ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
July 27, 2007
10:06 a.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Bob Roses, Vice Chair
Representative Anna Fairclough
Representative Paul Seaton (via teleconference)
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Mark Neuman

OTHER LEGISLATORS PRESENT

Senator Hollis French
Representative Andrea Doll

COMMITTEE CALENDAR

PRESENTATIONS ON ALASKA'S UNINSURED

-HEARD

HOUSE BILL NO. 140
"An Act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date."

-HEARD AND HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 140
SHORT TITLE: MEDICAL ASSISTANCE ELIGIBILITY
SPONSOR(s): REPRESENTATIVE(s) GARA

02/15/07	(H)	READ THE FIRST TIME - REFERRALS
02/15/07	(H)	HES, FIN
02/28/07	(H)	SPONSOR SUBSTITUTE INTRODUCED
02/28/07	(H)	READ THE FIRST TIME - REFERRALS

02/28/07	(H)	HES, FIN
03/15/07	(H)	HES AT 3:00 PM CAPITOL 106
03/15/07	(H)	Heard & Held
03/15/07	(H)	MINUTE(HES)

WITNESS REGISTER

PAT CARR, Director
Health Planning Systems Development
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Presented the Department of Health and Social Services study of the uninsured in Alaska.

ALICE RARIG, Planner
Health Planning Systems Development
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Answered questions during the presentation by the Department of Health & Social Services.

KARLEEN JACKSON, Commissioner
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Answered a question during the presentation by the Department of Health & Social Services (DHSS).

MARK FOSTER, Business Consultant
Anchorage, Alaska
POSITION STATEMENT: Presented the State Health Care Reform Initiatives Overview on behalf of the University of Alaska, Anchorage, Institute for Social and Economic Research (ISER).

REPRESENTATIVE LES GARA
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Presented HB 140 as the sponsor.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 10:06:42 AM. Representatives Roses, Fairclough, Gardner, and Wilson were present at the call to order. Representative Seaton attended via teleconference. Representative Cissna arrived as the meeting was in progress. Also in attendance were Senator French and Representative Doll.

Presentations on Alaska's Uninsured

10:07:08 AM

CHAIR WILSON announced that the first order of business is the first in a series of meetings concerning spending state health care dollars wisely. This meeting will focus on the uninsured in Alaska and will begin with a presentation by the Department of Health & Social Services (DHSS) on its findings, including options for expanding health care coverage. The second presentation will be by a consultant representing the University of Alaska, Anchorage, Institute on Social and Economic Research (ISER). There will then be discussion on HB 140. Chair Wilson announced that the next meeting on August 28, 2007, will feature an overview by the National Conference on State Legislators (NCSL) on how other states are addressing the problem.

10:10:49 AM

PAT CARR, Director, Health Planning Systems Development, Department of Health & Social Services (DHSS), informed the committee that she will present the findings of an Alaska State Planning Grant project that studied the uninsured in Alaska and looked at the options for expanding health care coverage. She stated that the focus of her presentation will be on who the study indentified as the uninsured in the state. In addition, the project revealed who in Alaska has what type of health care coverage; whether the coverage is an employment benefit or not, what is the structure of the type of coverage; whether the coverage is self-purchased; whether there are regional variations; the issues of coverage for families; what other states are doing for their uninsured; and what is the cost of coverage for the uninsured. She noted that Alaska was one the last states to participate in the planning grant process and the study gathered information from household surveys, employer surveys, focus groups, key informant interviews, economic analysis, and six forums across the state.

10:15:24 AM

MS. CARR continued to say that data was also gathered from a variety of national and state sources. The study determined that in excess of 17 percent of Alaska's population, or 114,000 people, are uninsured. In answer to a question from the chair, Ms. Carr clarified that the uninsured group does not include those who receive tribal benefits. She then said that 52

percent of the state receives insurance coverage through employers, 4 percent purchase private insurance, 16 percent are covered by Medicaid, 6 percent are covered by Medicare, and 5 percent are covered by other public programs. Categories of insurance coverage are: 33 percent covered by government insurance; 57 percent covered by employers; and 5 percent covered by self-purchased insurance. Ms. Carr informed the committee that those most likely to be uninsured are young adult males.

10:17:50 AM

REPRESENTATIVE GARDNER asked for the specific meaning of “counted as uninsured."

10:18:20 AM

ALICE RARIG, Planner, Health Planning Systems Development, Department of Health & Social Services (DHSS), answered that the current population survey counts as uninsured a resident who has not had insurance at any time for the past year.

10:19:39 AM

REPRESENTATIVE GARDNER asked whether the percentage would be higher if those who have had coverage for part of the year were included.

DR. RARIG said yes. She added that people coming in and out of care is a significant issue for the state.

10:19:50 AM

REPRESENTATIVE ROSES asked whether seasonal workers are accounted for. He suggested that their numbers could make the problem larger or smaller.

10:21:12 AM

MS. CARR responded that the question of coverage for seasonal workers will be addressed later in the presentation. She then pointed out that, after young, adult, males, the people who are most likely to be uninsured are: the self-employed; part-time workers; seasonal workers; and people who work for small firms. She stressed that over one-half of the uninsured are employed. Ms. Carr then informed the committee that 62 percent of the uninsured are white, 19 percent are Alaska Native, 6 percent are

Asian, 2 percent are African American, and 11 percent are of two or more races.

