INTERIM

Alaska State Legislature

House of Representatives

Committee on Judiciary

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

MEMO: March 29, 1979

TO: Representative Ramona Barnes

FROM: Charlie Parr, Chairman CP

RE: Interim Participation

During the interim the Committee will be investigating a number of areas in the broad fields of law enforcement and justice. I need to prepare a proposed schedule and budget for submission to the Legislative Council.

The amount of work we do (and the budget) will depend in large measure on how many members of the Committee are available for hearings and work sessions in various parts of the state. The areas of concentration will be largely determined by your perception of what the problems are.

Please let me know:

1. Whether you wish to participate.

2. Whether there are any periods when you will not be able to attend Committee meetings.

3. Your recommendations as to specific matters to be investigated.

4. The names of any groups or individuals who should be notified of Committee hearings.

5. Any other information which you think will be useful in planning the Committee's interim work.

1. Yes
2. Yes When I have an operation, but I can't tell you exactly when that will be -
3. Reference to letter [illegible] from Fairbanks Judge [illegible] Thelma [illegible] [illegible] the [illegible] Ramona [illegible].

Alaska State Legislature

REPRESENTATIVE
NELS A. ANDERSON, JR.
BOX 234
DILLINGHAM, ALASKA 99576
HOME PHONE 842-5302

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
PHONE 465-3736 OR 3739
HOME PHONE 789-7897

REPRESENTING DISTRICT 16
BRISTOL BAY — LOWER KUSKOKWIM

HOUSE MAJORITY LEADER
VICE CHAIRMAN JUDICIARY COMMITTEE
MEMBER, RULES COMMITTEE
MEMBER, SPECIAL COMMITTEE
ON SUBSISTENCE

House of Representatives

March 28, 1979

MEMORANDUM

TO: Representative Charlie Parr, Chairman

FROM: Representative Nels A. Anderson, Jr.

SUBJECT: Interim Committee Activity

1. I do wish to participate in an interim investigatory review of the entire law enforcement and justice system.

2. July and August would be difficult for me.

3. a) We should conduct an oversight review of the Judicial Sentencing Study to assure ourselves that legislative intent is being followed if HB 195 and HB 196 pass and are approved by the Governor.

   b) We should follow the history of several cases from the time of arrest through to final sentence and place of confinement.

   c) We should determine whether or not judges recommendations for rehabilitation are being followed after incarceration.

   d) We should visit the policemen, judges, public defenders, district attornies, law clerks, correctional officers, and the public Safety and Health and Social Services Commissioner.

4. Groups to contact:

   Anchorage Black Caucus
   Anchorage Native Caucus
   Fairbanks Native Association
   Alaska Federation of Natives
   Non-profit Regional Native Associations
   Human Rights Commission
   Ombudsman

cc: Judiciary Committee Members

NAA/ah

Alaska State Legislature

IN SESSION:
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4949

BOX 142
EAGLE RIVER, ALASKA
99577

Representative Randy Phillips
HOUSE DISTRICT 8

March 28, 1979

The Honorable Charles Parr, Chairman
House Judiciary Committee
Pouch V, Mail Stop 3100
Anchorage, AK 99811

RE: YOUR MEMO TO ME OF MARCH 29, 1979 CONCERNING INTERIM PARTICIPATION

Thank you for your memo dated March 29, 1979.

In answer to your questions:

1. Yes, I do wish to participate.

2. I work during the summer months and it is hard for me to get away to attend meetings during that time. For me, the best month is probably November; however, if adequate notice is given, I could make arrangements to attend meetings.

3. Specific matters to be investigated: Selection of jury and judges as a whole; slowness of the process; administration of court system in Anchorage.

