Senator Hollis French

Capitol Room 417
465-3892
465-6595 fax

M E M O R A N D U M

Date: 3/18/2009

To: Senator Joe Paskvan, Chair
Senate Labor and Commerce Committee

From: Senator Hollis French

RE: Request for Hearing -- SB 61

This is a request that you schedule a hearing on SB 61 "Affordable Universal Health Insurance" at the earliest possible date.

I have attached a sponsor statement, a sectional summary, a copy of the bill, a bill packet and a letters of support for your use.

If you have any questions, please don't hesitate to contact Andy Moderow in my office at 465-4923. I appreciate your consideration.

Attachments

Alaska State Legislature

Senator Hollis French

Sponsor Statement

SB 61 - Affordable Health Insurance for All Alaskans

The time has come for us to begin addressing the health care crisis in Alaska. Increasing costs have made it difficult for businesses and individuals to acquire the health services they need. This crisis is only getting worse; family health insurance premiums have risen 4.6 times faster than the median earnings of Alaskans over the past 6 years. As costs continue to increase, it is likely that additional hard working Alaskans will go uninsured. Employers who choose to provide employee health plans will watch their costs go up, making it difficult to run a competitive business in the state. The federal government might take action, but if it doesn't, Alaska needs to be ready to take the lead.

Many other states have joined the universal health care debate, but this bill is uniquely Alaskan. SB 61 puts people in control of their own health, giving them the tools they need to make smart investments. Vouchers, funded by a variety of stakeholders, make the prospect of acquiring health coverage realistic to all Alaskans. By guaranteeing that everyone has coverage, insurance premiums will go down. This bill ensures that everyone can purchase an affordable health plan that they select to fulfill their medical needs.

This bill establishes a framework mandating and ensuring affordable health coverage for all Alaskans. A board of 13 stakeholders will oversee the plan, making certain that residents are able to choose and purchase coverage that provides adequate care. The bill also provides:

A framework for personal choice: This bill facilitates a relationship between health insurance providers and individuals, and doesn't assume that a one size fits all solution will meet the health care needs of all Alaskans.

A unique voucher system: By pooling money from all stakeholders, a sliding scale voucher system will ensure that every Alaskan can take personal responsibility for acquiring health insurance coverage. The system will also make it easy for multiple entities to contribute towards a health plan for an individual.

A health care clearinghouse: The clearinghouse will disseminate information about quality health care products, assisting Alaskans who are utilizing vouchers under the Alaska health care plan.

The Alaska health care fund: This fund will receive contributions from individuals, businesses and government to ensure that all interested parties contribute to the health of Alaskans.

Satisfied with your current coverage? This bill will not affect employer based health plans that provide quality health care coverage. In addition, the bill may reduce cost increases for those who currently pay for coverage. A hospital cannot turn down anyone in need of emergency care, and when someone cannot pay their medical costs, those who can pay are forced to subsidize the cost of the uninsured. A recent study estimated that Alaska health insurance premiums are 13.6% higher than they would be if everyone had health coverage (Families USA report). Through ensuring equitable financing of the health care system, SB 61 will reduce the burden on individuals and businesses currently buying coverage.

This bill isn't really about reforming the health care system; it is about ensuring the health of residents across the state. I urge you to consider supporting this bill as we work to improve the quality of life for all Alaskans.

CS FOR SENATE BILL NO. 61(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered: 3/16/09
Referred: Labor and Commerce, Finance

Sponsor(s): SENATORS FRENCH, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state, the Alaska Health Care Board to administer the Alaska health care program and the Alaska health care fund, the Alaska health care clearinghouse to administer the Alaska health care program under the direction of the Alaska Health Care Board, and eligibility standards and premium assistance for health care coverage of persons with low incomes; creating the Alaska health care fund; providing for review of actions and reporting requirements related to the health care program; and providing for an effective date."

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

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

FINDINGS; PURPOSE. (a) The legislature finds that

(1) the current health care system is unsustainable;

(2) improving and protecting the health of Alaskans must be a primary goal of the state;

(3) all Alaskans should have access to essential health care services that are affordable, that are based on publicly debated criteria, and that consider the well-being of individuals across their life spans;

(4) Alaska has an economic interest in ensuring equitable financing of essential health care for Alaskans who do not have access to basic health care;

(5) health care policies should emphasize public health and encourage the use of quality service and evidence-based treatment that are appropriate and safe and that discourage over-treatment;

(6) health care providers and informed patients must be the primary decision makers who are accountable for an individual's health;

(7) health care funding should be explicit, predictable, and economically sustainable;

(8) an economically sustainable health care system requires that providers receive fair and adequate compensation;

(9) health care must be balanced with other programs that also affect health; and

(10) health care must account for the allocation of resources and the human consequences of funding decisions.

(b) The purpose of this Act is to address the findings and concerns listed in (a) of this section by creating the Alaska health care program.

* **Sec. 2.** AS 21.54 is amended by adding new sections to read:

Article 2A. Alaska Health Care Program.

Sec. 21.54.200. Alaska health care program. The Alaska health care program is established to

(1) ensure that residents of the state have access to affordable health care insurance;

(2) require that residents of the state have, at a minimum, insurance covering essential health care services;

(3) reduce unsustainable health care cost increases;

(4) establish a system of health care insurance that integrates public involvement and oversight, consumer choice, and competition within the private health care insurance market;

(5) use models of health care insurance benefits, service delivery, and payments that control costs and overuse, emphasizing preventative care and chronic disease management within a primary care environment; and

(6) provide services for humane and dignified end-of-life care.

Sec. 21.54.210. Alaska Health Care Board. (a) The Alaska Health Care Board is established in the division to manage the Alaska health care program.

(b) The board shall consist of 13 members, including 12 members appointed by the governor, subject to confirmation by the legislature, and the commissioner of health and social services or the commissioner's designee, serving ex officio. The members of the board appointed by the governor must include

(1) one representative who is a licensed insurance producer;

(2) one representative from a health insurance company licensed to transact health care insurance in the state;

(3) two representatives of the business community other than health care insurers, one representing large businesses, and one representing small businesses;

(4) one representative each from two Alaska hospitals;

(5) one representative of a labor organization;

(6) two physicians licensed in Alaska;

(7) two health care consumer advocates; and

(8) one registered nurse.

(c) Except for the commissioner or the commissioner's designee, who serves ex officio, each board member serves for a term of three years beginning on January 1 and until a successor has been appointed. A member is eligible for reappointment.

(d) If there is a vacancy, the governor shall make an appointment, effective immediately, for the balance of the unexpired term.

(e) Members of the board are entitled to per diem and transportation costs

under AS 39.20.180.

(f) The board shall select a member to serve as chair and a member to serve as vice-chair for a term and with duties and powers necessary to perform their functions.

(g) A majority of the board constitutes a quorum for transacting business.

Sec. 21.54.220. Powers and duties of the Alaska Health Care Board. (a) The Alaska Health Care Board shall

(1) administer, as a fiduciary, the Alaska health care fund established under AS 21.54.280 in accordance with the Alaska health care program established by AS 21.54.200 - 21.54.310;

(2) establish types or categories of health care insurance plans offered through the Alaska health care clearinghouse;

(3) classify each plan offered through the clearinghouse as a comprehensive or basic health care insurance plan, based on criteria including the financial cost of the plan, including premium cost, deductible costs, and co-pay provisions;

(4) establish criteria for participation by residents and insurers in the Alaska health care program;

(5) establish an Alaska health care voucher system that provides health care insurance to each individual who meets the needs-based participation criteria set out in AS 21.54.240 or who is the beneficiary of contributions made to the fund that specify the individual as the beneficiary under AS 21.54.280(b);

(6) ensure that eligible individuals are enrolled in a health care insurance plan that provides essential health care services;

(7) prescribe the method for determining individual income for the purpose of the Alaska health care program;

(8) establish procedures for enrolling a participant in the Alaska health care program, including enrollment procedures describing when an individual may enroll or select a different health insurance plan offered through the Alaska health care clearinghouse; the procedures established under this paragraph must allow an individual insured by a health care insurance plan offered through the Alaska health care clearinghouse to select a different health care insurance plan from the plans

offered through the clearinghouse and to make that selection at least annually;

(9) require that participants receive complete information regarding the cost of obtaining health care insurance;

(10) establish procedures for notice and hearings for a person aggrieved by a decision of the board or the Alaska health care clearinghouse; and

(11) ensure that every Alaskan who is required to participate in the Alaska health care program is offered health care insurance that protects the insured from severe financial hardship caused by the cost of receiving medical care.

(b) The board may hold regular and special meetings as the board considers necessary; board meetings may be held by teleconference; meetings shall be recorded and made available on request.

Sec. 21.54.230. Alaska health care clearinghouse. (a) The Alaska health care clearinghouse is established in the division.

(b) The clearinghouse shall be administered by the director.

(c) The clearinghouse shall

(1) administer the Alaska health care program under the direction of the Alaska Health Care Board;

(2) disseminate information about health care insurance products available through the clearinghouse; and

(3) provide assistance in the enrollment process for a small business or an individual.

Sec. 21.54.240. Essential health care services; eligibility. (a) Every resident of the state shall participate in the Alaska health care program except a resident who

(1) is a beneficiary of a health care plan that provides health care benefits that meet or exceed the benefits for essential health care services;

(2) is enrolled in a publicly funded medical assistance program providing services that meet or exceed the benefits required as essential health care services;

(3) is enrolled in Medicaid or Medicare;

(4) is covered under a health benefit plan offered in the group market;

(5) is an individual insured under an individual state plan of health

insurance under the Comprehensive Health Insurance Association under AS 21.55;

(6) is receiving health care benefits under a medical care program of the Indian Health Service; however, a person receiving health care benefits under a medical care plan of the Indian Health Service may elect to participate in the Alaska health care program;

(7) has resided in the state for less than one year; however, a person who has resided in the state for less than one year may receive services provided by the Alaska health care clearinghouse under AS 21.54.230; or

(8) demonstrates satisfactorily to the board, under criteria established by the board, that the person has deeply held religious beliefs contrary to the Alaska health care program and the requirement to purchase health care insurance for essential health care services.

(b) Except as provided in (g) of this section, the Alaska Health Care Board shall provide a voucher to a resident with an income that is not more than 450 percent of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), and who is only eligible for coverage through the Comprehensive Health Insurance Association (AS 21.55). A voucher authorized by this subsection must equalize the cost of insurance under the Comprehensive Health Insurance Association with the cost of purchasing a health care insurance plan that provides substantially equivalent benefits through the Alaska health care clearinghouse. For purposes of cost comparison under this subsection, the board shall determine whether a plan provided under the Comprehensive Health Insurance Association provides substantially equivalent benefits to a health care insurance plan offered through the clearinghouse.

(c) Except as provided in (g) of this section, a resident with an income that is not more than the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall receive private health care insurance coverage for essential health care services at no cost, paid from the fund.

(d) Except as provided in (g) of this section, a resident with an income between 100 percent and not more than 300 percent of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall pay premiums for health care insurance for essential health care services on a sliding scale established by the board.

(e) A resident with an income of 300 percent or more of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall pay the premium for health care insurance for essential health care services.

(f) A person who is an alien is not eligible for assistance under AS 21.54.200 - 21.54.310 unless the person is a qualified alien, as defined under 8 U.S.C. 1641, or an alien excepted under 8 U.S.C. 1612(b). However, a qualified alien may only be eligible for assistance under AS 21.54.200 - 21.54.310 if the person is not precluded by the limited eligibility provision of 8 U.S.C. 1613.

(g) A person who is exempt from being required to participate in the Alaska health care program under

(1) (a)(1) - (5) of this section, but who is eligible to participate in a program identified in (a)(1) - (5) of this section, may not receive benefits under (b) - (d) of this section.

(2) (a)(7) of this section may not receive benefits under (b) - (d) of this section until the person has resided in the state for one year or more.

Sec. 21.54.250. Essential health care services. For purposes of AS 21.54.200 - 21.54.310, essential health care services means medical services performed for an individual covered by a health care plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury. The medical services that must be performed for an individual covered by a health care plan include, as a minimum,

(1) preventative and primary care;

(2) emergency services;

(3) inpatient services and hospital treatment;

(4) ambulatory patient services;

(5) prescription drug coverage; and

(6) mental health services.

Sec. 21.54.260. Alternative or additional health care services. (a) An employer may offer health insurance coverage that meets or exceeds coverage for essential health care services.

(b) An individual or employer may purchase health care insurance for health care services in addition to the essential health care services required under AS 21.54.200 - 21.54.310.

(c) If an employer does not provide a health care insurance plan for all employees or provides a health care insurance plan that meets or exceeds coverage for essential health care services but does not enroll at least 25 percent of the employer's employees in the plan or does not offer to pay at least 33 percent of the premium for health care insurance under the plan, the employer shall pay the department as follows:

(1) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care plan under AS 21.54.240 is $500,000 or less, no payment is required;

(2) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care plan under AS 21.54.240 is greater than $500,000 but less than $1,000,000, the employer shall pay one percent of the gross payroll; or

(3) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care program under AS 21.54.240 is $1,000,000 or greater, the employer shall pay two percent of the gross payroll.

(d) An employer that establishes a cafeteria plan under 26 U.S.C. 125 (Internal Revenue Code) that offers employees the option to elect health care insurance coverage that meets or exceeds essential health care services is not subject to the payment requirements under (c) of this section, regardless of whether an employee elects to receive the offered health care insurance.

(e) In this section, "essential health care services" means those services set out in AS 21.54.250.

Sec. 21.54.270. Health care insurance plan; children's coverage. (a) A health care insurance plan that is approved by the director that provides coverage for essential health care services under AS 21.54.200 - 21.54.310 and meets the other requirements established under this title may be offered through the Alaska health care clearinghouse.

(b) A health care insurance plan offered through the Alaska health care clearinghouse may not deny enrollment to an eligible individual.