10:21:32 AM

REPRESENTATIVE GARDNER asked whether there were groups of Alaska Natives that do not have access to federal health care coverage through the Alaska Native Medical Center (ANMC), or through tribes.

MS. CARR answered that any Alaska Native can go to the ANMC; however, the mobility of the population brings in the issue of the portability of care and access to medical services. She explained that two-thirds of the Native population has some type of insurance coverage other than tribal coverage.

10:23:43 AM

MS. CARR further noted that, by age group, one-third of residents aged 18 to 24 years are uninsured and that 38 percent of this group is male and 25 percent is female. The study also revealed that, of households with less than $35,000 in annual income, 58 percent are uninsured. In comparison, of households with income greater than $35,000, 42 percent are uninsured. She pointed out that the problem is not limited to low income families. Looking at the employment status of the uninsured, 52 percent are employed, 9 percent are seeking employment, and 39 percent are children and others not in the labor force. Ms. Carr stated that 27 percent of Alaskan children do not have continuous insurance coverage throughout the year; this group has been identified as an especially needy population.

10:25:45 AM

CHAIR WILSON observed that some states have extended the designation of children, for coverage purposes, to age 24. She suggested that the committee study this issue.

10:26:38 AM

DR. RARIG informed the committee that the purpose of the Alaska household survey was to get information beyond the difficulties of interpreting national surveys that are not sufficiently specific regarding insurance coverage. In fact, the behavior risk survey conducted by DHSS, Division of Public Health, asks about health coverage at a point in time, as opposed to continuous coverage throughout one year. She pointed out the

complications of determining household insurance coverage. About 1,300 households were surveyed and it was reported that 31 percent, or 73,000, of Alaska households had not been covered by employer or union health insurance in the past year. In addition, 12 percent of households reported directly purchasing some type of health insurance in the past year. Dr. Rarig noted that some residents are dually insured or covered in various ways. These purchased policies may include short-term specialty policies, and policies with limited scopes; this would explain the duplication of percentages. The regional analysis indicated that Gulf Coast households were more likely to purchase insurance than rural households.

10:30:04 AM

DR. RARIG continued to compare regions. The statewide average of households with coverage through employment, or a union, is 69 percent; in rural Alaska it is 55 percent; in the Gulf Coast it is 59 percent; in Fairbanks and vicinity it is 69 percent; in Anchorage, Mat-Su, and Southeast it is 73 percent. The household survey also asked for respondent's primary place of employment and revealed that 83 percent of males, and 92 percent of females, indicated that their employment was a permanent, not seasonal, position. She reminded the committee that respondents may have part-time employment; therefore, one job may be held by more that one person and one person may have more than one job. This situation also makes the task of determining who is uninsured a difficult task. The survey did determine that 13 percent of those employed had been in their positions for less than 6 months. The primary place of employment reported by respondents during 2006 to 2007 was: 50 percent by private for-profit companies; 11 percent by not-for-profit, exempt, or tribal employers; 12 percent are self-employed; and 27 percent by government. The survey also determined the number of employees per employer.

10:33:43 AM

DR. RARIG informed the committee that one-quarter of firms with fewer than ten employees offer health insurance. Nearly all firms with more than 100 employees offer health insurance, but not necessarily to all employees. The Alaska Employer Survey 2006 indicated that, due to the expense, 53 percent of employers do not offer insurance. Other reasons given are: seasonal employees; not enough employees; and employees covered by other health plans. National surveys have revealed that Alaska has twice the percentage of seasonal workers than any other state in

the U.S. Furthermore, Alaska is above the national average for the length of the waiting period before new employees in the private sector are eligible for health insurance. Dr. Rarig stated that seasonal employees have difficulties obtaining and retaining health coverage for a variety of reasons. The Medical Expenditure Panel Survey conducted by the Department of Labor & Workforce Development (DLWD) indicates that over 300,000 individuals worked in the state during some part of 2004; thus one-third of the people who are reflected in the average annualized jobs are non-residents. She continued to say that one-half of the respondents have worked during at least a portion of three of the quarters of the year; and one-half have worked for portions of all four quarters of the year.

10:38:24 AM

CHAIR WILSON asked whether workers who work for three quarters of the year draw unemployment for the fourth quarter.

10:39:05 AM

DR. RARIG answered that this data is from DLWD; however, she will research the answer to that question.

10:40:17 AM

REPRESENTATIVE ROSES questioned whether those who were employed for three quarters of the year include school teachers.

DR. RARIG expressed her belief that teachers, who work at least part of each quarter of the year, would not be part of that group.

REPRESENTATIVE ROSES asked for confirmation of these figures from the DLWD.

10:41:12 AM

REPRESENTATIVE CISSNA questioned whether it was possible to figure out the job categories of the seasonal workers.

DR. RARIG said she believes that the DLWD can analyze the workforce by quarter worked and by category. She reminded the committee that many in the fishing industry are not reflected in this data because they are self-employed.

