT OF INCREASING PREMIUMS ON COVERAGE

Health care costs are rising for many reasons including changes in medical practice, the development of costly new technologies, and greater use of prescription drugs and other services. A 1998 article in the *Wall Street Journal*, for example, described some of the new high-cost technologies that had recently come onto the market.[5] They included new brain surgery techniques for treating Parkinson's disease, three different $10,000-a-year drugs for treating multiple sclerosis, and improved inhalers for asthma patients that cost three times as much as other inhalers. Technological breakthroughs are also resulting in a wide range of powerful new drugs including antidepressants, medications for acquired immunodeficiency syndrome (AIDS), and drugs for reducing cholesterol levels. Demand for such drugs is being driven in part by direct-to-consumer advertising, and many health plans are reporting that their drug costs are soaring. Those rising costs are redistributed in the health care system in various ways including changes in covered health insurance benefits, higher premiums for health insurance, and reductions in coverage.

Government regulation at both the state and federal levels can also increase the costs of health insurance and lead to higher premiums. Examples of such regulations include:

- Mandates to cover specific benefits such as chiropractic services or minimum hospital stays for births;
- Regulations to change the way in which health plans operate--for example, requiring appeals procedures when benefits are denied or reducing insurers' ability to reject applicants with preexisting conditions; and
- Taxes on health insurance premiums.

States also regulate the premiums that insurers charge for health policies, often by requiring premiums charged to small firms to fall within specified limits. Such regulation is frequently thought to keep premiums affordable for employees in those firms. Higher-risk groups have lower insurance costs because of the upper premium limit. But the lower premium limit is generally higher than insurers would charge to the good risks--people who are healthier and less likely to use health services. Consequently, the good risks tend to drop their coverage, which raises the average cost of insurance for those who remain in the small-group market.

The Congressional Budget Office (CBO) assesses the likely private-sector costs of proposed federal mandates on health insurers and health plans as part of its duties under the Unfunded Mandates Reform Act of 1995 (UMRA). The act requires CBO to estimate the aggregate amount that private-sector entities would have to spend to comply with the mandates, assuming that such entities take all reasonable steps to mitigate those costs. CBO's analysis is limited to the costs of the proposed legislation and does not consider its benefits. In recent years, CBO has analyzed proposals to require parity in the provision of mental health services, to ensure access and portability of insurance coverage, and, more recently, to expand patients' rights.

CBO's analysis of a proposed health insurance mandate takes into account how employers who offer health coverage would react to the additional costs imposed by the mandate. Employers might respond to such costs by reducing the generosity of insurance coverage, perhaps by raising cost-sharing requirements imposed on beneficiaries or by eliminating some benefits. Some employers might drop health coverage altogether. They might also reduce the generosity of other employee benefits or the size of wage increases. Such actions limit the rise in labor costs that would otherwise occur because of an insurance mandate.

Employees and others buying insurance in the individual market would also respond to rising health insurance costs. Some would drop their coverage as premiums increased, while others would select less

generous coverage if that option was available. Even beneficiaries who retained their health coverage without change after enactment of an insurance mandate would be affected, since their costs would increase.

In general, higher premiums are likely to result in some loss of coverage, although the magnitude of the reduction is difficult to predict. One should be cautious, however, about applying a single rule of thumb to assess the effects on coverage of changes in premiums that arise from different sources. Any mandate on health insurance that raises premiums, for example, could cause some decline in coverage--just as an increase in the price of any product could cause demand for that product to fall. But the specific nature of any insurance mandate will affect its impact on coverage. Consequently, potential declines in coverage can be estimated only by analyzing specific legislative proposals individually.

In particular, the loss of coverage that is likely to result from imposing an insurance mandate depends on a number of factors including the following (to simplify the discussion, consider a mandate to add a new benefit):

- A mandated benefit that is highly valued by consumers would cause fewer people to lose insurance coverage than a benefit of lower value having the same cost.
- A mandated benefit that is already offered by many health plans on a voluntary basis would cause fewer people to lose coverage than a benefit that is not commonly offered.
- Some states may already require the mandated benefit, which would lower the impact of the mandate for the nation as a whole. (Employer plans that are fully insured must comply with states' benefit mandates, but those that are self-insured are exempt from those mandates under the Employee Retirement and Income Security Act of 1974, or ERISA.
- A mandate that primarily affects insurance offered by large firms would be expected to lead to a smaller decline in coverage than one that primarily affects small firms. Small firms and their workers are more sensitive to premium increases and are more likely to drop coverage because of a mandate.

CONCLUSION

The number of people without health insurance continues to grow despite the booming economy, expansions in Medicaid eligibility, and other efforts to increase insurance coverage. Rising health care costs have made insurance less affordable for many Americans. Proposals that would impose new mandates on health plans and insurers are meant to improve the value of insurance to consumers, but they could also raise insurance costs and exacerbate the problem of growing numbers of the uninsured. Other proposals are intended to increase health insurance coverage by creating a less regulated environment in the small-group market through such vehicles as association health plans and health marts. Although those proposals could encourage the entry of some lower-cost health plans into the health insurance market, they might also decrease coverage among high-risk groups. Balancing the advantages and disadvantages of competing policies is a significant challenge facing the Congress in the months ahead.

---

1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," *EBRI Issue Brief*, no. 204 (Washington, D.C.: Employee Benefits Research Institute, December 1998).

2. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987

and 1996," *Health Affairs*, vol. 16, no. 6 (November/ December 1997), pp. 142-148.

3. Fronstin, "Sources of Health Insurance."

4. Cooper and Schone, "More Offers, Fewer Takers." This study uses data from the National Medical Expenditure Survey, 1987, and the Medical Expenditure Panel Survey, 1996.

5. Ron Winslow, " Health Care Inflation Revives in Minneapolis Despite Cost-Cutting," *Wall Street Journal*, May 19, 1998.

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Representative Norman Rokeberg

LETTERS OF SUPPORT
March 20, 2000

Attached is a list of letters of support received by Rep. Norman Rokeberg concerning HB 211.

LastName	FirstName	Organization
		Alaska Physicians and Surgeons
		Alaska State Medical Association
Alexander, MD	David G.	David G. Alexander, MD
Anschuetz, MD, FACC	Richard A.	Alaska Heart Institute
Arita, MD	Adam A.	Adam A. Artia, MD
Armstrong, MD, FACR	Michael B.	Michael B. Armstrong, MD
Baker, MD	Beth	Internal Medicine Associates
Baldauf, MD, FACC	James A.	Alaska Heart Institute
Barnett, MD	Mark R.	
Beacham, MD	Sherman	Sherman Beacham, MD
Bell, MD	Owen R.	Owen R. Bell, MD, Wendy Thon, ANP, RN-C, Martha Linden, CNM, MSN, PC
Bergeson, M.D.	Marvin E.	Tanana Valley Clinic
Bruce	Doug	Provide Alaska Medical Center
Buchanan, MD	Richard	Internal Medicine Associates
(cannot read signature)	Robert	Opthalmic Associates
Cates, MD	J C	J C Cates, MD
Cates, MD	Vern	Vern A Cates, MD
Chen, MD	Barbara M.	Barbara M. Chen
Child, DO	Gary	Medical Park Family Care, Inc.
Coalwell, MD	Timothy	Medical Park Family Care, Inc.
DeKeyser, MD	John	John B. Dekeyser, MD, PC
DeMers, DO, MPH	Mary P.	Mary P. DeMers, DO, MPH
Endres, MD	Donald R.	Geneva Woods Ear, Nose &
Farah, MD	Richard F.	
Farleigh, M.D.	Richard M.	Richard M. Farleigh, MD, PC
Ferris, MD	Glenn A.	Alaska Spine Institute