(c) A health care insurance plan offered through the Alaska health care clearinghouse may include

(1) different benefits for network or out-of-network providers;

(2) varied levels of copayment, coinsurance, deductable amounts, out-of-pocket maximums;

(3) high deductible health plans as defined by 26 U.S.C. 223(c)(2) (Internal Revenue Code); and

(4) special insurance terms applicable only to individuals between 18 and 30 years of age.

(d) A health care insurance plan offered through the Alaska health care clearinghouse that covers children must provide that the coverage will continue until the earlier of the child's reaching 25 years of age or two years after the child no longer resides with the family.

(e) Notwithstanding AS 21.54.110(a), a health care insurance plan offered through the Alaska health care clearinghouse may not exclude coverage for a preexisting condition that

(1) relates to a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received more than two years before the enrollment date;

(2) considers genetic information as a condition for which a preexisting exclusion may be imposed in the absence of a diagnosis of the condition related to the genetic information;

(3) extends more than 12 months after the enrollment date; or

(4) excludes a condition relating to pregnancy.

(f) A period of a preexisting condition exclusion permissible under (e) of this section must be reduced by the aggregate periods of creditable coverage, if any, as determined under AS 21.54.120, including creditable coverage resulting from participation in a plan offered through the Alaska health care clearinghouse, or a plan described in AS 21.54.240(a)(1) - (6). The aggregate of periods of creditable coverage is determined by adding all periods of creditable coverage before the enrollment date, excluding periods of creditable coverage before a continuous break in coverage of more than 90 days. This subsection does not apply if an individual's most recent period of creditable coverage ended on a date more than 90 days before the enrollment date. This subsection does not preclude application of a waiting period to all new enrollees under a health care insurance plan.

Sec. 21.54.280. Alaska health care fund. (a) The Alaska health care fund is established as a separate trust fund of the state. The fund consists of

(1) state money appropriated to the fund;

(2) federal money appropriated to the fund;

(3) private employer and employee health care contributions or fees received by the department and appropriated to the fund;

(4) health care premiums received by the department and appropriated to the fund;

(5) other appropriations by the legislature;

(6) contributions appropriated to the fund from the United States government and its agencies or from any other source, public or private, provided for purposes that are consistent with the goals of the Alaska health care program; and

(7) interest earnings from investments of the fund appropriated to the fund.

(b) Contributions may be made to the fund by an employer, employers, or an individual that is specified for a particular beneficiary. If a contribution is made to the fund for the benefit of a particular beneficiary, the beneficiary shall receive a health care voucher in the amount of the contribution that may be used to purchase a health

care insurance plan. Money collected under AS 21.54.260(c) is not considered made for the benefit of a particular beneficiary.

(c) The board may use the fund for the purpose of administering the Alaska health care program consistent with AS 21.54.200 - 21.54.310.

Sec. 21.54.290. Disputes and appeals. A person is entitled to notice and an opportunity for a hearing under regulations adopted by the Alaska Health Care Board if

(1) the board or the Alaska health care clearinghouse denies enrollment to the person;

(2) an accountable health care plan refuses to enroll an individual or fails to provide essential health care services; or

(3) the person is adversely affected or aggrieved by a decision of the board or the clearinghouse.

Sec. 21.54.300. Reporting. The Alaska Health Care Board shall submit a written report on the operation of the Alaska health care program to the commissioner and to the legislature by January 1 of each year. The report must include

(1) the number of individuals enrolled in the Alaska health care program;

(2) the cost savings to the state, to employers, and to health care providers;

(3) a measure of patient satisfaction;

(4) an assessment of patient access to essential health care services;

(5) a description of the changes or adjustments made to the program during the period covered by the report;

(6) a discussion of the state agencies delivering redundant services, if any, relating to health care benefits;

(7) an evaluation of state programs that regulate or deliver health care benefits;

(8) recommendations for legislative changes necessary to meet the goals of the program;

(9) an evaluation of and recommendations on the following topics:

(A) the use of electronic health records;

(B) children's health insurance programs;

(C) the effectiveness of Medicaid and the potential expansion of the Alaska Medicaid program, including a comparison between the costs of expanding the Alaska Medicaid program and the cost of providing benefits through the Alaska health care program;

(D) the effect of mandated benefits;

(E) prescription drug bargaining;

(F) evidence-based treatment procedures including a comparison of the use of evidence-based treatment in other states;

(G) the recruitment and retention of medical professionals in the state;

(H) expanding offerings of the University of Alaska in medical fields;

(I) maximizing federal funding to implement the program;

(J) innovations that could produce health care cost savings, including waivers under 42 U.S.C. 1315 (sec. 1115, Social Security Act), which allows experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.

Sec. 21.54.310. Regulations. The Alaska Health Care Board shall adopt regulations under AS 44.62 (Administrative Procedure Act) consistent with AS 21.54.200 - 21.54.310.

* **Sec. 3.** AS 21.54.500 is amended by adding new paragraphs to read:

(30) "alien" means a person who is not a citizen or national of the United States;

(31) "board" means the Alaska Health Care Board;

(32) "fund" means the Alaska health care fund;

(33) "resident" has the meaning given in AS 01.10.055.

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

TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210, enacted by sec. 2

of this Act, the initial terms for members of the Alaska Health Care Board, except for the commissioner of health of social services who serves ex officio, are as follows:

(1) four members shall be appointed to serve for a term ending December 31, 2010;

(2) four members shall be appointed to serve for a term ending December 31, 2011; and

(3) the remaining members shall be appointed to serve for a term ending December 31, 2012.

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

TRANSITIONAL PROVISIONS: REGULATIONS. The Alaska Health Care Board established under AS 21.54.210, enacted by sec. 2 of this Act, may proceed to adopt regulations necessary to implement this Act under AS 21.54.310, enacted by sec. 2 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

* **Sec. 6.** AS 21.54.210, 21.54.220, and 21.54.230, enacted by sec. 2 of this Act, and sec. 5 of this Act take effect immediately under AS 01.10.070(c).

* **Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2010.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: **CSSB 61(HSS)**
(S) Publish Date: 3/16/09

Identifier (file name): SB61-CED-INS-03-02-09
Title: MANDATORY UNIVERSAL HEALTH INSURANCE
Sponsor: Senator French
Requester: Senate Health & Social Services

Dept. Affected: DCCED
RDU: Insurance
Component: Insurance Operations
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	878.1		1,756.1	1,756.1	1,756.1	1,756.1	1,756.1
Travel	48.2		96.4	96.4	96.4	96.4	96.4
Contractual	1,979.5		1,134.0	1,134.0	1,134.0	1,134.0	1,134.0
Supplies	24.0		12.0	12.0	12.0	12.0	12.0
Equipment	431.4		9.0	9.0	9.0	9.0	9.0
Land & Structures							
Grants & Claims							
Miscellaneous (Premium Costs)	1,146,000.0		1,146,000.0	1,146,000.0	1,146,000.0	1,146,000.0	1,146,000.0
TOTAL OPERATING	**1,149,361.2**		**1,149,007.5**	**1,149,007.5**	**1,149,007.5**	**1,149,007.5**	**1,149,007.5**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (1105)	**564,000.0**		**564,000.0**	**564,000.0**	**564,000.0**	**564,000.0**	**564,000.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	585,361.2		585,361.2	585,361.2	585,361.2	585,361.2	585,361.2
1005 GF/Program Receipts	564,000.0		564,000.0	564,000.0	564,000.0	564,000.0	564,000.0
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,149,361.2**		**1,149,361.2**	**1,149,361.2**	**1,149,361.2**	**1,149,361.2**	**1,149,361.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	24		24	24	24	24	24
Part-time							
Temporary							

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

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates an Alaska health insurance program. The bill establishes the Alaska Health Care Board to oversee the program and the Alaska Health Care Clearinghouse to administer the program, under the direction of the Board. The effective date of the Act is January 10, 2010.

(Continued on page 2)

Prepared by: Linda Hall, Director — Phone (907)269-7900
Division: Insurance — Date/Time 3/2/09 9:00 AM
Approved by: Emil R. Notti, Commissioner — Date 3/2/2009
Department of Commerce, Community and Economic Development

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. CSSB 61(HSS)

ANALYSIS CONTINUATION

Caveat: The Division of Insurance has no existing expertise in establishing or administering State benefits programs. The Division of Insurance oversees the conduct of insurance companies, ensures solvency, and approves rates and forms. The Division of Insurance does not determine what are minimum essential health services or how they should be priced. Further, the Division of Insurance has no expertise in determining the eligibility of individuals for government subsidies. All of this expertise will have to be developed by the Division of Insurance from scratch, primarily by recruiting and hiring a substantial number of employees with this type of expertise.

Senate Bill 61 allows for a wide range of options that may be considered essential health care services. As a result, it is not possible to determine the cost of the bill with a high confidence in accuracy. The range of possible costs is wide, depending upon how the Board defines certain terms.

This fiscal note examines the potential cost of the program , as well as the estimated cost of administering the benefit. Costs for insurance premiums are very preliminary until the "essential health care services" are defined. This fiscal note reflects the high-premium scenario using the State of Alaska employee plan as a model and is not broken out by budget component.

Assumptions:
*The Health Care Fund only pays for the non-Medicaid eligible population. State matching funds for Medicaid do not come from the Fund.
*The estimated cost for insurance premiums is $12,000 per person per year (based on the State of Alaska employee insurance plan).
*The cost of premiums to purchase insurance are on a needs-based sliding scale. The State share of premiums will be paid from the Fund.
*Co-pays and deductibles are not addressed in the bill so we assume none are required by any plan.
*There are an estimated 115,000 uninsured persons in Alaska, 83% of whom are adults.

Cost Estimates for Alaska Health Care Program:
*There are 27,000 uninsured persons who are below 100% of the poverty level. Insurance is provided at no cost to the individual. Total cost to the state is $324,000,000.

*43,000 have incomes between 100% and 300% of poverty. They would pay premiums on a needs-based sliding scale. With an estimated average cost of $6,000 per person, the total cost to the state is $258,000,000.

Above 300% of poverty: $0 total. No cost to the State.
*There are about 25,500 uninsured individuals who are above 300% of the poverty level. They would bear the full cost of the mandatory insurance. These individuals would bear a total cost of about $306,000,000.

Fund Source
*A portion of the cost will be paid by a payroll tax of up to 2%, depending upon the size of the business. The Division of Insurance is aware of no statistics on which to estimate the amount of money that would be raised by the tax.

* A portion of the cost will also be funded by premiums paid in part by persons with income between 100% and 300% of the poverty line. These revenues are shown in the general fund program receipts fund source.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: **CSSB 61(HSS)**
(S) Publish Date: 3/16/09

Identifier (file name): **SB061-DHSS-PAFS-02-28-09**
Title: Mandatory Universal Health Insurance
Sponsor: French
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Public Assistance
Component: Public Assistance Field Services
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	1,234.7		1,646.3	1,646.3	1,646.3	1,646.3	1,646.3
Travel	10.0		10.0	10.0	10.0	10.0	10.0
Contractual	255.3		340.4	340.4	340.4	340.4	340.4
Supplies	35.6		47.5	47.5	47.5	47.5	47.5
Equipment	250.0						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**1,785.6**	**0.0**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	892.8		1,022.1	1,022.1	1,022.1	1,022.1	1,022.1
1003 GF Match	892.8		1,022.1	1,022.1	1,022.1	1,022.1	1,022.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,785.6**		**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**23.0**		23.0	23.0	23.0	23.0	23.0
Part-time							
Temporary							

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

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program, which is administered by the Division of Insurance.

The bill is expected to increase enrollment in Medicaid, since enrollment in Medicaid is one of the criteria that makes a person ineligible for health care coverage under the new program. The Division of Public Assistance accepts applications and determines whether a person meets program criteria and financially qualifies for the Medicaid program. This fiscal note reflects the additional administrative costs needed to support the increased workload as a result of more people applying for Medicaid.

(continued on page 2)

Prepared by: Ellie Fitzjarrald, Director
Division: Public Assistance
Phone (907) 465-5847
Date/Time 2/27/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 2/28/2009

FISCAL NOTE # 2

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB 61(HSS

ANALYSIS CONTINUATION

SB 61 has a January 1, 2010 effective date.

Assumptions:

In FY2010, the department anticipates receiving 14,000 Medicaid applications from persons who do not currently receive Medicaid, and that 10,000 will qualify and be enrolled. Additional staff will be needed to manage the increased application volume and workload. The Division of Public Assistance assumes that funding for additional staff in FY 2010 will include a three month start-up period beginning October 2009 to accommodate hiring and training of new staff.

Fourteen Eligibility Technicians are needed to make decisions on applications and act on changes in household income or other factors affecting a household's eligibility; two Lead Eligibility Technicians are needed to perform quality assurance, training on program rules, and other lead worker duties; one Eligibility Supervisor is needed to oversee and manage the work of the new staff; and four administrative support staff are needed to provide customer service, manage phone lines, and perform clerical support.

The increased volume of applications is anticipated to result in increased denials of eligibility and fair hearing requests. Hearing requests usually result when applicants do not receive an affirmative decision on their application. This increased demand will result in the need for one additional Public Assistance Analyst to serve as a hearing representative and support the fair hearing function.

Additionally, interaction with another department will also increase complexity of referrals and processing of applications. A Program Coordinator is necessary to establish and maintain service coordination and collaboration with the Alaska Health Care Program, and to facilitate consumer education, etc.

