

ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 2, 2009

1:37 p.m.

MEMBERS PRESENT

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
Senator Johnny Ellis
Senator Joe Thomas

MEMBERS ABSENT

Senator Fred Dyson

COMMITTEE CALENDAR

SENATE BILL NO. 96

"An Act relating to nonpayment of child support; relating to certain judicial and administrative orders for medical support of a child; relating to periodic review and adjustment of child support orders; relating to relief from administrative child support orders; relating to child support arrearages; relating to medical support of a child and the Alaska Native family assistance program; amending Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

MOVED CSSB 96(HSS) OUT OF COMMITTEE

SENATE BILL NO. 61

"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."

HEARD AND HELD

SENATE BILL NO. 47

"An Act relating to the statute of limitations for certain sexual offenses and permitting causes of action for certain

sexual offenses that would otherwise be barred by the statute of limitations to be brought during a certain one-year period."

MOVED FROM COMMITTEE 2/27/09

PREVIOUS COMMITTEE ACTION

BILL: SB 96

SHORT TITLE: CHILD SUPPORT/ CASH MEDICAL SUPPORT

SPONSOR(s): HEALTH & SOCIAL SERVICES

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|----------|-----|---------------------------------|
| 02/04/09 | (S) | READ THE FIRST TIME - REFERRALS |
| 02/04/09 | (S) | HSS, JUD, FIN |
| 02/25/09 | (S) | HSS AT 1:30 PM BUTROVICH 205 |
| 02/25/09 | (S) | Heard & Held |
| 02/25/09 | (S) | MINUTE(HSS) |
| 03/02/09 | (S) | HSS AT 1:30 PM BUTROVICH 205 |

BILL: SB 61

SHORT TITLE: MANDATORY UNIVERSAL HEALTH INSURANCE

SPONSOR(s): SENATOR(s) FRENCH

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|----------|-----|---|
| 01/21/09 | (S) | PREFILE RELEASED 1/16/09 |
| 01/21/09 | (S) | READ THE FIRST TIME - REFERRALS |
| 01/21/09 | (S) | HSS, L&C, FIN |
| 01/21/09 | (S) | HSS RPT RECD W/CS AWAIT TRANSMITTAL NXT |
| 03/02/09 | (S) | HSS AT 1:30 PM BUTROVICH 205 |

WITNESS REGISTER

SENATOR HOLLIS FRENCH
Alaska State Legislature
Juneau, AK

POSITION STATEMENT: Sponsor of SB 61.

ANDY MODEROW
Staff to Senator French
Alaska State Legislature
Juneau, AK

POSITION STATEMENT: Presented sectional analysis of SB 61.

LINDA HALL, Director
Division of Insurance
Department of Commerce, Community & Economic Development
POSITION STATEMENT: Answered questions on SB 61.

MARIE DARLIN
AARP Capital City Taskforce

POSITION STATEMENT: Supported SB 61.

BEVERLY SMITH

Christian Science Committee on Publication for the State of Alaska

POSITION STATEMENT: Commented on SB 61.

PATTY BOILY, representing herself
Homer, AK

POSITION STATEMENT: Supported SB 61.

ACTION NARRATIVE

[1:37:16 PM](#)

CHAIR BETTYE DAVIS called the Senate Health and Social Services Standing Committee meeting to order at 1:37 p.m. Present at the call to order were Senators Paskvan, Ellis, Thomas and Davis.

SB 96-CHILD SUPPORT/ CASH MEDICAL SUPPORT

[1:38:06 PM](#)

CHAIR DAVIS announced SB 96 to be up for consideration. [Version E committee substitute for SB 96 was before the committee.]

SENATOR PASKVAN moved to report CS for SB 96, 26-LS0485\E, from committee with individual recommendations and attached fiscal note(s). There being no objection, CSSB 96(HSS) moved from committee.

SB 61-MANDATORY UNIVERSAL HEALTH INSURANCE

[1:38:47 PM](#)

CHAIR DAVIS announced consideration of SB 61.

[1:39:12 PM](#)

SENATOR HOLLIS FRENCH, sponsor of SB 61, said 123,000 working Alaskans are without health insurance, and this bill is designed to make it affordable for all of them. They are not as lucky as we are to have health insurance provided to them as a job benefit, and they lack the economic wherewithal to afford an increasingly out-of-reach health insurance policy. He explained that SB 61 keeps the health insurance landscape much the same as it is now - a mix of private and government insurance and simply makes private insurance affordable. If you have an existing insurance policy, nothing changes; it simply reaches out to those Alaskans without health insurance.

