

**ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672**

**9940 HOUSE LABOR & COMMERCE**

## **Executive Summary**

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The American Medical Association (AMA) commissioned William M. Mercer, Incorporated (Mercer) to develop an actuarial model (the "Model") to assess the cost impact of managed care accountability legislation. The Model derives the estimates of cost impact from projections of medical services and malpractice claims experience.

The Model examines the impact of a Model Managed Care Accountability Law that 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 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 subspecialty. 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. This result is converted to a percent of MCO premium.

A complex array of formulas and quantitative and qualitative assumptions underlies the general logic flow. A technical committee formed by Mercer and the AMA, which included attorneys, economists, and actuaries, derived the assumptions from a review of the literature and an analysis of various data sets.

The Model takes into consideration a number of variables thought to affect the impact of the Model Law. These variables include (i) three levels of legislative impact related to the impact of the Model Law's prohibition of the corporate practice of medicine defense; (ii) two constructions of ERISA preemption to capture the extent to which the actions brought by enrollees of ERISA plans could be preempted by ERISA; (iii) alternative types of MCOs to account for different mixes of plan types found across the country; (iv) alternative enrollment mixes; and (v) three types of caps on malpractice awards to account for different state tort reform laws.

## Executive Summary

The Model produces the following estimates for the three levels of legislative impact for narrow and broad ERISA construction.

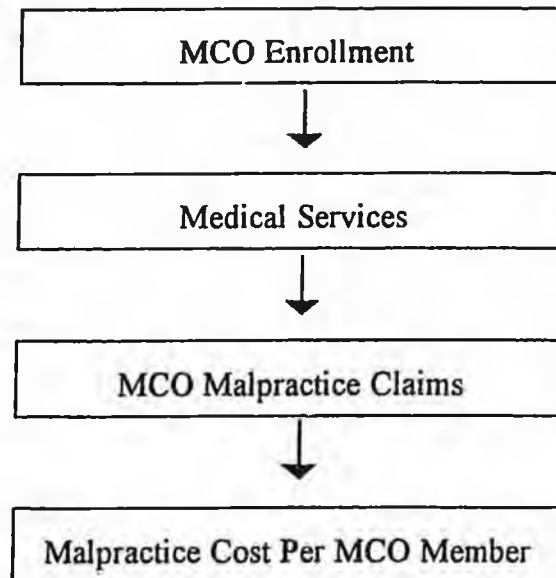
### **Increase as a Percent of MCO Premium – No Cap on Awards**

Legislative Impact	<u>ERISA Preemption</u>	
	Narrowly Construed	Broadly Construed
Significant	1.8%	0.5%
Moderate	1.2%	0.3%
Low	0.9%	0.2%

## Background

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In order to estimate the impact of managed care accountability legislation, a model (the "Model") was developed. The Model's general logic flow 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 (employer-sponsored), Medicare, and Medicaid managed care programs. William M. Mercer, Incorporated (Mercer) cost models produce medical service projections by physician subspecialty. 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. This result is converted to a percent of MCO premium. The schematic below summarizes the general logic flow:



A complex array of formulas and quantitative and qualitative assumptions underlies the general logic flow. A technical committee formed by Mercer and the AMA, which included attorneys, economists, and actuaries, derived the assumptions from a review of the literature and an analysis of various data sets, some in the public domain and others that are proprietary.

In early discussions, a number of approaches to developing cost estimates were reviewed, and the technical committee decided to construct the estimates from medical services projections and malpractice claims experience. This approach was selected over the alternative of using malpractice insurance premiums as the basis for projections. Malpractice insurance coverage varies significantly. Policies are sold with a variety of deductibles and coverage limits. Price changes usually reflect anticipated increases in claims, prior premium deficiencies, and profit margins. Thus, it was determined that using malpractice insurance premiums as the basis for cost estimates was not the best approach to determining the expected impact of managed care accountability legislation.

## **Model Managed Care Accountability Law**

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The Malpractice Liability Assessment Model examines the impact of a Model Managed Care Accountability Law (the "Model Law"). The Model Law applies to all managed care organizations, but does not apply to employers that sponsor group health plans.

Under the Model Law, 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. The Model Law defines a health care treatment decision 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 Model Law also provides 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. In many states, MCOs are already subject to claims for malpractice under this type of vicarious liability theory. However, as discussed later in this report, MCOs assert a number of defenses to malpractice actions, including the corporate practice of medicine doctrine and the preemption of state law causes of action under the Employee Retirement Income Security Act of 1974 (ERISA). The Model Law prohibits MCOs from asserting the corporate practice of medicine doctrine as a defense to malpractice actions. Whether a court will determine that ERISA preempts a cause of action under the Model Law when brought against an MCO contracting with an ERISA plan is unknown. As discussed later in this report, the Model accounts for the potential impact of ERISA by considering both a broad and narrow construction of the preemption provisions.

The Model Law provides that, as a defense to a cause of action under either a direct negligence or vicarious liability theory, an MCO may assert that it did not control, influence or participate in the treatment decision, and did not deny or delay payment for any treatment recommended by a provider.

The Model Law also prohibits MCOs from including indemnification provisions in contracts with providers that would require the providers to hold the MCO harmless for the MCO's conduct.

## Variables in the Model

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The Malpractice Liability Assessment Model takes into consideration a number of variables thought to affect the impact of the Model Law. Each of these variables and the reasons for including them are discussed below.

### A. Legislative Impact

The Model considers three levels of legislative impact--significant, moderate and low--designed to reflect the impact of the Model Law's prohibition of the corporate practice of medicine defense.

The corporate practice of medicine is a legal doctrine that may prevent a non-professional corporation, such as a general business corporation, from employing physicians. Although few states have statutes explicitly prohibiting the corporate practice of medicine, many states have a body of older case law and Attorney General opinions that have established this doctrine.

The bar against the corporate practice of medicine is not enforced in all states. Where it is enforced, MCOs often assert the doctrine as a defense to malpractice actions, under the theory that MCOs are legally precluded from practicing medicine and, thus, are incapable of committing malpractice.

Research determined that states generally fall within one of three scenarios with respect to how the corporate practice of medicine doctrine is enforced:

- *Scenario 1:* The state actively enforces a complete bar against the corporate practice of medicine.
- *Scenario 2:* The state actively enforces a bar against the corporate practice of medicine, but excepts from the bar certain providers, such as hospitals, HMOs, and professional corporations.
- *Scenario 3:* The state has no bar against the corporate practice of medicine *or* has a bar that is not enforced.

The Model Law prohibits MCOs from asserting the corporate practice of medicine doctrine as a defense. The impact of this prohibition is captured by the legislative impact variable. In a state that falls within Scenario 1, the Model Law is assumed to have the most significant impact because the corporate practice of medicine doctrine, which has served as an effective barrier to suits against MCOs, will no longer be available as a defense. A state that falls within Scenario 2 will experience a more moderate impact from the Model Law, based on the assumption that some MCOs already have been exposed to malpractice liability. In a state that

## **Variables in the Model**

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falls within Scenario 3, the Model Law has the least impact, because the state has not recognized the bar against the corporate practice of medicine as a barrier to actions against MCOs.

### **B. ERISA Preemption**

The Model considers two constructions of ERISA preemption--broad and narrow. ERISA limits the ability of states to regulate employee benefit plans, including health benefit plans, and establishes the federal government as the primary regulator of these plans. ERISA preempts all state laws that relate to employee benefits, although the statute expressly preserves states' ability to regulate the business of insurance. Under this framework, claims appeal procedures are regulated at the federal level, and MCOs that offer a product through a health benefit plan are often protected by ERISA from state court litigation.

While there is an increasing trend toward allowing state malpractice claims against MCOs that are based on the quality of care--as opposed to the quantity of care--it is unclear whether a court would rule that the Model Law is preempted by ERISA. Given this uncertainty, the Model is designed to capture how broadly ERISA preemption is construed. If ERISA preemption is broadly construed to preempt all actions against MCOs by ERISA enrollees other than claims for vicarious liability arising from alleged malpractice of a provider, the MCO liability exposure from ERISA enrollees remains limited. Alternatively, 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.

A substantial percentage of MCO enrollees are in employer-sponsored plans. For this set of calculations, the Model assumes that 90% of the MCO enrollees are covered under an ERISA employee benefit plan. This percentage varies significantly across states. Thus, the extent to which ERISA enrollees may bring a state law cause of action against MCOs will have an impact on results of the Model.

### **C. Type of MCO**

The Model considers alternative types of MCOs to account for the different mix of plan types found across the states. The Model assumes that the Model Law will 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 (with which preferred provider organizations (PPOs) are included) will, conversely, experience a greater impact from the Model Law because they have generally not been subject to vicarious liability claims.

## **Variables in the Model**

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It is assumed that a staff model HMO will incur 30% of the additional liability incurred by IPA/network model HMOs. Based on industry reports, it is also assumed that 96% of enrollment in MCOs is in IPA/network model HMOs and the remaining 4% of enrollment is in staff model HMOs.

### **D. MCO Enrollment Mix**

The Model allows for different mixes of commercial, Medicaid, and Medicare enrollment. Medical services vary in nature and intensity for each of these populations. Medicaid enrollees, predominantly mothers and children, require considerable obstetric and pediatric services. Medicare enrollees, on the other hand, typically require more cataract surgery and joint replacements than other populations. These variations in medical needs impact the malpractice liability exposure associated with each population.

### **E. Caps on Malpractice Awards**

The Model considers three types of caps on damage awards to account for different state tort reform laws. The Model provides estimates 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. While there are numerous variations in state law with respect to damage caps, research indicated that the alternatives selected were representative of many states.

## The Malpractice Liability Assessment Model

### A. Expected MCO Malpractice Claim Incidence

The Model derives the expected MCO malpractice claims for three categories of enrollment: commercial, Medicare, and Medicaid. There are significant differences in the nature and intensity of the medical services provided to each of these populations. Mercer claim cost models provide medical services distributions by physician subspecialty for each of these populations.

Services for the three categories of enrollees provided by physicians are measured in terms of RVUs (relative value units). These units reflect both the frequency and complexity of the services provided. Total RVUs quantify a physician's annual practice in terms of volume and complexity. Studies provide the average number of RVUs for a given specialty. Comparing the RVUs provided annually by physicians to the number reflected by an MCO's medical services experience yields the share of a physician's practice dedicated to providing health services to MCO members. The MCO's share of a physician's practice translates to a share of the physician's professional liability exposure. For example, if 1,000 members require 90 RVUs of cardiology services annually and a cardiologist, on average, performs 9,000 RVUs per year, the members' services occupy 1% of a cardiologist's practice. We assume, therefore, that MCO members account for a 1% share of a cardiologist's professional liability. Assuming the annual incidence of professional liability claims for a cardiologist is 0.169, the annual incidence per 1,000 MCO members is 0.00169 ( $0.01 \times 0.169$ ).

Since this technique maps only physician professional liability claims to MCO members, another adjustment is required to assign hospital liability claims to MCO members. The estimated ratio of the total physician and hospital liability claims to physician professional liability claims is 1.14. Applying this factor to the annual incidence of physician professional liability claims per 1,000 members produces an estimate of the incidence of claims that includes both physician and hospital liability claims.

In addition, assumptions were developed regarding the expected incidence of malpractice claims against MCOs. To bring an action against an MCO, the MCO must somehow participate in the health care treatment decision, by denying or delaying payment or otherwise controlling or influencing the decision. Many malpractice claims will be based exclusively on the physician's or hospital's conduct, and will not meet this threshold. Because this is a new area of law, there is a paucity of data available on MCO malpractice claims.