FY 2010 Administrative Costs (for 9 months): $1,785.6
Personal Services: $1,234.7 (salary and benefits for 23 new positions)
Travel: $10.0 (for training)
Contractual: $255.3 (for 9 month's cost for information technology, telecommunication, office space, phones)
Supplies: $35.6 (program materials and general office supplies
Equipment: $250.0 (One-time cost for desktop computers, printers, and workstations, and other office equipment

FY 2011 – FY 2015 Annual Administrative Costs: $2,044.2
Personal Services: $1,646.3 (salary and benefits for 23 new positions)
Travel: $10.0 (for training)
Contractual: $340.4 (annual cost for information technology, telecommunication, office space, phones)
Supplies: $47.5 (program materials and general office supplies)

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: **CSSB 61(HSS)**
(S) Publish Date: 3/16/09

Identifier (file name): **SB061-DHSS-BHMS-02-28-09**
Dept. Affected: Health & Social Services
Title: Mandatory Universal Health Insurance
RDU: Behavioral Health
Component: Behavioral Health Medicaid Services
Sponsor: French
Requester: Senate HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	3,000.0		6,000.0	6,000.0	6,000.0	6,000.0	6,000.0
Miscellaneous							
TOTAL OPERATING	**3,000.0**	**0.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,830.0		3,660.0	3,660.0	3,660.0	3,660.0	3,660.0
1003 GF Match	1,170.0		2,340.0	2,340.0	2,340.0	2,340.0	2,340.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**3,000.0**	**0.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

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

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program, which is administered by the Division of Insurance. The effective date for coverage is January 1, 2010.

This bill is expected to increase enrollment in Medicaid, which will increase costs. This fiscal note reflects the portion of additional costs to the Medicaid program for behavioral health services.

continued on page 2

Prepared by: William J. Streur, Deputy Commissioner
Phone 907-269-7827
Division: Health Care Services
Date/Time 1/27/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 2/28/2009
DHSS Finance & Management Services

FISCAL NOTE #3

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB 61(HSS)

ANALYSIS CONTINUATION

ASSUMPTIONS

Enrollment

Participation is required for every resident who is not enrolled in a public medical assistance program (e.g. Medicaid, Medicare) or a private insurance program that provides essential health care services. About 20% of the uninsured are Native who have coverage under Indian Health Services. Most children who need long term care are expected to have already applied for Medicaid.

There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, and elderly = 800) who would be required to take up coverage. Of the 109,500 uninsured persons, **an estimated 10,000 persons, mostly children below 175% of poverty, could be enrolled in Medicaid/SCHIP** without changes to the current eligibility guidelines. This includes the eligible Native population who we assume would enroll in Medicaid as a result of outreach/advertising for the AK Health Care program.

Cost of Benefits

Once deemed eligible, a Medicaid enrollee is entitled to all Medicaid services, and is not limited to only those "essential health care services" listed in the bill. The average cost for all Medicaid benefits for children is **$3,000 per person per year** (based on analysis of Medicaid claim payments for non-disabled children). The total additional cost for benefits (all Medicaid components) is $30 million per year (10,000 persons x $3,000).

This component is allocated about 20% of the total Medicaid costs. Behavorial Health Medicaid Services include acute psychiatric hospital, residential psychiatric treatment centers and outpatient mental health services.

Fund Source

The federal government reimburses the state approximately 50% of the cost for most Medicaid claims. Some claims get an enhanced match rate (e.g. Indian Health Services is 100% federal). The fund source is based on the projected weighted average federal revenue for Behavioral Health Medicaid Services of **61% federal funds**. State matching funds for Medicaid are GF/M and do not come from the AK Heath Care Fund.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: **CSSB 61(HSS)**
(S) Publish Date: 3/16/09

Identifier (file name): **SB061-DHSS-MS-03-06-09**
Title: Mandatory Universal Health Insurance
Sponsor: French
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Health Care Services
Component: Medicaid Services
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	12,000.0		24,000.0	24,000.0	24,000.0	24,000.0	24,000.0
Miscellaneous							
TOTAL OPERATING	**12,000.0**	**0.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	8,112.0		16,224.0	16,224.0	16,224.0	16,224.0	16,224.0
1003 GF Match	3,888.0		7,776.0	7,776.0	7,776.0	7,776.0	7,776.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**12,000.0**	**0.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

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

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program, which is administered by the Division of Insurance. The effective date for coverage is January 1, 2010.

This bill is expected to increase enrollment in Medicaid, which will increase costs. This fiscal note reflects the portion of additional costs to the Medicaid program for health care services, other than behavioral health.

continued on page 2

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services
Phone: 907-269-7827
Date/Time: 3/6/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/6/2009

FISCAL NOTE # 4

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. CSSB 61(HSS)

ANALYSIS CONTINUATION

ASSUMPTIONS

Enrollment

Participation is required for every resident who is not enrolled in a public medical assistance program (e.g. Medicaid, Medicare) or a private insurance program that provides essential health care services. About 20% of the uninsured are Native who have coverage under Indian Health Services. Most children who need long term care are expected to have already applied for Medicaid.

There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, and elderly = 800) who would be required to take up coverage. Of the 109,500 uninsured persons, **an estimated 10,000 persons, mostly children below 175% of poverty, could be enrolled in Medicaid/SCHIP** without changes to the current eligibility guidelines. This includes the eligible Native population who we assume would enroll in Medicaid as a result of outreach/advertising for the AK Health Care program.

Cost of Benefits

Once deemed eligible, a Medicaid enrollee is entitled to all Medicaid services, and is not limited to only those "essential health care services" listed in the bill. The average cost for all Medicaid benefits for children is **$3,000 per person per year** (based on analysis of Medicaid claim payments for non-disabled children). The total additional cost for benefits (all Medicaid components) is $30 million per year (10,000 persons x $3,000).

This component is allocated about 80% of the total Medicaid costs. Health Care Services - Medicaid Services include inpatient/outpatient hospitals, physicians & clinics, prescription drugs, dental, transportation, lab/x-ray, durable medical equipment, physical/occupational/speech therapy, vision, and home health/hospice.

Fund Source

The federal government reimburses the state approximately 50% of the cost for most Medicaid claims. Some claims get an enhanced match rate (e.g. Indian Health Services is 100% federal). The fund source is based on the projected weighted average federal revenue for Health Care Services - Medicaid Services of **66.7% federal funds**. State matching funds for Medicaid are GF/M and do not come from the AK Heath Care Fund.

Senator Hollis French

Anchorage LIO
269-0234
269-0238 fax

M E M O R A N D U M

Date: April 6, 2009

To: Senator Joe Paskvan, Chair
Senate Labor and Commerce Committee

From: Andy Moderow, Staff
Senator Hollis French Office

RE: Change to Senate Bill 61 in the Senate HSS CS

One change was made to Senate Bill 61 in the Senate Health and Social Services committee. The Senate HSS CS replaced the old language listed under (a)(4) on page 5 line 30 of the legislation. The old language exempted employees from the obligation to acquire health coverage if they receive health benefits under a plan regulated by ERISA that meets or exceeds the standards of essential health care services on page 7 and 8 of the bill. The new language modifies that exception by including a broader range of employer based coverage.

Sec. 21.54.240(a)(4) now reads "is covered under a health benefit plan offered in the group market."

The first word – covered - requires that a person be covered by a plan, and not merely offered one. The second term – health benefit plan – is defined in AS 21.54.500. It includes self insured employer based coverage regulated by ERISA and other state regulated health care insurance plans. The final portion of the new language requires that this plan be offered in the group market. By including the 'group market,' the exemption is targeted to business offerings in particular.

The new Sec. 21.54.240(a)(4) also removed the requirement that coverage meet or exceed benefits for essential health care services. By doing so, the new CS ensures that employer based offerings won't have to be modified to guarantee that employees are in compliance with the provisions of Senate Bill 61.

SB 61 *Health Insurance For All Alaskans*

Detailed Bill Summary

SECTION 1 of the bill – Findings **Corresponds with version \S**

SECTION 2 of the bill - Provides the framework for the bill

Sec. 21.54.200: Establishes the health care program
This section lays out what the legislation will accomplish.

- it ensures that all state residents can afford quality health coverage that suits their particular needs
- it requires that health coverage is meaningful, as discussed later in AS 21.54.250
- it reduces unsustainable health care cost increases, through encouraging primary care and prevention
- it centers on consumer choice by providing a framework for competition, where insurance plans must compete to acquire and retain customers

Sec. 21.54.210: Establishes the Alaska Health Care Board
This section establishes the Alaska Health Care Board under the Division of Insurance. The board will have 13 voting members, and will include:

- one insurance producer licensed to do business in the state
- one representative from a health insurance company licensed in Alaska
- one representative that works for a large business
- one representative that works for a small business
- two representatives from Alaska hospitals
- one representative of a labor organization
- two licensed Alaska physicians
- two consumer advocates
- one registered nurse
- the commissioner of Health and Social Services, or their designee

Each member, except the commissioner, serves a 3 year term and are subject to appointment and reappointment by the Governor. Members will be entitled to standard per diem and transportation costs under AS 39.20.180. The board will select a chair and a vice chair, and a majority of the board will be considered a quorum for transacting business.

Sec. 21.54.220: Defines the powers and duties of the Alaska Health Care Board
The board oversees two of the main elements in this bill: the health care Clearinghouse and the health care fund, the function of which are described in later sections of the bill.

In particular, the board will:

- ensure that a variety of plans are available in the clearinghouse, where individuals make plan selections based on their personal needs
- help educate the public about different plan options, and ensure that residents are enrolled in a health benefit plan
- establish enrollment criteria and procedures for individuals, and provide for an annual open season when customers can change their plan selections.

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

SB 61 *Health Insurance For All Alaskans*

Detailed Bill Summary

In particular, the board will *(continued)*:

- The board will hear complaints or objections to decisions made by the program or clearinghouse. Individuals who feel aggrieved by a decision of the board are entitled to a hearing
- Establish criteria and implement the voucher system, which will be discussed in a later section
- Ensure that plans protect individuals from severe financial hardship in times of medical need

Sec. 21.54.230: Alaska Health Care Clearinghouse
The health care clearinghouse will be the 'place' where Alaskans are connected up with private health plans that suit their needs. The clearinghouse will disseminate information about health insurance and the plans that are 'certified' to fulfill the essential health care services criteria, as defined later in the bill.

The Clearinghouse will be the place where individuals with health care vouchers make plan selections and are connected up with quality insurance products.

Sec. 21.54.240: Establishes the Voucher system, and includes the individual responsibility clause
This section ensures that all Alaskans can afford quality health coverage. It begins in (a) with the individual responsibility clause, which requires that all Alaskans have health coverage that provides essential health care services. This requirement will only affect those who don't currently have coverage: (1) – (8) outline specific examples of individuals who will be exempt from the individual responsibility clause. Excepted from the requirement are individuals who receive benefits under employer plans or publicly funded programs, including IHS recipients. In addition, individuals who have objections to the requirement to have health coverage on religious grounds can apply to be exempt from the individual responsibility clause.

Subsections (b) through (e) describe the sliding scale voucher system which makes health coverage affordable for all legal residents. Sliding scale vouchers are issued to individuals in households based on the federal government's federal poverty level criteria (FPL), which sets a poverty line annually based on household size. This year the FPL has been set at $13,000 of gross income a year for an individual, or $26,500 per year for a family of four.

Subsection (c) provides a guarantee that anyone who falls below the federal poverty line won't have to pay for health coverage.

Subsection (d) provides vouchers, on a sliding scale, to individuals in households that earn between 100% and 300% of the FPL. Using the numbers from above, this means that an individual who earns between $13,000 and $39,000 a year or a family of four that has a household income between $26,500 and $79,500 will be eligible for a sliding scale voucher that makes health insurance affordable. The amount of these vouchers will be set by the board, and will vary, with more assistance going to those who earn less.

Subsection (e) requires that all individuals over 300% of the FPL acquire health coverage. While these individuals will not receive needs based vouchers, they will be eligible to receive specified beneficiary vouchers, which are discussed in a later section of the bill.

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SB 61 *Health Insurance For All Alaskans*

Detailed Bill Summary

Subsection (b) provides larger vouchers to individuals who only qualify for ACHIA coverage, making the cost of coverage equal to that available in the normal market. These vouchers will be issued to people who earn up to 450% of the FPL.

Subsection (f) ensures that only legal residents of Alaska receive needs based vouchers.

Subsection (g) clarifies that an individual who is eligible for health coverage funded by a source other than the health care clearinghouse won't receive needs based vouchers to make insurance affordable.

Sec. 21.54.250: Defines essential health care services
This section defines the benefits that all health insurance plans sold through the clearinghouse must include. Insurance plans will include coverage for:

- preventative and primary care
- emergency services
- inpatient services and hospital treatment
- ambulatory patient services
- prescription drug coverage
- mental health services

Sec. 21.54.260: Relates to employer provided health coverage
(a) and (b) are included to make it clear that nothing in this legislation changes employer based health coverage for companies that elect to provide it.

(c) and (d) relate to the employer levy, which ensures that all employers contribute to the health of employees around the state. This tax is only levied against employers who don't offer health coverage, and the amount depends on the number of employees who lack health coverage and are required to attain it under this legislation. For businesses that pay below $500,000 gross annually to employees that are required to participate, no levy will be charged. For businesses with $500,000 to $1 million a year in gross payroll to employees required to participate in the plan, the levy will be 1% of gross payroll. For $1 million or greater, the levy will be 2%. If an employer either a) offers to pay 33% of premium costs or b) successfully enrolls 25% of employees in an employer sponsored plan they will be exempt from this tax. In addition, if an employer establishes a so-called 'Section 125' cafeteria plan that allows employees to purchase health coverage with pre-federal tax dollars, the employer will be exempt from this levy.

Sec. 21.54.270: Relates to the structure of insurance plans available in the clearinghouse
This section requires that plans provide coverage for essential health care services, as described in 21.54.250. (b) in this section mandates that an insurance company not turn down an individual looking for coverage.

Subsection (c) makes clear that health insurance plans can have varied levels of deductibles, co-pays, co-insurance and out of pocket maximums. They can include high deductible health care plans, and benefit levels can be different for in network and out of network providers. In addition, this subsection encourages lower

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cost plans that are especially designed for young adults, ages 18-30, which have different terms than are found in normal plans.

Subsection (d) increases the length of time that a child must be covered under a clearinghouse plan to 25 years of age, or until 2 years after the dependent no longer resides with the family.

Subsection (e) borrows language from Alaska's small group health insurance law that limits the length of time a preexisting condition limitation can be imposed on new enrollees to a maximum of 12 months. It also only allows a two year look back for determining when preexisting conditions exist.