LastName	FirstName	Organization
Fortson, MD	Jayne	Jayne Fortson, MD
Gerboth, MD	Gregory	Internal Medicine Associates
Gordon, M.D.	Thomas	Alaska Neurological Consultants, LLC
Gordon, M.D.	Thomas	Alaska Neurological Consultants, LLC
Gower, MD	Roland E.	Roland E. Gower, MD
Hadley, MD	Shawn	Alaska Rehabilitation Medicine, Inc.
Hayams, D.O., FACOS	Stephen	Stephan P. Hayms, D.O., LLC
Hummer, MD	Milton T.	Milton T. Hummer, MD
Janis, MD	Burton	Burton Janis, MD
Jayich, Ph.D., MD	Steven	Pathology Associates
Jones, MD	F. Leland	Medical Park Family Care, Inc.
Koval, MD	Janice	Internal Medicine Associates
Krauss, MD	Seth L.	Alaska Heart Institute, LLC
Ladyman, MD	George H.	Health South
LastName	FirstName	Organization
Lawrason, MD	Peter	Fairbanks Clinic
LePique, MD, FACOG	Marcelyn	Marcelyn LePique, M.D.
Lipke, MD,	Robert W.	Robert W. Lipke, MD, APC
Makin, MD	Harbir	Harbir S. Makin, MD
Manuel, MD	Michael D.	Michael F. Manuel, MD
Mason, DO	Bret L.	Orthopaedic Trauma Care
Mayer, MD, FACC, FACP	William P.	American College of Cardiology
McCormic, MD	John J.	Health South
McCray, MD	William	Internal Medicine Associates
McGuire, MD	David A.	David A. McGuire, MD
Mues, MD	John C.	John C. Mues, MD, FACP

LastName	FirstName	Organization
Neubauer, MD, FACP	Richard	Richard L. Neubauer, MD, FACP
Nolan. DO	Patrick M.	Patrick M. Nolan, DO, Inc.
Norman, MD	Michael C.	Michael C. Norman, MD
Nyboer, MD		Dr. Nyboer and Associates
Peach, MD	David	Internal Medicine Associates
Peters, MD	Richard	Richard A. Peters, MD
Richey, MD	Mark E.	Mark E. Richey, MD, PC
Roberts, PA-C	John R.	Orthopaedic Trauma Care
Sahagun, MD	Geronimo	Internal Medicine Associates
Schultes, MD	Glenn	Medical Park Family Care, Inc.
Schultz, DO	John	John Schultz, DO
Senter, MD	Thomas P.	Thomas P. Senter, MD
Smith, MD	Jack Arlyn	Jack Arlyn Smith, MD
Steiner, MD	Griff C.	Griffith C. Steiner, MD
Tamai, MD	Jim	Tanana Valley Clinic
Taylor, MD	R. Randy	Medical Park Family Care, Inc.
Weale, PT	Mary	Alaska Physicial Therapy Association, Inc.
White. MD	R. Matison	Medical Park Family Care, Inc.
Wilder, MD	Norman J.	Norman J. Wilder, MD
Williams, MD	J. David	Geneva Woods Ear, Nose & Throat Associates, Inc.
Worrell, MD	Paul	Paul M. Worrell, MD

Nation & World : Sunday, March 12, 2000

So far, Texans happy with patient-rights law

by Jim Brunner
Seattle Times Olympia bureau

FORT WORTH, Texas - This week, Gov. Gary Locke is expected to sign a Patient Bill of Rights that will make Washington the fourth state to give its citizens the right to sue health plans for denying medical care.

In passing the legislation, Washington lawmakers from both parties largely ignored the warnings of the health-insurance and **managed-care** lobby, which predicted the law would encourage a flood of lawsuits, cause a big leap in health-care costs and price thousands out of health-insurance coverage.

Here in Texas, which in 1997 became the first state to give people the right to sue their health plans, the criticisms sound familiar. The insurance lobby fought tooth and nail against that law, using arguments identical to those now being leveled against the Patient Bill of Rights in Olympia.

But in the Lone Star State, those doomsday predictions haven't come to pass.

"They were saying it was going to be awful, that the apocalypse was going to visit us all," said George Parker Young, a Fort Worth attorney who took on the **managed-care** industry in several lawsuits before the new law. "It hasn't happened."

Only a few lawsuits - estimates are between five and 10 - have been filed in three years under the Texas reforms. The insurance industry acknowledges that the law has so far not driven up health-care costs.

And doctors, patients and lawyers in Texas say the statute,

while not perfect, has given them more leverage to demand treatment from their health plans.

Some early doubters have come around, most notably Texas Gov. George W. Bush - who allowed the measure to become law without signing it because of concerns about its impact on health-care costs. On the presidential campaign trail, Bush now touts the measure as evidence of his record as a "reformer with results" and says he would favor similar legislation on the national level.

But critics of the Texas law warn that its true impacts are yet to be felt.

"Those who draw a conclusion that the flood of lawsuits didn't happen are premature," said Jerry Patterson, executive director of the Texas Association of Health Plans.

The Texas law is being challenged in a federal appeals court, which will decide whether the law is superseded by federal law that prohibits such lawsuits. If the Texas law is upheld, Patterson predicted that there could be many more lawsuits. He said attorneys have been holding seminars around the state to teach lawyers how to sue HMOs successfully.

Costs will rise, agencies warn

In Washington, some state agencies issued warnings about the potential costs of the state's Patient Bill of Rights as it sailed to Locke's desk with broad bipartisan support. Early estimates are that the measure could add $34 million to health-insurance costs for state employees - a daunting price tag in the post-Initiative-695 era of shrinking tax revenues.

Some analysts say that medical costs could balloon, either because of multimillion-dollar lawsuit awards against health plans, or if the plans feel pressured to approve unnecessary medical treatments as a precaution against lawsuits.

According to industry studies, every 1 percent increase in health-care costs means 8,400 Washington residents lose coverage, either because they or their employers can't afford it, said Karen Merrikin. The director of health policy development for Group Health Cooperative of Puget Sound, she testified before state lawmakers in January. Merrikin said the industry predicts that Washington's Patient Bill of Rights could boost insurance costs by 2 to 8 percent.

But in Olympia and across the nation, worries about costs are being trumped by high-profile stories of how managed-care plans have interfered with the doctor-patient relationship.

When health-care costs skyrocketed in the 1980s, many employers turned to **managed care** to control costs. HMOs and other forms of **managed care** encouraged prudence and careful oversight by refusing to pay doctors for performing what the plans considered unnecessary tests or procedures.

But those strategies produced horror stories about patients who claimed they were denied coverage for lifesaving treatments. **Managed-care** reform has become a huge national issue, with Congress now negotiating over a national patient bill of rights and presidential front-runners Bush and Vice President Al Gore both pledging their support.