To develop reasonable assumptions on the percent of existing malpractice claims that will become MCO claims following enactment of the Model Law, the technical committee considered the expected incidence of MCO malpractice claims under the three legislative impact scenarios. Direct negligence claims are introduced separately. The Model assumes that existing claims against physicians and hospitals will remain the same, and makes the

## The Malpractice Liability Assessment Model

following assumptions for additional vicarious liability claims against MCOs.

Legislative Impact for the State	Percent of Malpractice Claims that Become MCO Claims
Significant Impact	20%
Moderate Impact	10%
Low Impact	5%

Thus, under the scenario in which the Model Law will have the most significant impact in eliminating existing barriers to suits against MCOs, a maximum of 20% of the existing malpractice claims against hospitals and physicians are assumed to be asserted against MCOs on the basis of vicarious liability. In the low legislative impact scenario, it was assumed that 5% of the existing malpractice claims would be asserted against MCOs. This range is attributable to the relationship between existing bars to the corporate practice of medicine and the incidence of vicarious liability claims against MCOs.

The Model Law also allows for a direct negligence theory of liability that is not necessarily linked to physician or hospital malpractice, and requires a threshold showing that MCO conduct was the proximate cause of injury. Direct negligence claims are assumed to arise in addition to claims against physicians and hospitals. It is assumed that there will be a 10% increase over existing malpractice claims against physicians and hospitals for all legislative impact scenarios. Unlike the expected incidence of vicarious liability claims, it is assumed that the incidence of direct negligence claims is not linked to the corporate practice of medicine doctrine. Rather, the availability of a cause of action on direct negligence grounds is based directly on enactment of the Model Law. Therefore, the expected incidence of direct negligence claims is constant across the three legislative impact scenarios.

To illustrate this approach, the calculation of malpractice claims is shown for an MCO with one million members. This calculation is for a commercial (employer-sponsored) population, and would be repeated for Medicare and Medicaid enrollees by assigning a different number of physician professional liability claims.

### MCO Claims In a State In Which Model Law Has a Significant Impact

Calculation Steps	Malpractice Claims
Physician malpractice claims involving MCO members	147.4
Physician and hospital malpractice claims	$147.4 \times 1.14 = 168$
Vicarious liability claims against MCO	$168 \times .20 = 33.6$

## The Malpractice Liability Assessment Model

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Direct negligence claims against MCO	168 x .10 = 16.8
MCO malpractice claims	33.6 + 16.8 = 50.4

The incidence of MCO claims is also related to ERISA preemption. The following assumptions were made regarding the incidence of MCO claims under the broad and narrow constructions of ERISA preemption.

ERISA Construction	MCO Claims Allowed
Narrow	100%
Broad	5%

### B. Average Award per MCO Malpractice Claim

After the MCO malpractice claim incidence is estimated, the Model then determines the average cost of an MCO malpractice claim. The distribution of awards was developed from statistics in "Civil Jury Cases and Verdicts in Large Counties," Bureau of Justice Statistics, July 1995. The award amounts include verdicts in the Nation's 75 largest counties for physician and hospital malpractice awards. The technical committee determined that hospital data should be included in deriving the average award for MCOs based on certain similarities between the types of organizations. For example, like hospitals, MCOs are an institutional provider, subject to vicarious liability claims, and generally carry higher insurance coverage than physicians as a result of their potentially greater financial exposure.

Another study published by Tillinghast-Towers Perrin, "Tort Cost Trends: An International Perspective," reports that physician malpractice award payments account for approximately 63% (\$6.6 billion/\$10.5 billion) of the total malpractice payments. The 63% is based on 1995 award payments. This percentage has been fairly stable over the last several years. A study of hospital malpractice claims in Ohio, published in the Journal of Healthcare Management entitled "11 Years of Million-Dollar Malpractice Claims," provides information that reveals that 67% of the hospital malpractice claims include physicians as a principal party in the case. Collectively, these statistics suggest that physicians are defendants in 80-90% of medical malpractice cases. This supports using physicians as the primary means to link malpractice claims to MCOs.

The malpractice awards data from the Bureau of Justice Statistics included the following statistical characteristics for cases *with plaintiff awards*.

## The Malpractice Liability Assessment Model

### Original Awards Distribution

Median Award	\$201,000
Average Award	\$1,484,000
Awards over \$250,000	47.1 %
Awards over \$1,000,000	24.8 %

Because the data includes hospital awards, which account for a significant percentage of the awards in excess of \$1 million, the awards distribution is substantially higher than what would be expected from physician awards.

The original awards distribution was adjusted to:

1. Remove the influence of damage caps (the distribution is adjusted for caps on damages after steps (2) and (3));
2. Reflect the increasing number of \$1 million plus awards observed over the last several years; and
3. Accommodate the expectation that MCOs will be subject to higher malpractice awards than physicians.

Adjusting the original malpractice claim distribution was an iterative process. Each iteration was compared to information from various sources as described below. This change produced the following:

### Adjusted Awards Distribution for MCOs

Median Award	\$875,000
Average Award	\$1,718,600
Awards over \$250,000	82.0 %
Awards over \$1,000,000	52.0 %

To test the reasonableness of the adjusted awards distribution, we compared the statistics to other sources. The Health Care Liability Alliance reported that 50% of the medical

## The Malpractice Liability Assessment Model

malpractice awards in 1994 were between \$120,000 and \$1,300,000. The Model's adjusted malpractice award distribution produces a comparable statistic of 55%. The 1994 California Medical Malpractice Large Loss Trend Study reported that the average cost for claims over \$1,000,000 was approximately \$2.5 million over five years. The comparable statistic for the adjusted claims distribution is \$2,875,000. Given the adjustment made to account for MCOs' greater financial resources and the observed growth of \$1 million plus awards, the distribution produces reasonable results. Jury Verdict Research similarly reported a median physician malpractice claim cost of \$500,000 for 1994. The adjusted claims distribution produces a somewhat higher median claim cost of \$874,000. Again, considering the Model's adjustments, the median derived from the adjusted award distribution appears appropriate. Although the data used in these comparisons were not perfectly compatible, the comparisons were determined to be sufficient to support the reasonableness of the adjusted malpractice awards distribution.

Because the awards distributions are based only on plaintiff awards, the statistics must be converted to an average for all claims. The Model takes into account the prevailing assumption that plaintiffs are successful in 25% of the cases. Therefore, the average award is multiplied by 25% to arrive at an average for all cases.

### Average Cost per MCO Award

Source	Plaintiff Verdict	All Awards
Bureau of Justice Statistics	\$1,484,000	\$371,000
Adjusted Claims Distribution	\$1,718,600	\$429,651

The Model's figure for all claims (\$429,651) is applied to the expected MCO malpractice claims incidence to produce the estimated malpractice liability. Legal expenses are assumed to average \$125,000 over all suits.

### C. Per Member Per Month Cost Calculation

The MCO malpractice claim incidence and average award per claim translate to a cost per member per month (PMPM).

$$\text{Cost PMPM} = \frac{(\text{MCO Malpractice Claim Incidence per 1,000 members})}{(\text{Average Award} + \text{Legal expense}) / 1,000 \text{ members} / 12 \text{ months}}$$

Substituting factors in the formula further illustrates the calculation for an IPA model with commercial enrollment.

## The Malpractice Liability Assessment Model

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$$\text{Cost PMPM} = .0504 \times (\$429,651 + \$125,000) / 12,000 = \$2.33 \text{ PMPM}$$

Using the variables outlined above, this estimate is for an IPA/network model HMO in a state in which the Model Law has a significant impact. The MCO malpractice claim incidence will be lower in the moderate and low impact scenarios, thus producing a lower cost PMPM.

This illustrative calculation is for commercial (employer-sponsored) programs. Similar formulas are applied to derive costs PMPM for Medicare and Medicaid managed care programs. The cost PMPM is converted to a percent of premium increase.

### D. Additional Assumptions

The Model is designed to assess the direct costs associated with the legislative changes that increase malpractice liability exposure. Specifically, the Model estimates the increase in malpractice exposure and the expenses involved in defending against these claims.

Indirect costs may result from an increase in MCO malpractice liability exposure, such as the cost of defensive medicine. The Model does not include an adjustment for the cost of defensive medicine. It was determined that an adjustment was not warranted for several reasons. Physicians, hospitals and other providers, including MCOs, albeit to a lesser extent, have been subject to malpractice liability for many years, and, as such, many of the costs of defensive medicine are already reflected in current claims experience. In addition, MCOs in many states already are subject to consumer protection laws and customer demand for managed care accountability. Thus, many MCOs already have adapted their patterns of care delivery to respond to these demands. At the same time, given the motivation in a managed care environment to control costs in order to increase enrollment and remain competitive, defensive medicine practices may not be as prevalent as in a fee-for-service environment. In today's competitive environment, the motivation to control costs may prevail even if the business risk of malpractice suits increases. Moreover, relative to individual physicians, MCOs are better able to manage and bear risk--a fact that should lessen the likelihood and extent of defensive medicine on the part of these organizations. Lastly, any increase in utilization as a result of the Model Law would likely be offset by a decrease in malpractice liability. Few estimates of defensive medicine take this offset into account.

### E. Cost Impact Estimates

*Exhibit 1* summarizes the variables and assumptions applied in the Model. *Exhibits 2, 3, and 4* provide cost projections for each of the legislative impact scenarios based on the corporate practice of medicine doctrine (i.e., significant, moderate, and low impact).

## **The Malpractice Liability Assessment Model**

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For each scenario, the estimates are provided for the alternative constructions of ERISA preemption (i.e., narrowly construed and broadly construed) and for the three alternative caps on damages. Hypothetical enrollments are applied that can be adjusted to account for individual state variation. The Model is designed to accommodate state-specific assessments.

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## Model Assumptions

### Assumptions in All Legislative Impact Scenarios

Average MCO malpractice award for all filed claims		\$ 429,651
Average legal expense per malpractice claim		\$ 125,000
Plaintiff success rate		25%
Ratio of physician and hospital claims to physician claims		1.14
MCO claim incidence: broad vs. narrow ERISA preemption (Applies only to employer-sponsored programs )		5%
Additional direct negligence malpractice claims against MCOs		10%
Increase in malpractice claims in staff model vs. IPA/network model		30%
Total premium PMPM (Source: Mercer Cost Model)		
	Commercial	\$ 139.17
	Medicare Managed Care	\$ 309.35
	Medicaid Managed Care	\$ 111.84
Enrollment Assumptions		
IPA/Network	96%	Commercial 90%
Staff Model	4%	Medicare Managed Care 5%
		Medicaid Managed Care 5%

### Legislative Impact Scenarios - Percent of Malpractice Claimants Who Will Sue MCO

Significant Impact	20%
Moderate Impact	10%
Low Impact	5%

**Model Law Cost Estimates for Significant Legislative Impact Scenario**

Enrollment by Payor	Enrollment Distribution	ERISA Preemption Narrowly Construed			ERISA Preemption Broadly Construed		
		Premium PMPM	Additional Cost PMPM	Percent Change	Premium PMPM	Additional Cost PMPM	Percent Change
Employer Sponsored	90%	\$ 139.17	\$ 2.33	1.67%	\$ 139.17	\$ 0.12	0.09%
Medicare Managed Care	5%	\$ 309.35	\$ 7.19	2.32%	\$ 309.35	\$ 7.19	2.32%
Medicaid Managed Care	5%	\$ 111.84	\$ 4.36	3.89%	\$ 111.84	\$ 4.36	3.89%
Payor Composite Increase				1.83%			0.47%
<b>Enrollment by MCO Type</b>							
IPA/Network	96%			1.83%			0.47%
Staff Model	4%			0.55%			0.14%
MCO Type Composite Premium Increase (No Damage Caps)				<b>1.78%</b>			<b>0.46%</b>
<b>Alternative Caps on Damages</b>							
No cap				1.78%			0.46%
\$500,000 on non-economic damages				1.07%			0.28%
\$250,000 on non-economic damages				0.92%			0.24%