Subsection (f) requires insurers to give credit for prior coverage when determining preexisting condition exclusion periods on newly issued health insurance plans sold through the clearinghouse.

Sec. 21.54.280: Establishes the Alaska Health Fund and Specified Beneficiary vouchers
The health fund is established as a separate trust fund of the state, and will include:

- state money and appropriations
- federal money, pursued through a variety of routes including 1115a waivers
- employer levy established in 21.54.260
- health care premiums received and appropriated to the fund
- money from any source that is given with purposes consistent with the purpose of the program

(b) establishes specified beneficiary vouchers, which gives an employer, employers or individuals the ability to contribute to the health premium of a given individual, through a voucher.

Sec. 21.54.290: Disputes and appeals
This section gives an individual the opportunity for a hearing if they are denied health coverage by a certified plan, or if a plan fails to deliver essential health care services. In addition, if a person feels adversely affected or aggrieved by a decision of the board or clearinghouse, they have the right to a hearing.

Sec. 21.54.300: Reporting
This section provides for an annual report by the health care board that includes statistics relating to how the health reform program is performing. In addition, the board will also give an evaluation and recommendations on a variety of important health reform topics, including the use of electronic health records, S-CHIP, the effect of mandated benefits, prescription drug bargaining, ways to maximize federal health care dollars, recruitment and retention of medical professionals, evidenced based treatment procedures, Medicaid effectiveness/expansions and more.

Sec. 21.54.310: Regulations
This section requires that the board establish regulations under the Administrative Procedure Act.

The remainder of the bill deals with definitions, transitional provisions and effective dates.

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

[redacted]

Health Insurance For All Alaskans

A Bipartisan Solution To Cover The Health Needs Of All Alaskans

SB 61 - AFFORDABLE HEALTH INSURANCE

Comments about the legislation:

Anchorage Daily News Editorial:

"BOTTOM LINE: Here's a promising, market-based, consumer-driven approach to universal health insurance in Alaska."

- Published September 23rd, 2007

Al Parrish, VP/Chief Executive, Providence Health Systems Alaska:

"I believe it is crucial for Alaskans to engage in a public policy debate on this important issue and this legislation provides an excellent forum around which this discussion can be held."

- Written in a letter to Senator French and included in this packet

Laile Fairbairn, Managing Owner, Snow City Café (located in Anchorage, AK):

"I feel that [this bill] is a very promising solution to a significant problem faced by a large number of Alaskan businesses."

- Testimony during a September 10th, 2007 bill hearing in Anchorage, AK

SB 61 *Health Insurance For All Alaskans*

Legislation Summary

Senate Bill 61 is an innovative, market based solution to the national health care crisis in Alaska. It is not socialized medicine. By maximizing consumer choice and creating a health insurance clearinghouse, this legislation guarantees affordable quality health coverage for all legal Alaskan residents.

Many working Alaskans cannot acquire insurance because the cost of coverage places a plan out of reach. While all Alaskans have legal 'access' to insurance products, those who cannot afford the full cost must hedge their bets on good health. Alaska's unique economy adds additional challenges: seasonal employees, for instance, find themselves outside the traditional 'group' market, lacking an easy route to maintain continuous, portable coverage. And with the amount of uncompensated care rising, the pressure on individuals and businesses who do buy coverage will only increase, because unpaid hospital bills are essentially transferred to those who pay for services. SB 61 will reduce uncompensated care and ensure that all Alaskans have meaningful access to health coverage, regardless of job type.

The solution requires that all Alaskans participate. While individuals will have the responsibility to acquire coverage under the bill, the state will guarantee that a quality insurance product will be affordable. Sliding scale vouchers will assist Alaskans that cannot afford the full price of coverage on their own. The bill allows for unique plans that cater specifically to young Alaskans. This legislation does not assume that a one size fits all solution will work for Alaska.

The health care 'clearinghouse' will give participating Alaskans choices when it comes to health coverage, in a competitive marketplace framework. It allows for unsatisfied consumers to change insurers or plans without a loss of benefits, and provides a private market solution to rising costs. By placing the consumer in control and providing information about comparable products, the clearinghouse should reduce cost increases while increasing customer satisfaction.

In short, this legislation will ensure that all Alaskans have access to health care in times of great need, through an equitably financed system.

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For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us

www.healthyalaskans.com

SB 61

Health Insurance For All Alaskans

Frequently Asked Questions

Why is this bill necessary?
As medical costs increase uninsured Alaskans have greater difficulty taking charge of their own health, because the cost of insurance becomes prohibitive. Through a unique voucher system, this bill will allow individuals to purchase coverage that is affordable, putting everyone in charge of their own medical future.

Why is this bill necessary now?
Recent reports show that medical expenses for Alaska's families have increased 4.3 times faster than the median family income. Businesses across the country have expressed concern about rising insurance costs and the difficulty of providing quality health coverage to employees. The time has come to ensure that all Alaskans have access to affordable coverage, since without action things will only get worse.

How many Alaskans currently lack health insurance?
The latest numbers developed by the Lewin Group estimate that 15.5% of Alaskans lack health insurance, for a total uninsured population of 97,689.

I already have insurance, so why should this bill be of interest to me?
The impact of the uninsured is felt by all Alaskans, not only socially, but economically. When someone cannot pay their medical bills, the costs for their care is essentially covered by hospitals, businesses and the individuals who can pay. A recent legislative research report found that the State of Alaska, as an employer, paid an extra 18.9 million dollars for state employee benefits because of the increased prices caused by uncompensated care.

This bill ensures equitable financing of the health care system while reducing expensive emergency room procedures by encouraging preventative care.

Does this bill change my current employer based health insurance plan?
No – if you are satisfied with your current coverage and it provides essential health services no changes will occur.

Is this bill socialized medicine?
No, and far from it. Socialized medicine is characterized by government run health care; this bill protects consumer choice and encourages competition through a unique voucher system. Under the bill, the government only acts as a facilitator in the health coverage arena, making certain that everyone can afford quality health coverage.

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SB 61

Health Insurance For All Alaskans

Personal Choice Under The Bill

For more than 70 years a majority of Americans have received health coverage through their employer. Some see the system of employer based coverage as an unfortunate historical accident, largely resulting from federal tax loopholes following World War II. Others note that employers worldwide play a large role in providing coverage to their employees. SB 61 works within this country's traditional employer-based framework while guaranteeing portable, consumer centric coverage. This legislation places Alaskans in full control of health care decisions that dramatically affect their lives.

Nothing in SB 61 would require a person to change their health coverage if they are satisfied with the benefits they receive today. However, many Alaskans want more options. Through the health care Clearinghouse, this legislation will facilitate a new relationship between individuals and insurance providers: the bill does not assume that a one size fits all solution will work for all Alaskans.

SB 61 places individuals in control of their coverage decisions. Under the employer based system, the employer is a middleman between an individual and health coverage. Currently 80% of employer offerings give only one plan option to employees, and the individual must either accept or refuse that coverage. When employers decide which insurance company to contract with, the way a plan serves employees is clearly considered but coverage decisions aren't left to the individual. The clearinghouse under this legislation provides consumers with information, leaving decisions of plan type and provider up to the person who is affected most by the decision.

The health care clearinghouse established under this legislation will create a marketplace where health insurance information is shared. The annual open season encourages competition by allowing individuals to change plan types and providers seamlessly, which has the potential to reduce rates. In short, this legislation will put Alaskans in a new position of control when designing their plan and choosing an insurer, through a competitive, market based framework.

80% of employers who offer subsidized health plans only offer employees one type of plan design.

- Heritage Foundation

References/For More Information:
Edmund Haislmaier - "The Mass. Health Reform: Assessing Its Significance and Progress" - Heritage Foundation 2007

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SB 61 *Health Insurance For All Alaskans*

Reducing Medical Bankruptcy

Half of all personal bankruptcies in America are caused by medical problems. While health insurance alone won't provide perfect protection from large health costs, SB 61 could dramatically reduce the bankruptcy rates of Alaskans who will be faced with high medical expenses.

Coverage through the Clearinghouse separates insurance from employment, making a health insurance plan continuous despite job status. Sliding scale vouchers will exist for those who truly cannot afford the full price of a plan on their own, helping those who haven't had access to health coverage. For seasonal employers who generally don't offer a group plan to employees, the option of contributing some funds towards an employee's plan would become easier, and multiple employers could contribute. By ensuring affordable coverage, individuals will have financial protection in times of great need.

Three out of four people who cite medical problems as a partial reason for declaring bankruptcy had health coverage when their ailment began, but most had a lapse in that coverage before declaring bankruptcy. In an employer based coverage system, a job loss is coupled with a loss of employer subsidized benefits. While options do exist to extend coverage, these options charge an individual the full price of the employer offering, and often leave little or no choice in plan design. As mentioned earlier, over 80% of employer sponsored health plans across the country only offer one type of plan that employees can either accept or reject. Often, employees with pre-existing conditions must either drop coverage altogether or pay for a 'Cadillac' plan if they want continuation of benefits, since private carriers in the individual market aren't required to provide them with a plan. For people participating in the clearinghouse, this legislation would open up options when it comes to plan design and portability.

To protect Alaskans, SB 61 makes certain that insurance products are of good quality, with the capability to protect the plan holder from a medical catastrophe. Insurance plans come in all shapes and sizes today, and that is a great thing for consumer choice. However, a one size fits all approach won't work in Alaska. As an example, while many Alaskans may prefer a low premium, high deductible health plan, a policy that has a $10,000 deductible won't be of much use to an individual who makes minimum wage, amounting to approximately $15,000 a year. By setting deductible, co-pay and out of pocket maximums for plans that qualify for sliding scale vouchers, SB 61 ensures that everyone has access to quality coverage that fits their financial needs.

References/For More Information:
David U. Himmelstein et al - "Marketwatch: Illness And Injury As Contributors To Bankruptcy"-Health Affairs 2005

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SB 61

Health Insurance For All Alaskans

Voucher System Ensures Affordability, Access

The voucher system in this legislation promotes consumer choice for all Alaskans. Two types of vouchers will be issued under the bill. The first type puts the price of insurance within the reach of all Alaskans by providing assistance, on a sliding scale, to those who cannot afford the full cost of a plan. The funding for these vouchers would come from the levy charged to non-providing employers, as well as from state and federal contributions. Without sliding scale vouchers the individual responsibility component of the legislation wouldn't be meaningful, because insurance is priced out of reach for many working Alaskans.

The second type of voucher is issued to specified individuals, who have had contributions made on their behalf by an employer or another individual, for use on health insurance products. These vouchers create a convenient way for employers to pool health contributions for an individual, whether they have one or many jobs. In particular, specified beneficiary vouchers are particularly appealing for individuals with multiple jobs, because it helps multiple employers share the cost of coverage. The system also gives businesses some certainty of their health expenditures in a given year, since expenses can be defined by contribution level and not by benefit package. The choice of plan type is left to the individual, for the obvious reason that he or she is most affected by the selection.

Contributions to specified beneficiary vouchers will not be mandated; instead, that element of the bill promotes equitable financing of health coverage by making it easier than ever for employers to contribute to the health and well being of their employers.

Alaskans spent $5.3 billion on health care in 2005, a 230% increase from 1991.

- ISER

Affordability provides true access

Under current Alaska law any small business can buy private coverage, and every individual can buy an insurance plan, either through the private market or ACHIA (the state high risk pool). However, claiming that this equals access to health insurance is simply false. Access to health care must be more than just the legal right to buy a policy; it should ensure that all Alaskans have coverage in times of need. SB 61 mandates true access to health care through a unique voucher system that makes coverage affordable for all Alaskans.

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SB 61

Health Insurance For All Alaskans

Prevention, Innovation and The Affordability Guarantee

Prevention and Innovation

This legislation acknowledges that lowering costs while improving quality requires innovative solutions to old problems. Under SB 61, the Alaska health care board will weigh in on potential cost and quality improvements, including but not limited to recommendations on:

- Electronic health records and health information exchanges
- Denali Kid Care/Medicaid effectiveness
- Prescription drug bargaining
- Insurance market reforms
- Mandated benefits
- Evidence based treatment procedures
- Recruitment and retention of medical professionals
- University of Alaska offerings in medical fields

The health care board's suggestions regarding cost and quality improvements will be given to the commissioner of the Department of Health and Social Services and the legislature in an annual report. This report will get the consideration of both the legislative and executive branches, where substantive health policy changes can be considered, discussed and implemented.

More than half of Alaska's uninsured population is employed.

- Families USA

The Affordability Guarantee

SB 61 requires that quality basic health insurance is made affordable for all Alaskans. If an individual feels that he or she cannot afford coverage under the legislation's framework, that person has a right to an appeal before the health care board. If the board reviews the case and agrees that an insurance plan places an undue financial burden on the household, the requirement to have coverage will be lifted. While SB 61 should place the price of coverage within reach for all Alaskan families, the affordability clause in the bill provides a guarantee that no one will be forced to purchase coverage they cannot afford.

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SB 61

Health Insurance For All Alaskans

Individual Responsibility - Financial Relief

Critics of the new type of universal health care efforts being implemented around the country have questioned the necessity of requiring that all residents have some form of health coverage. Yet, judging from these efforts, a consensus has been reached: Until something is enacted on a federal level, mandating coverage is the only responsible option for promoting universal health coverage in a state today. Beyond the social benefit of making certain that all residents have better access to health care, there are also economic reasons why reform efforts must include everyone.

Financial Relief For Current Policyholders

In a sense, universal health care is already provided in America because emergency rooms cannot turn down a person in need of medical attention. While this system may provide emergency care for all Alaskans, it doesn't equal universal access to health care in times of need, nor does it protect the financial concerns of the insured or uninsured alike. In addition to producing less than ideal health outcomes for those who lack coverage, it also places an undue financial burden on people who do buy coverage. And this financial burden is large.