The role of independent review

Under Texas' new patient bill of rights law, the lawsuits filed so far allege that penny pinching by **managed-care** outfits has interfered with sound medical judgments, with disastrous results.

In one case, a 66-year-old woman with a cancerous tumor in her jaw claims she was unable to get a referral from her doctor - the doctor she also worked for - to begin chemotherapy with an oncologist. The doctor was allegedly reluctant to refer patients to specialists because of an HMO plan, later ruled illegal, that put more money in the pockets of physicians who were stingy with referrals.

She eventually got the chemotherapy. But the woman, who is terminally ill, claims the delay blocked her chance at recovery.

In another case, a 68-year-old man with a history of depression killed himself just one day after being discharged from a hospital where he had been admitted after an earlier suicide attempt. His family sued, claiming the hospital prematurely discharged him because of HMO regulations discouraging long hospital stays.

In both of those cases, the lawsuits come too late to save the patients involved. That's why insurers, lawyers and doctors agree the most important part of the Texas law is that it gives people the right to an independent review of HMO decisions.

"That's been the ticket, that's been the most important part," said Dr. Paul Handel, a Houston urologist.

The reviews, similar to those which would be allowed by Washington's Patient Bill of Rights, are conducted by three independent review organizations certified by the Texas Department of Insurance. Doctors review cases where insurers

deny coverage as medically unnecessary.

The results of the reviews have been almost evenly split.

As of January, 791 complaints had been fielded by the independent review organizations. In 365 cases, the insurers' refusal to authorize a treatment was upheld. In 374 cases, their decisions were overturned. In 52 cases, their decisions were partially overturned.

For Jackie Burros, a Fort Worth woman fighting breast cancer, an independent review allowed her to win treatment for lymphedema - a painful swelling of the limbs caused by the removal of her lymph nodes during treatment for the cancer.

Burros is a serene woman who maintains a cheerful outlook despite a five-year battle with breast cancer and two mastectomies. A sign in her bathroom says, "Good morning, this is God. I will be handling all your problems today."

But that optimism didn't come so easily last year. After an exhausting regimen of chemotherapy, Burros said her HMO refused to authorize the lymphedema treatment her doctor insisted was necessary.

Burros' condition is treatable with specialized massage and tight-fitting fabric sleeves that keep the lymph fluid from building up in her arms. Her insurer, Harris Methodist, had approved the treatment in 1995 following Burros' initial diagnosis. But Harris denied the treatment last year when Burros and her doctor sought it again.

In February, the independent review organization ruled that Burros' lymphedema treatment was medically necessary, overturning Harris' denial.

"Thank God," said Burros.

Threat of lawsuit is powerful

Sometimes just the threat of an independent review or a lawsuit is enough to persuade reluctant HMOs to authorize medical care.

Cynthia Vance, a Fort Worth mother of three, fought successfully to get her HMO to pay for nursing care for her 19-month-old son, Jordan, who was born nearly four months premature.

Jordan suffers from underdeveloped lungs and a windpipe so narrow he would suffocate if not for the tube in his neck. He is

fed through another tube attached to his belly.

All of these conditions are normal for premature babies, says Dr. John Pfaff, a pediatric pulmonologist who treated the boy. With proper **care**, Jordan will probably grow up to be a healthy, normal child, Pfaff said.

In fact, he could have been sent home from the hospital several weeks earlier if his insurer had not resisted paying for in-home nursing **care**. Without that **care**, Pfaff said, he refused to let Jordan be discharged, even though the insurer was threatening to stop paying for his **care**.

"There's no doubt in my mind the child's life would have been imperiled," Pfaff said.

After months of wrangling and a call to Young, the Fort Worth attorney, Vance got the HMO to pay. Vance is convinced the law gave her the leverage she needed.

Handel, the Houston urologist, said the law hasn't erased all his concerns about **managed care** but it has provided more tools to people like Vance.

"There have been fewer problems. That is a sense across the state," Handel said. "To my thinking there really has not been a downside."

Jim Brunner: 360-236-8266.

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Office of the Governor

Date: March 15, 2000
FOR IMMEDIATE RELEASE
Contact: Governor's Communications Office, 360-902-4136

Locke signs 'Patient's Bill of Rights' legislation

TACOMA - Gov. Gary Locke today took a giant step in helping people get the care they need from managed health care providers.

Locke signed into law what has been called a "patient's bill of rights" that strikes a balance between providing quality health care and containing rising health-care costs. The legislation will make sure consumers can get information to make informed decisions when they purchase health care and hold accountable their health care plans.

"It's just unacceptable that medical treatment can be delayed because HMOs and insurance companies question a doctor's diagnosis," Locke said. "People need to be able to make decisions about their health care with their doctors, not insurance companies, accountants or auditors."

Sen. Lorraine Wojahn, prime sponsor of the bill, echoed the governor's comments.

"I am calling the patient's bill of rights a 'people bill,'" she said. "A life can sometimes hang in the balance while an insurance company decides whether or not to pay. Without the protection of this bill, people could be forced to suffer needlessly or, yes, even die."

The legislation provides several basic rights:

- A fast and impartial grievance process to resolve health care disputes.
- A timely external and independent medical review of health care disputes.
- The right to sue managed care plans if patients believe their managed care system has harmed them through negligence.
- The right to get access to information about health care plans.
- Protection from unnecessary invasions of health care privacy.
- A health plan medical doctor who is a licensed doctor.