### Model Law Cost Estimates for Moderate Legislative Impact Scenario

Enrollment by Payor	Enrollment Distribution	ERISA Preemption Narrowly Construed			ERISA Preemption Broadly Construed		
		Premium PMPM	Additional Cost PMPM	Percent Change	Premium PMPM	Additional Cost PMPM	Percent Change
Employer Sponsored	90%	\$ 139.17	\$ 1.55	1.12%	\$ 139.17	\$ 0.08	0.06%
Medicare Managed Care	5%	\$ 309.35	\$ 4.79	1.55%	\$ 309.35	\$ 4.79	1.55%
Medicaid Managed Care	5%	\$ 111.84	\$ 2.90	2.60%	\$ 111.84	\$ 2.90	2.60%
	Payor Composite Increase			1.22%			3.31%
<u>Enrollment by MCO Type</u>							
IPA / Network	96%			1.22%			0.31%
Staff Model	4%			0.37%			0.09%
	MCO Type Composite Premium Increase (No Damage Caps)			1.19%			0.30%
<u>Alternative Caps on Damages</u>							
No cap				1.19%			0.30%
\$500,000 on non-economic damages				0.71%			0.18%
\$250,000 on non-economic damages				0.61%			0.15%

### Model Law Cost Estimates for Low Legislative Impact Scenario

Enrollment by Payor	Enrollment Distribution	ERISA Preemption Narrowly Construed			ERISA Preemption Broadly Construed		
		Premium PMPM	Additional Cost PMPM	Percent Change	Premium PMPM	Additional Cost PMPM	Percent Change
Employer Sponsored	90%	\$ 139.17	\$ 1.17	0.84%	\$ 139.17	\$ 0.06	0.04%
Medicare Managed Care	5%	\$ 309.35	\$ 3.59	1.16%	\$ 309.35	\$ 3.59	1.16%
Medicaid Managed Care	5%	\$ 111.84	\$ 2.18	1.95%	\$ 111.84	\$ 2.18	1.95%
Payor Composite Increase				0.91%			0.23%
<u>Enrollment by MCO Type</u>							
IPA / Network	96%			0.91%			0.23%
Staff Model	4%			0.27%			0.07%
MCO Type Composite Premium Increase (No Damage Caps)				0.88%			0.22%
<u>Alternative Caps on Damages</u>							
No cap				0.88%			0.22%
\$500,000 on non-economic damages				0.53%			0.13%
\$250,000 on non-economic damages				0.46%			0.12%



**Blue Cross  
Blue Shield of Alaska**  
A PREMIERA HEALTH PLAN  
Indemnities Licensee of the Blue Cross and Blue Shield Association

2550 Denali Street, Suite 600  
Anchorage, Alaska 99503-2737

February 2, 2000

Representative Norman Rokeberg  
PO Box 221721  
Anchorage, AK 99508

Dear Representative Rokeberg:

As you recall, last Fall you sat down with me and Jerry Reinwand to discuss your bill, HB 211, the "Patients' Bill of Rights". We appreciate the time we have worked together on this bill with the goal of providing Alaskans with the best healthcare coverage possible.

As we discussed at that meeting, Blue Cross Blue Shield of Alaska (BCBS of AK), is 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 health care 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 healthcare 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 light 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 as 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.

As you know, Congress has been debating these same issues. A conference committee on the Federal Patients' Bill of Rights will start meeting within the next few weeks, if not earlier. We should know the outcome of that conference committee prior to the Alaska Legislature's adjournment and I would like to recommend that the Alaska Legislature consider holding off the passage of HB 211 until we know the outcome of this conference committee at the Federal level. To pass a bill in Juneau that will be different than what will be required of the approximately 60% of Alaskans that are covered under the ERISA law could create a two-tiered system of health care for Alaskans. It could also result in increased expenditures in administrative costs that are better spent in increased health care delivery.

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

February 1, 2000

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

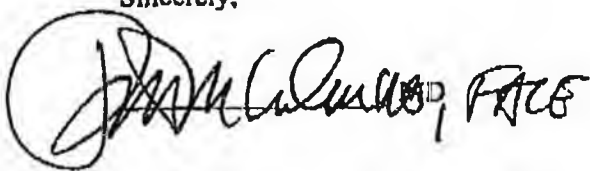
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Internal Medicine/  
Endocrinology. I practice in  
Anchorage, AK at Providence hospital. I am writing to ask for your support in  
advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



PATRICK M. NOLAN, D.O. INC.  
3300 PROVIDENCE DR.  
SUITE 208  
ANCHORAGE, ALASKA 99508  
(907) 581-6100

MARY P. DeMERS, D.O., M.P.H.

Occupational Medicine  
Internal Medicine

3300 Providence Drive, Suite 202  
Anchorage, AK 99508  
Telephone: (907) 261-5070

February 1, 2000

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

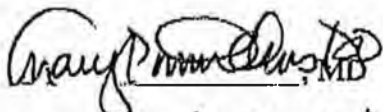
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Internal Med. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

  
Mary P. Demers DO

RECEIVED  
FEB 07 2000

P.S. Hi Norm -

MICHAEL B. ARMSTRONG, M.D.  
Diplomate American Board of Internal Medicine  
Subspecialty of Rheumatology  
2841 DeBarr Rd., Suite 44  
Anchorage, Alaska 99508  
Telephone: (907) 277-1375  
Fax: (907) 277-1376

February 3, 2000

Honorable Norm Rokeberg  
STATE OF ALASKA  
House of Representatives  
Chairman, House Labor & Commerce Committee  
State Capitol  
Juneau, AK 99801-1182

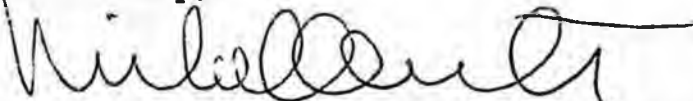
Re: **HB211 - Regulations of Managed Care Insurance Plan**

Dear Representative Rokeberg:

I am a private practice physician specializing in rheumatology. I practice in Anchorage, AK, at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB11:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for the meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity".
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Michael B. Armstrong, M.D., F.A.C.R.  
Diplomate  
American Board of Internal Medicine  
Subspecialty of Rheumatology

MBA/lal

February 1, 2000

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

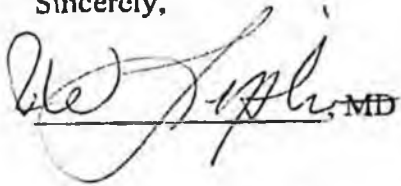
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Anchorage. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Robert W. Lipke, MD, APC  
P.O. Box 231969  
Anchorage, AK 99523

JOHN B. DEKEYSER, M.D., P.C.  
Obstetrics & Gynecology

Alaska Medical Plaza  
1200 Airport Heights Drive, #280A  
Anchorage, Alaska 99508 2955  
(907) 264-2317 (800) 818-2229  
Fax (907) 264 2320

February 1, 2000

Honorable Norm Rokeberg  
State of Alaska  
House of Representatives  
Chairman, House Labor & Commerce Committee  
State Capitol  
Juneau, AK 99801-1182

Re: ~~HB 211-Regulations of Managed Care Insurance Plan~~

Dear Representative Rokeberg,

I moved to Alaska in 1984 to enter the private practice of medicine. I practice out of both Providence and Alaska Regional Hospitals. I am encouraging you to support HB211.

This bill will help keep the playing field level and help keep insurance companies accountable. It will allow patients to keep continuity of care with the physician of their choice.

Thank you for your thoughtful consideration.

Sincerely,

  
John DeKeyser

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FEB 07 2000

JOHN SCHULTZ, D.O.  
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY  
4048 LAUREL STREET, SUITE 301  
ANCHORAGE, ALASKA 99508  
—  
TELEPHONE (907) 562-2510

February 3, 2000

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

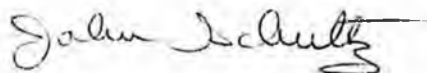
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in dermatology. I practice in Anchorage, AK on Laurel Street. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



John Schultz, D.O.  
JS:jm

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FEB 07 2000

**Alaska Physicians & Surgeons, Inc.**  
4120 Laurel Street, Ste. 206  
Anchorage, Ak 99508  
Phone: 907-561-7705 Fax: 907-561-7704  
Email: akphys@alaska.net

Tuesday, Feb. 1, 2000

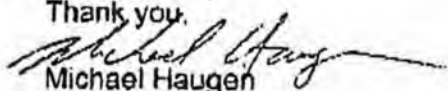
## URGENT ACTION MEMO

### Alaska Physicians & Surgeons Members:

This Friday, February 4, 2000 there will be a hearing in Juneau regarding HB211 the "Alaska State Patients Bill of Rights." HB211 has many important provisions that will benefit physicians and patients in Alaska including: the AMA definition of medical necessity, a prudent layperson standard for emergency services, a neutral external appeal of denied claims, a point of service option, and a prohibition on gage clauses and on all products clauses.

Attached is a form letter for Individual APS members to put on your own letterhead, and fax to Representative Norm Rokeberg by noon Friday, February 4th. Representative Rokeberg's fax number is 907-465-2040.

Please support APS in its efforts to improve the delivery of health care for all Alaskans.

Thank you.  
  
Michael Haugen  
Executive Director

*Pls Fax*

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FEB 03 2000

Owen R. Bell, M.D.  
Wendy Thon, ANP, RN-C  
Martha Linden, CNM, MSN  
Professional Corporation

February 2, 2000

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

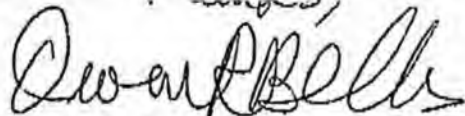
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private physician specializing in Obstetrics and Gynecology. I practice in Anchorage, AK at Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity".
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely, *Thanks,*



Owen R. Bell, MD

ORB:jlh



# American College of Cardiology

HEART HOUSE 9111 OLD GEORGETOWN ROAD BETHESDA, MARYLAND 20814 1699 (301) 897-6400  
800-253-4636  
FAX (301) 897-9745

Office of the ACC Governor  
for Alaska

Please Reply to:  
WILLIAM P. MAYER, M.D., F.A.C.C.  
Number 205  
3300 Providence Drive  
Anchorage, Alaska 99508  
Tele no. (907) 662-2079  
Fax (907) 563-2025

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SYLVAN LEE WEINBERG, M.D.

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- DANIEL J. ULLYOT, M.D.
- SYLVAN LEE WEINBERG, M.D.
- WILLIAM L. WINTERS, JR., M.D.
- DOUGLAS P. ZIVLES, M.D.

February 3, 2000

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

Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Cardiology. I practice in Anchorage, Alaska, at Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

William P. Mayer, MD, FACC, FACP

RECEIVED  
FEB 03 2000

Executive Vice President  
F. LYNN MAY

*Roland E. Gower, M.D.*  
A PROFESSIONAL CORP.  
2841 DE BARR RD #41  
ANCHORAGE ALASKA 99508  
907-270-3564

PRACTICE LIMITED TO GENERAL SURGERY

BY APPOINTMENT ONLY

February 1, 2000

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

Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in General Surgery. I practice in Anchorage, AK, at both Providence and Alaska Regional hospitals. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treatment physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Roland E. Gower, MD

REG/eas

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FEB 03 2000



ALASKA PHYSICAL THERAPY ASSOCIATION, INC.