10:42:27 AM

DR. RARIG further explained that adjusting the estimate for fish harvesting employment by adding to the 2004 and 2005 seasonal data increases the estimate of people working in Alaska in July to 270,000. The percentage of mining and manufacturing firms that offer health insurance is about 50 percent in Alaska and 70 percent nationwide; the percent of retail and service firms that offer health insurance is about 30 percent in Alaska and about 50 percent nationwide. Dr. Rarig pointed out that seasonal workers in Anchorage total about 10,000; in fact, about one-half of the residents employed in Alaska live in Anchorage. Southeast, and the fishing area of Bristol Bay, are extreme examples of seasonal employment. The study also shows that the percentage of employees holding annualized jobs, and that are covered by health insurance, is: 48 percent in Anchorage, 35 percent in the rest of Alaska, and 53 percent nationwide. Dr. Rarig concluded by informing the committee that further analysis of the household survey will be posted on the DHSS website.

10:46:24 AM

MS. CARR stated that qualitative information has been gathered from residents of the state, employers, key informant interviews, focus groups and forums. ISER conducted the focus groups and the McDowell Group in Juneau conducted the key informant interviews. Sixteen focus groups were held around the state by DHSS and they included individuals, representatives of the Alaska Native population, small business employers, and health insurance representatives. She highlighted that most focus group respondents desire preventive coverage and see it as a way to be healthy. In addition, employers feel a sense of social responsibility to provide health coverage for their employees. The focus groups raised concerns about where residents get medical services and the cost of care and insurance. The expense can mean that residents feel that medical service is inaccessible. Individuals and employers cite cost when asked why health care coverage is not purchased. Ms. Carr opined that most individuals are willing to pay $100 per month and that amount does not go a long way to cover the cost of insurance coverage. In response to a question, she said that amount included "that dimension as well for coverage for the family." Ms. Carr continued to explain that uninsured residents seek health care from hospital emergency rooms and clinics with sliding fee schedules, such as the 23 federally funded health centers in the state. Unfortunately, there are residents who have incurred great debt while trying to pay for medical services out-of-pocket. In addition, there are those who seek

treatment in Canada, or other destinations, and those who simply delay care.

10:52:21 AM

CHAIR WILSON observed that Canadians have to wait a long time for non-emergency procedures and health care.

MS. CARR said that she has only anecdotal information about residents that travel for medical care. She continued to explain that there were 50 key informant interviews around the state. The major issues discussed were: the high cost of health care and insurance; attitudes and resistance to change; the low priority of health insurance to other issues; the challenges of the payment system; and the impact of seasonal employment to the economy of employment-based insurance.

10:55:12 AM

REPRESENTATIVE GARDNER asked for clarification regarding the state's perception that the need to address access and the availability of care is seen by some as more important than insurance.

MS. CARR responded that some key informants, and others, felt that it is that more important to provide more financial support to providers, or primary care delivery sites, rather than to subsidize insurance coverage.

10:56:15 AM

MS. CARR advised that, through the study, DHSS has gathered information about what other states are doing to address this problem, whether it is universal coverage, more comprehensive care, or incremental steps to coverage. This analysis will be forthcoming, along with the economic analysis, later in the meeting. Further, she encouraged the committee and members of the public to refer to the DHSS web site for the posting of subsequent reports.

10:58:14 AM

REPRESENTATIVE CISSNA asked whether social costs are included in the study of this issue. For instance, nationwide, there are bankruptcies, homelessness, and individuals in the prison system, due to the lack of medical coverage.

10:59:11 AM

DR. RARIG said that the economic analysis contractor has been asked to examine the literature on the issues of direct and indirect costs of people being uninsured. This part of the question will be difficult to examine thoroughly.

10:59:55 AM

REPRESENTATIVE CISSNA questioned the value of anecdotal survey information and asked about the possibility of developing good health policy without spending any money. She asked Dr. Rarig for recommendations.

DR. RARIG suggested that the economists attending may wish to address that question. Her division has asked for the economic cost to cover all Alaskans and for assessments on covering the uninsured that are presently using the system. She stated that there are two types of uninsured individuals; those who are healthy and do not have much need, and the unhealthy who are passing their costs along to public programs and increasing the cost of private premiums. Social costs that do not appear as a cost to the health care system include, but are not limited to; the loss of life, the loss of a job, and the choice not to work because of subsequent ineligibility in some type of public program. She expressed her hope that the report, when completed, will reveal opportunities for Alaska.

11:03:03 AM

REPRESENTATIVE FAIRCLOUGH asked for the definition of "uninsured versus access." She observed that many Alaska Natives are eligible for medical coverage except for the issue of access.

11:03:45 AM

DR. RARIG responded that, for the purpose of considering who is uninsured for economic assessment, DHSS is using the current population survey national definition: someone who has not been insured at all in the past year. About one-quarter of Alaska Natives are in the category of people counted as uninsured, but two-thirds to three-quarters of Alaska Natives do have other coverage. The minority, who do not have other coverage, are limited to services available in their local area for tribal benefits.