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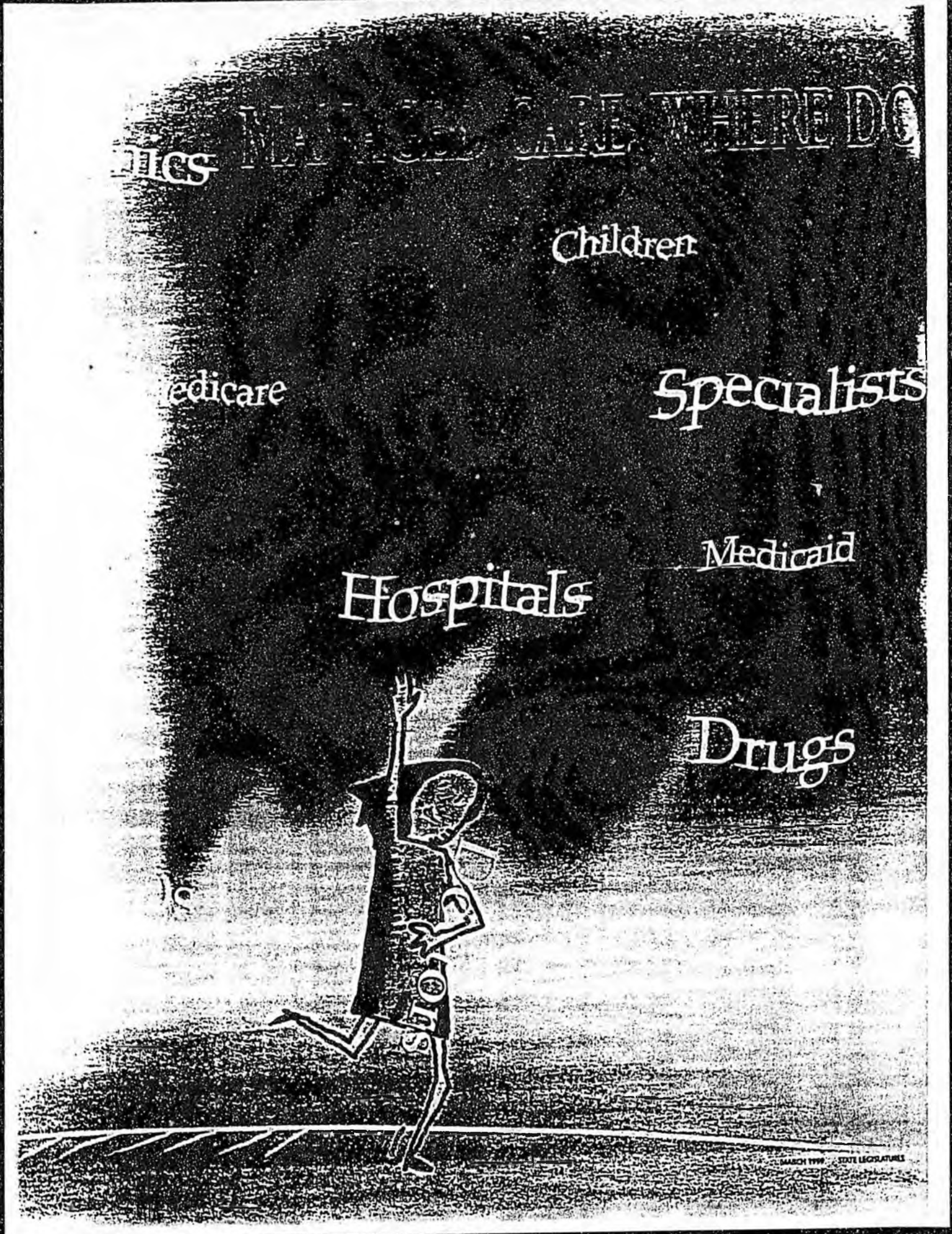
MANAGED CARE: WHERE DO
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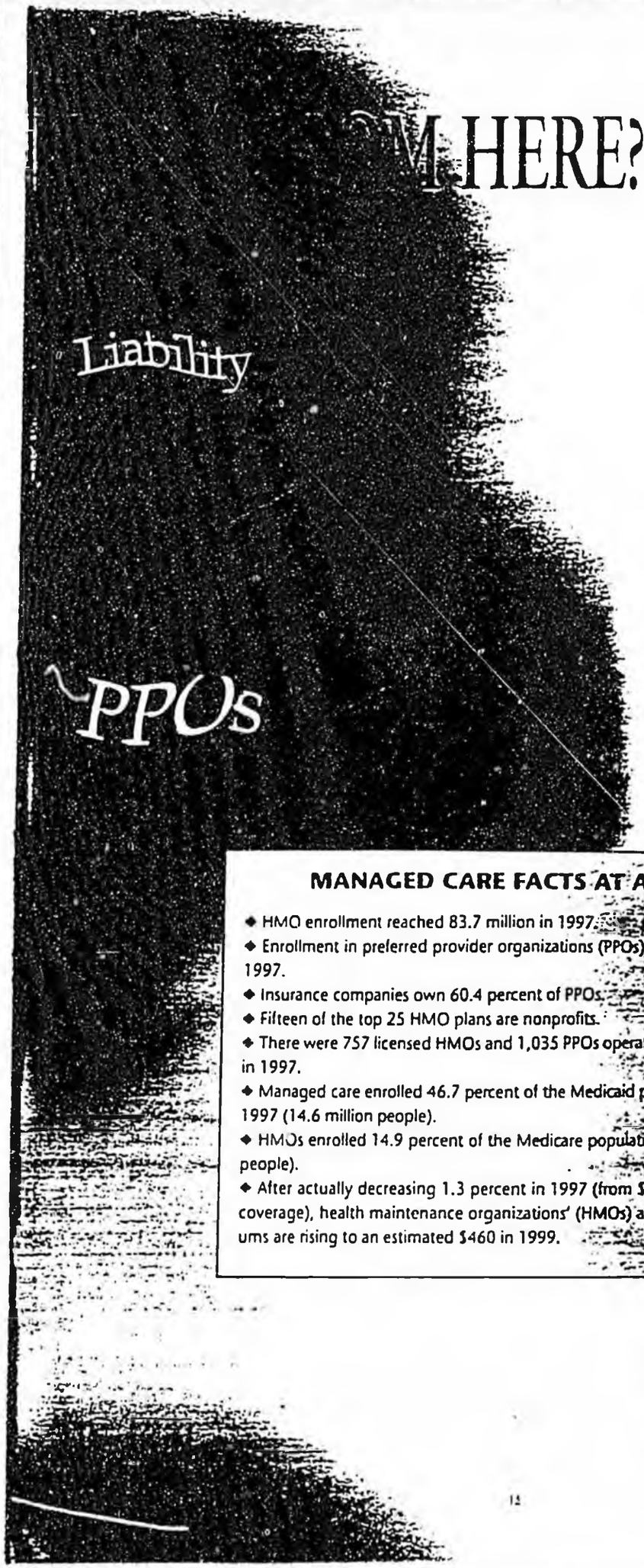
I'M HERE?

In 10 years, managed care has changed the landscape of American health care, saving money, simplifying paperwork and engendering lots of new legislation — but all the problems haven't been solved.

By Richard Cauchi



When Helen Hunt's character in the movie "As Good as it Gets" blasted her managed care plan for not giving her asthmatic son the help he needed, audiences cheered.

Is dissatisfaction with managed care organizations as widespread as headlines lead us to believe? Or are we in danger of "over-managing" managed care, defeating its purpose with micro-oversight of health care decisions?

Certainly the 1998 congressional debate about patient protection legislation caught the public's ear. Meanwhile, the real action has been in state legislatures. Between 1994 and 1998, 39 states approved "patient protection acts" or "comprehensive consumer bills of rights" affecting managed care. Eleven of those were adopted in 1998. The remaining 11 states have considered similar legislation.

Much legislative activity is driven by consumer complaints. For example, legislators heard about women being released from hospitals less than 24 hours after delivering babies because managed care plans wouldn't pay for longer stays. Under this so-called "drive-through delivery" practice, most women and babies did fine, but some had serious problems. In the first year after this issue made headlines, 27 states enacted laws requiring coverage for longer stays, typically 48 hours.

In Colorado, a personal story came from a mother who also happened to be a legislator and chair of a legislative health committee. During a 1998 managed care hearing, she told of her daughter, "Marcia," who was diagnosed with uterine cancer at age 30. Marcia's older sister also had the disease at a young age, resulting in a hysterectomy several years previously. With Marcia's diagnosis and family history, her doctor recommended a full hysterectomy. But her health maintenance organization (HMO) said "no, it would pay only for a partial procedure," and continue to monitor her condition.