The amount of uncompensated care in Alaska is staggering. Families USA estimate that $125 million of uncompensated care is provided each year in Alaska, and that only 21% of that bill is reimbursed by federal, state and local governments. That leaves medical providers with $100 million of unpaid bills every year. This doesn't mean that hospitals 'lose' money every year: To make up for outstanding bills, hospitals charge more to people who can actually pay for services. Since government health care reimbursement rates are often at or below the actual price of providing care in Alaska, nearly the entire burden of uncompensated care is recouped through inflated insurance premiums.

How much does the cost of an average plan go up? Families USA estimates that 13.6% of an insurance premium in Alaska covers uncompensated care costs, meaning that, for a family of 4 with a comprehensive policy, nearly $1,500 a year go towards covering uncompensated care. SB 61 ensures that everyone can afford quality basic coverage, potentially reducing the amount of uncompensated care given out by hospitals. This element of the bill will give much needed relief to everyone who currently invests in health coverage.

An estimated 125 million dollars of medical bills aren't paid each year in Alaska.

- Families USA

References/For More Information:
Families USA - "Paying a Premium: The Added Cost of Care for the Uninsured" - June 2005

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SB 61 *Health Insurance For All Alaskans*

Individual Responsibility - Improving The 'Pool'

Improving the 'Pool' to Increase Affordability

An insurance 'pool' is a bundle of risks. It works this way: for the sake of determining premiums, a 'pool' is a group of individuals who are considered together when determining expected medical costs. Once anticipated costs are determined, each member of that pool can be billed for a fair portion of what expenses the 'pool' is likely to incur on their behalf.

Adverse selection occurs when individuals utilize their private knowledge of their own health when deciding whether to buy health insurance. Since an individual has better knowledge of their lifestyle, habits and health then an insurance company, adverse selection has the potential to greatly affect who buys insurance. Simply put, people who expect to be sick want health insurance more than healthy people.

Certain pools are affected by adverse selection more than others. As an example, in the individual market, the decision to buy or forego insurance isn't left to chance – someone must make the conscious decision to buy a plan. Employer provided coverage, on the other hand, doesn't always require that the employee opt in: Often coverage is highly subsidized or provided free of cost.

The best insurance pool includes both healthy and sick individuals. If pools are structured to distinguish between people by health, the cost of insurance for those with severe illnesses will be extraordinarily high, and out of reach for most Alaskans. Similarly, if a pool only includes healthy individuals, the costs of a plan may be lower for those who are included, but the amount of uncompensated care would be high, since plans for those with severe health problems would be cost prohibitive. Today the amount of uncompensated care is large, and as discussed earlier, that cost is transferred to Alaskans that do have coverage.

Adverse selection has undoubtedly raised the costs of plans in Alaska's health insurance marketplace through self selection within the individual market. And while the Alaska Comprehensive Health Insurance Association (ACHIA) was created by the state to provide health coverage to individuals with pre-existing health conditions, the offered plans are often cost prohibitive for normal Alaskans. This legislation will reduce adverse selection by ensuring that all Alaskans participate.

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Individual Responsibility - Avoiding Price Spirals

Damaging price spirals are often caused by adverse selection in voluntary participation health reform efforts. When an individual weighs the decision to buy coverage they consider many factors, including the cost of a plan, what they can afford, and the probability of requiring care. This often causes people of good health to forego insurance, since they figure the odds are in their favor. And when healthier individuals don't acquire coverage, the pool of people who do purchase insurance is more likely to require health attention. As a result, premiums increase.

The price of coverage in voluntary state reform efforts that include some individual contributions have often spiraled upward after introduction, with plan costs increasing when the healthiest individuals decide to hedge their bets on good health. Once the healthiest people in the pool leave, the expected cost per member increases. If these price increases are charged to individuals within the pool, additional people may reconsider their participation in a voluntary plan. Maine's Dirigo program ran into this problem, when fewer people than expected signed up, and once the program began, the spiraling effect occurred as the participation price increased. If everyone is required to get 'in the pool' this price spiral will be eliminated.

"The problem is that the individuals in the insurance pools don't cooperate. Guaranteed issue and community rating regulations cause premiums to be higher than would otherwise be the case. As a result, the healthiest individuals drop their coverage, leaving the members with the highest health care costs in the pool. As the cost of care rises, premiums also go up, causing more members to drop out and creating a rising spiral of cost and premium increases."

- Portland Press/Maine Sunday Telegram, October 28, 2007

References/For More Information:

David U. Himmelstein et al - "Marketwatch: Illness And Injury As Contributors To Bankruptcy"-Health Affairs 2005

Martin Jones - "Rules make health insurance in Maine costly" - Portland Press/Maine Sunday Telegram, published October 28th 2007

Not Socialized Medicine

This legislation does not create a socialized system of medicine in Alaska. Socialized medicine is characterized by government run health care: Under this legislation, the only role of the government is to guarantee that all residents have true access to health coverage.

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SB 61

Health Insurance For All Alaskans

Proven Concepts - Learning From Programs That Work

While many critics of consumer centered health reform claim that the ideas haven't been tested, these critics fail to recognize several extremely successful consumer driven programs in place today.

The first is the Federal Employees Health Benefit program. This program provides federal employees, retirees and their survivors with the "widest selection of health plans in the country" through a mechanism much like the clearinghouse under SB 61. The program provides information about numerous plan providers and types, giving consumers a meaningful role in choosing their health coverage. Plans offered through the FEHB program feature no waiting periods for enrollees, and all participants are guaranteed that a plan will accept them. The health care clearinghouse in SB 61 will provide a similar system which can be accessed by all Alaskans.

The bi-partisan reform effort being implemented in Massachusetts is still young, but the results thus far are encouraging. One year after the legislation was enacted over 200,000 previously uninsured residents gained health coverage in Massachusetts. This effort ensures that similar successes can be seen in Alaska, largely through the Massachusetts inspired sliding scale voucher system under SB 61.

Since the passage of Governor Romney's health reform effort, consumer choice has drastically increased while uncompensated care has decreased in the state of Massachusetts. Over 44 different types of plans are available in the Massachusetts Connector, which, when compared to the standard employer offering of only one plan type, represents a large improvement of choice for residents of the state. Furthermore, uncompensated care has decreased by almost 13% in the state during the first year, even though the plan was just being implemented during that time. When everyone has coverage further declines should be seen.

By no means is this to say that a silver bullet exists, but, so far, the results of both programs are encouraging. This legislation builds an Alaskan version of health reform practices like these that are working in different parts of the country.

Learn about these successful programs online

Federal Employee Health Benefits Program:
http://www.opm.gov/insure/health/

Massachusetts Commonwealth Connector:
http://www.mahealthconnector.org/

References/For More Information:

Federal Employee Health Benefits Program:
http://www.opm.gov/insure/health/about/fehb.asp

Lisa Eckelbecker - "The Insurance Countdown" - Worchester Telegram and Gazette, published November 18th, 2007

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SB 61 ***Health Insurance For All Alaskans***

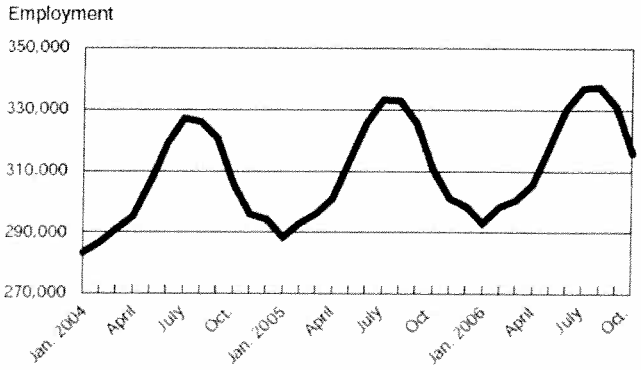
Continuity of Coverage

Seasonal Employment Requires a Creative Solution

Alaska's natural landscape provides unique employment opportunities in the state. Both the tourism and fishing industries peak during summer months, with relatively little activity during the middle of winter. Judging from historic employment data, there are roughly 45,000 fewer jobs during the peak of winter compared to the busiest months in the summer. While the economic benefits that come with seasonal employment are great for Alaskans – tourism alone brought $1.8 billion into the state last year - many workers in seasonal industries work for multiple employers over the course of a year. Unfortunately, this doesn't line up with the traditional employer based health insurance model.

The United Fishermen of Alaska have expressed particular concern over this issue, noting that a lack of health insurance options creates a significant barrier of entry for future generations of commercial fishermen. In particular, they note difficulty with the traditional group market structure, because fishing organizations don't fit the traditional mold of a group client. The marketplace solution provided through the health care Clearinghouse should help fishermen, and all other seasonal employees, get many of the group benefits of coverage while maintaining the portability that seasonal workers require. Edmund Haislmaier, a senior research fellow at the Heritage Foundation, noted that few people are uninsured for years at a time: In fact, he has found that up to 40% of the national uninsured problem could be solved if coverage was tied to an individual, and not an employer, because the shorter lapses of coverage could be prevented. Alaska's seasonal industries give the state even more reason to tie coverage to the individual, to make certain that benefits are available when they are needed.

Chart from "Making sense of Alaska's unruly numbers":



Source: Alaska Department of Labor & Workforce Development, Research and Analysis Section: Employment and Earnings Report

References/For More Information:

Dan Robinson - "Making sense of Alaska's unruly numbers" - Alaska Economic Trends, December 2006

United Fishermen of Alaska - "Alaska Fishermen's Health Care - Challenges and Opportunities" - Aug. 2001

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SB 61

Health Insurance For All Alaskans

Unique Solutions for Business, Young Alaskans

Structured With Small Business In Mind

Most Alaskans who lack health coverage also work for a living, leaving behind the notion that only the unemployed require assistance when it comes to making health coverage affordable. Even the most successful small Alaskan businesses can have difficulty providing coverage, because of the high costs of health plans. This legislation aims to strengthen businesses around the state by putting coverage in reach for all employees.

Clearly a healthy workforce is more productive, because absenteeism and productivity is tied to the health of an individual. But in addition to health benefits that would arise if everyone had access to basic medical care, Alaska's businesses have much to gain through this legislation economically. Retaining qualified employees is difficult for businesses that cannot afford coverage. This forces high retraining expenses on employers, since they must fill vacancies more frequently than businesses that provide coverage. In addition, recruitment is more difficult for companies that don't offer coverage.

Not all businesses can afford the full price of health coverage. In addition, not all employees need insurance through their employer - many have coverage through spouses or public programs. Roughly 20% of Alaskans have limited health coverage through the Indian Health Service. Because of this, an employer will not be taxed under this legislation for not providing coverage to someone that already has health access, as defined in the legislation.

The employer levy is simple. It is calculated by adding up the gross payroll of all employees who participate in the framework of this bill. For businesses that pay less than $500,000 gross annually to employees who lack health coverage, no levy will be collected. For businesses that pay between $500,000 to $1,000,000 a year, the levy will be 1% of payroll. For over $1,000,000 annually, the payroll tax will be 2%. Companies that currently invest even a small amount of money into employee health coverage will be exempt from this levy, whether that investment consist of a modest contribution towards the price of a premium, or through the establishment of a Section 125 account, which facilitates pre-federal tax purchases of health coverage.

Young Alaskans Have Unique Needs

Young Alaskans have special needs when it comes to their health coverage. Statistically, they require less health services than their older counterparts. They also show less of a willingness to pay for expensive, comprehensive coverage, and even a moderate deductible can be difficult to pay, particularly for college aged students. This legislation acknowledges that young Alaskans have unique needs, and it provides for a special category of plans that are designed specifically to fulfill their health requirements.

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SB 61

Health Insurance For All Alaskans

Massachusetts and SB 61 Compared

Issue Area	Alaska - SB 61	Massachusetts - Enacted
Sliding Scale Subsidies *Definitions:* FPL = Federal Poverty Line	**Yes:** Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage affordable. Residents only eligible for ACHIA coverage will receive vouchers up to 450% FPL. Health care vouchers will put the consumer in control when choosing a plan and a provider.	**Yes:** Households with income below 300% receive subsidized health coverage through the connector. For individuals who utilize vouchers, one plan type is available to households below 200% FPL and two plan types are available to those earn between 200-300% FPL.
Establishing A New Insurance Marketplace	The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.	The Connector provides information, encourages competition, and helps residents learn about different coverage options. It is a web-based marketplace.
Requirements for Consumers	All Alaskans would be required to have a minimum level of coverage, as defined by statute. If a product isn't affordable a hearing process allows for some exceptions.	All residents must have a minimum level of coverage, as defined by the Connector board. However, some residents have been exempted from the mandate because an affordable product isn't available to them.
Effect on Existing Public Programs	No changes to existing publicly funded programs.	Free care funds will still be available to hospitals, but the program will shift dollars from this account to the reform effort as more people get coverage and don't require free care. Medicaid reimbursement rates were also increased under the legislation.
Financing	Employer payroll tax, varying from 0-2% of payroll depending on payroll size and the number of uncovered employees. Federal dollars will be pursued through 1115 waivers. State funds will also be used.	Employer payroll tax of up to $295 per employee for employers with more than 10 full time workers. A free rider surcharge can also be assessed if employers don't help employees get coverage and they utilize free care. Federal dollars from 1115 waivers have been funneled to the project.
Insurance Market Reforms	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. Preexisting condition limitations can extend no longer than 12 months for plans sold under the clearinghouse, and credit for prior coverage is required.	**Yes:** By merging the non-group and small group markets, insurance is portable and not tied to employment. Massachusetts already had guarantee issue laws and provisions that regulate preexisting condition limitations and credit for prior coverage within the individual market.