REPRESENTATIVE FAIRCLOUGH noted that the DHSS number is including those who have access to health care, but did not use the services available, and therefore are counted as uninsured.

DR. RARIG clarified that they are counted as uninsured because they do not have what we typically call insurance coverage. Those individuals will have access to primary care services if they live nearby. If living in a remote area of Alaska, an Alaska Native will not have access to services. There are limitations to what is available through the tribal care system, with travel remaining a big issue. Her department is using the number of 114,000 uninsured as a starting point. Using the data available from the national surveys and the state study, it is possible to use actuarial approaches to determine the costs of coverage for a reasonable and comprehensive plan.

REPRESENTATIVE FAIRCLOUGH observed that the offered definition is not sufficiently succinct for legislators to explain to the general public. A clear definition is needed to clarify access to coverage; whether it is because of heritage or location. She further asked whether the number of uninsured includes people who are out of state.

DR. RARIG confirmed that the 114,000 uninsured are residents of Alaska. In further response to a question by Representative Fairclough, she clarified that the DLWD data about workers in Alaska that work one, two, three, or four quarters, includes non-residents. This data reflects those who just come to work in the summer and non-residents who may work for periods of all four quarters. In addition, there are Alaska residents that choose to work for only three quarters or portions there-of. Dr. Rarig stated that the data shows that Alaska has a very complex picture of employment and insurance coverage.

11:11:38 AM

REPRESENTATIVE FAIRCLOUGH expressed her appreciation for the work of the DHSS on this issue.

11:11:58 AM

CHAIR WILSON said that there are people who have insurance that do not feel they can afford to use it.

11:12:36 AM

MS. CARR summarized that defining access to coverage includes the issues of those who may not use insurance because of the cost of deductibles; those who do not have services in their community; those who can not receive Medicare services due to their location; and those with other problems. She expressed her hope that sharing information from the survey with the committee will facilitate its exploration for solutions to these problems.

11:13:44 AM

REPRESENTATIVE ANDREA DOLL, Alaska State Legislature, observed that there are many organizations that provide health services, such as Catholic Community Services, and other nonprofit groups. She asked whether the DHSS has studied data on these services.

11:14:24 AM

MS. CARR confirmed that focus groups have relayed comments that people can be covered through other services; social service networks and nonprofits are certainly key players in health care. However, the study does not summarize this facet of care. She deferred the question to Karleen Jackson, Commissioner, DHSS.

11:15:23 AM

KARLEEN JACKSON, Commissioner, Department of Health & Social Services (DHSS), reminded the committee that the focus of the grant that funded this report is on the uninsured. At this time, the presenters are looking at this one small piece of the many aspects of health care and social services.

11:16:38 AM

The committee took an at-ease from 11:16 a.m. to 11:24 a.m.

11:24:56 AM

CHAIR WILSON announced that the next presenter is Mark Foster, who will be discussing the ISER report.

11:25:03 AM

MARK FOSTER, Business Consultant, informed the committee that he has been working with ISER and co-authored the "Health Care Market in Alaska Report." He stated that he has other clients

in the medical care community, and that he has advised them on business modeling and business issues. Mr. Foster said that the views expressed today do not represent the views of a particular client. He then offered a brief history of the U.S. health care policy beginning in the 1930s with the implementation of the Social Security Act. At that time, universal health care began to be debated. During the Second World War, there were caps and a freeze on wages, but employment based coverage was excluded from taxable income, thus began the competition of offering benefit packages to prospective workers. As health care costs increase, the federal government begins to take a larger role. In the 1960s Medicare and Medicaid were introduced; and further expansions of Medicaid occurred in the 1980s. During the 1990s there was a large expansion of children's care by the introduction of the State Children's Health Insurance Program (SCHIP). Because of the major influence of the federal government on health care, the state, as a policy maker, needs to consider the federal funding of medical programs and the long term effects of federal rules and regulations. Mr. Foster noted that the state's role in health care is also affected by the Employment Retirement Income Security Act of 1974 (ERISA). He explained that this federal law preempts state laws relating to private sector employee retirement benefit plans, thus if a self-insured company is impinged by the state, state law will be preempted. Mr. Foster warned that state health reform efforts must be mindful of impacts on existing employer's insurance plans.

11:28:38 AM

MR. FOSTER referred to a health care reform system developed by the State of Hawaii; Hawaii has a mandate that requires all employers of full-time employees to provide insurance. Hawaii's law is exempted from ERISA, thus its situation is very different from that of other states. The uninsured rate in Hawaii now is about 10 percent.

11:30:49 AM

REPRESENTATIVE GARDNER asked why the uninsured rate in Hawaii is that high.

MR. FOSTER explained that employers and employees have adjusted to the mandate; employees who seek higher wages and no insurance have migrated to part-time jobs and employers have created more part-time jobs to avoid the mandated insurance law.

REPRESENTATIVE GARDNER observed that part-time work is the employee's choice. She then shared her personal experience as an office manager.

MR. FOSTER agreed that some employees will make the choice of higher wages.

11:32:19 AM

REPRESENTATIVE FAIRCLOUGH suggested that the preceding report data should indicate that Hawaii is operating under an employer mandate.