MANAGED CARE FACTS AT A GLANCE

- HMO enrollment reached 83.7 million in 1997.
- Enrollment in preferred provider organizations (PPOs) reached [illegible] million in 1997.
- Insurance companies own 60.4 percent of PPOs.
- Fifteen of the top 25 HMO plans are nonprofits.
- There were 757 licensed HMOs and 1,035 PPOs operating in the United States in 1997.
- Managed care enrolled 46.7 percent of the Medicaid population [illegible] in 1997 (14.6 million people).
- HMOs enrolled 14.9 percent of the Medicare population in 1997 (5.6 million people).
- After actually decreasing 1.3 percent in 1997 (from $434 to $429 for annual coverage), health maintenance organizations' (HMOs) average monthly premiums are rising to an estimated $460 in 1999.

Richard Cauchi covers health insurance for NCSL at the Denver office. NCSL staff Molly Stauffer, Marla Rathouse and Jo Johnson Wilson contributed material used in this article.

SELECTED STATE LAWS ON MANAGED CARE / HMOs

STATE	Comprehensive consumer law (year)	Ban on financial incentives	Ban on gag clauses	Direct Access to ob/gyn	Continuity of Care	HMO Medical Director	Emergency Prudent layperson	Insurer Liability	Independent Review
Alabama	-		■	■		■			
Alaska	1998	■	■	**					
Arizona	*		■				*		■
Arkansas	1997		■	■ **	■	■	■		
California	1994, '95	■	■	■	■	■	*		exp
Colorado	1997		■	■	■		■		■
Connecticut	1997		■	■			■	hh	■
Delaware	Regulations	■	■	■	■	■	■		■
Florida	1997	■	■	■	■	■	*		■
Georgia	1996	■	■	■ **			■		
Hawaii	1998		■				■		■
Idaho	1997	■	■	■			■	hh	
Illinois	-			■					
Indiana	1998		■	■	■	■	■		
Iowa	Voluntary		■				■		
Kansas	1997	■	■		■		■		
Kentucky	1998		■	**		■	■		
Louisiana	1997	■	■	■			■	hh	
Maine	1996		■	■ **			■	hh	
Maryland	1995	■	■	■	■	■	■	hh	■
Massachusetts	-		■						
Michigan	-		■				■		■
Minnesota	1997	■	■	■	■		■		
Mississippi	1995			■					
Missouri	1997	■	■	■	■	■	■	hh	■
Montana	1997	■	■	■ **		■			
Nebraska	1998	■	■	■			■		
Nevada	1997	■	■	■		■	■		
New Hampshire	1997		■	■				hh	
New Jersey	1997	■	■	■	■	■			■
New Mexico	1998	■	■	■			*		■
New York	1996		■	■	■		■	hh	■
North Carolina	Regulations		■	■			■		■
North Dakota	-		■					hh	
Ohio	1997	■	■			■	■		exp
Oklahoma	1997		■			■			
Oregon	1997		■	■			■	hh	
Pennsylvania	1998	■	■	■	■		■		■
Rhode Island	1996	■	■	■		■		hh	■
South Carolina	1998		■	■	■		■	hh	
South Dakota	-								
Tennessee	1998		■	■	■			hh	■
Texas	1997	■	■	■	■	■	■	hh	■
Utah	-		■	■					
Vermont	1996	■	■	■	■	■	■	hh	■
Virginia	1995, '98		■	■	■		■	hh	■
Washington	1996		■	■			■		
West Virginia	-	■	■	■			■		
Wisconsin	1998		■		■	■	■		
Wyoming	-		■						
Dist. of Columbia	1998		■	■	■				■
Puerto Rico	-								
TOTAL	39	22	46	37	20	18	31	1	22

** Alaska and Kentucky have direct access only to chiropractors; Maine covers ob/gyn and chiropractors; Arkansas also covers optometrists; Colorado, Connecticut, and Montana also cover advance practice nurses or midwives and Florida and Georgia also cover dermatologists.

Source: Health Policy Tracking Service, National Conference of State Legislatures.

* State has adopted a variation of the prudent layperson standard
hh = ban on health plan "hold harmless" clauses, which shift all liability to doctor or health facility
exp = applies to experimental treatments
Note: In some cases, state provisions are contained in regulations or administrative code.

"I believe the HMO made its decision based on financial considerations and not on what was best for Marcia," asserts her influential mother. She believes legislators play an important oversight role to protect consumers.

Another issue making headlines concerns access to emergency services under managed care plans. When 2-year-old Michael Silver cracked his head open on Thanksgiving eve several years ago, his parents rushed him to the nearest emergency room, five minutes away. The child received three layers of stitches from a plastic surgeon, but the family's HMO refused to pay the $560 bill because Michael's case didn't constitute an "emergency" under the plan. Nor had his parents contacted the HMO for prior permission to take him to a facility outside the network.

"My son was gushing blood. I was scared to death, and my hands were holding his wound shut," reports Michael's mother. "It certainly was an emergency in my mind, and it never occurred to me to take him the 40-minute drive to our HMO's closest emergency center or to call them up. Getting my baby immediate help was all that was on my mind."

In response to similar cases, more than 30 states have implemented "prudent layperson" standards to make getting emergency care easier. Such laws require plans to cover emergency care if a "prudent layperson" believes that immediate treatment is needed.

Personal stories such as Marcia's, Michael's and others made managed care a top constituent issue for many state legislators in the 1990s. With lives, livelihoods and votes at stake, states acted decisively. Among the 50 states, nearly 900 laws passed that affect managed care, according to NCSL's Health Policy Tracking Service (HPTS).

PRO-CONSUMER LEGISLATION

State laws addressing these issues have not followed any single model act, although insurance regulators, physicians and consumer advocates have circulated several such examples. In fact not all were high visibility packages. Many of the 900 state laws addressed particular issues reported by consumers negotiating the managed care system, such as gaining access to a specialist, being fully informed of medical options, getting coverage for emergency room services, obtaining 48-hour hospital coverage following birth for maternity cases, receiving adequate hospital coverage for mastectomies, appealing a denial of coverage for a specific service or procedure, or even just knowing what is covered.

Along the way, legislatures also have addressed structural and financial issues not as visible to the individual enrollee. These include: requiring consumer "report cards," requiring all HMO medical directors to be licensed MDs, allowing more providers to join health plans, requiring advance notice when terminating doctors and other providers and requiring prompt payment for doctors or specialists.

Many of these recent laws expand state authority or mandate additional action or services. However, at the same time, the legislative sponsors generally made it clear that they did not intend to restrict enrollment or hurt the growth of managed care plans. In fact, some would say the pro-consumer regulations may well make HMOs more acceptable and ultimately more popular.

With all these laws in effect, has managed care finally been "managed?" For 1999, many legislators would answer, "No way!" An HPTS survey of legislators active in health issues conducted in December indicates that managed care in general is still a priority in all 50 states and D.C."