4. Names of groups of individuals to be notified: Lee Jordan, Editor, Chugiak-Eagle River Star, PO Box 1007, Eagle River, AK 99577; Robbie Robinson, Chugiak Community Council, Box 309, Chugiak, AK 99567; Bob Johnson, Eagle River Community Council, PO Box 456, Eagle River, AK 99577; Stephen Dunning, Eagle River Valley Community Council, Box 1644, Anchorage, AK 99510; Tom Henry, Birchwood Community Council, SRA Box 760, Chugiak, AK 99567; Rex Campbell, North Mt. View Community Council, 819 N. Klevin, Anchorage, AK 99504; Fred Selkregg, Northeast Anchorage Community Council, 5811 Radcliffe, Anchorage, AK 99504; Gene Buck, Russian Jack Park Community Council, 5222 East 24th Avenue, Anchorage, AK 99504; Kathleen Bush, 6631 East Eighth, Anchorage, AK 99504; The Brown Family, 442 South Flower, Anchorage, AK 99504; Clifford and Jane Bissell, Box 656, Eagle River, AK 99577; Marion E. Daley, PO Box 108, Chugiak, AK 99567; Mike Briggs, Esq., Ely, Guess & Rudd, 510 L Street, Anchorage, AK 99501.

5. Other information: I would like to have hearings at following areas in House District 8 -- Eagle River, Mt. View, Muldoon, Nunaka Valley.

If you need further information, please do not hesitate to contact me.

Best Regards,

Randy Phillips
State Representative

RP:js

Alaska State Legislature
House of Representatives

April 2, 1979

To Rep. Charlie Parr

From Rep. Thelma Buchholdt

Subject Judiciary Committee Interim Activity

Yes, I'd like to participate in the interim work of the House Judiciary Committee.

I'll be available to attend hearings in and out of the state, except during the following:

June 16-30; July 1-13; August 20-26; September 16-30;

October 1-6; November 21-24; December 22-31.

Specific topics that I want considered include the following:

POLICE: Ethics, Recruitment, Training, Organization, Funding Source.

Because of the importance of public confidence in our policemen/state troopers, we must be sensitive to how the general public views our police. Working with respected policemen from all parts of Alaska, the Committee should review police behavior, recruitment policy, training programs and staffing, working relations of local and state officers, budgetary needs and sources.

Additionally, the Committee should become familiar with law enforcement priorities, and how such priorities get set.

PRISON: Public policy in Alaska has historically opposed the construction of a maximum security prison, and prison classification staff has awesome power to transfer men and women to outside facilities. Is this power being used wisely? Because of the importance of public confidence in fair and just punishment, the Committee should discuss prisoner classification with respected correctional officials with a view of recommending appropriate legislative action.

The Committee should also research ways at expanding reliable alternatives to institutionalizing convicted felons, including penitential employment on public works projects.

PAROLE: Parole is the most commonly-used alternative to jail, and our parole system should be reviewed by the Committee to see if it is functioning effectively as a re-entry program.

EQUAL JUSTICE: We know from recent judicial studies that certain groups of people wind up in jail faster than others. The Committee should strive to determine the degree to which justice now obtains in law enforcement, in the courts, and in the correctional institutions.

There is that hope in the New Criminal Code which may help to correct previous inequities in the system. But the Committee should maintain that there is plenty of work yet to be done to straighten out the problems spelled out in the sentencing studies.

GROUPS TO BE NOTIFIED OF HEARINGS:

Commission on the Status of Women
League of Women Voters
Alaska Legal Services
N.A.A.C.P.
Alaska Black Caucus
All Alaska Native organizations
PTA groups
AkPIRG
Other minority group organizations
In District 9 for hearings in Anchorage:

Spenard Community Council (Myron Igtanloc)
Turnagain Community Council (Wilda Marston)

Note: I'm particularly interested in working on the topics listed on the first page, as what happens between the arresting officer and the suspect, I believe, may determine the trend that follows thereafter to the defendant, the inmate, the parolee.

Needless to say, public confidence with the correctional/judicial system has to be maintained, perhaps restored.

Here's to hard labor during the interim!

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Judiciary Committee Interim Activity

Questions Need Answers

Police Ethics: Are Alaskan police behaving as they should? Hear and review complaints about police behavior and administration.

Police Training: Review of training programs and opportunities. What can be learned of police attitudes from training curricula and training staff?

Police Organization: Relationships between local police and state troopers; probation officers; federal marshall and other law enforcement officers (FBI, etc.)

Communication systems; cooperation between agencies.

Police Funding Sources: Personnel; equipment; state and federal budget;(LEAA, Peace Officers groups, etc.)

Law enforcement priorities: How crimes get classified (when does it suit the victim, the offender?); How are police handling narcotic-related crimes(alcohol-related crimes) in order of priorities?