11:33:05 AM

MR. FOSTER advised that the state can regulate health insurers. However, regulation of what employers can offer employees is preempted. He turned to discuss state law in Massachusetts.

11:33:56 AM

CHAIR WILSON observed that the state can make demands on insurance companies, but not on employers.

MR. FOSTER agreed. He pointed out that the recent reform of Massachusetts law created potential ERISA problems such as high fines against employers who do not offer coverage. Massachusetts set its fines at a low rate to avoid the problem.

11:35:59 AM

REPRESENTATIVE GARDNER opined that the low fine of $250 will be ineffective.

MR. FOSTER concurred.

CHAIR WILSON observed that because the new laws are not being enforced yet this data may not be useful.

MR. FOSTER stated that the regulations are in place; there is some revealing initial data based on the reactions of employees, employers, and residents. The amounts of fines in the early stages of legislation are often smaller and are intended to ratchet up over time.

REPRESENTATIVE GARDNER asked whether there will be options of lower rates and incentives for employers if Massachusetts

succeeds in increasing the number of residents who have access to coverage.

MR. FOSTER said that it is too early for him to have a judgment about that. He continued to explain that another consideration is whether state regulations on self-insurance plans will violate ERISA. In addition, the legality of whether there can be different levels in the quality of Massachusetts insurance plans, may be challenged in court. This could mean that very generous executive level compensation packages must be available for all employees.

11:38:45 AM

REPRESENTATIVE ROSES noted that reform may drive employers to set higher deductibles on care. For example, when the co-pays are high, employees opt for higher deductibles, thus the combination of the deductible for a family, plus the co-pay, may be as high as the bill for medical services.

MR. FOSTER highlighted that the minimum coverage on the Massachusetts plan allows a maximum deductible of $4,000 per family. The result could be that this will become the new floor for a plan and that there will be an adjustment in the market.

11:42:06 AM

MR. FOSTER referred to the 1990s state health care reform cycle. The prominent examples of Massachusetts, Minnesota, Oregon, and Tennessee attempted to expand health insurance coverage through Medicaid waivers. The results were that state revenues drove the expansion of coverage and contractions in growth and tax revenue imposed limits on enrollment and coverage. Initial projections on the amount of people enrolled were not achieved, primarily due to the fluctuations in state revenue and decreases in federal matching funds. Mr. Foster listed aspects of the Massachusetts plan; an individual mandate, an employer "pay or play" mandate, an insurance pool for small employers, an insurance coverage minimum, and a sliding scale subsidy for low income residents.

11:45:29 AM

REPRESENTATIVE ROSES asked what provisions were included for employees that did not use the funds set aside under [Internal Revenue Service Section 125 Cafeteria Benefits and Health Savings] legislation.

MR. FOSTER answered that there are no provisions for the employer, but there are penalties for the employee.

REPRESENTATIVE ROSES re-stated his question to ask whether there are provisions to warn employees when they are going to lose the funds they have set aside.

11:46:34 AM

MR. FOSTER explained that open enrollment is the time to remind people of the consequences of different plans.

REPRESENTATIVE ROSES shared his personal experience.

11:47:31 AM

MR. FOSTER stressed that the data from Massachusetts shows that there is a shortage of primary care physicians. In addition, in reaction to insurance reform, some physicians stopped seeing new patients. The result has been increased wait-time to see a physician throughout the state.

11:48:35 AM

REPRESENTATIVE GARDNER asked whether this data suggests that people who now have coverage are going to the doctor more?

MR. FOSTER confirmed that there is a strong correlation that once you have insurance you will use it.

REPRESENTATIVE GARDNER opined that this can create a new problem.

11:49:38 AM

REPRESENTATIVE ROSES asked whether the increased wait-time would be a combination of the shortage of physicians for new patients and a general increase in doctor visits.

MR. FOSTER said that he did not enough analysis of the data to determine the effect of both influences. He continued to explain that many early signups for the new plans were people who were qualified for, but not previously enrolled in, Medicaid. In fact, the enrollment rate of subsidized programs has gone up significantly due to the publicity surrounding the reforms.

11:50:44 AM

CHAIR WILSON asked whether those who were previously qualified, but who did not sign up before, were influenced by the name of the program: insurance, not welfare.

11:51:15 AM

REPRESENTATIVE CISSNA commented that the inclusion of the uninsured will increase the initial cost of coverage, but ultimately will save the community money by fewer calls to the hospital emergency room.

11:52:24 AM

MR. FOSTER recalled that the actuarial data in a prior study suggested that there is not a net system savings; overall, medical procedures and visits are increased and incremental savings to emergency rooms are small.

11:54:21 AM

REPRESENTATIVE CISSNA stated that preventive health measures and lifestyle changes generate economic growth.

CHAIR WILSON opined that residents may not have enough exposure to prevention recommendations to be aware of its importance.

REPRESENTATIVE GARDNER expressed her belief that the public does not understand the connection between health issues and money issues.