Some people wonder why the state should advance this bill when it looks as if President Obama is going to fix this problem in Washington. There are two reasons; one is that it would be foolish to wait for Washington "to swoop into the rescue with the other enormous problems that confront our nation." Two, it may very well be that the solution adopted by Washington requires states to show initiative in adopting their own state plan that comports with a broad federal mandate. So, it's important for Alaskans to become acquainted and familiar with the basic building blocks of insurance reform so that we can offer an Alaskan solution when the time comes.

SENATOR FRENCH said that SB 61 is modeled after the Massachusetts plan that passed a little over two years ago and that has encouraging results. Many states are pursuing similar models. For example, Massachusetts has registered about 100,000 new entrants into the insurance market, and the dire prediction of private employers dropping their employees from coverage has not occurred. It has led to a decrease in the number of hospital admissions as people get primary care instead of going to an emergency room, and looks in general looks like it will be a success.

SENATOR FRENCH said his staff created a web site that has tens of thousands of hits. It has a calculator for people to use to estimate what it would cost them for different insurance options. The bill has enjoyed broad support from the health care industry even though there is some trepidation from the insurance industry and small businesses about hidden costs. However, for many small employers there will be no cost at all.

The bill has two technical elements; one is what is known as an individual mandate, which means that each person must get his own insurance policy. The reason is that insurance works best when there are more people in the pool; this will lower the cost for everyone. It includes arrangements for young people who don't have the insurance needs of the middle-aged.

The other side of the picture is the guaranty issue - every person who presents themselves must be issued a policy. The insurance industry will not be able to turn people away because of disqualifying conditions, but with some exceptions. The idea is that those are two sides of a coin - guaranty issue and individual mandate. The insurance industry will get tens of thousands of healthy people into its ranks, and in return it

will be required to insure those who have some difficulty getting insurance.

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ANDY MODEROW, staff to Senator French, gave a sectional analysis of SB 61. Section 1 provides the findings that go over many of the themes that Senator French just presented. The real meat of the bill begins on page 2, line 24, where it establishes the program, itself.

AS 21.54.200 spells out the goals that are going to be implemented to help fulfill some of the problems mentioned during the finds. One is to make insurance affordable for all residents of the state and the other is to get everybody covered. The real structure of what the bill creates begins on page 3, line 9, which contains the structure of the health care board. It will be an oversight committee under the Division of Insurance, which implements this plan. It will have 13 members to include six individuals who focus more on the business side of health care transactions, an insurance producer (someone who is more in touch with the individual policies as they are issued to the consumers), an insurance representative, two business representatives (one from a large business and one from a small business), two hospital representatives; from the consumer side it has a labor organization representative, two Alaskan physicians, a registered nurse, two consumer advocates and the commissioner of the Department of Health and Social Services or his designee. This last individual will cast a deciding vote if needed.

Sec. 21.54.220 on page 4, line 5, outlines the powers and duties of this board. It has the primary oversight responsibility of the health care clearing house and the health care fund. An important function the board takes on (page 4, lines 10-15) is it classifies plans that are available through the clearing house. Part of the goal of this bill is to encourage competition and consumer choice, and this places plans in more of an apples to apples comparison for consumers when they go to the clearing house to choose one. The Massachusetts Connector has three different levels of plans; Alaska has gold, silver and bronze. These classifications are based on the fiscal elements, such as deductibles, co-pays, co-insurance, and out-of-pocket maximums. The board will also recommend essential health care services that all plans sold through the clearing house should include. These recommendations would then be put in front of a body such as the legislature where they could be fleshed by a committee and discussed for possible implementation.

The financial criteria of the plans are not specified by this bill, and a lot of people have raised concerns. The bill does provide a very broad definition of essential health care services and everyone will not be forced to get a \$10,000 health care plan that has \$100 deductible. The only direction it provides can be found on page 5, lines 6-8, which requires that "a health care plan issued through the clearing house that can protect an insured from severe financial hardship caused by the cost of receiving care." The goal is to maximize consumer choice, not limit it. Studies have shown that most personal bankruptcies include a medical element.

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MR. MODEROW said the board will also provide procedures for an annual open season where customers can change their plan choices. This season will reduce a moral hazard of someone buying a high deductible plan and then deciding once they get into a car accident, which they caused and therefore their plan must cover, from then upgrading to a low deductible plan.

The next section describes the health care clearing house on page 5, line 12. It will be the place where Alaskans become connected with private health care plans that suit their needs. Two examples exist now - the Massachusetts Health Care Connector that needs a zip code to work and another example is the Federal Employee Health Benefits Plan System.