Public Defender Agency: How much time is spent by a Public Defender with his client during pre-trial, during trial, etc.

Judges: qualifications; selection; early retirement incentives(?); Constitutional changes on salary schedule; etc.

Bails: how set are they for specific crime; bail bonding agencies;

Parole Board: criteria in releasing an inmate for parole; quality of decisions made by the board.

Jury: how much influence on punishment for crime committed; selection, certain groups of people seem to be serving more often than others (except those excused due to professional constraints).

General Public: What is the public perception of certain crimes and appropriate punishment; priorities in law enforcement.

(1)

EDUCATION

It is time now for the Legislature to investigate what has become a steady stream of complaints about the state in which ~~the~~ Alaska's education industry finds itself after several years of generous fiscal support. Now, after years of being fairly unanimously urged to fund without much question ~~all of~~ the budget requests submitted by education progarm administrators, the Legislature is being asked to adopt a more critical view of ~~the education priorities we are having to fund~~ education as we must ~~face~~ begin to ~~have to~~ deal with problems of widespread adult illiteracy. This is a real political problem because the education industry does not ~~accept~~ gracefully accept critical views. However, the House ~~Education Sub~~ HESS Committee will accept responsibility to bring the following aspects of public education under critical review during the interim:

1) Federal and State and local Funding Sources. There must be more public understanding of funding sources available to local school districts. Some critics feel these are so numerous and uncoordinated as to make education program administrators unaccountable to ~~political~~ our political leadership on our local school boards, borough assemblies, and the Legislature. The Committee will focus upon the school systems of the Ketchikan Gateway ~~Borough, the Anchorage Unified Municipality~~ selected REAA's, and the North Slope Borough to learn how improved education program funding systems might contribute to improved education. ~~formula (Gateway, Anchorage, Juneau)~~ ~~weight~~ the base instructional unit

~~)//Children in K to 12 - The Committee will try to evaluate the problems of education in our communities. Are our kids learning to read and write? How many are not? Is there a growing attendance problem? Is illiteracy part of this problem? How well do our kids do compared with other parts of the country? What about these educational achievement~~

2) Children in K to 12 grades - The Committee will try to evaluate the problems of education in our communities. Are our kids learning to read and write? How many are not? Is there a growing attendance problem? Is illiteracy part of this problem? How well do our kids do compared with other parts of the country? What about these educational achievement

tests? Can they be trusted, or are they written to mask the failure of our schools as many feel? What do our kids think of their schools? And our truants and drop-outs - what do they think of our schools? What do their parents think? What educational alternatives are there to help them continue their education?

3) Teacher Recruitment and Pay. There are many questions being asked about how teachers are recruited, and how much they are paid. The public's image of teaching has moved from one of an inadequately paid profession to one of a well-paid profession, one in which too few Alaskans have been encouraged to enter as Alaska's education industry has become a $000-million industry employing _____ teachers and administrators, as well as _____ non-professional support personnel. What about local hire in education, one of Alaska's largest industries? How can this be improved? And for those teachers we must continue to recruit from outside, how can we improve recruitment to insure we employ only the best teachers available? How might the University of Alaska help toward the training and employment of Alaskan teachers, and improved outside teacher recruitment?

4) School Administration. There is a widely-shared perception of rapid growth of the number of educational program administrators employed in Alaska's education industry whose combined strength has weakened the role of the School Board as a moderating influence in the growth of this industry. What is the truth of these perceptions? How well are the School Boards making educational policy? Is rapid growth in the ranks of school administrators a sign of School Board weakness to resist inflationary costs? How many administrators are there? What are they paid? What do they do? How are they typically recruited, and from where? How do they relate with classroom teachers? What do classroom teachers think about the rapidly expanded corps of administrators? The Committee will focus upon educational administration as a much-complained of problem affecting influencing educational failure in Alaska.