11:57:05 AM

MR. FOSTER, again referring to the Massachusetts plan, continued to explain that about 30 percent of the people with existing private insurance are interested in switching to the subsidized plans. This impact is called "crowd out" of private insurance. Furthermore, some small businesses are reviewing cost options and attempting to get under the full-time limit cap. The "play option" may turn out to be more expensive than the penalty "pay option," and small businesses may pass this expense on to their employees. He concluded that, even though the goal is increased access to care, employees and employers have different views regarding the value of insurance coverage; therefore, the gain

of increased coverage for the uninsured could prove relatively modest.

11:59:51 AM

CHAIR WILSON surmised that, when people switch from private to subsidized insurance, there will be an increase in cost to the provider.

MR. FOSTER recommended that, prior to initiating changes here, the actuarial work from other states should be studied in order to take advantage of the accumulation of previous experience.

12:01:28 PM

MR. FOSTER pointed out a number of differences between Massachusetts and Alaska. Massachusetts began with a lower uninsured population and the percentage of small businesses offering health insurance was significantly higher. In addition, the number of employees working for small business is higher in Alaska, as are seasonal and part-time employment. Comparing health outcomes, Alaska has a lower premature death rate. He suggested that the committee consider how to measure the existing health care system, and how to measure the change that reforms will make to resident's health outcomes.

12:04:13 PM

REPRESENTATIVE FAIRCLOUGH pointed out that Alaska has a younger population and asked what year [is reflected].

MR. FOSTER replied that his information is based on 2002 underlying data with age adjustments to remove the bias of a younger population.

CHAIR WILSON expressed her understanding that, in the last 15 years, the life expectancy of Alaska Natives has increased by 30 years.

MR. FOSTER commented on Alaska and access trends. Based on survey data from 2005, employer based insurance coverage is covering about 400,000 residents. Indian Health Service (IHS), including Medicaid, Medicare, and private insurance, covers about 125,000. Additionally, Medicaid covers 100,000; 90,000 are not covered; and Medicare covers about 50,000. Mr. Foster estimated that one-quarter of the Alaska population may be uninsured for some time during a period of two years. This

figure is high due to the state's percentage of seasonal workers, part-time workers, and young people. He further explained that the number of uninsured is related to the economic outlook for the state and for the U. S.

12:09:23 PM

REPRESENTATIVE GARDNER pointed out that, in recent years, the oil prices have been climbing.

MR. FOSTER explained that the current population survey reflects a decline in the percentage of the population not covered. He opined that the trends in changing coverage are not dramatic and the measurement error of the survey is large. Therefore, the trend data supports a correlation with the economy; the better the economy, the more people who will get insurance.

REPRESENTATIVE GARDNER expressed her belief that the issue here may be the degree to which high oil prices correlate with a strong economy.

12:11:11 PM

REPRESENTATIVE ROSES asked for the impact of the double digit increases in health insurance costs that took place between 1999 and 2001. Health insurance premiums were increasing at 16 percent to 19 percent per year, and he stated that rising prices may be the reason for the decrease in coverage more so than a slump in the economy.

12:11:57 PM

MR. FOSTER stated that the economy, over time, tends to dominate the insurance underwriting cycle.

REPRESENTATIVE ROSES relayed that, during the time he was working in the area of insurance benefits, he saw a pattern of double coverage until the co-pays increased; after that a high percentage of employees opted out of group insurance altogether.

12:13:16 PM

MR. FOSTER reminded the committee that the uninsured populations who get served have proximity to the critical care facilities around the state. Current data indicates that critical care facilities have increased their care of the uninsured from less than 25 percent to 35 percent.

12:14:19 PM

CHAIR WILSON asked whether it might be less expensive to fund community health care centers than to purchase health insurance.

MR. FOSTER speculated that providing Alaskans with health care must include expanding critical access facilities and expanding the health care workforce. The long term vision must include all of these pieces as part of the strategy.

12:16:08 PM

REPRESENTATIVE GARDNER expressed her understanding that it is less cost effective to have a health insurance mandate than to expand the health care workforce. She asked whether the cost effectiveness applied to the state or to individual employers.

MR. FOSTER responded that he is trying to look at it from the total cost of providing service within the state. The costs are split between the state and federal government, employers, and employees. The difference may not be dramatic, but all of these pieces need to be considered.

REPRESENTATIVE GARDNER commented that the ranking of the "ease of implementation" [in the report] was intriguing.

MR. FOSTER said that it is useful to think about what we can achieve.

12:18:00 PM

REPRESENTATIVE FAIRCLOUGH questioned whether the 30 percent migration of those with private insurance to a subsidized plan was included.

MR. FOSTER said yes. He explained that this information shows how effective an insurance coverage mandate is on the net economic benefit. He encouraged the committee to consider that the system must provide insurance, facilities, and people.

12:20:01 PM

REPRESENTATIVE FAIRCLOUGH asked Mr. Foster to comment on dental insurance.

12:20:11 PM

MR. FOSTER informed the committee that one of the challenges Alaska faces is to find the health care workforce needed. Increased training is a start; however, the shortage of health care workers is a function of what they are paid. Alaska is below average in the ratio of dentists per population when compared to the U. S., and price premiums are higher. The number of dentists has increased between 1998 and 2006, at least partly due to the higher price premiums for dental work in the state. He concluded that price premiums can make a difference; however, opportunities in the rest of the country are also a factor.