Others worry, however, that overregulation of managed care plans may defeat their very purpose. While the horror stories make the headlines, the reality is that managed care has become a way of life for most Americans. At last count, more than 160 million people were enrolled in some form of managed care. These plans appear to serve the needs of many enrollees, especially those with few

SOME STANDARD FEATURES

After five years of state actions some clear trends have emerged for managed care. At least 20 states have enacted laws with these requirements:

- **Any willing provider:** In response to complaints that consumers want to use a local drug store, 22 states require that managed care organizations allow any pharmacy to be a provider to their enrollees; several states also include doctors or other providers.
- **Bans on gag clauses:** Forty-six states have laws prohibiting any agreement that limits doctors' ability to inform patients of treatment options, especially if some choices may cost the insurer more. A 1997 federal law now bans gag clauses for Medicaid and Medicare managed care.
- **Bans on financial incentives:** Twenty-two states prohibit a managed care plan from rewarding doctors for performing a less costly procedure or prescribing a less costly drug.
- **Direct access to women's health specialists:** Thirty-six states and the District of Columbia now allow women to see an obstetrician or gynecologist without first getting permission or a referral from a primary care provider.
- **Hospital stay after childbirth:** Forty-three states require reimbursement for (typically) at least a 48-hour maternity stay. A federal law requiring coverage for a 48-hour stay took effect in January 1998.
- **Independent review of denials:** Twenty-one states and the District of Columbia now require an independent panel to evaluate the validity of denied care. Once opposed as too costly by the managed care industry, this idea now is embraced as a "reasonable" alternative to court suits. In Texas an HMO association actually urged a federal judge to retain that state's external appeals process. Aetna, the nation's largest managed care company, has announced it will voluntarily allow such appeals for enrollees in 30 states, as of June 30, 1999. In addition, all 50 states require some form of internal appeal for denials of care.
- **Prudent layperson standard for emergencies:** Thirty-one state laws specify automatic coverage for emergency medical conditions "of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy."
- **Financial standards and licensing:** All 50 states provide for structural regulation of managed care organizations, usually requiring a "certificate of authority" to operate, financial solvency standards, periodic reporting and filing of operational plans.

INNOVATIVE AND CONTROVERSIAL IDEAS

As the managed care debate evolves in the media and on the floor of state legislatures, new (some might say far-reaching) provisions have been enacted by selected states:

- **The right to sue your HMO:** Texas is the first state to enact an "insurer liability" provision that holds health maintenance organizations liable for health treatment decisions. Missouri used another approach by repealing an earlier law prohibiting the "corporate practice of medicine." Health plans decry right to sue provisions and say they will prompt premium increases of up to 10 percent; in addition federal law limits the reach of states' authority. However, 31 states reported that this is a legislative issue for 1999.
- **Report cards:** In an effort to assist consumers in choosing a plan, 11 states now require publication of an evaluation booklet, commonly called a "report card." In Vermont, for example, the public report card will measure how well plans are complying with about 60 selected state laws and regulations. "Ultimately it will be a great tool for consumers," noted William Little of Kaiser Permanente, Vermont's largest HMO.
- **Specialists as primary doctor:** For people with a single chronic health problem, the usual procedure of calling a primary care provider first can be frustrating and unproductive. In 1998, Indiana, Kentucky, New Mexico and Pennsylvania joined New Jersey, New York and Texas in allowing an enrollee to select a specialist (such as a neurologist, a mental health provider or a cancer specialist) to be their main provider.
- **Medical director requirements:** Some managed care organizations' chief officers have business degrees rather than medical credentials. In the past two years, 18 states have established specific qualifications and responsibilities for HMO medical directors; most require a current in-state medical license. Several states make such directors "responsible for treatment policies...of the carrier," which means they could be legally liable for actions of their staff.
- **Consumer assistance/ombudsman programs:** Over a dozen states established ombudsman programs for Medicaid managed care. Now California, Maine and Vermont have launched such publicly funded advocacy programs for private market enrollees, and other states are looking closely at these examples.

major health problems. And they do so with fewer complaints than most people believe.

Some legislators are looking for a middle ground. "Yes, I believe some regulation is necessary, but we don't want to drive HMOs out of business," says Representative Gregg Underheim, chair of the Wisconsin Assembly Health Committee. He adds, "Some HMOs behave very appropriately. Clearly there are some bad actors in the HMO industry and they are making the environment more difficult for those who have operated ethically and efficiently."

Representative Gregg Underheim Wisconsin

"It was really the private employer who caused the rapid growth of managed care over the last decade," says John Iglehart, founding editor of *Health Affairs*, a leading national journal. "It wasn't really until the private sector came along with the private employer's contribution and decided that rather than put it into indemnity insurance, which was uncontrolled at that point, they would move into managed care.

"So we should remember that the conflict and the commotion really isn't a consequence of governmental action ... governments we all like to kick around; it really was a result of private decision making," he says.

MANAGED CARE HERE TO STAY

Agree or disagree, policymakers recognize that managed care is here to stay. The business community accepts the analysis of health leaders such as Stanford University's Dr. Alain Enthoven that managed care has the best chance of increasing access, improving quality and moderating the rate of increase in health care costs.

For private employers and governments alike, the biggest HMO success story is cost savings.

"The role of managed care is to attack unnecessary and inappropriate costs," says Stephen de Montmollin, vice president of WMed Health Plan of Florida, a managed care plan. "Double digit inflation caused millions to lose access to affordable health care insurance," he emphasizes. "In 1988, the average per employee cost for medical benefits in the United States shot up 18.6 percent; in 1989, another 16.7 percent, in 1990, up 17.1 percent, in '91 up 12.1 percent. With managed care, these figures have been reduced dramatically, with increases below 2 percent for 1998. In 1997, premiums actually decreased by 1.3 percent."

Citing several national and local polls, de Montmollin also says that most Americans, including those enrolled in managed care plans, are satisfied with their health care coverage. He also warns that burdensome regulations will result in higher costs, and that the alternative to a managed care system often is "uncoordinated care. Don't put the entire managed care system at risk in the absence of conclusive evidence that there is some systemic problem."

A SYSTEMIC PROBLEM?

Others believe there is a systemic problem. "The U.S. health care system is in chaos," asserts Ted Lewers, a vice chair of the American Medical Association's executive committee. "A lot of the satisfaction statistics that you've seen are from people who probably have not used the health care system—who have not had any chance to know whether it works or doesn't work.

"For example, if you look at mental health care, only 5 percent of Americans use those benefits. So if you look at your satisfaction questionnaire, you'd say you're satisfied with your mental health coverage, even if you haven't used it," he points out.

Many people aren't aware of the innovative things HMOs do, de Montmollin counters. Commenting on the Helen Hunt character and her asthmatic son, he says, "The irony is that many HMOs have been pioneers in putting together comprehensive asthma programs that help children control their symptoms and reduce

continued on page 19

WHAT ELSE TO LOOK FOR IN 1999

◆ **Higher premiums:** After several years of almost level rates charged to employers and consumers, premiums are headed up. The latest survey, released in January, confirmed HMO premiums are rising 8 percent to 10 percent this year, the largest jump since 1993 (the year of President Clinton's national health reform proposal). At the same time, traditional indemnity health insurance rates also are rising 8 percent, but HMO premiums remain about 20 percent cheaper.

However, copayments and deductibles will become higher and more widespread, as many employers seek ways to continue health benefits for employees without footing the entire bill. Some state regulators may again examine the possibility of capping certain insurance rates.

In the private market, the Midwest Business Group, representing 110 large employers in 11 midwestern states, is "strongly encouraging members to hold the line on premium renewals and to consider tactics such as freezing enrollment in plans where there are large rate increases, raising copayments and deductibles for employees, and warning employees that more drastic changes might be contemplated," according to Larry Boress, the group's vice president.