A CHAPTER OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION  
11132 PLACER CIRCLE EAGLE RIVER, AK 99577

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FEB 03 2000

PO Box 240286  
Douglas, AK 99824  
(907) 586-4315  
Feb 2, 2000

Rep. Norman Rokeberg  
Chairman, Labor + Commerce  
Sponsor of HB 211

Dear Representative Rokeberg,

I would like to thank you for sponsoring  
~~HB 211~~ to protect Alaskans.

I am a Juneau physical therapist and  
represent the Alaska chapter of the American  
Physical Therapy Association.

We would like to request that HB 211  
include internal utilization review by a clinical  
peer. Currently it seems there is no peer  
review required until the external review  
which may cost a patient up to 25\$.  
The point-of-service in last

- 2 -

Spring's working draft section 21.07.030 (a) was worded better than in the new draft.

Also, the new draft eliminates the ability of a patient to ~~be~~ continue to be followed by their health care provider if the health care provider is terminated by the plan. This was in section 21.07.030(c). and should be included in the new draft.

Thank you for working on this. Please let me know if I can be of any assistance in getting this bill passed.

Sincerely,

Mary Veale P.T.

MEDICAL  
PARK  
FAMILY CARE, Inc.



"Prompt, Thorough, Concerned"

F. LELAND JONES, M.D.  
KENNETH S. LAUFER, M.D.  
R. MATISON WHITE, JR., M.D.  
RICHARD R. TAYLOR JR., M.D.  
CHARLES L. AARONS, M.D.

GLENN J. SCHULTES, M.D.  
GARY L. CHILD, D.O.  
TIMOTHY COALWELL, M.D.  
MARIO A. LANZA, M.D.  
MICHELE A. CHASE, M.D.

Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

February 2, 2000

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

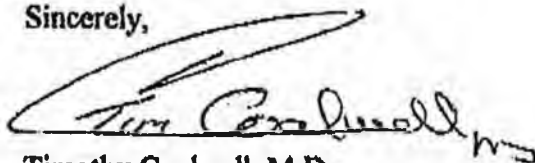
RE: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am a private physician specializing in Family Practice. I practice in Anchorage, Alaska at Medical Park Family Care. I am writing to ask for your support in advocating the following aspects of HB211:

- Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity"
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- Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

  
Timothy Coalwell, M.D.

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FEB 04 2000

MEDICAL  
PARK  
FAMILY CARE, Inc.



"Prompt, Thorough, Concerned"

F. LELAND JONES, M.D.  
KENNETH S. LAUFER, M.D.  
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Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

February 2, 2000

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

RE: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg

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- Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

F. Leland Jones, M.D.

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FEB 04 2000 FEB 04 2000

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FAMILY CARE, Inc.



F. LELAND JONES, M.D.  
KENNETH S. LAUFER, M.D.  
R. MATISON WHITE, JR., M.D.  
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"Prompt. Thorough. Concerned"

Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

February 2, 2000

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

RE: HB211 - Regulations of Managed Care Insurance Plan

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Sincerely,

R. Randy Taylor M.D.

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FEB 04 2000

MEDICAL  
PARK  
FAMILY CARE, Inc.



"Prompt, Thorough, Concerned"

F. LELAND JONES, M.D.  
KENNETH S. LAUFER, M.D.  
R. MATISON WHITE, JR., M.D.  
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Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

February 2, 2000

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

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Sincerely,

*Glenn Schultes, M.D.*

Glenn Schultes, M.D.

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FEB 04 2000

MEDICAL  
PARK  
FAMILY CARE, Inc.



"Prompt, Thorough, Concerned"

F. LELAND JONES, M.D.  
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MICHELE A. CHASE, M.D.

Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

February 2, 2000

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State of Alaska  
House of Representatives  
Chairman, House Labor and Commerce Committee  
State Capitol  
Juneau, AK 99801-1182

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- Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

R. Matison White, M.D.

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FEB 04 2000

MEDICAL  
PARK  
FAMILY CARE, Inc.



"Prompt, Thorough, Concerned"

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KENNETH S. LAUFER, M.D.  
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RICHARD R. TAYLOR JR., M.D.  
CHARLES L. AARONS, M.D.

GLENN J. SCHULTES, M.D.  
GARY L. CHILD, D.O.  
TIMOTHY COALWELL, M.D.  
MARIO A. LANZA, M.D.  
MICHELE A. CHASE, M.D.

Diplomates American Board of Family Practice

2211 EAST NORTHERN LIGHTS BOULEVARD, ANCHORAGE ALASKA 99508

February 2, 2000

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

RE: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am a private physician specializing in Family Practice. I practice in Anchorage, Alaska at Medical Park Family Care. I am writing to ask for your support in advocating the following aspects of HB211:

- Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity"
- Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
- Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Gary Child, D.O.

RECEIVED

FEB 04 2000



**Internal  
Medicine  
Associates**

2841 DeBarr Road  
Suite 50  
Anchorage, Alaska  
99508

Telephone  
(907) 276-2811

Fax  
(907) 258-6590

**GASTROENTEROLOGY**

Richard F.  
BUCHANAN, MD

William H.  
MCCRAY, JF, MD

David E.  
PEACH, MD, FACP

Gerry  
SAHAGUN, MD

Charles R.  
SHANNON, MD

**PULMONARY**

Beth A.  
BAKER, MD,  
FCCP, FACP

Gregory D.  
GERBOTH, MD,  
FCCP

**ENDOCRINOLOGY**

Janice A.  
KOVAL, MD

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Gastroenterology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

David Peach, MD

RECEIVED  
FEB 04 2000

MILTON T. HUMMER, M.D.  
ANESTHESIOLOGY  
4215 Charing Cross Circle  
Anchorage, Alaska 99504  
Phone 333-9939

February 4, 2000

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

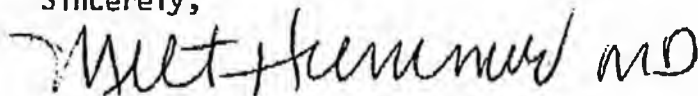
RE: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in anesthesiology. I practice in Anchorage, AK at Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Milton T. Hummer, M.D.

RECEIVED  
FEB 04 2000



*Richard A. Anschuetz, MD, FACC  
 Leo B. Bustad, MD, FACC  
 John C. Finley, MD, FACC  
 Seth L. Krauss, MD, FACC  
 Paul A. Peterson, MD, FACC  
 George S. Rhyner, MD, FACC  
 David W. Souleborn, MD, FACCD*

*Jonas A. Daldau, MD, FACC  
 Colleen M. Coughlin, MD, FACC  
 Thomas K. Kramer, MD, FACC  
 William P. Mayer, MD, FACC  
 Robert L. Fulliam, III, MD, FACC  
 Mark A. Scrand, MD, FACC*

February 4, 2000

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

Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Cardiology. I practice in Anchorage, Alaska, at Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Richard A. Anschuetz, MD, FACC

RECEIVED  
 FEB 04 2000



*Richard A. Anschuetz, MD, FACC*  
*Lea E. Bustad, MD, FACC*  
*John C. Finley, MD, FACC*  
*Seth L. Krauss, MD, FACC*  
*Paul A. Peterson, MD, FACC*  
*George S. Rhymer, MD, FACC*  
*David W. Sonneborn, MD, FACC*

*James A. Baldauf, MD, FACC*  
*Colleen M. Coughlin, MD, FACC*  
*Thomas K. Kramer, MD, FACC*  
*William P. Mayer, MD, FACC*  
*Robert L. Pulliam, III, MD, FACC*  
*Mark A. Selland, MD, FACC*

February 1, 2000

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

Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in cardiology. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

James A. Baldauf, M.D., F.A.C.C.

RECEIVED  
 FEB 04 2000

3260 Providence Dr., #537 (907) 562-7575 / Fax (907) 563-9386  
 3340 Providence Dr., #522 & 2841 DeBarr Rd., #21 (907) 561-3211 / Fax (907) 561-4652  
 1200 Airport Heights, #330 (907) 258-3856 / Fax (907) 258-3984  
 Anchorage, AK 99508

**JACK ARLYN SMITH, M.D.**  
FELLOW-AMERICAN ACADEMY OF OTOLARYNGOLOGY  
4001 DALE STREET - SUITE 201  
ANCHORAGE, ALASKA 99508-5498  
FAX 561-0927 TELEPHONE (907) 561-1185

February 1, 2000

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

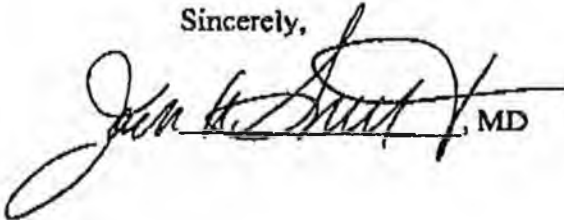
Re: HB211 -- Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in otolaryngology. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

 MD

RECEIVED  
FEB 03 2000

**Richard A. Peters, MD., L.L.C.**  
Thoracic, Vascular and General Surgery  
Board Certified, Surgery and Surgical Critical Care

3300 Providence Drive, Suite 04  
Anchorage, Alaska 99508

Phone (907) 261-4970

February 2, 2000

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

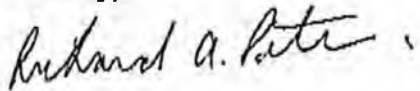
Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am a private practice physician specializing in surgery. I practice in Anchorage, AK at Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Richard A. Peters, MD

RECEIVED  
FEB 02 2000

February 1, 2000

Honorable Norm Rokberg  
State of Alaska  
House of Representatives  
Chairman, House Labor and Commerce Committee  
State Capitol  
Juneau, AK 99801-1182

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokberg:

I am a private practice physician specializing in Family Practice practice in Anchorage, AK at AK Regional hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

JC Carter, MD

RECEIVED  
FEB 02 2000

RECEIVED  
FEB 02 2000

February 1, 2000

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

Re: HB211 -- Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Gen. Pract. I practice in Anchorage, AK at AK Regional hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

*Vern A. Carter MD*

*I believe these three separate points should be separate bills.*

*Vern A. Carter MD*

**Sherman Beacham, M.D.**  
1200 Airport Heights Drive, Suite 210  
Anchorage, Alaska 99508  
(907) 264-2030/FAX (907) 276-0366

February 2, 2000

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

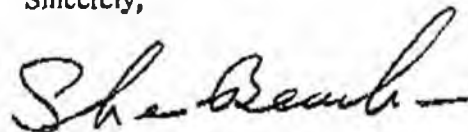
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Internal Medicine. I practice in Anchorage, AK, at Alaska Regional Hospital and Providence Alaska Medical Center. I am writing to ask for your support in advocating the following aspects of HB211.

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Sherman Beacham, M.D.

jo

RECEIVED  
FEB 02 2000



**Norman J. Wilder, MD**  
Pulmonary Disease & Aviation Medicine

Fellow, American College of Physicians (FACP)  
Fellow, American College of Chest Physicians (FCCP)  
Diplomate, American Board of Internal Medicine in  
Internal Medicine and Pulmonary Disease

1200 Airport Heights Drive, Suite 210  
Anchorage, AK 99508-2952  
Tel: (907) 264-2030 Fax: 276-0366  
E-mail: wilder@alaska.net

February 2, 2000

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Pulmonary Disease. I practice in Anchorage, AK, at Alaska Regional Hospital and Providence Alaska Medical Center. I am writing to ask for your support in advocating the following aspects of HB211.