CHAIR WILSON offered that the same thing is happening in education, many other professions, and industry.

12:23:12 PM

REPRESENTATIVE CISSNA opined that dentists are not a good example of what is happening with other health care workers; in fact, there are a sufficient number of them per capita, except where there are none at all. She stated that the uninsured are only part of the health problem. There is the problem of the health care worker shortage and sufficient training. Representative Cissna advised that there must also be analysis of the cost of medical care facilities, the shortages of health care workers, and changes in lifestyle habits to effect good health.

12:26:21 PM

CHAIR WILSON asked Mr. Foster to address her concern about decreases in federal funding mechanisms for [critical care] facilities.

MR. FOSTER said that the last 15 years have seen an expansion of health care facilities across the state. More recently, there has been an expansion of clinics in rural areas. He acknowledged that there may be a slowing of money invested in state infrastructure and choices will have to be made between insurance, workforce development, and facilities.

12:28:26 PM

CHAIR WILSON thanked the presenters.

12:29:54 PM

The committee took an at-ease from 12:29 p.m. to 1:34 p.m.

HB 140-MEDICAL ASSISTANCE ELIGIBILITY

1:34:18 PM

CHAIR WILSON announced that the final order of business would be HOUSE BILL NO. 140 "An Act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date." [Although not formally scheduled/noticed, the committee discussed HB 140.]

1:35:12 PM

REPRESENTATIVE LES GARA, Alaska State Legislature, as a sponsor of the bill, presented HB 140. He informed the committee that universal health coverage for everybody is a difficult, complex, and costly issue for debate. However, the sponsors of HB 140 realized that, in the meantime, universal health care could be provided for kids for very little money. The fiscal notes for HB 140 indicate that, depending on how much families are charged to buy into children's health care, the income qualification level, and the costs through Denali Kid Care, the cost will be between $2 million and $5 million. Representative Gara noted that this is a simple bill, complicated only by the fact that Congress is debating the reauthorization of the federal State Children's Health Insurance Program (SCHIP) that pays for 70 percent of Denali Kid Care (DKC). He expressed his belief that the federal program will be continued.

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REPRESENTATIVE GARA explained that DKC insures parents who do not work and working families who earn up to 174 percent of the federal poverty level (FPL). Thus, HB 140 is only about working families who do not get health insurance at work and who can not afford private insurance. For example, a single parent with one child who earns about $28,000 per year, does not qualify for DKC. He acknowledged that the number of uninsured children could be as high as 22,000, but 8,000 of those children may have some coverage through IHC; therefore, the sponsors assume that approximately 12,000 to 15,000 children of working families remain uninsured. Representative Gara pointed out that approximately 50 percent of Alaska employers do not offer health

insurance; in fact, most businesses with less than 25 employees do not offer coverage.

REPRESENTATIVE ROSES asked whether the calculations for the bill's fiscal notes are based on 22,000, or 12,000, uninsured children.

REPRESENTATIVE GARA answered that these numbers will not be used for any calculations in this presentation and clarified that 12,000 children are known to be uninsured. He continued to explain that studies have shown that uninsured children receive less preventive care and fewer physicals and are treated for more acute care, later in illness. In addition, uninsured children are more likely to develop serious dental problems, asthma, diabetes, and are four times more likely to use the emergency room. In fact, uninsured kids are 25 percent more likely to miss school. Hospitals in Anchorage estimated that they provided $89 million in uncompensated care in 2004; this cost was passed along to co-payers. Representative Gara recalled that there was an appropriation to reimburse Alaska hospitals for some of their losses.

1:42:59 PM

REPRESENTATIVE GARA called the committee's attention to solutions from other states. Eight other states leverage federal money from SCHIP and cover children of families that earn up to 300 percent of the FPL. Forty states provide health insurance to families earning up to 200 percent of the FPL. He pointed out that Virginia, New York, and Washington provide free coverage up to a certain income level, and then let families above that level buy coverage. This plan keeps the state's cost very low.

1:44:40 PM

REPRESENTATIVE GARDNER asked whether there is a federal limit to a family's income level.

REPRESENTATIVE GARA answered that there is not. Right now, Congress appropriates a certain amount of money to each state; some states put caps on the qualifying income level to prevent overspending their allotment. Congress is debating whether to cap the family income level on the basis that states should not provide health care to families who can afford to purchase private insurance. According to the U. S. Department of Health and Human Services, the federal government pays roughly 70

percent of the cost of DKC insurance; the state share per child is $420 per year. HB 140 proposes that families buy in on a sliding scale with the income limits set by policy. In addition, Representative Gara explained, the bill proposes a sliding scale that could go up to the state's full cost for families with higher incomes.

1:48:24 PM

REPRESENTATIVE GARA informed the committee that HB 140 gives DHSS the flexibility to charge families an acceptable amount that also maintains federal eligibility. The federal law is unclear on the acceptable co-pay and the bill allows DHSS to negotiate with the federal government to protect the federal SCHIP contribution of 70 percent of the cost. He warned that, if SCHIP rules are violated, or the state program is non-qualifying, the state will only receive a 50 percent match. Currently the cost per policy averages $1,387 and $420 of that is the state match. However, if higher income families are allowed to buy in, DHSS assumes that children with higher needs will be covered and the cost of each policy will double.