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SENATOR THOMAS said that Massachusetts is small state and had a small population that wasn't covered by insurance and asked how this would insure that Alaska's remote areas that don't even have telephone get the clearing house information.

MR. MODEROW replied that is a great question and is part of the reason for leaving the clearing house decision and fine print up to the board to determine.

SENATOR THOMAS asked the difference between a licensed insurance producer and somebody who is licensed to transact health care insurance in the state.

MR. MODEROW replied that a producer is someone who looks and works with individuals on the ground on the specifics of a particular health care plan, and an insurance representative would be more from the business side aggregate.

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LINDA HALL, Director, Division of Insurance, Department of Commerce, Community & Economic Development, added that the difference is that the first one is an insurance agent, and the second is the actual insurance company.

MR. MODEROW directed attention to Sec. 21.54.240 on page 5, line 22, that created needs-based vouchers and includes the individual responsibility clause, two major components of the legislation that make it possible. Section (a) includes that individual responsibility clause which outlines that all Alaskans shall have meaningful health coverage. Sec. 21.54.240 (1)-(7) has specific examples of what will qualify to fulfill that end - individuals who are covered under an employer plan or other publicly funded options and IHS recipients are considered in compliance with having health coverage. Subsection (8) is a religious exception that allows someone who has deeply held religious beliefs who objects to the overall program to opt out health coverage altogether. Massachusetts has a similar exception.

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MR. MODEROW said subsection (g) on page 7, lines 20-26, mention that people who have health coverage under (1)-(7) or elsewhere will not be eligible to receive needs-based vouchers to purchase health coverage. The idea is if you are eligible for Medicaid, that is where you get health coverage; you don't have the option to receive money to buy an additional health coverage plan.

SENATOR PASKVAN asked what the function of the one-year minimum requirement was on page 7, line 26.

MR. MODEROW replied the purpose of this legislation was to reduce the impact of people moving to Alaska just to get affordable health coverage. It is similar to the Permanent Fund Dividend.

He explained that under the needs-based vouchers, this year's federal poverty level has been set at \$13,530 for individuals or \$27,570 for a family of four. On page 6, line 28, subsection (c) provides a guaranty that anyone who falls below that line will not have to pay for the health coverage they receive. He explained that many people who fall below the poverty line are qualified for other publicly funded options like Medicaid. They might have co-pays or deductibles, but this will have to protect them from severe financial hardship in the future.

On page 7, line 3 (d) sets up a sliding scale for vouchers. Individuals who earn from 100 to 300 percent of the federal poverty level will get vouchers based on earnings with more assistance going to those who earn less. On page 7, line 10 (e) requires all who earn over 300 percent of the federal poverty level who do not fall under one of those exceptions in (a) acquire health coverage. They won't receive needs-based vouchers, but they might receive specified beneficiary vouchers which are provided for later in the bill.

On page 6, line 15, subsection (b) provides larger vouchers to individuals who only qualify for ACHIA coverage. Subsection (f) insures that only legal residents of Alaska will receive these needs-based vouchers.

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Sec. 21.54.250 is where essential health care services are defined; it requires that all health plans sold in the clearing house include coverage for certain things such as preventative and primary care, emergency services, inpatient services and hospital treatment, ambulatory patient services, prescription drug coverage and mental health services.

MR. MODEROW said on page 8, line 7, Sec. 21.54.260 begins and relates to employer coverage and the employer levy; (a) and (b) are included so nothing has to change in employer-based plans should an employer want to keep those plans going the way they are currently set up. On page 8, line 13, (c) and (d) relate to employer levy; the rules are pretty simple. If you are a small employer who has a payroll of less than \$500,000 there is no levy required on the payroll. For businesses with a payroll between \$500,000 and \$1,000,000 there will be a 1 percent levy. For business with a payroll greater than \$1,000,000 there will be a 2 percent levy.

He explained that there are multiple ways that this levy is not actually levied against a payroll, and if you provide employees with health coverage, you don't have to pay it. The definition of being a providing employer requires that an employer either offers to pay 33 percent of the health care premium or successfully enrolls 25 percent of his employees. Another element on page 8, line 29, (d) that says if an employer sets up a Section 125 account, a way for employees to purchase health services with pre-federal tax dollars, they are exempted from levies entirely.

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Sec. 21.54.270 on page 9, line 5, discusses the structure of insurance plans available in the clearing house; (a) outlines that plans sold in the clearing house must meet the requirements of this legislation and those under the insurance statutes in Title 21. This insures a baseline of quality for plans. Subsection (b) mandates that an insurance company not be able to turn down people looking for coverage for a plan sold through the clearing house (the guaranty part). Subsection (c) clarifies that health insurance plans can have financial conditions such as deductibles, co-pays and co-insurance that vary; (d) increases the dependent age to 25 years of age or until two years after the dependent no longer resides with the family.