◆ **Prescription costs:** Most analysts, including the federal Health Care Financing Administration (HCFA), say the main cause of 1999 rate increases is pharmaceutical prices, which are up about 17 percent since last year. Perhaps that's why 24 legislatures say they will look more closely at drug costs, either through regulating formularies and generic substitutes or acknowledging special drug copayments.

◆ **Slow-down of government program enrollment:** After almost a decade of enthusiasm for enrolling Medicaid consumers in managed care, the focus is shifting. There is more emphasis on enforcing the rights of consumers, as well as legislative studies and audits to determine if cost savings are real, and if they can continue. Meanwhile, a push to enroll Medicare recipients in managed care collapsed in a high-visibility dispute between HCFA and managed care organizations about reimbursement rates. HMOs in 29 states announced they were pulling out of the Medicare market, affecting over 450,000 seniors. This dispute may fuel state legislative oversight hearings and investigations, although the resolution remains under federal jurisdiction.

◆ **Direct contracting:** Many large employers and some smaller ones are watching very closely an experiment in Minneapolis-St. Paul. A business consortium has pooled resources to contract directly with doctors and hospitals to provide health care, effectively bypassing HMOs. Policymakers in some other states may conduct their own studies to determine how direct contracting might work in their regions.

◆ **Voluntary improvements:** The American Association of Health Plans is putting its faith in improving quality and in convincing consumers that new regulatory burdens will make things worse, says Karen Ignani, trade association president and corporate executive officer. She expects a "continued evolution" that puts consumers in the driver's seat by giving them more choice of providers and benefits. However, legislators remain skeptical. As Massachusetts Senator Mark Montigny, chair of the Senate Ways and Means Committee and chief sponsor of a 1999 consumer rights bill, notes: "Health care decisions are now driven by third party money managers, obsessed with the bottom line. A comprehensive managed care reform bill will restore the provider-patient relationship and ensure quality health care delivery at reasonable cost. Angry consumers will demand reform in 1999 and we must act with an aggressive bill that puts patients first."

Senator Mark Montigny Massachusetts

◆ **Health vouchers:** Some private sector employers are proposing a simplified voucher system, providing each employee with a standardized monthly payment. This could get employers out of the health decision business in which they have to preselect a limited list of health plans. However, some policymakers question whether the average employee will be able to pick up the remaining costs, especially of family coverage. Expect to see some state interest in either encouraging or further regulating such arrangements.

◆ **Congressional action.** Both parties in Congress and the Clinton administration have said "patient protection" is a top priority for 1999. In the wake of last year's debate over sharply differing bills, key questions are not yet resolved: Will a new federal law replace or preempt existing state laws, especially when the state law is stronger? Will it fully cover other insurance plans that now are outside state regulatory authority?

"The future of state regulation of insurance hangs in the balance of the ongoing debate on regulating managed care," notes Joy Johnson Wilson, director of NCSL's Health Committee.

(Continued from page 18)

the need for emergency hospitalizations."

In fact, says de Montmollin, the most noteworthy thing about the movie scene is that a single waitress in a diner has health insurance for her son at all. "Wow, that's fabulous—fewer than half the women in her situation have any access to coverage," he says.

Rising costs make it harder for businesses and governments alike to provide coverage for the nearly 44 million Americans who remain uninsured. Managed care has been touted as a way to save money that can be used to cover additional people. However, the numbers of uninsured have increased in the past 10 years.

Compared to other insurance, "HMOs generally offer more benefits, including coverage for prescription drugs, and fewer deductibles and copayments," notes William Falk of Towers Perrin, a research firm in Chicago. He expects most employers to stick with HMOs. They are "still an attractive alternative."

But striking a balance between consumer protections and micromanagement remains a challenge.

CONSUMERS NEED HELP

Establishing publicly funded consumer assistance or "ombudsman" programs may be one way to address consumer needs without overregulating managed care plans.

"The public is very confused," says Ron Pollack, executive director of Families USA, a consumer advocacy group. He says the managed care backlash comes from a variety of factors. "I think people clearly do not understand

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today what their choices are, what their rights are and how they can claim those rights. To the extent that we're really going to address the core of people's problems or concerns, we need to provide some specific assistance to consumers."

Pollack says consumer assistance programs would give people information about plans, help them understand their choices and rights, answer questions through free phone access, and help those who want to file an appeal. He also says that such programs can help the managed care plans, employers and regulators. "They can provide a basis for getting quick information about what the problems are that arise as our health care system changes.

"A 'patients bill of rights' should not dictate clinical decisions or redesign health benefits packages," Pollack says. "But such state laws are very important because they help to ensure that patients get the care they need, when they need it. And they give patients and physicians effective tools to fight HMOs' wrongful denials and delays of care," he explains.

THE FUTURE

Evidence points to continued lively and high visibility debate about managed care, including new state laws, renewed congressional debate and more indepth studies of the effect of the recent state laws.

"What will eventually shake out as the health care system in the next century likely will be a muddle of market, policy, regulatory and professionally driven solutions," says Edward O'Neil, director of the Center for the Health Professions at the University of California.

"Such pluralistic approaches are typically the American way of doing things. The best solutions occur when we are clear about our aims and use the various vehicles of market, policy and professions to implement what we desire. But in this case, we do not have the capacity to generate a community or public definition of aim. Until we find a genuine voice for the varied interests in health care, we are likely to continue to suffer the cacophony of competing interests clashing over the $ 1.1 trillion that is health care in America, and to blame managed care for it all."

HB 211
3/24/00
JUD

Blue Cross
Blue Shield of Alaska
A PREMERA HEALTH PLAN

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

March 21, 2000

Repres ..ive Pete Kott
Chairm .n House Judiciary Committee
State Ca .ol, Room 118
Juneau, AK 99801-1182

As you know, Blue Cross Blue Shield of Alaska (BCBS of AK) has been working with Representative Norman Rokeberg on HB 211, the Patients' Bill of Rights with the goal of providing Alaskans with the best health care coverage possible.

As we discussed in meetings with Representative Rokeberg, we are supportive of a number of concepts in HB 211. However, we do have concerns with aspects of the bill that have the potential to substantially drive up costs in Alaska to our approximately 100,000 subscribers, while at the same time, not creating a corresponding improvement in the health care delivery system.

BCBS of AK does support concepts in the bill dealing with patient and healthcare provider protection; required contract provision; confidentiality and external health care appeals. We do believe, however, that we need to continue working together on the language in these sections so that the final bill will benefit both the health care delivery system and our subscribers.

At a time when the national uninsured population is reaching almost 50 million and when national statistics reflect that more and more employers are making the decision NOT to provide health care to their employees, BCBS of AK cannot support sections in the bill relating to liability and concepts relating to any willing provider. We believe that this is not the time to address these issues in lights of these trends.

BCBS of AK has historically provided high quality coverage to Alaskans. We have also focused on holding down health care costs to the highest degree possible. Recent studies by the Congressional Budget Office and the firm of Milliman & Robertson have shown that similar Patients' Bill of Rights Legislation at the Federal and Washington State level will increase insurance premiums by as much s 4%. To put that percentage into perspective, for BCBS of AK members, the passage of this bill has the potential to increase Alaska premiums by $5.6 million, not including the 30,000 individuals covered under the Federal program. This would be on top of the 12% increase that Alaska State's health benefit consulting firm of Watson Wyatt has projected.