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Norman J. Wilder, M.D.

RECEIVED  
FEB 02 2000

jo

**Burton Janis, M.D.**  
1200 Airport Heights Drive, Suite 210  
Anchorage, Alaska 99508  
907/264-2030

February 2, 2000

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Infectious Diseases. I practice in Anchorage, AK, at Alaska Regional Hospital and Providence Alaska Medical Center. I am writing to ask for your support in advocating the following aspects of HB211.

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Burton Janis, M.D.

jo

RECEIVED  
FEB 02 2000

**Richard L. Neubauer MD, FACP**  
1200 Airport Heights Dr. Suite 210  
Anchorage, Alaska 99508-2952  
Telephone 907-264-2030  
Fax 907-276-0366

February 2, 2000

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Internal Medicine. I practice in Anchorage, AK, at Alaska Regional Hospital and Providence Alaska Medical Center. I am writing to ask for your support in advocating the following aspects of HB211.

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

  
Richard L. Neubauer, M.D.

jo

RECEIVED  
FEB 02 2000

**Mark E. Richey, M.D., P.C.**

*Obstetrics, Gynecology & Infertility*

February 2, 2000

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

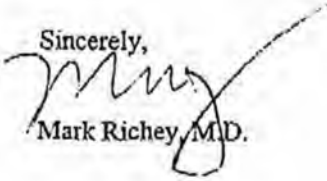
RE: HB 211 - Regulations of managed care insurance plan

Dear Representative Rokeberg:

I am a private practice physician specializing in obstetrics and gynecology. I practice in Anchorage, Alaska at both Providence and Alaska Regional Hospitals. I am writing to ask your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Mark Richey, M.D.

RECEIVED  
FEB 9 2 2000



*Geneva Woods Ear, Nose and Throat Associates, Inc.*

FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

J. DAVID WILLIAMS, M.D.  
DONALD R. ENDRES, M.D.3730 RHONE CIRCLE, SUITE 203  
ANCHORAGE, ALASKA 99508  
TELEPHONE: (907) 583-3515  
FAX: (907) 562-0425

January 2, 2000

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

Re: HB211- Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private physician specializing in otolaryngology (ear, nose and throat). I practice in Anchorage, Alaska, utilizing both private sector hospitals. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity".
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,



Donald R. Endres, M.D.

DRE/ag

RECEIVED  
FEB 02 2000



# Internal Medicine Associates

2841 DeBarr Road  
Suite 50  
Anchorage, Alaska  
99508

Telephone  
(907) 276-2811

Fax  
(907) 258-6590

## GASTROENTEROLOGY

Richard F.  
BUCHANAN, M.D.

William H.  
MCCRAY, JR., M.D.

David E.  
PEACH, M.D., FACP

Garry  
SAHAGUN, M.D.

Charles R.  
SHANNON, M.D.

## PULMONARY

Beth A.  
BAKER, M.D.  
FCCP, FACP

Gregory D.  
GERBOTHY, M.D.  
FCCP

## ENDOCRINOLOGY

Janice A.  
KOVAL, M.D.

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Gastroenterology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Richard Buchanan, MD

RECEIVED  
FEB 02 2000



# Internal Medicine Associates

2841 DeBarr Road  
Suite 50  
Anchorage, Alaska  
99508

Telephone  
(907) 278-2811

Fax  
(907) 259-6580

## GASTROENTEROLOGY

Richard F.  
BUCHANAN, M.D.

William H.  
MCCRAY, JR., M.D.

David E.  
PEACH, M.D., FACP

Gerry  
SAHAGUN, M.D.

Charles R.  
SHANNON, M.D.

## PULMONARY

Beth A.  
BAKER, M.D.  
FCCP, FACP

Gregory D.  
GERBOTH, M.D.  
FCCP

## ENDOCRINOLOGY

Janice A.  
KOVAL, M.D.

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Endocrinology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

*Janice A. Koval, MD*

Janice Koval, MD

RECEIVED  
FEB 02 2000



# Internal Medicine Associates

2841 DeBarr Road  
Suite 50  
Anchorage, Alaska  
99508

Telephone  
(907) 276-2811

Fax  
(907) 258-6590

## GASTROENTEROLOGY

Richard F.  
BUCHANAN, MD

William H.  
MCCRAY, JR., MD

David E.  
PEACH, MD, FACP

Gerry  
SAHAGUN, MD

Charles R.  
SHANNON, MD

## PULMONARY

Beth A.  
BAKER, MD,  
FCCP, FACP

Gregory D.  
GERBOTH, MD,  
FCCP

## ENDOCRINOLOGY

Janice A.  
KOVAL, MD

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Gastroenterology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Geronimo Sahagun, MD

RECEIVED  
FEB 02 2000



# Internal Medicine Associates

2841 DeBarr Road  
Suite 50  
Anchorage, Alaska  
99508

Telephone  
(907) 276-2811

Fax  
(907) 258-6530

## GASTROENTEROLOGY

Richard F.  
BUCHANAN, M.D.

William H.  
MCCRAY, JR., M.D.

David E.  
PEACH, M.D., FACP

Gerry  
SAHAGUN, M.D.

Charles R.  
SHANNON, M.D.

## PULMONARY

Beth A.  
BAKER, M.D.  
FCCP, FACP

Gregory D.  
GERBOTH, M.D.  
FCCP

## ENDOCRINOLOGY

Janice A.  
KOVAL, M.D.

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Pulmonology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

*Gregory Gerboth MD*

Gregory Gerboth, MD

RECEIVED  
FEB 02 2000

RECEIVED  
FEB 02 2000

*Geneva Woods Ear, Nose and Throat Associates, Inc.*

FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

J. DAVID WILLIAMS, M.D.  
DONALD R. ENDRES, M.D.

3730 RHONE CIRCLE, SUITE 200  
ANCHORAGE, ALASKA 99508  
TELEPHONE: (907) 563-3515  
FAX: (907) 562-0425

January 2, 2000

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

Re: HB211- Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private physician specializing in otolaryngology (ear, nose and throat). I practice in Anchorage, Alaska, utilizing both private sector hospitals. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity".
2. Provide a more "level playing field" in the contractual arrangements between Alaska's physicians and the large managed care health insurance companies.
3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

  
J. David Williams, M.D.

JDW/ag

JOHN C. MUES, M.D., F.A.C.P.  
INTERNAL MEDICINE

2-1-00

To: Honorable Norm Rokeberg  
State of Alaska, House of Representatives  
Chairman, House Labor and Commerce Committee  
State Capitol  
Juneau, Alaska 99801-1182

Re: HB 211- Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am a General Internist in Anchorage. I practice Primary Care Internal Medicine and see a wide variety of people in differing age groups for multiple medical problems. I am writing to ask for your support in Advocating the following aspects of HB 211:

1. Require Managed Care Insurance Companies to allow Alaska's Patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on an Insurance Company's determination of the lack of "medical necessity".
2. Provide a more "level playing field" in the contractual arrangements between Alaska's Physicians and the large Managed Care Health Insurance companies.
3. Hold Managed Care Health Insurance Companies accountable for the negligent health care decisions they might make.

Please remember that Physicians in fighting for reasonable rules of work are fighting for patient rights and the ability to continue with the quality of Health Care that Alaskans enjoy at this time.

Lack of Insurance or concerns about Insurance Coverage are often the primary factor in decisions by patients to delay or avoid appropriate health care visits. This ultimately costs more for health care and can seriously impact the lives of patients.

Remember- we are all going to access the Health Care System for care. The concept of being a Patient is not theoretical for any of us. We need to preserve our right to select appropriate Health Care according to our own needs and perceptions rather than the needs of a profit hungry bureaucracy.

Sincerely,

  
John C. Mues, M.D.

4120 Laurel St., Suite 204 Anchorage, Alaska 99508  
Ph: 907-561-4362 Fax: 907-563-4498

RECEIVED  
FEB 02 2000

February 1, 2000

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

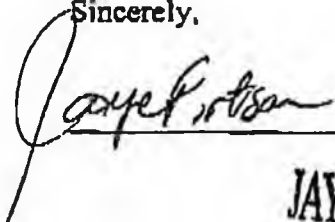
Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Dermatology. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

 , MD

JAYNE FORTSON, M.D.

JAYNE FORTSON, M.D.  
2401 E. 42nd Ave., Suite 301  
Anchorage, Alaska 99508  
(907) 563-3204

RECEIVED  
FEB 02 2000

**GRIFFITH C. STEINER, M.D.**

OPHTHALMOLOGY

3340 Providence Drive, Suite 565  
Anchorage, Alaska 99508  
Tel. (907) 561-1167  
Fax (907) 561-7051

February 1, 2000

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


Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Ophthalmology I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

 , MD  
GRIFF C. STEINER, MD



# Internal Medicine Associates

2841 DeBarr Road  
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## GASTROENTEROLOGY:

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PEACH, M.D., FACP

Gerry  
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Charles R.  
SHANNON, M.D.

## PULMONARY

Beth A.  
BAKER, M.D.  
FCCP, FACP

Gregory D.  
GERBOTH, M.D.  
FCCP

## ENDOCRINOLOGY

Janice A.  
KOVAL, M.D.

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 – Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Gastroenterology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

William McCray, MD

RECEIVED  
FEB 03 2000



# Internal Medicine Associates

2841 DeBarr Road  
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99508

Telephone  
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Fax  
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## GASTROENTEROLOGY

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David E.  
PEACH, M.D., FACP

Gerry  
SAHAGUN, M.D.

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GERBOTHY, M.D.  
FCCP

## ENDOCRINOLOGY

Janice A.  
KOVAL, M.D.

February 2, 2000

Via Fax (907) 465-2040

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

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Pulmonology. I practice in Anchorage, AK at Alaska Regional Hospital and Providence Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patients' physician, and for a meaningful external, neutral review of claims denied or reduced based on an insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Beth Baker, MD

RECEIVED  
FEB 03 2000

Feb-01-00 11:47A APS

February 1, 2000

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

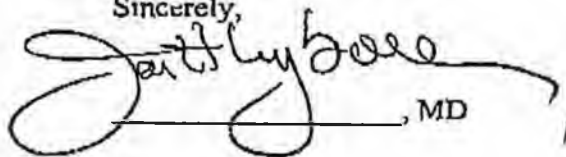
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in OPHTHALMOLOGY. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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Sincerely,

  
MD

RECEIVED  
FEB 02 2000

February 1, 2000

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House of Representatives  
Chairman, House Labor and Commerce Committee  
State Capitol  
Juneau, AK 99801-1182

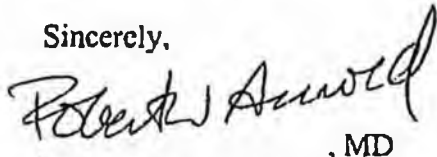
Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in PEDIATRIC EYE. I practice in Anchorage, AK at PROVIDENCE hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

  
\_\_\_\_\_, MD

RECEIVED

FEB 02 2000

February 1, 2000

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

Re: HB211 -- Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg:

I am a private practice physician specializing in Anesthesiology. I practice in Anchorage, AK at Providence hospital. I am writing to ask for your support in advocating the following aspects of HB211:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians, reasonable continuation of care by the patient's physician, and for a meaningful external, neutral review of claims denied or reduced based on a insurance company's determination of the lack of "medical necessity."
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

Barbara M. Chen MD  
BARBARA M. CHEN, MD

RECEIVED  
FEB 02 2000

**HEALTHSOUTH**  
Diagnostic Center of Anchorage

RECEIVED  
FEB 14 2000

February 1, 2000

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

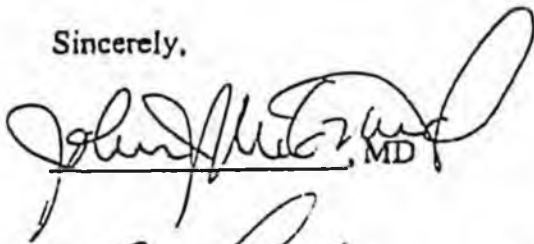
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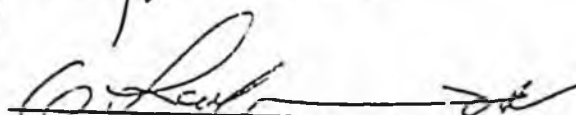
Dear Representative Rokeberg:

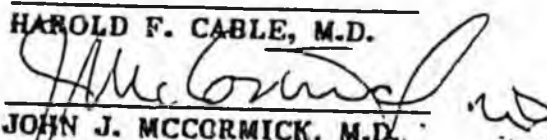
I am a private practice physician specializing in RADIOLOGY. I practice in Anchorage, AK at Health South Hospital. I am writing to ask for your support in advocating the following aspects of HB211:

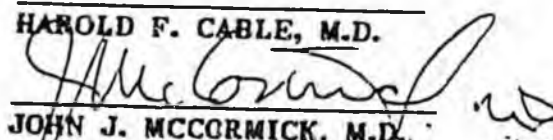
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3. Hold managed care health insurance companies accountable for the negligent health care decisions they might make.