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Other State Reform Efforts

Issue Area	Alaska - Senate Bill 61	California - Governor Schwarzenegger's Plan 2008	Colorado–Legislature's Blue Ribbon Commission '08
Sliding Scale Subsidies *Definitions:* FPL = Federal Poverty Line	**Yes:** Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage affordable. Residents only eligible for ACHIA coverage will receive vouchers up to 450% FPL. Health care vouchers will put the consumer in control when choosing a plan and a provider.	**Yes:** Households with incomes below 400% of the FPL will receive a tax subsidy to help cover insurance costs, residents below 250% FPL won't pay more than 5% of income for coverage, and individuals below 150% FPL won't pay anything- including co-pays and deductibles - for health care	**Yes:** Full subsidy of most basic plan for households with incomes below 250% FPL and partial subsidy for households below 300%. Colorado is also proposing a asset test and an additional subsidy to households below 400% of the FPL if a premium will be more than 9% of household income.
Establishing A New Insurance Marketplace	The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.	A purchasing pool will be established for residents who receive sliding scale assistance to cover health insurance costs.	The Coverage Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.
Requirements for Consumers	All Alaskans would be required to have a minimum level of coverage, as defined by statute. If a product isn't affordable a hearing can allow an exception.	All Californians must have a minimum level of coverage, as defined by the Secretary of Health and Human Services, through the regulatory process.	All legal residents of Colorado must have basic plan coverage, with some exceptions if a product isn't affordable. Basic coverage includes plans with benefit caps.
Effect on Existing Public Programs	No changes to existing publicly funded programs.	Expansion of S-CHIP to 300% regardless of immigration status, and Medicaid expansions to certain groups up to 250% FPL.	Expansion of S-CHIP to 250% and Medicaid. Allows for a Medicaid buy in program for households at 200% FPL and up.
Financing	Employer payroll tax, varying from 0-2% of payroll depending on payroll size and the number of uncovered employees. Federal dollars will be pursued through 1115 waivers. State funds will also be used.	Employer payroll tax, varying from 1-6.5% of payroll depending on payroll size. Hospitals will pay 4% of revenue towards the reform effort. Federal dollars will be pursued through 1115 waivers.	Increases in alcohol and tobacco taxes. In addition, taxes on snacks and soda will be established. Increase the state income tax. Federal dollars will be pursued through 1115 waivers.
Insurance Market Reforms	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. Preexisting condition limitations can extend no longer than 12 months for plans sold under the clearinghouse, and credit for prior coverage is required.	**Yes:** Guarantee issue and guarantee renewal to all Californians in the individual market. Rating bands will ensure that only age and geography determine premiums. Health plans will have to spend 85% of premiums on patient care.	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. High risk pool will exist for those who currently are uninsured. Premiums will equal the normal price paid in the individual market.

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Universal health care can work for us

By SEN. HOLLIS FRENCH
(Published: March 16, 2007)

A wave is beginning to build in state capitols across the country. In the face of inaction by the federal government, Maine, Massachusetts, Oregon, Vermont and now California are leading the effort to promote universal health care coverage among their citizens. In May 2006, Gov. Mitt Romney signed a bill that ensures health care coverage for all Massachusetts residents. California Gov. Arnold Schwarzenegger recently proposed a similar plan for the people of his state.

In the past, powerful interests have opposed universal health coverage. However, recent policy innovations have convinced many business and political leaders that fears about health care rationing and restricted access to doctors and hospitals are no longer valid.

These new plans do not call for the replacement of the current health care system with a new and untested model. This is not socialized medicine. Indeed, it is not the so-called single-payer system sought by the most progressive reformers. Instead, policymakers are taking the more pragmatic approach of retooling health care delivery methods that are currently in use.

The first principle of this new wave of health care legislation is individual responsibility. These laws impose a duty on each citizen to acquire some minimal form of health insurance coverage. This key idea recognizes that while the government has a role in shaping the health insurance landscape, ultimately it is the individual who must see to his or her own basic needs. This provision also ensures that the cost of health care is shared as broadly as possible.

Another major change in the law calls for employers who do not offer health insurance to their employees to contribute to a fund that would help pay for coverage of the working uninsured. This is a particularly needed reform here in Alaska. While many small business owners would like to offer health insurance to their employees, the cost is often out of reach. Some subsidy will be necessary to help those who work for very small businesses.

A comparison between Alaska and Lower 48 small businesses reveals the necessity of this reform. A March 2006 ISER study showed that only a third of Alaska businesses with fewer than 50 employees offer coverage, compared with 43 percent nationwide. The ISER study noted that 91,500 of the state's 224,500 private industry employees work for small businesses, meaning that over 60,000 working Alaskans do not get health care insurance through their jobs. This study helps defeat the notion that only the lazy or the poor are not covered by health insurance.

This reform does not have to be expensive. For example, the California plan requires businesses that do not offer health insurance and that have 10 or more workers to pay 4 percent of their total wages to a state fund that would be used to subsidize the purchase of health policies.

Another innovation redistributes Medicaid coverage in a couple of ways. The first is simply to expand Medicaid eligibility guidelines for children and adults and add enhancements such as dental and vision benefits. The other change is to take the Medicaid dollars currently being spent to reimburse hospitals and other providers for the free care they provide to the uninsured, and use

the money instead to subsidize health insurance for those who cannot afford it. Stop for a moment and consider what a good idea this is: Take the money spent on hospital bills each year for the uninsured, and buy health insurance instead.

These policy changes all lead to the goal of covering every citizen with a basic form of health insurance. I believe it is time for Alaska to take up the same challenge. I plan to introduce legislation that uses these enhanced policy tools to pave the way to universal health care coverage for all Alaskans.

Changing the health insurance system is not easy. Yet I am certain that someday we will look back on this era and ask ourselves, "What took so long?" There is no reason not to begin what will certainly be a spirited debate.

Hollis French is a Democrat who represents northwest Anchorage in the Alaska Senate.

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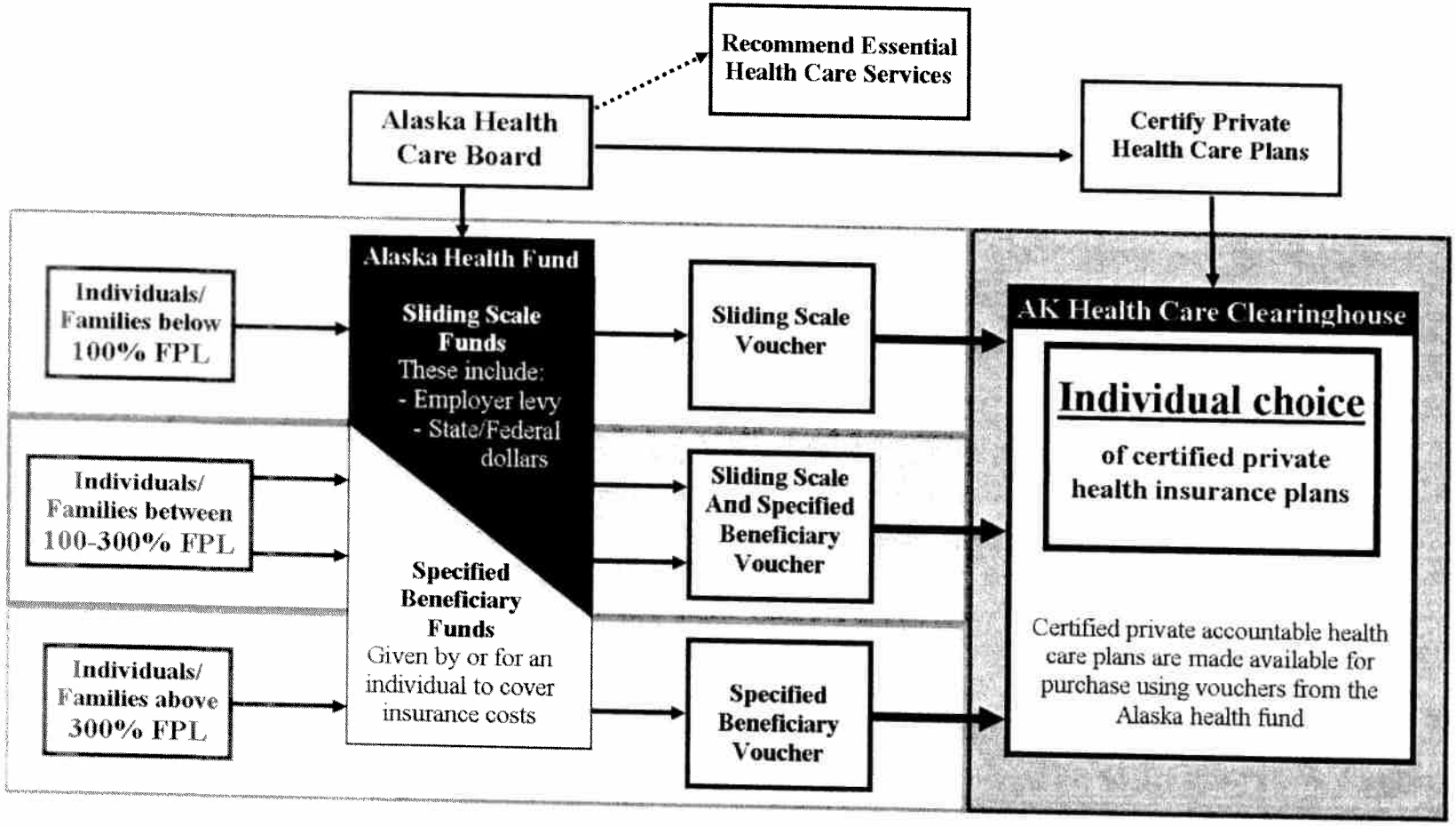
Alaska Health Care: The Framework For Change

SB 61

Health Insurance For All Alaskans



For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

AARP

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March 2, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Re: SB 61 (French)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 61, authored by Senator Hollis French and co-sponsored by Senator Johnny Ellis.

We applaud Senator French's efforts to develop a health care plan that works toward access to adequate coverage for all residents of all ages.

AARP pledges that we will work with Senator French and your colleagues in the Legislature to support efforts to provide high quality, accessible and affordable health care that offers reasonable choices for all Alaskans.

The current health system costs too much, makes too many mistakes, and often returns little value for our money. Access to affordable coverage is increasingly difficult—especially for AARP's 50- to 64-year old members who are among the fastest growing groups of uninsured. Even those with Medicare, if they can find a physician, are struggling to keep up with rapidly rising premiums costs that threaten their health and financial security.

One of the basic legislative principles AARP supports is that expansion of health coverage is desirable. Those who lack either private or public coverage are less likely to receive access to timely medical care and more likely to experience adverse health outcomes.

We understand that SB 61 is a work in progress and is probably the initial effort in what make take several sessions to work out. That's fine with us. The more participatory the debate, the more all Alaskans will understand how important it is to cover all of us. There are major issues that should be addressed in SB 61 and each of these issues should be thoroughly debated in the Legislature, in the media, and over the dinner table by Alaskan families.

Who is covered and how comprehensive is the coverage?

Is SB 61 efficient and economically practical?

Will the bill result in fairness and equity?

How much choice and autonomy does the bill permit?

Health care, as you know, is extremely complex. For example, if SB 61 passes, will there be a need for additional physician visits and nursing care? Do we have the health professionals to provide them? What new or expanded medical technology resources will be consumed as a result of coverage expansion? Conversely, what will we save in fewer visits to an emergency room through program expansion?

What will be the effect on quality of care, eg., medical outcomes and patient satisfaction?

What will be the effect on physician patterns of practice, eg., will we have greater adherence to practice guidelines?

The questions can go on for pages...and they should. SB 61 is a bill that deserves serious debate in every Committee of referral. AARP believes that we will eventually come out with a bill that all of us can live with and one that will improve the health status of all Alaskans of all ages. Let's keep that discussion going in the Senate Health and Social Services Committee.

We urge an "AYE" vote on SB 61.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Hollis French

Testimony 3/9/2009 SB 61

The Alaska Nurses Association is pleased to support Senator French's Senate Bill 61, Mandatory Universal Health Insurance. The legislative committee of the Association also represents the affiliate groups of the Alaska Chapter of Nurse Midwives, Alaska Home Health and Hospice Association, Alaska Nurse Anesthetists Association, Alaska Nurse Practitioner Association, Alaska School Nurses Association and the Alaska Chapter of the Forensic Nurses Association.

Our members are on record in support of innovative legislation that would make health insurance affordable for businesses and individuals. This bill meets that goal. According to a national survey by Consumer Reports [3/2008], 81% of respondents were concerned about being able to afford health care in retirement, 68% worry about being bankrupted by medical bills following a serious illness or accident and 65% feared losing their job-related coverage. The current economic picture with rising unemployment has exposed the weakness of relying on job-related health insurance. Senator French's bill addresses that problem.

The Alaska Nurses Association applauds Senator French's commitment to ensuring that health care become available for all Alaskans. We sincerely hope that SB61 will pass in the 26th legislative session.

Respectfully,

Lynn Hartz MSN
Family Nurse Practitioner
For the legislative committee of the Alaska Nurses Association
3701 E Tudor, ste. 208
Anchorage, AK 99507

ALLIANCE FOR REPRODUCTIVE JUSTICE

2009 Women's Summit

March 20, 2009

Senator Joe Paskvan,

I am a constituent of Joe Thomas of Fairbanks. I'm writing to you about SB 61, the Universal Healthcare bill. As a young person who is fast approaching the gap were I am no longer under my parents insurance, but I can't afford my own health care yet, this bill is very important to me. I think this bill is a good idea, but there are a few things that I would like attached to it. Namely I want Women's health to be explisitly worded in the bill. To me Women's health includes birth control, annual exams, and abortion. I would also like to point out that not all of us in the gap need catastrophic insurance. Many like me need preventative insurance like dental and eye exams. I hope I can count on you to help the many Alaskans in this tough situation by supporting this bill.

Thank you,

Meghan Malone

NFIB
The Voice of Small Business®

Alaska

January 25, 2009

The Honorable Hollis French
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 61

Dear Senator French,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 61. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

We're reminded weekly, if not daily, that 47 million Americans are uninsured. This hits especially close to home for small businesses, since approximately 27 million of those uninsured are the self-employed and small-business owners, their employees and their families. Many of those are in Alaska. Insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term.

National Federation of Independent Business — ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

Unfortunately, SB 61 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll. It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers.

The NFIB has adopted **Small Business Principles for Health Care Reform**. I have enclosed a copy for your review. NFIB knows that no one solution will help all the uninsured Alaskans cover health-care costs, but a multi-faceted approach will allow many more to find health care at costs they can afford. This approach should include health-insurance purchasing pools for small businesses, tax-based incentives to assist with the purchase of health insurance and implementing cost-containment measures.