Subsections (e) and (f) are new elements, and like the guaranty provision, they are made possible by getting everyone into the insurance pool. Both borrow from current small group insurance regulation in statute.

On page 9, line 25, subsection (e) defines pre-existing condition exclusions that are allowable in plans sold through the health care clearing house. They are patterned off of the currently applicable small group insurance statutes in Sec. 21.54.110(a) and they provide protections to individuals who have employment-based coverage to those in the individual market and plans sold through the clearing house. Subsection (e)(1) requires that insurers consider no more than two years of medical history when establishing that a preexisting condition exists; (e)(2) prohibits the creation of a preexisting condition only on the grounds of genetic information; (e)(3) prevents these exclusions from extending longer than 12 months, though depending on prior coverage that may be shortened; (e)(4) prohibits considering pregnancy as a preexisting condition.

Subsection (f) relates to credible coverage and how that relates to the preexisting condition exclusions under (e). Language on page 10, line 5, requires that any pre existing condition exclusion is reduced by periods of credible coverage if it is applicable. This language is mostly taken from 21.54.110(b).

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Page 10, lines 5-9, describe plans that count as credible coverage under the bill; these are essentially any plan that count as credible coverage under small group rules plus any plan sold through the health care clearing house; it also includes Medicaid recipients. It requires that a pre-existing condition exclusion must be reduced from the maximum of 12 months by the length of continuous credible coverage an individual had before

they acquired new coverage through the health care clearing house. It requires that any type of plan that fulfills the individual mandate under AS 21.54.240 of this legislation will count as credible coverage in addition to plans that fit the definition under AS 21.54.120 (current small group regulation).

Language on page 10, lines 9-12, outlines that the term "continuous" means that a 90-day break in coverage prior to an enrollment date in a clearing house plan will not be counted as continuous. Lines 14-15 allow for waiting periods if they are applicable for a health plan; the State of Alaska has a waiting period where new employees have to wait until coverage kicks in, and that is still allowable despite this new language. Mr. Moderow said (e) and (f) insure that people aren't penalized when they switch from one benefit plan to another in the health care clearing house whether it be due to a change to their employment, their financial situation or family status. Many other states include similar protections for consumers and in Alaska these requirements currently do exist in the small group market.

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SENATOR THOMAS said that insurance coverage usually runs month to month, and a 90-day period could start or end in the middle of any particular month. Was there some reason for using 90 days versus using calendar months?

MR. MODEROW answered they patterned this off the small group statutes and didn't consider using a calendar month. He would look into it for him, though. Other states use days or years.

MR. MODEROW said Sec. 21.54.280 on page 10, line 16, establishes the health care fund and describes the specified beneficiary vouchers. The health fund will be a separate trust fund of the state and will include state money and appropriations, any federal dollars and the employer levy. This fund will be used to pay out the sliding scale vouchers.

MR. MODEROW said subsection (b) describes another source of funding that can come into the fund, but these will not be used for the needs-based vouchers. These are specified beneficiary vouchers which give an employer the option of providing a set number of dollars to their employees to purchase health benefit plans. Last year they heard testimony from business owners who wanted to contribute something to an employee's health benefits, but they couldn't sponsor an entire plan. This will give them an

accountable way to give dollars to their employees to use for the purchase of health coverage.

Sec. 21.54.290 on page 11, line 7, discusses disputes and appeals and the process that can go through. Page 11, line 16 relates to reporting and provides for an annual report by the health care board that includes statistics relating to how the program is performing and it has other topics that should be discussed annually to be presented to the legislature and other bodies related to electronic health records, S-chip programs, effective mandated benefits and other things.

MR. MODEROW said Sec. 21.54.310 says that any regulations will be established under the Administrative Procedure Act.

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SENATOR THOMAS asked if they got the idea of people contributing to plans from the Massachusetts plan.

MR. MODEROW replied that Massachusetts has something like that, but this was requested last year by the owner of Snow City Café whose owner actually contributes dollars to her employees' health care.

SENATOR THOMAS asked if the 2 percent of gross payroll for the sliding scale vouchers goes to the health care fund.

MR. MODEROW answered yes.

CHAIR DAVIS announced the beginning of public testimony.