Sincerely,

  
\_\_\_\_\_  
JOHN J. MCCORMICK, M.D.

  
\_\_\_\_\_  
GEORGE H. LADYMAN, M.D.

  
\_\_\_\_\_  
HAROLD F. CABLE, M.D.

  
\_\_\_\_\_  
JOHN J. MCCORMICK, M.D.

4003 Lake Otis Pkwy., Suite 101 • Anchorage, AK 99508 • Clinic 907 563-3493 • Fax 907 561-2596



Health Insurance Association of America

## **"MEDICAL NECESSITY"**

### **What is "Medical Necessity"?**

- Several of the so-called patient protection legislative proposals before Congress contain language regarding the determination of "medically necessary" treatment in health care plans that would – if enacted – have a profound effect on how all health plans and insurers function.
- These provisions, referred to as Section 151, are found in that section of both the Daschle/Kennedy/Dingell bills (S. 6/H.R. 358) and Dr. Ganske's bill (H.R. 719), and in Section 129 of Senator Chafee's bill (S. 374).
- Section 151 would prohibit group health plans and health insurance issuers from arbitrarily interfering with or altering the decision of the treating physician regarding the manner or setting in which particular services are delivered, if the services are medically necessary or appropriate for treatment or diagnosis.
  - ◆ The term "manner or setting" is defined as the "location of the treatment, such as whether treatment is provided on an inpatient or outpatient basis, and the duration of treatment, such as the number of days in a hospital."
  - ◆ The term "medically necessary or appropriate" is defined as a service or benefit that is "consistent with generally accepted principles of professional medical practice."
  - ◆ There is a limited safeguard in that all services determined to be medically necessary by the treating physician must be "otherwise a covered benefit." However, how this would be interpreted in regulation and by the courts in tandem with the potential breadth of the "generally accepted principles of medical practice" standard for treatment would be an open question.

### **"Medical Necessity" Provisions Are Unnecessary.**

- According to two recent studies, in 97 percent of the cases involving utilization review, the courses of treatment recommended by physicians were approved. One of the studies (Remler *et al*, *Inquiry*, Fall 1997), based on a survey of over 2,000 physicians caring for patients covered under plans utilizing managed care techniques, found that the final overall coverage denial rate for physician-proposed treatment plans in eight categories of care was less than 3 percent, and that the figure was much less for most categories of care. The majority of physicians reported no coverage denials whatsoever.

**"Medical Necessity" Provisions Would Apply To All Types of Plans, Not Just To Managed Care Plans.**

- While sponsors of these provisions contend that they are aimed at reforming the practices of managed care plans, Section 151 would apply to all types of plans, from closed panel HMOs to fee-for-service plans.
- This is because the legislation would amend the Public Health Service Act's group health plan provisions of Title XXVII and the individual health insurance rules of Title XXVII, and would incorporate the rules into the Employee Retirement Income Security Act (ERISA).

**"Medical Necessity" Provisions Would Drive Up Health Care Costs and Increase the Number of Uninsured Americans.**

- If enacted, Section 151 and other similar proposals would – at a minimum – have a chilling effect on health plan utilization management, increasing costs to plans and consumers.
- Utilization review and other quality and cost-containment mechanisms could be characterized as "arbitrary interference with," or "alteration of," the physician's medically necessary treatment plan.
- Control of coverage and payment decisions would shift from insurers and managed care plans and plan fiduciaries to providers.
- Even in the era of only fee-for-service medical coverage, insurers reviewed claims for "medical necessity and appropriateness" in an early attempt to prevent the unconstrained flow of reimbursement for health care services that persistently drove up costs.
- This concept was adopted by the federal government in establishing the Medicare and Medicaid programs, and is found in other government sponsored health programs such as FEHBP and the Military Health Services System.

**"Medical Necessity" Provisions Would Increase Fraud, Waste, and Abuse.**

- Section 151 raises significant legal barriers to private sector efforts to combat waste, fraud, and abuse in the health care system.
- Saddling private health plans with additional legal barriers to challenging coverage determinations on the basis of "medical necessity" would encourage fraudulent claims, and they would become much more commonplace in the private sector.
- The cooperative anti-fraud efforts of HHS, DOJ, the FBI – and now even AARP members – to reduce fraud in Medicare have received a good deal of media attention in the past few weeks.

- In announcing the results of the Medicare audit in February, HHS Secretary Donna Shalala indicated a 45 percent reduction in improper payments in the past two years. June Gibbs Brown, Inspector General of HHS, indicated that \$12.6 billion is still misspent, either through fraud or error. However, providers that claim that items and services are medically necessary when, in fact, they are not, continue to be a problem. HHS officials indicated that the largest remaining cause of improper payments is "lack of medical necessity."  
(Washington Post, 2/10/99)
- Testifying before Congress in 1997, Charles L. Owens, chief of the FBI's Financial Crimes Section, stated that health care fraud has become the number one white collar crime in America, and that "[h]ealth care fraud is causing a serious financial drain on the country, and we must continue our collective efforts to combat it."

#### "Medical Necessity" Provisions Would Threaten Quality.

- By turning medical necessity determinations over to providers, the legislation threatens to undermine the considerable progress made in the last decade with respect to quality and cost.
- The utilization review process that is fundamental to the managed care "choice" would be severely curtailed and unforeseen, extra-contractual obligations imposed that would require premium increases or threaten health plan and insurer solvency.

#### "Medical Necessity" Provisions Would Undermine Private Contracts and ERISA's Fiduciary Duty Provisions.

- Interference with the medical necessity determinations of plans and insurers changes the nature of the health insurance contract. Medical necessity provisions would nullify the central tenet of insurance contracts, which are in fact agreements in which the insurer pledges to maximize the pooled resources of the many to the advantage of all beneficiaries. This obligation to make the best use of pooled resources is fundamental to all forms of insurance. With health coverage, insurers fulfill this responsibility to those who have paid premiums by agreeing to pay only for "covered" items and services determined to be medically necessary and appropriate.
- If providers were able to obligate health plans to pay for costs related to medical services that had not been reflected in the actuarial assumptions used to price the policy, they would not simply drive up reimbursement costs, but could also threaten the financial stability of the plans and would play havoc with the claims administration of employer-provided benefit plans. This will undermine well-established fiduciary responsibilities under ERISA, such as ensuring that decisions by administrators of ERISA group health plans are properly made solely in the interests of participants and beneficiaries. A fiduciary can be held personally liable for a breach of that duty.

### Conclusion

- "Medical necessity" proposals would remake the world of health benefit plans. In doing so, they would:
  - ◆ threaten utilization management and undermine other quality and cost containment mechanisms;
  - ◆ increase the opportunity for fraud and abuse, and for the possible risk of harm to patients;
  - ◆ abrogate private contract and fiduciary responsibility under ERISA; and
  - ◆ needlessly raise costs for plans, thereby driving up premiums and reducing the affordability of health insurance.
- Such legislative proposals threaten to reduce the availability of coverage and would increase the number of uninsured Americans.



HEALTH INSURANCE ASSOCIATION OF AMERICA

**“MEDICAL NECESSITY”  
AND  
HEALTH PLAN CONTRACTS**

March 1999

## **“Medical Necessity” and Health Plan Contracts**

### **Executive Summary**

Is it sound public policy for legislators to shift the responsibility for interpreting “medical necessity”—a key concept in health insurance policies—from insurers to providers? This is the core question addressed by this white paper, which is based on a legal opinion commissioned by the Health Insurance Association of America in January 1999 from William G. Schiffbauer, Esq.

The question is provoked by legislation that has been proposed on Capitol Hill<sup>1</sup> and in many states. At first blush, such legislation, which would place determinations of “medical necessity” solely into the hands of treating physicians, seems innocuous, even reasonable: Why shouldn’t treating physicians *define* what is *medically necessary*? But, in fact, this proposed change—which would have a detrimental effect on health care in America—reflects the widespread public confusion about “medical necessity” as a boundary of health coverage and “medical necessity” as a clinical determination by a treating physician.

The “medical necessity” provisions in currently proposed federal legislation represent a radical rewriting by public officials of the contract between insurers and health plans and their customers. When the provider, rather than the health plan or insurer, interprets the scope of coverage under the contract, health plans and fiduciaries cannot guarantee to the insured that health care dollars are being spent fairly and equitably on medical treatments that are safe, proven, and effective. Indeed, such legislation could give some providers incentives to overtreat patients to enhance their incomes. Under such a regime, who can doubt that insurers’ denials of payment or determinations of noncoverage would be regularly challenged?

In effect, the proposed “medical necessity” provisions represent an attempt to turn back the clock. Such proposals would do more than simply return the health care system to the unconstrained fee-for-service system of payment that was responsible for the double-digit inflation in health care costs of the 1970s and 1980s. It would undermine efforts by all types of health plan delivery models, from HMOs through PPOs and fee-for-service coverage. Even in the earlier era of fee-for-service medical coverage, insurers reviewed claims to ensure that the services already delivered had in fact been medically necessary.

Far from protecting patients, passage of such legislation would be deeply inimical to the interests of health care consumers, driving up the cost of medical care and possibly even placing patients in harm’s way. The legislation would needlessly raise costs for plans, thereby promoting premium increases and reducing the affordability of health insurance. In the long run, such legislation threatens to diminish the availability of coverage and increase the number of the uninsured.

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The basis for these misguided proposals is the perception that insurers routinely make numerous, unfounded adverse coverage determinations. A 1997 study based on a survey of over 2,000 physicians caring for patients covered under plans utilizing managed care techniques found that the final overall coverage denial rate for physician-proposed treatment plans in eight categories of care was less than 3 percent, and that the figure was much less for most of the categories of care.<sup>2</sup> The majority of physicians reported no coverage denials whatsoever. Under specific types of care, coverage for hospitalization was denied only 1 percent of the time; surgical procedures, 1.2 percent; and specialist referrals, 2.6 percent. The rate of initial denials was higher, but between one-half and two-thirds of these first level denials were reversed by the health plans, resulting in the lower final denial rate.