Sincerely Yours

Dennis L. DeWitt
Alaska State Director

Enclosure

5 24C

NFIB

The Voice of Small Business®

Small Business Principles for Health Care Reform

Our current system of health insurance and health care is financially unsustainable and threatens the health and financial security of the American people. Small-business owners and their employees are especially vulnerable to the weaknesses of our current system. NFIB supports policy reforms to balance the competing goals of access to quality care, affordability, and predictability and consumer choice. The resulting health care system would be:

Universal: All Americans should have access to quality care and protection against catastrophic costs. A government safety net should enable the neediest to obtain coverage.

> Several reasons underlie our support for universal access to care. First, lack of insurance is especially problematic for small businesses and their employees. Second, having millions of uninsured Americans distracts us from focusing on affordability, quality and comprehensiveness of care and coverage. Third, laws already provide some level of insurance for everyone, but coverage is expensive, inefficient and often inadequate – guaranteed access to emergency rooms is one example. Under this piecemeal coverage, costs fall arbitrarily and inequitably on individuals, providers, governments and businesses.

Private: To the greatest extent possible, Americans should receive their health insurance and health care through the private sector. Care must be taken to minimize the extent to which governmental safety nets crowd out private insurance and care.

> One-size-fits-all insurance and care are not wise options in a nation of 300 million people. Restoring and invigorating America's health care system requires rapid innovation; history shows that such rapid advances rarely come from government and more often come from private enterprises. America's health care system is far from perfect, but the world's single-payer systems have deep problems of their own. We need better health care delivery models, financial-management systems and risk-sharing arrangements. America remains the world's engine of health care innovation, and entrepreneurship is the key to that innovation. Given the current financial path of health care, governments ought to be wary of taking on the entire burden.

Affordable: Health care costs to individuals, providers, governments and businesses must be reasonable, predictable and controllable.

> America's health care costs are high and growing more rapidly than earnings. The burden of costs often falls arbitrarily on individuals, businesses, providers and governments. Wages stagnate as health care costs eat further into take-home pay. Employers and governments struggle to balance budgets as health care costs rise. Health care uncertainties paralyze long-term financial planning. Through excessive malpractice judgments, we penalize good doctors practicing good medicine when their patients happen to experience bad outcomes.

Unbiased: Health care and tax laws should not push Americans into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Small employers should be treated the same as large employers, who can already pool across state lines. A health care system built on employer mandates or on play-or-pay taxes is unacceptable.

Today, our tax and insurance laws riddle the health insurance market with inefficiencies. An employer who buys insurance for employees can write off the cost on its taxes. But if employees wish to purchase different policies on their own, they receive no tax benefit. Thus, an oddity of the tax code, not economic efficiency, artificially herds businesses and workers into the employer-based market. Current laws allow large employers to build large interstate risk pools and enjoy a reasonable level of regulatory oversight. Laws deny small employers the same opportunities, forcing them to offer insurance with inadequate risk pools. The result is to arbitrarily load a competitive disadvantage on the small firms that are an engine of America's productivity. Employer mandates compound the problem, penalizing the most vulnerable firms and workers, including cutting-edge startups, lower-income workers striving to rise and companies operating in economically disadvantaged markets. These mandates can force a promising enterprise out of business, sweeping away jobs and future economic growth.

Competitive: Consumers should have many choices among insurers and providers. Policymakers must alleviate the limitations that state boundaries and treatment mandates place on competitiveness.

In the next decades, America's capacity to deliver high-quality health care will face increased financial pressures. Maintaining or improving upon our current quality of care will depend critically upon our ability to develop newer and less expensive modes of treatment and delivery systems. Innovation is unlikely to come from a system where insurers or providers face little risk of competition. Under our current system, restrictions on interstate purchases of policies place powerful limits on choice. Some states are left with close to monopoly control on the issue of insurance as fewer and fewer insurers offer coverage in the small-group market. A cautionary note is in order: Any competitive system must guard against adverse selection—a situation in which some individuals purchase policies only after learning that they are likely to face high medical costs. Adverse selection can render insurance too expensive for healthier individuals. (In property insurance, an example would be someone who buys fire insurance only after he moves dangerous, combustible materials into his house.)

Portable: Americans should be able to move throughout the United States and change jobs without losing their health insurance.

Our current health-insurance system locks people into jobs and localities. An existing health problem may make it impossible for an individual to change jobs. Employer-based health insurance and restrictions on purchasing insurance across state lines limit a worker's ability to seek higher pay, greater opportunity, or a better locality for his or her family. This phenomenon of job lock is not only a tragedy for the locked-in worker. It harms the overall economy by preventing workers from discovering their own entrepreneurial talents or accepting more productive jobs. It creates a significant impediment to those who wish to leave positions as employees and start small businesses of their own. Health care reform must maximize the mobility of American workers by eliminating health insurance as an impediment to changes in job and residence.

Transparent: Information technology should enable all parties to access accurate, user-friendly information on costs, quality and outcomes. Providers must be able to obtain relatively complete medical histories of patients. At the same time, patients' privacy must be guarded zealously. The private sector must play a vital role in developing the new technologies.

In any market, buyers and sellers need accurate and useful information on costs, quality and performance of the product. Health care is no different in this respect. Well-functioning health insurance and health care markets require information that is easy for consumers, providers and insurers to obtain and that is comprehensible to all. Today, information is often difficult to obtain and incomprehensible to consumers and providers alike. This is a function of the system we have, and not an inherent characteristic of health care

data. Governments will have a role in the development of new and better information technologies, but many of the breakthroughs can come only from the private sector.

Efficient: Health care policy should encourage an appropriate level of spending on health care. Laws, regulations and insurance arrangements should direct health care spending to those goods and services that will maximize health. Adequate risk pools throughout the health care system are vital to accomplishing these goals.

Today's health care system encourages misallocation of resources. All parties lack access to vital information for making medical decisions. Providers can give too little guidance on cost-effective treatments because they lack access to accurate, comprehensible, comparable cost data that provide true "apples-to-apples" comparisons of services and treatments. Reimbursement systems encourage excessive spending on health care and poor spending choices within health care. Medical delivery systems are poorly structured. American health care is on an impossible path, with costs rising much more rapidly than the country's real economic output. To avoid catastrophe, incentive structures across the system need to be reconfigured to give consumers, providers and insurers the educational tools and the motives to use their dollars wisely and efficiently.

Evidence-based: The health care system must encourage consumers and providers to accumulate evidence and to use that evidence to improve health. Appropriate treatment choices and better wellness and preventive care should be key outcomes.

Current information and decision systems make it difficult to accumulate, interpret and use evidence affecting treatment decisions. One result is overspending on treatments and underspending on prevention. Decision-makers must understand the impact of their decisions on both costs and outcomes. Such an understanding must be based on solid clinical and economic evidence.

Realistic: Health care reform should proceed as rapidly as possible, but not so quickly that firms and individuals cannot adjust prudently. It is important to assure that no one's quality of care suffers as we move to provide coverage for all Americans.

Reform is a delicate balancing act. Moving too slowly will allow costs to rise too far and too fast. In the process, the health of Americans will suffer, and the financial security of some will be disastrously impacted. But excessive speed is also risky. Thus, we must assure that reform does not allow some Americans to slip through the cracks—to lose coverage or see their costs rise too rapidly. Somewhere in between is a seamless transition from the status quo to a more efficient and equitable system.

Feb 3 2009
Heartland Inst

MANDATORY HEALTH INSURANCE FAILS IN MASSACHUSETTS

America's Health Insurance Plans (AHIP), a trade group representing more than 1,000 insurance providers, has come out in favor of a law requiring everyone to buy what they sell. This may be the wave of the future: if people don't want to buy what you sell, get a law passed making them do it anyway, says health economist Greg Scandlen.

But this mandate approach isn't going so well in Massachusetts, which remains the highest profile state to implement an individual insurance mandate. In fact, if the demands for "evidence-based medicine" were applied equally to public policy, policymakers would run away from the idea of mandatory coverage as fast as possible, says Scandlen:

* State costs have gone up so much that Massachusetts has decided to cut payments to physicians and hospitals, reducing access to medical services.
* The state is also planning to mandate an increase of 10-12 percent in insurance premiums while cutting payments to physicians and hospitals by 3-5 percent; this will reduce access to care even more.
* Even the poor (who have been aided under other programs) are being hurt; the Cambridge Health Alliance, which has long provided care to the indigent, is cutting staff, reducing services and limiting referrals to specialists in an effort to stay solvent in the face of rising costs and reduced payments.

In addition to all these problems, costs are skyrocketing because of special interest pleading the politicians crafting Massachusetts's mandate found simply irresistible. Thus, the program is now costing taxpayers $400 million more than originally advertised, 85 percent more than the promised cost.

Mandatory insurance violates insurers' and consumers' right to act in their own best interests by forcing insurers to sell and customers to purchase insurance on terms and prices dictated by government decree. This destroys the very conditions that give insurance any value at all, concludes Scandlen.

Source: Greg Scandlen, "Mandatory Health Insurance Fails In Theory and in Massachusetts," Health Care News (Heartland Institute), February 2009.

For text:

http://www.heartland.org/policybot/results.html?articleid=24504

Summaries of four research pieces from NFIB

"The Case Against Mandated Employer-Provided Employee Health Insurance"

NFIB white paper by William J. "Denny" Dennis (NFIB)

Outlines the **negative effects of an employer mandate**, particularly on small business.

- **Analyzes a "pure mandate,"** requiring an employer to provide and pay a fixed percentage of an employee's health insurance premium. Mandates to contribute a fixed percentage of payroll or pay-or-play options have similar effects.
- An employer mandate would mean a **20% increase in labor costs for each uninsured $25,000-a-year employee** needing a family plan or a 7% increase for each one needing an individual plan. The cost increases are 10% and 4%, respectively, per $50,000-a-year employee
- The mandate makes **both employer and employee worse off financially**.

There are three main arguments against an employer mandate:

- **The policy is highly regressive.** The uninsured, often low-income, eventually pay for their own health insurance through job loss, depressed wages and erosion of other benefits;
- **The policy is inefficient** because it is too blunt to distinguish between those needing and those not needing assistance to purchase health insurance; and,
- **The policy is unfair to small employers and employees** because it fails to address the real problems of the insurance market for small businesses (especially costs), while retaining rigidities that injure both, and substituting a hefty, direct penalty on them.

Conclusion

An employer mandate amounts to a tax on the poor and a tax on those who hire the poor. The research suggests that compliance with a mandate would adversely affect employers and low wage-workers because employers would be more likely to:

- **Reduce the number of workers** whom they employ;
- **Use part-timers** instead of full-timers;
- **Turn full-timers into part-timers** by reducing their hours;
- **Freeze other forms of compensation**, such as wages or non-health insurance benefits;
- **Replace workers with machines**;
- **Turn to foreign suppliers** who don't have to bear these insurance costs;
- **Cancel business investment** to cover the costs of health insurance; or
- **Go out of business**.

"Small Business Effects of a National Employer Healthcare Mandate"

NFIB study by Michael J. Chow (NFIB) and Bruce D. Phillips (NFIB)

Chow and Phillips examined the impact of an employer mandate on employment and real output in the American economy. They used a BSIM model with data by region, industry, and firm size and defined a mandate as a requirement to provide insurance and to provide a minimum 50% contribution. Their findings included:

- A mandate would **reduce U.S. employment by 1.6 million jobs** within five years and would cause **the American economy (measured by real GDP) to contract by $200 billion** over the same period.
- The **biggest effects** would occur in small firms, labor-intensive firms, and industries relying on discretionary spending. **Small business account for 66% of the job loss** (1 million) and **56% of the GDP decrease** ($113 billion).
- **Labor-intensive firms** (retail, restaurants, drinking places, construction) would account for 932,000 of the jobs lost.
- **Other hard-hit industries** include real estate (190,000 jobs lost); professional scientific, and technical services (125,000); social assistance (113,000); and wholesale trade (91,000).

Conclusion

- **Healthcare reform must address rising costs and cannot place unmanageable burdens on business.**
- Employer mandates in any form – pay-or-play, payroll tax increases, mandatory provision and contribution – all **lead to job cuts and stifle job creation.**
- Even more troubling, the workers **most devastated** by these short-sighted policies are **America's low-wage workers**, who are already the least likely to have health insurance.

Summaries of four research pieces from NFIB

"Rising Costs for Healthcare: Implications for Public Policy"

NFIB-sponsored study by Louis Rossiter, PhD (Schroeder Center for Healthcare Policy, College of William and Mary)

Lou Rossiter is a health economist and research professor at the College of William and Mary. He was previously Medicare/Medicaid policy official at CMS and Virginia Secretary of Health and Human Services. His study examines health costs, the quality of care, and specific ways policy makers can balance freedom of choice with serious cost restraint. NFIB doesn't endorse every Rossiter proposal, but he presents the vital issues in one highly readable document. The following summarizes the study:

- **Much is right about American healthcare** (high life expectancy, improved mortality stats for big diseases, comparisons with other countries).
- **Costs shift from Medicare and Medicaid to private plans** – especially to plans sponsored by small businesses.
- **The prime offender in costs is fee-for-service** reimbursement.
- **But there are unacceptable disparities**, and costs are rising rapidly.

Americans place high value on choice of insurance and provider, and employer-based insurance isn't working well.

Conclusion

Rossiter provides 24 possible policies for reducing or restraining costs. They fall into four broad categories:

- Policies to **change government-induced incentives**: These include changes to Medicaid, Medicare, medical liability, and private insurance rules. The federal government would encourage state initiatives for Medicaid, pay-for-performance, market-based pooling, and healthcare courts as substitutes for today's tort system.
- Policies to **change how care is delivered**: Includes competition among medical groups, health IT, changes in reimbursement rules, and pay-for-performance.
- Policies to **change the actions of individuals**: Includes chronic disease management and better end-of-life care.
- Policies to **reduce demand for and raise supply of health services**: Includes better cost-sharing, tax changes, wellness incentives, clinic subsidies, incentives for innovation, research on outcomes.