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MARIE DARLIN, AARP Capital City Taskforce, supported SB 61. AARP wanted to get something started that would address the problem of those without insurance. They are also concerned that access to affordable coverage is getting increasingly difficult to get particular before people are covered by Medicare in the 50-64 age group; even those with Medicare have trouble finding a physician. She submitted a letter with questions that AARP was asking, and said they would be following the bill and hope for progress this year.

CHAIR DAVIS said she also was particularly concerned about that age group as well and that she would have a subcommittee looking at some of these issues.

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BEVERLY SMITH, Christian Science Committee on Publication for the State of Alaska, wanted to make sure the committee had accurate information regarding spiritual healing as practiced in Christian Science so that this cost effective and reliable form of health care is not overlooked or restricted in the state's health care reform efforts in SB 61. In this regard, she said, it is important to preserve peoples' choice to pursue spiritual means for the prevention and cure of disease including Christian Science treatment and care and this legislation can be an important avenue for doing so. She thanked the sponsors for including the opt-out provision; however, to meet the health care needs of all Alaskans, they feel health care reform legislation should include coverage for spiritual care similar to state and federal government plans which currently do so.

To accomplish this, she requested that they incorporate an amendment that includes a definition of "essential healthcare services as used in Sec. 21.54.250 that says "shall be interpreted to include non-medical healthcare services provided by a religious non-medical provider is defined in AS 21.07.250(15)." This definition says "religious non-medical provider" means a person who does not provide medical care, but who provides only religious non-medical treatment or nursing care for an illness or injury.

MS. SMITH also provided an attachment called "Access to Spiritual Care" which sets forth the explanation for including religious non-medical care in SB 61. It says that prayer-based healing has been a mainstay in American life for years; it has remained some people's primary means of health care because they trust its effectiveness, its completeness and its reliability. Having the option to choose is important to many more. She said Christian Science is a method of spiritual care that is accessible to everyone. She said that Christian Science doctors provide the prayer and nurses take care of daily physical needs while the patient prays for healing.

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MS. SMITH said she identified two areas where statutory provisions may be needed to achieve public access to spiritual care. One is that it should be covered by insurance, and two is that religious non-medical care should be accommodated in managed care insurance plans, which Alaska is already pursuing. If people are finding cures through spiritual means without large health care costs, it should be encouraged.

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PATTY BOILY, representing herself, Homer, Alaska, said she has worked in health care as a certified coding specialist for physician-based offices for 25 years, and that she hasn't been insured since June 2008, and prior to that she had ACHIA, but it became too expensive - at \$10,000 per year plus 20 percent.

MS. BOILY said she supported SB 61. She supported a universal single payer system, but didn't see that happening soon; so she thought it was time for the State of Alaska to do something. People who are not insured can't afford to pay their bills, so either they go through bankruptcy or they go through the poverty programs at the hospitals.

She related that her son who is now 28 years old had to have urgent open heart surgery about a year ago. He had no history of heart problems; it happened suddenly. Alaska Medicaid doesn't have anything for single adults that don't have dependent children. He was able to get preemptively disabled by Social Security, which made him eligible for Medicaid that picked up all his bills. But now that the surgery is over and he is no longer disabled, he no longer has Social Security or Medicaid. He still needs to have an \$1,800 echocardiogram, which he has no money for, and he is now uninsurable. She strongly encouraged them to get this bill passed.

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CHAIR DAVIS said she agrees that Alaska has to do something, and gave her hope that the federal government would address situations like her son's this year.

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CHAIR DAVIS, seeing no further testimony, closed the public hearing. She asked for volunteers for a subcommittee and if Senator Ellis would be willing to work on it.

SENATOR ELLIS responded that he is a supporter of the bill as it is.

CHAIR DAVIS said that may be so, but there are some issues that need to be addressed.

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SENATOR ELLIS said he would be happy to serve on a subcommittee; Senator Paskvan volunteered as well.

SENATOR THOMAS asked what the penalty is for not purchasing insurance.

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MR. MODEROW replied that it isn't specified, but Senator French said he didn't anticipate throwing people in jail for not having health care coverage. This issue would be addressed in regulations.

SENATOR THOMAS asked as more people get into that system, would that increase the number of physicians who would take Medicaid/Medicare patients.

MR. MODEROW replied that Massachusetts found that the time it took to get in to see a primary care physician actually increased after their plan increased coverage. This was partially caused by the fact that there were new customers able to afford primary care for the first time. It reduced the number of people whose needs were not cared for in the first place.

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CHAIR DAVIS said she would pass all the information on to the subcommittee and get back to the sponsor to schedule the next meeting. [SB 61 was held in committee.]

[2:32:24 PM](#)

There being no further business to come before the committee, Chair Davis adjourned the meeting at 2:32.