Thank you for your consideration of our thoughts. We look forward to working with you in establishing a Patients' Bill of Rights that will enhance healthcare for all Alaskans, while not increasing cost to a point where it becomes unaffordable for many residents.

Sincerely,

Jack C. McRae

3/31/00
JAD

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
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Representative Norman Rokeberg

Sponsor Statement for CSHB 211 (L&C)

Alaska Patients Bill of Rights

An Act relating to liability for providing managed care services, to regulation of managed care insurance plans, and to patient rights and prohibited practices under health insurance; amending Rule 602(b), Alaska Rules of Appellate Procedure; and providing for an effective date.

Updated: March 18, 2000

Patients need assurance that the quality of their health care will not be compromised as managed care expands. CSHB211 (L&C) requires managed care entities to provide a reasonable standard of health care, and holds them civilly liable if they do not. It also establishes requirements for contracts between managed care entities and their health care providers, patients and their group managed care plans, and health care insurers and their insureds, providing patients with the following:

- access to emergency room services
- availability of medical services or adequate referral options
- full disclosure of treatment options
- choice of health care providers, including specialists
- clear descriptions of covered items and services, benefits, procedures, compensation methods, availability (and exclusions) of prescription medications and the availability of translation or interpreter services
- a point-of-service plan option
- follow-through of preapproved payment
- quick utilization review decisions
- opportunity for appeals of utilization review decisions
- added protection from denial, reduction, or termination of payment for health care services

In addition, this legislation gives health care providers the freedom to share all testing and treatment options with their patients, and lets them advocate for their patients without the risk of being penalized or terminated by the managed care entity they contract with. It also prohibits contracts between managed care entities and health care providers from including "hold harmless" clauses for the managed care entity or financial incentives for providers to withhold medically necessary services.

While it streamlines the health care system, managed care may also increase the vulnerability of patients and doctors, resulting in a lower quality of care. HB211 is necessary to ensure continued quality health care in the face of a growing managed care industry.
I urge you to support this legislation.

AETNA
State Employee Plan.

2/16/00
HB 211
JCP

COVERED MEDICAL EXPENSES

The medical plan provides extensive and valuable benefits for you and your eligible dependents. Benefits are available for medically necessary services and supplies necessary to diagnose, care for, or treat a physical or medical condition.

To be medically necessary, the service or supply must be:

- care or treatment which is expected to improve or maintain your health or to relieve pain and suffering without aggravating the condition or causing additional health problems;
- a diagnostic procedure which is expected to provide information to determine the course of treatment; and
- no more costly than another service or supply which could fulfill these requirements.

In determining if a service or supply is medically necessary, the claims administrator will consider:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and

- any other relevant information brought to the claims administrator's attention.

In no event will the following services or supplies be considered medically necessary:

- those that do not require the technical skills of a medical or dental professional who is acting within the scope of their license;

- those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider or health care facility;

- those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or

- those furnished only because of the setting if the service or supply can be furnished in a doctor's or dentist's office or other less costly setting.

Physician's Services

The medical plan pays for covered medical treatment and surgery performed by a qualified physician. Providers who are covered by the plan are people licensed to practice:

- medicine and surgery (M.D.)
- osteopathy and surgery (D.O.)
- dentistry (D.D.S. or D.M.D.)

Also covered are:

- psychologists
- occupational therapists
- physical therapists
- licensed clinical social workers
- licensed marital and family counselors

EVIDENCE OF MEDICAL NECESSITY

The claims administrator may require that any person who receives services under this plan submit a certificate of medical necessity within a reasonable time from people or organizations considered appropriate. If evidence of medical necessity is requested, members cannot continue to receive benefits under this plan unless they provide a requested certificate, subject to a medical review board, that substantiates the medical necessity for continued care. The claims administrator will not request such a certificate more frequently than every 10 days.

FACILITY OF PAYMENT

Whenever payments which should have been made under this plan are made under other programs, this plan has the right, at its discretion, to pay over to any organizations making other payments, any amounts it determines are warranted. These amounts are considered benefits paid under this plan, and, to the extent of such payments, this plan is fully discharged from liability under this contract.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

You may select any hospital who meets the criteria on page 29. You may select any physician or surgeon who meets the definition of provider on page 27.

The payments made under this plan for services that a physician or surgeon renders are not construed as regulating in any way the fees that the physician or surgeon charges.

4/10/00
JUD
(brought up by Cole.)

Alaska State Medical Association

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

April 6, 2000

RECEIVED
APR 08 2000

Honorable Pete Kott
Chair, House Judiciary Committee
House of Representatives
State Capital, Room 118
Juneau, Alaska 99811-1182

RE: CS HB 211—Alaska's Patients' Bill of Rights

Dear Representative Kott

CS HB 211 (version "N" as amended.) contains some significant protections for Alaska's patients. However, the job is not yet completed. Two major issues remain—managed care entity accountability ("liability issue") and the issue pertaining to the definition of "medical necessity" with its impact on the external appeal mechanism and with liability.

Given the short time remaining in this session and the complexity of the above two issues; ASMA feels that those two issues cannot receive the amount of attention warranted for the Legislature to make a reasoned policy decision. ASMA also is very aware that Congressional action is expected on the "National" Patient's Bill of Rights (with such action possibly having an impact on what may or may not be adopted in Alaska). Therefore, it is ASMA's intent to come back to the Legislature early in the next session with separate legislation pertaining to those issues. Although, ASMA feels that the ERISA pre-emption of the various states regulating "quality of care" issues has been significantly narrowed through recent court decisions, it is expected that the "National" Patient's Bill of Rights will directly address that issue.

So, therefore, ASMA supports CS HB 211 version "N" as amended, as on balance it provides important patient protections, but the issues of "liability" and "medical necessity" still need to be addressed by the Legislature in the next session.

Thank-you for all the work you, your committee, and the special sub-committee has done on this important legislation.

Sincerely,

Peter Lawrason

BY: Peter Lawrason, MD, President
FOR: The Alaska State Medical Association

cc: Judiciary Committee Members
Rep. Joe Green
Rep. Jeannette James
Rep. Lisa Murkowski
Rep. Norm Rokeberg
Rep. Eric Croft
Rep. Beth Kerttula

kms

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April 6, 2000

The Honorable Pete Kott
Alaska State House of Representatives
Room 118, State Capitol Building
Juneau, Alaska 99811

Dear Representative Kott:

Alaska Physicians & Surgeons supports amended version N of House Bill 211. However, we have concerns about supporting a bill that does not have a definition of "medical necessity" nor c[illegible] amended version N of House Bill 211 managed care entities.

By supporting this version of HB211, we are not waiving our commitment to enact into law these two provisions. Given that there are only a few weeks of session left, we will pursue enacting these sections in separate legislation next year.

We appreciate your attention to HB211 and the work your committee has done, especially by Reps. Joe Green and Lisa Merkowski. We also look forward to working with you in the future to resolve the important issues left out of HB211.

Sincerely,

George S. Rhyneer, MD
Chairman and President
Alaska Physicians & Surgeons