"Health Insurance Reform in an Experimental Market"

NFIB-sponsored study by Stephen Rassenti (Chapman University) and Carl Johnston (George Mason University)

This is one of the first-ever applications of experimental economics to healthcare policy. Rassenti and Johnston built an insurance market in a laboratory and tested various scenarios with the help of paid participants. They are protégés of Nobel laureate Vernon Smith. Smith wrote a foreword to the study, calling Rassenti and Johnston's work "path-breaking." NFIB is proud to have originated a project that earned praise from one of the great names of modern economics.

- Experimental economics allows researchers to lab **test the potential effects of a legislative proposal. This helps officials weed out ideas that will not work before actually enacting them into law**.
- **The eight alternative scenarios tested included:** mandating that employers provide coverage, requiring employers to contribute 50 percent of the cost of employee insurance, mandating that individuals purchase coverage, and combining employer and individual mandates (with and without a minimum contribution level).
- **Other scenarios included** wider choice of plans and restrictions on insurance premiums.

Key findings included:

- **Mandates:** Employer and individual healthcare mandates, separately or combined, don't improve outcomes for all stakeholders. Some reform scenarios actually come close to making everyone worse off.
- **Profit margins:** Large companies with low profit margins tend to exhibit behavior similar to small companies, even though they have many employees and otherwise act 'large.'
- **Small businesses are especially vulnerable:** Small employers and their employees would be especially vulnerable to policy errors, which is why it is important to consider the negative impact of policy decisions on this group.
- **Bankruptcy:** The greatest likelihood of bankruptcy for employers occurs in the two scenarios where employers are mandated to provide insurance and pay at least 50 percent of the premium.
- **Choosing an insurance plan:** Employers are not better equipped to select plans for their employees, as is often alleged. Individuals (employer or employee) are better able to pick insurance plans for themselves than for others. This suggests that an employer role in plan selection may not yield additional benefits.

Conclusion

The findings suggested that there is **no panacea for health reform** and that a **"one-size-fits-all" solution will not work** for our nation's employees and employers – small or large.

Summary: "The Case Against Mandated Employer-Provided Employee Health Insurance"
NFIB white paper by William J. "Denny" Dennis

NFIB's Denny Dennis outlines the negative effects of an employer mandate, particularly as they relate to small business. The paper analyzes a "pure mandate," requiring an employer to provide and pay a fixed percentage of an employee's health insurance premium. The effects of this type of mandate are essentially the same as mandates to pay a fixed percentage of payroll or a pay-or-play (insurance or tax) option.

Dennis's paper walks the reader through statistics on the costs of insurance and ranges of income among the uninsured. From this, he derives key observations: An employer mandate would mean a 20% increase in labor costs for each uninsured $25,000-a-year employee needing a family plan or a 7% increase for each one needing an individual plan. The cost increases are 10% and 4%, respectively, per $50,000-a-year employee. To put it another way, "An uninsured 10-employee firm with seven employees requiring a family plan and three employees requiring an individual plan will experience an annual immediate payroll cost increase of $40,329. That expense recurs every year and actually increases in real terms, rising faster than inflation and/or wages because health care costs rise faster than either." Both employer and employee are made financially worse off by a substantial amount.

Dennis argues that there are three basic arguments against an employer mandate:

- The policy is highly regressive as the uninsured, typically though not always low-income, eventually pay for their own health insurance through job loss, depressed wages and erosion of other benefits;
- The policy is inefficient because it is too blunt to distinguish between those needing and those not needing assistance to purchase health insurance; and,
- It is unfair to small employers and employees because the policy fails to address the real problems of the insurance market for small businesses, while retaining rigidities that injure both, and substituting a hefty, direct penalty on them, i.e., a tax, in large part because they are small and lack market power.

In other words, an employer mandate amounts to a tax on the poor and a tax on those who hire the poor. The research suggests that compliance with a mandate would adversely affect employers and low wage-workers because employers would be more likely to:

- Reduce the number of workers whom they employ;
- Use part-timers instead of full-timers;
- Turn full-timers into part-timers by reducing their hours;
- Freeze other forms of compensation, such as wages or non-health insurance benefits;
- Replace workers with machines;
- Turn to foreign suppliers who don't have to bear these insurance costs;
- Cancel business investment to cover the costs of health insurance; or
- Go out of business.

Summary: "Rising Costs for Healthcare: Implications for Public Policy"

NFIB-sponsored study by Louis Rossiter, PhD

Lou Rossiter is a health economist and research professor at the College of William and Mary. He was previously Medicare/Medicaid policy official at CMS and Virginia Secretary of Health and Human Services. His study examines health costs, the quality of care, and specific ways policy makers can balance freedom of choice with serious cost restraint. NFIB doesn't endorse every Rossiter proposal, but he presents the vital issues in one highly readable document. The following summarizes the study:

General background information: Much is right about American healthcare (high life expectancy, improved mortality stats for big diseases, comparisons with other countries). Americans enjoy choices among insurers and providers. But there are unacceptable disparities, costs are rising rapidly, and some aspects of employer-based insurance are problematic. The blame lies primarily with two culprits:

[1] Inadequate reimbursement rates in Medicare and Medicaid shift costs to private plans – especially those sponsored by small businesses. [2] Fee-for-service reimbursement impedes the tendency of competition to drive out high-cost, inefficient producers. Employers have had some success using managed care to hold down costs, though technological innovations continue pushing costs up.

Without appropriate policy changes, these problems will flare as Baby Boomers age. Older adults are the most frequent and costliest users of care. Growth in chronic disease explains half the recent increase in spending. To restrain costs, Rossiter suggests four broad categories of policy changes, listed below.

Policies to Change Government-Induced Incentives: [1] Base Medicaid eligibility solely on income and the federal poverty level; [2] Finance this eligibility, including a 5% pay-for-performance fund on cost, coverage, and quality; [3] Make Medicare benefits a new four-benefit package: medically necessary care, long-term care, experimental care, and lifestyle care; [4] Swap long-term care coverage (currently under Medicaid in the states) for state initiatives to cover the uninsured; [5] Undertake a 10-year effort to enroll all Medicare beneficiaries in managed care organizations; [6] Reform malpractice law, including a $0.5 million cap and mandatory arbitration; [7] Bring young uninsured (mostly healthy small business employees) into health insurance via market-based pooling, HSAs, and national health insurance rules.

Policies to Change How Care Is Delivered: [8] Use federal grants and loans to encourage medical groups and hospital and health systems to develop further in ways that promote competition; [9] Invest in standard medical language for health information technology; [10] Replace global pay for performance (from public payers to individual providers) with renewed emphasis on pay for performance toward process goals, such as implementing health information technology; [11] Use public policy to foster pay for performance at the organizational level of the medical group and hospital and health system.

Policies to Change the Actions of Individuals: [12] Continue policies supporting disease management for chronic disease; [13] Promote a better understanding of alternatives for end-of-life care.

Policies to Reduce Demand for and Raise Supply of Health Services: [14] Balance health coverage and cost sharing; [15] Offer federal and state tax incentives for work-site health promotion; [16] Make demand management a public policy priority; [17] Encourage competitive markets and competitive bidding; [18] Reduce or eliminate the tax exclusion for employer-provided health insurance; [19] Create a standard deduction for personal health insurance premiums and out-of-pocket costs for everyone up to $15,000 for a family and $7,500 for an individual; [20] Make tax deductions for healthcare costs contingent upon purchase of a health insurance plan; [21] Offer refundable tax credits up to a maximum amount to subsidize the purchase of health insurance; [22] Subsidize free clinics and referral networks by redirecting funds from the disproportionate share of payments hospitals receive; [23] Spur the development and diffusion of innovations that reduce costs, including new regulations, methods of payment, insurance benefit design, competition policy, and tax incentives; [24] Support research on health outcomes and effectiveness of medical treatment alternatives with government funding.

These proposals include federal incentives to encourage specific state innovations: Medicaid initiatives, pay-for-performance, market-based pooling, and healthcare courts as substitutes for today's tort system.

Summary: "Health Insurance Reform in an Experimental Market"

NFIB-sponsored study by Stephen Rassenti and Carl Johnston

A new NFIB-sponsored study of health insurance markets yields striking results and gives researchers a valuable new analytical tool. In one of the first-ever applications of experimental economics to healthcare policy, Stephen Rassenti and Carl Johnston, with NFIB's help, tested reform proposals in a laboratory. Rassenti and Johnson are protégés of Nobel laureate Vernon Smith, who calls the study "path-breaking."

The researchers built an insurance market in a laboratory and tested various scenarios on paid participants. The study compared wages, profits, and bankruptcies under scenarios involving individual mandates, employer mandates, premium restrictions, minimum employer contributions, number of policies offered, and the degree to which employees understand health insurance. The text below lists the study's results, provides an overview of experimental economics, and explains the methodology developed for this study by Rassenti and Johnston.

What were the findings?

- **No panaceas:** Employee and individual mandates, separately or combined, don't improve outcomes for all stakeholders. Some reform scenarios actually come close to making everyone worse off.

- **Small is vulnerable:** Small employers and their employees are especially vulnerable to policy changes and mandates. Small companies lack the advantage of size when optimizing their health care spending and pay disproportionately higher costs for providing benefits.

- **Low-margin resembles small:** Large companies with low profit margins tend to exhibit preferences similar to small companies, even though they have many employees and otherwise act 'large.'

- **Choosing for others:** Individuals seem better able to pick insurance plans for themselves than for other people. One reason is that employers have better information about their own needs than about their employees' needs.

- **Minimum contributions:** Requiring employers to pay for half of individual insurance costs reduces employer earnings, but increases employee incomes – at least in the short run. Small and low-margin companies are especially hurt by minimum contribution requirements. Without a mandatory employer contribution, an individual mandate increases employer profits but reduces employee incomes.

- **Restricted rating:** Restricted rating increases the earnings of individual employees by shifting the higher costs of premiums from the employees to the employers. Faced with restricted rating, employers seem to shield employees from the costs and, in doing so, cut their own profits.

- **Bankruptcy:** The relative risk of employer bankruptcy varies widely among scenarios. Chances of bankruptcy went down in some scenarios, including individual mandates alone and individual mandates + employer mandates with no minimum employer contribution. However, the individual mandate can actually increase the risk of bankruptcy when combined with other factors, such as restricted rating or poor estimation of health risks and costs by employees. The greatest likelihood of bankruptcy occurs in the two scenarios where employers face the mandatory burden of providing insurance and paying at least 50% of the cost of premiums.

- **Employee cognition:** In real-world policy discussion, one rationale for employer involvement in health insurance is the belief that employers are better than employees at choosing health insurance. However, when the virtual employees were programmed to be more error-prone in choosing insurance policies, the results varied considerably. In some scenarios, mandates hurt some stakeholders and helped none.

- **More choices:** The addition of three extra insurance choices depressed earnings for employees and most types of firms. This effect may have been due to the fact that one of the choices was a policy with a low premium and poor benefits. Employees with lower expected healthcare costs often bought this policy to comply with the individual mandate at the lowest cost.

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What is experimental economics?

Public policy innovations expose the public to possible expense and risk. Economic experiments let officials compare ideas in laboratories before launching new policies. Previous experimental economic projects/investigations have helped design markets for stocks, radio frequencies, electricity, airport takeoff and landing slots, and space station resource allocation.

Experimental economists, like experimental psychologists, create controlled environments in which to observe test subjects' behavior. As in real life, subjects affect the fortunes of those around them, and none knows all the actions and motives of others. Learning-by-doing occurs as participants begin to "feel" the market. Experiments reveal surprises and unintended consequences.

Experimental subjects earn cash, based on how well they perform in these artificial markets. Payoffs are small (from $7.00 to $50.08 in this case), but induce participants to act as they would in real-world markets. So, they are self-interested, though not entirely self-aware. In contrast, traditional survey research gives interviewees less motive for honesty or introspection. With scaled-down rules, laymen perform about as well as experts; in a laboratory stock market, for example, undergraduates perform about as well as stockbrokers, even though they may be less able to explain their own performance.

Results provide evidence, not proof. Like surveys and other research methodologies, experimental markets omit many real-world variables. This experiment omitted wage flexibility and taxes. Also, employers here were motivated only by profit, thus ignoring real entrepreneurs' love of their work, concern for employees, and desire for independence.

How was the study run?

Subjects, mostly undergraduates, acted as employers for 360 "months." Each produced two goods, using virtual employees they could hire and lay off. Employers paid virtual salaries to workers. To attract employees, firms chose which insurance policies to offer and how much to contribute toward the premiums. In two scenarios, employers had to offer insurance and cover at least 50% of the cost. Goods, income, employees, salaries, and premiums were virtual – existing only on subjects' computers.

Insured workers were healthier and missed less work time and salary. Employers sold goods produced. As production increased, goods prices declined, reducing the incentive to produce. Employers could finish with profits or losses. Some employers were large (more than 12 employees in this experiment), and others small. Employers could grow or shrink depending on their success. Some employers had thick profit margins; others had thin margins. Employees had different skill sets, commanding different salaries.

Each subject participated in one of nine market scenarios: (1) The status quo: no employer mandate (EM) or individual mandate (IM); (2) IM, but no EM; (3) EM, but no IM; (4) IM + EM; (5) IM + restricted rating; (6) IM + a larger number of insurance choices; (7) IM + employees with poor understanding of health insurance; (8) EM (with minimum 50% contribution rate) + IM; and (9) EM with minimum 50% contribution rate, but no IM. The scenarios were generic – not replicas of actual reform plans under consideration.

Conclusion

The findings suggested that there is no panacea for health reform and that a "one-size-fits-all" solution will not work for our nation's employees and employers – small or large.

Like all studies, this one omitted many important variables, leaving much work for future researchers. NFIB hopes others will build on the foundation laid by this study, using its new methodology to test a broader array of policy variables and to ask other questions.