1:50:54 PM

REPRESENTATIVE GARDNER asked whether the inclusion of higher income families will result in the loss of the federal match.

REPRESENTATIVE GARA responded that the federal allocation is based upon the expansiveness of the state's plan and that other states have been approved for universal health care. However, the federal regulations will change in September, 2007. In response to a question from Chair Wilson, Representative Gara said that the state can wait until the new regulations are known to finalize its plan.

1:52:25 PM

REPRESENTATIVE ROSES relayed that he attended a health care conference in Chicago in April; presenters there warned states not to expand SCHIP until after the new regulations are issued.

REPRESENTATIVE GARA expressed his understanding that expansion referred to the federal program and not to state's programs.

REPRESENTATIVE ROSES explained that speakers at the conference indicated that the expansion of state's programs would be disapproved.

REPRESENTATIVE GARA disagreed.

REPRESENTATIVE ROSES said, "They were using those states as examples when they talked about what they meant by expanding the program."

CHAIR WILSON asked whether an estimate of those who might drop private insurance is factored in.

REPRESENTATIVE GARA replied that the sponsors have prepared a CS that includes a qualification to require families to use their employer based insurance, if available. This will keep the costs down and prevent this problem.

REPRESENTATIVE ROSES asked whether there has been a legal opinion on this qualification.

REPRESENTATIVE GARA said no. He noted that the federal government would have to define this restriction and approve its purpose. He gave several examples of restrictions that could be included in the bill.

1:58:04 PM

REPRESENTATIVE GARA stated that there is a provision by some states that requires an applicant to certify that they have not had insurance at work within the last six or nine months. This will prevent families from dropping employer based coverage. He continued to say that DHSS can negotiate regulations for coverage and that a portion of Sec. 3 of the bill will cover that intention.

1:59:26 PM

REPRESENTATIVE GARA stated that it is the committee's responsibility to set the level at which families can buy coverage. He suggested that Senator Wielechowski's version of the bill, that sets a limit of family income at 175 percent of the FPL, is appropriate. In addition, the committee will need to set policy to allow, or disallow, families with higher income levels to purchase coverage and at what premium. HB 140 proposes a cap of 300 percent of the FPL: a middle class income. Research indicates that private insurance can cost around $3,000 per child, and $7,000 for a family of three. In response to a question from Chair Wilson, Representative Gara said that Premera Blue Cross offers a plan that will just insure

the children in a family. Representative Gara gave an example of the federal poverty line scale: for a single parent with one child, 175 percent of the FPL is $35,000 per year; for a single parent with one child, 300 percent of the FPL is $50,000 per year. He pointed out that families at the poverty level do not pay income taxes; however, families with higher incomes do. Representative Gara concluded by saying that the fiscal notes on HB 140 are between $2 million and $5 million, depending on the expansion of coverage. He opined that this is the first step to universal health care and is a worthwhile investment that will assist a substantial portion of the population that can not afford insurance in Alaska. This expense is more important than some other funding requests and he urged that it be funded.

2:04:19 PM

REPRESENTATIVE GARA reviewed the policy decisions needed for the bill: the qualification of families that can get insurance at work, the qualification income levels, and the amount of premiums charged to families that wish to purchase coverage. He encouraged the committee to also look at the senate version of the bill, and concluded that this legislation is an easy solution.

CHAIR WILSON announced that HB 140 was held over for further discussion.

2:05:55 PM

CHAIR WILSON stated that her goal for the committee during the interim is to gather enough information before the start of next session so that legislation is ready to be drafted. She asked whether committee members had any suggestions for further discussion.

2:08:21 PM

REPRESENTATIVE FAIRCLOUGH pointed out that the causes of the rising cost of health care need to be studied; pharmaceutical [cost], malpractice insurance, diabetes, and obesity. Preventive care of the precursors to disease are not covered by insurance and are not being treated. She cited her experience with the National Resource Center for Sexual Violence. Representative Fairclough stressed that a mandate for the treatment of precursors to diabetes would make a difference in the treatment of this disease in Alaska.

2:10:54 PM

REPRESENTATIVE GARDNER said that she was troubled about medical decisions being made on the basis of insurance coverage. Mandated coverage is acceptable for some, but not all, procedures.

2:11:48 PM

REPRESENTATIVE FAIRCLOUGH stated that the issue needs to be raised so that long term solutions can begin. She re-stated her desire to study the costs of health care in Alaska because they are rising at a rate above the national average.

2:14:10 PM

REPRESENTATIVE CISSNA distributed reports presented at the Alaska Legislative Health Caucuses over the last four years. She said that the reports are also available online at www.akhealthcaucus.org, and encouraged the committee to review the information, especially the presentations regarding the health care workforce.

2:15:38 PM

ADJOURNMENT

There being no further business before the committee, the Department of Health and Social Services meeting was adjourned at 2:15 p.m.