Health plans use national standards validated by evidence-based scientific studies or prepared by prominent medical experts to understand what treatments and services are appropriate. Using those standards, medical professionals at health plans make decisions about which procedures should be covered. These decisions are coverage determinations for payment purposes. Treating physicians are ultimately responsible for recommending a course of treatment for their patients, regardless of coverage.

To illustrate some of the most egregious problems which could result from this legislation that would give physicians authority over plan coverage determinations, we have analyzed legislation under debate in the 106<sup>th</sup> Congress: the Patients' Bill of Rights (S. 6/H.R. 358).<sup>3</sup> Section 151 of this bill states that insurers and health plans may not "arbitrarily interfere with or alter the decision" of a treating physician for services that the physician has determined to be "medically necessary."<sup>4</sup> This proscription would apply to health plans of all designs, from fee-for-service indemnity to staff model health maintenance organizations and those of other managed care organizations (MCOs).<sup>5</sup>

If enacted, the proposed law would:

- (1) Undermine utilization management and increase costs by:
  - (a) turning over coverage determinations based on medical necessity solely to the treating physicians who have both economic and non-economic incentives to inflate reimbursement;
  - (b) eliminating, or sharply curtailing, effective utilization review and other cost-containment mechanisms; and
  - (c) imposing extra-contractual obligations on insurers and plans, thereby driving up premiums.
- (2) Encourage fraud and abuse, especially by providers.
- (3) Undermine quality and perhaps even expose patients to danger.
- (4) Undermine contract law by:
  - (a) permitting public officials to change essential terms and conditions of the agreement between contracting parties, to the benefit of an interest group that is not party to the contract;

- (b) preventing insurers from making appropriate coverage determinations, thus limiting their ability to meet their contractual obligations to premium payers and patients; and
  - (c) changing the essence of the fiduciary responsibility of plan administrators.
- (5) Create a unique coverage regime for private insurance inconsistent with governmentally funded programs.

This proposal is a solution in search of a problem. Currently, according to two studies,<sup>6</sup> in 97 percent of the cases involving utilization review, the physicians' recommended courses of treatment were approved. Therefore, this proposed change would remake the world—threatening utilization management, increasing fraud, increasing cost, increasing the risk of harm to patients, undermining quality, and abrogating fiduciary responsibility under ERISA—because of adverse determinations in less than 3 percent of the coverage determinations made under current practices.

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## **"Medical Necessity" and Health Plan Contracts: Complete Provider Deference Means Higher Costs, Lower Quality**

### **I. Introduction**

Proposals have been advanced to remove the interpretation of a private health insurance contract's medical necessity requirement from the private contract process and place it in the hands of providers. For example, federal legislation, such as the Patients' Bill of Rights, would propose that a health plan may not arbitrarily interfere with or alter the decision of a treating physician regarding services that the physician has determined to be "medically necessary." As discussed below, the direct object of this legislation is the substitution of the provider for the group health plan or issuer of the health insurance coverage as the party who will interpret and determine the scope of coverage and payment under the group health plan or health insurance contract.

This proposal would:

- convert coverage and payment determinations for health care expenses into medical decisions;
- disable the private contract structure and process for coverage and payment determinations in every type of plan design ranging from fee-for-service indemnity to staff-model health maintenance organizations;
- eliminate the utilization review process that is fundamental to the managed care "choice";
- foster opportunities for fraud and abuse;
- diminish health care quality; and
- impose unforeseen, extra-contractual obligations that will require premium increases or threaten health plan and insurer solvency.

The proposed legislation, if enacted, would simply shift control of coverage and payment decisions from insurers and managed care plans to providers, and it would have the effect of raising costs, thereby possibly reducing the availability of coverage and increasing the number of uninsured Americans.

### **II. Description of Proposal**

#### **A. In General**

The core change that would be brought about by the Patients' Bill of Rights is that individual providers would be granted statutory deference to control coverage and payment decisions. Section 151 of S. 6/H.R. 358, the Patients' Bill of Rights, would prohibit group health plans and issuers of health insurance coverage from "arbitrarily interfering with" or

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“altering the manner or setting” of covered health care services when that care is determined by the treating physician to be medically necessary or appropriate.<sup>7</sup> The treating physician may be the patient’s primary care physician or a specialist to whom the patient has been referred. “Manner or setting” would be defined as the location of treatment (such as inpatient or outpatient) and the duration of a service (such as number of days in a hospital).<sup>8</sup> Finally, the section defines “medically necessary or appropriate” as a service or benefit that is “consistent with generally acceptable principles of professional medical practice.”<sup>9</sup> Separately, the legislation provides that consumers may appeal the plan’s or insurer’s adherence to this section to an external review entity.<sup>10</sup> Additionally, other legal options, including judicial review, may be pursued.<sup>11</sup> Finally of note, the legislation would preempt state laws that would “prevent application” of federal law, including Section 151.<sup>12</sup>

While the sponsors of this legislation contend that it is aimed at reforming the practices of “managed care” plans, in fact, Section 151 would apply to any group health plan or health insurance coverage regardless of the type of plan.<sup>13</sup> The legislation incorporates the definitions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);<sup>14</sup> under this definition, a “group health plan” subject to this provider-determined coverage and reimbursement rule is any employee welfare benefit plan that provides coverage for medical care.<sup>15</sup> In addition, this rule would apply to any “health insurance coverage,” meaning those benefits consisting of medical care provided directly, through insurance or reimbursement or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, or insurance or HMO contract or certificate.<sup>16</sup> The legislation would amend the Public Health Service Act’s group health plan provisions of Title XXVII, incorporating this rule and other provisions by reference.<sup>17</sup> It would also amend the individual health insurance rules of Title XXVII.<sup>18</sup> Finally, the proposed legislation would incorporate the rule and other new mandates into the Employee Retirement Income Security Act (ERISA).<sup>19</sup>

The proposed legislation does include a limited safeguard in that all services determined by a treating physician to be medically necessary must be “otherwise a covered benefit.”<sup>20</sup> However, whether a benefit is itself “covered” is often the subject of interpretation and litigation<sup>21</sup>—and Section 151 would clearly lead to even greater litigation in this area. Although the “covered benefit” rule may offer some protection against physicians’ attempts to impose payments for excluded “experimental or investigational” treatments, that interpretation of the proposed bill must be weighed against the potential breadth of the “generally accepted principles of medical practice” standard for treatment—which, if interpreted liberally, may sweep in excluded therapies and procedures.<sup>22</sup> In addition, many coverage disputes center on whether certain facilities are included in the word “hospital.”<sup>23</sup> The legislation would, however, specifically protect a treating physician’s determination of the “manner or setting” of the treatment.<sup>24</sup>

## B. Consequences of Establishing Statutory Deference for Providers

Clearly, the proposed legislation is far reaching and would bring dramatic changes to how health care is financed. Nor would the legislation be easy to understand, interpret, and

administer. The terminology alone would provoke nearly endless litigation. For example, since the plain meaning of the word "arbitrary" is "without adequate determining principle, or not according to reason or judgment,"<sup>25</sup> the question will arise as to whose standard of reason or judgment is adequate. The words "interference" and "alteration" are equally debatable. Indeed, the very ambiguity of these terms would serve as a deterrent to any challenge of a provider's treatment decisions. At best, it would take years and years of litigation in jurisdictions across the country to provide some guidance in this area. The CBO cost estimate, prepared in relation to the identical Section 151 in the 1998 version of current S. 6/H.R. 358, stated that:

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 and the courts 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.<sup>26</sup>

In addition to litigation, the consequences of providing legal deference to provider coverage determinations would be far-reaching and would affect the entire health care system. If enacted, Section 151 and other similar proposals:

- would—at a minimum—have a chilling effect on health plan utilization management, increasing costs to the plans;
- would lead to increased fraud and abuse in the private health care sector, diverting enormous resources from patient care;
- would have both direct and indirect impacts on the cost of providing coverage to patients;
- would have an adverse effect on quality as providers would have increased incentives to overtreat, which could be contrary to the patient's best interests and to the delivery of quality care; and
- would abrogate the well-established fiduciary responsibility of health plans and plan administrators to the people covered under the plan.

Health insurance premiums could again spike as the effects of Section 151 requirements on utilization review are felt, and plan operational and administrative costs increase. These new legal barriers to health plan oversight could even place patients in harm's way. These requirements would radically rewrite the terms of private contracts through government fiat in a manner that is fundamentally inconsistent with the nearly identical rules followed for over three decades by public programs. Each of these concerns is discussed in greater detail below.

### III. Analysis

#### A. Concerns About Increased Fraud and Abuse

##### 1. Fraud Would Become More Difficult to Challenge

Section 151 raises significant legal barriers to private sector efforts to combat waste, fraud, and abuse in the health care system. Treating providers, who would be required only to observe the "generally accepted principles of professional medical practice" (even if such practices have been shown to be unnecessary or only marginally beneficial), would be able to challenge health plan coverage denials as arbitrary interference in or alteration of their decision making. This provision, therefore, would stand in marked contrast to increased recognition of the pervasiveness of fraud and abuse during the past decade and the commensurate expansion of public and private resources to combat fraud and abuse.<sup>27</sup>

In a 1992 report to Congress, the General Accounting Office estimated that fraud accounted for 10 percent (\$70 billion) of the nation's health care spending in 1991.<sup>28</sup> Today, that 10 percent would be more than \$100 billion.<sup>29</sup> Testifying before the House Committee on Ways and Means in 1997, Charles L. Owens, Chief of the FBI's Financial Crimes Section, stated that health care fraud has become the number one white collar crime in America.<sup>30</sup> In testimony before the Senate Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs earlier in that year, Mr. Owens had stated that "[h]ealth care fraud is causing a serious financial drain on the country, and we must continue our collective efforts to combat it."<sup>31</sup> A study by the Health Insurance Association of America found that 78 percent of all reported health care fraud cases were the result of provider actions.<sup>32</sup>

Taxpayers pay higher taxes because of fraud and abuse in public programs such as Medicare and Medicaid, and employers and individuals pay higher private health insurance premiums because of fraud and abuse in the private health care sector. Moreover, the resources wasted paying fraudulent claims reduce the number of dollars available to be spent on patient care.

As awareness of health care fraud and abuse and their increasing pervasiveness has grown during the past few years, both the government and private sector payers have significantly increased their anti-fraud activities. For example, HIPAA significantly strengthened penalties against health care fraud and established and provided funding for a coordinated fraud and abuse control program.<sup>33</sup> Penalties for committing fraud against federal government programs were further enhanced by the Balanced Budget Act of 1997.<sup>34</sup>

As part of these stepped-up anti-fraud activities, in February 1999, the Office of the Inspector General (OIG) of the Department of Health and Human Services announced that improper Medicare payments to doctors, hospitals, and other health care providers declined 45 percent from fiscal year 1996 to fiscal year 1998. HHS reported that a heightened focus since 1993 by the OIG, the FBI, the Health Care Financing Administration, the Department

of Justice, and others in government had yielded "a new, more detailed picture of fraudulent activities aimed at" government health care financing programs.<sup>35</sup>

Moreover, HHS has launched Operation Restore Trust, a project to coordinate federal, state, local, and private resources to fight fraud. According to HHS, during its two-year demonstration phase, the project identified \$23 in overpayments for every \$1 in project costs.

The stepped-up efforts resulted from years of abuse of Medicare payment policy. The Medicare program is rife with examples of fraudulent schemes designed to bilk taxpayers by claiming that items and services are "medically necessary" when they are not. For example, the government overpaid more than \$1.5 million to a New York durable medical equipment (DME) supplier that gave Medicare beneficiaries angora underwear, power massagers, air conditioners, and microwave ovens as an inducement for beneficiaries' Medicare billing numbers so that the company could charge for items that never were delivered.<sup>36</sup> A Texas DME supplier defrauded Medicare of over \$1 million by charging the government for \$1,300 orthotic body jackets while instead providing inferior wheelchair pads that cost less than \$100 to manufacture—a mark-up of over 2,500 percent.<sup>37</sup>

Government investigators also have uncovered numerous instances of providers billing for phantom psychotherapy sessions or grossly inflating the number of psychotherapy hours provided to reap overpayments from Medicare and private insurers.<sup>38</sup> A New York community center director was indicted for stealing nearly \$1 million by fraudulently billing the state for over 25,000 sessions that never occurred.<sup>39</sup> The billings were so excessive that staff psychiatrists would have had to work well over 24 hours a day to handle the number of visits claimed. In Pennsylvania, the owner of a rehabilitation service was indicted for defrauding Medicare by falsifying patient medical records so that they would appear to be eligible for "medically necessary" speech therapy.<sup>40</sup> And a Pennsylvania physician was convicted on 59 counts of illicit distribution of Valium, Apidex, Darvocet, and Vicodin for writing prescriptions to drug abusers and dealers that he claimed were "medically necessary."<sup>41</sup>

The private sector has also been active in combating fraud. A recent report by the Health Insurance Association of America indicates that nearly 90 percent of private health insurance companies have established anti-fraud programs, including employee training, claims audits, consumer hotlines, and information-sharing among payers and law enforcement agencies.<sup>42</sup> These activities are beginning to bear results. Private-sector anti-fraud operations saved over \$7.50 for every dollar spent in 1995, compared to \$4.30 just two years earlier.<sup>43</sup>

## **2. Marginal or Unnecessary Care Could Be Covered and Become More Pervasive**

Saddling private health plans with additional legal barriers to challenging coverage determinations on the basis of "medical necessity" would encourage fraudulent claims, and they would become much more commonplace in the private sector. In fact, several classic court decisions demonstrate how fraud and abuse would increase in the private sector if

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significant deference were to be conferred upon providers in making "medical necessity" decisions.

There have been many cases where payment has been required for treatments that were of dubious value. In one instance, a court required payment for medical services to an insured at a Bahamian clinic utilizing a cancer treatment that had never been approved by any agency of the U.S. government, because the court deferred to the physician's determination of medical necessity over that of the health plan.<sup>44</sup> Indeed, many patients—or their providers, who were seeking reimbursement—have prevailed even when the treatment (whether preventive, exploratory, or investigative or experimental) was explicitly not covered under the terms of the plan.<sup>45</sup> Courts (and juries) often rely on the "good faith judgment" of treating physicians as to the medical necessity of services, especially in the absence of an explicit contractual provision to the contrary.<sup>46</sup> Sometimes, however, decisions even fly in the face of contractual provisions.<sup>47</sup>

In addition, the line between inappropriate care and fraud could again become less distinct, as in the classic Duncan case. There, the court, deferring to a treating physician, required insurance coverage under multiple policies for two three-week periods of hospitalization for a husband and wife who suffered bruises and sprains. The facts of the case strongly indicated a motive on the part of the couple to "reap financial gain."<sup>48</sup>

## B. Concerns About Rising Costs and Inflation

### 1. Every Service Could Be Deemed Covered and Payment Required

Since the advent of managed care, premium increases, which had risen sky-high under fee-for-service medicine, leveled off dramatically, and are now roughly parallel with the consumer-price index. The application of the concept of "medical necessity" in managed care has been responsible for much of its success to date.

The concept of "medical necessity" was developed in tandem with the fee-for-service system, in an early attempt to prevent the unconstrained flow of reimbursement for health care services that persistently drove up costs. While the cost-increasing characteristics of the fee-for-service system have been exhaustively documented,<sup>49</sup> it may bear repeating that when economic incentives to increase both the types and frequency of medical services marry up with noneconomic incentives, bad results obtain. These perverse incentives not only drive up costs but could also be detrimental to patient care or could even harm patients. Providers could overprescribe treatments to ensure their patients every possible advantage, no matter how remote; to decrease a perceived risk of medical malpractice liability; or simply because the money is available. But it simply is not feasible to provide every conceivable treatment for every patient without driving up costs substantially for all customers.

While concerns about cost and quality are not new, and payers of medical expenses have always had to assess claims, pressure mounted in the mid-1960s as the medical economy absorbed an ever-growing and disproportionate share of our nation's resources.

Private insurers used medical necessity standards to examine claims and, as technological developments accelerated in the 1970s, added exclusions for experimental or investigational procedures. The federal government adopted the medically necessary and appropriate language used by private insurers for Medicare, Medicaid, and other government health programs.<sup>50</sup>

## **2. Standard of Care Could Become Lowest Common Denominator**

Under Section 151, nearly every medical service that a treating physician determines to be necessary, whether appropriate for the patient, could be deemed covered and would trigger payment. Indeed, the bill so broadly defines medical necessity that the term could apply to any service or treatment consistent with "generally accepted principles of medical practice."<sup>51</sup> Inevitably, questions would arise as to whether practices are "generally accepted" nationally, regionally, or locally. To make matters worse, the term "generally accepted" could apply to practices that may be inappropriate for a particular patient or are no longer considered effective. This is because once a treatment is considered medically necessary, few—if any—treatments are discredited as such, regardless of whether other treatments for the condition being treated have been developed and are considered to be "best practices." In addition, statutory protection for what is "generally accepted medical practice" in a given locality could provide a legal basis for resisting a more appropriate setting for the treatment.

## **3. Increased Risk of Health Plan Insolvency Due to Infinite Coverage Obligation**

In essence, Section 151 would encourage "extra-contractual" benefits—benefits and coverage that are not part of the original bargain between policyholder and insurer. Moreover, if providers were able to obligate health plans to pay for costs related to medical services that had not been reflected in the actuarial assumptions used to price the policy, they would not simply drive up reimbursement costs, but could also threaten the financial stability of the plans. Thus, the basic principle of health economics—the greater the volume and intensity of medical services delivered, the higher the cost to patients and insurers—has a corollary: that unanticipated costs can lead to health plan insolvency.

In short, the terms and conditions of the contract between the health plan or insurer and the customer regarding medically necessary and appropriate services would be eviscerated and replaced with a system that grants the treating provider a presumption of correctness. That could result in increased plan liability. Other provisions in the Patients' Bill of Rights legislation would explicitly expand liability.

At present, in policies that provide coverage for providers not affiliated with the plan, those providers are not part of the coverage contract between the insurer and the policyholder and become involved in the claim payment determination process as such only if patients "assign" payment for medical services rendered directly to them. In most managed care plans providing such coverage, the patient would have to meet the prior authorization requirements of the plan, except in emergency treatment cases. Indeed, third-party review of

the treating physician's determination of medical necessity—particularly if done before the delivery of services—provides a useful check on the appropriate use of health care resources. But should providers become the sole decision makers as to whether a service is medically necessary and appropriate, this system of checks and balances that works to provide good medicine at an affordable price would be seriously undermined, if not destroyed.

#### **4. Utilization Review and Other Quality and Cost Controls Rendered Moot**

Utilization management and other quality and cost-containment mechanisms would fall before the juggernaut of Section 151. Utilization review is a process, or series of processes, to address quality of care. Within a plan, it is developed and managed by health care professionals to assess whether a treatment plan is medically necessary or appropriate and, therefore, a covered benefit (deserving of payment under the coverage plan). A well-functioning utilization review program, under the direction of medical professionals, manages the use of available resources to optimize the effectiveness of the care. Physicians and nurses review requests for prior authorization or precertification determinations to make sure that a planned procedure is a covered benefit and to determine that it is medically appropriate (i.e., the right procedure in the right setting, at the right time). Precertification determinations not only protect plan participants from undergoing unnecessary procedures, they also offer other protections, such as care provided in a contracted facility that has met the health plan's standards, provided by a physician who is credentialed by the health plan. It's unclear at this time how extensively this proposal would undermine the emerging health plan programs targeting management of specific diseases such as asthma, diabetes, and heart disease. Under Section 151, however, utilization review and other quality and cost-containment mechanisms could arguably be characterized as "arbitrary interference with" or "alteration of" the physician's medically necessary treatment plan.

Moreover, Section 151's deference to the treating physician's decision with respect to the "manner or setting" of treatment also would weaken utilization review. Indeed, under such strictures, health plans may well be tempted, in the words of the CBO Report, "to reduce the frequency with which they challenge[d] physicians' decisions," regardless of their medical necessity to avoid the administrative costs of adjudicating challenges. (See endnote 26.)

Resources to pay for health care services are limited for both government and private payers. The proposed legislation would put pressure on health plans to approve requests for utilization review determinations that would be questioned under the current system, and to pay any and all claims regardless of their true medical necessity, simply to avoid the expanded liability for denial of payment. This would have an adverse effect on the quality and cost of the care.

#### **5. Provider Financial Conflicts Could Become More Problematic**

Insurers—public and private—have relied on the medical necessity standard to help discourage overuse of medical services. Studies comparing the use of certain medical

procedures by geographic region have found large differences in physician practice patterns not clearly justified by patient demographics or outcomes. This raises concerns about the efficacy and basis of many medical practices.<sup>52</sup> Indeed, a myriad of studies have shown that many services patients received had no significant medical benefit and were, in some instances, harmful.<sup>53</sup> Unfortunately, Section 151, by providing the physician with statutory "leverage" over the coverage and payment determinations, could motivate physicians to overtreat.<sup>54</sup> Incentives to overtreat include:

- the inherent and intractable nature of fee-for-service itself;
- payment and receipt of inducements or kickbacks for referrals—currently illegal only in Medicare and Medicaid;
- income earned by a physician referring patients to medical facilities owned or invested in by the physician—limited in only certain instances in Medicare;
- income earned by a physician for dispensing drugs, products, and other ancillary medical services;
- payments made by hospitals to doctors to purchase physicians' medical practices and pressure to increase admissions;
- hospital joint ventures and income guarantee arrangements and loans to physicians to promote referrals to the sponsoring hospital;
- hospital provision of management functions such as billings, collections, and accounting to promote referrals to the sponsoring hospital;
- gifts to doctors from medical suppliers offering products that require a physician's prescription to be sold; and
- sale of information from patients' files by doctors to marketing firms, pharmaceutical firms, and others.

### C. Concerns About Diminished Quality of Care

#### 1. Evidence-Based Quality Standards Rendered Moot

Each year, as many as 120,000 Americans die, and about 1 million are injured, because of medical mishaps and errors.<sup>55</sup> In some cases, doctors prescribe unorthodox or unnecessary courses of treatment that could be defended as consistent with "generally acceptable principles of professional medical practice" under Section 151, but that place patients at significant risk for injury or death.

Patient injuries resulting from medication occur at the rate of about 2,000 a year in each large teaching hospital; about 28 percent are preventable based on current knowledge.<sup>56</sup> The 1984 Harvard Medical Practice Study of New York State Hospitals, published in the *New England Journal of Medicine* in 1991, estimated that more than 27,000 patient injuries are due to negligent care.<sup>57</sup> Section 151 could exacerbate these problems because it would give individual providers the authority to bypass the carrier's utilization review process and its application of practice guidelines to coverage decisions.