(3)

5) Foundation Program. The Schools Foundation Program has been amended to provide sharp increases of State support annually for several years. ~~every year since 1973.~~ Some have suggested local governments are avoiding mill-rate increases by passing on their educational cost increases on to the State treasury. Thus, local jurisdictions have been able to appear fiscally frugal to local property tax payers, ~~some~~ (one going so far as to even begin closing neighborhood schools,) while ~~passing on~~ depending upon annually-increased levels of ~~foundation support~~ State foundation support. ~~This has enabled local school jurisdictions to avoid political accountability to~~

Right here

Additionally, with the creation ~~The creation~~ and funding of REAA's, extraordinary costs ~~has severely~~ compounded this trend ~~into a serious fiscal problem at a time when Alaska's economic growth has~~ anticipated and unknown educational costs have contributed to State budget growth ~~must be [illegible] sharply reduced.~~ ~~What are the factors contributing to annual increases in State Foundation~~ ~~for 18~~ up to 10% bi annually.

Is the Foundation Program in need of overhaul? The Committee will seek answers to this question in an effort to ~~retain present the~~ make Foundation support equitable to everyone.

6) Rural School Construction, Operation and Maintenance - The Committee will undertake to study and comprehend the economic and problems of rural village school construction, operation and maintenance as it ~~will~~ has become a major budget consideration ~~in future~~ about which too little is understood. What are the politics and economics of village high school construction? Have village school construction and O&M estimates proved reliable in the past? What has been the experience with cost-overruns, and what caused them? ~~What influence does the architectural profession have upon~~ What is the real square-foot cost of village school operation and maintenance? How have village high school stood up to wear and tear so far? What are the outstanding and most difficult O&M problems? What about heat. How will new village high schools affect rural Alaska's need for fuel? ~~Is~~ Will there be enough, or will village homes have to compete with

schools for fuel? What is the life-cycle cost estimate of village schools, and what is being done to try to reduce it? Why are these schools so important to ~~the/villa~~ rural Alaska? How is a village school used? ~~What/impact/will new/village/school/facility/have/upon~~ Against the background of perceptible political reaction against capital expenditure for ~~y~~ new village high schools, the Committee will try to determine their real monetary cost, as well as the costs to be incurred if the schools are not built and operated as planned.

7) Small High School Programs. The Committee will respond to growing ~~political/opposition/to~~

criticism that Alaska's small high school program operated by our new REAA School Boards are providing substandard high school educations, and turning out graduates unable to read or write properly. How are small village high school designed, and for what are they designed? How is curriculum designed and used, and how relevent are small high school curricul to community needs?~~and/problems/~~

How are these small high schools staffed? w are teachers and administrators recruited, and from where? How do they perform? How are they regarded by their communities? How long do they stay? How much are they paid? How well are small school organized and managed? What alternatives exist for rural high school students who do not want to attend small village high schools? ~~Against/a/rising/ discontent~~ What do small high school students and their parents think of their experience? Many Alaskans feel the small high school program produces the world's most expensive high schools and the most poorly educated high school ~~students/~~ students fluent and literate in neither English or their Native languages. The Committee will determine how true this may be, but it will also seek to learn what is good about the small high school program, and how it can be ~~a~~ improved.

8) Youth Centers . The Committee will respond to the continuing requests for a State-supported youth center program. Many communities throughout Alaska, both urban and rural, feel the need for stability and direction it is felt a good youth center program could provide to increasingly unemployed and unemployable young people both in and out of school. Youth Centers are being advanced ~~as~~ more as community education and guidance programs rather than as merely recreation and social centers. At a time when Alaska ~~can~~ must sharply restrict budget growth, what is the proper policy we should adopt regarding State support of community youth center construction and operation? The Committee will seek ~~out answers~~ to determine if Alaska's social + education investment should provide for community youth centers.

9) Adult Basic Education. Increasing educational program failure produces increased need for adult basic education, an activity now ~~in~~ shared between the U. of A. and several non-profit ~~corporations in rural Alaska~~ ~~UESS~~ corporations especially in rural Alaska. ~~As this matter of illiterate high school graduates grows, ABE becomes a last chance program we might want to~~ The Committee will review ABE in Alaska to determine how it might be improved to mitigate increasing failure to properly educate children. It may be we must face up with the necessity to provide ~~local~~ for local District ABE programs.

10) Community Schools Program. Slated for termination as a State-funded program, the Community Schools Program proved to have a large and effective constituency able to convince this Committee to extend the program's support one more year, with the understanding the Legislature would study the Community Schools Program ~~as a candidate for permanent inclusion in the foundation program~~ to make recommendations about its future. The Committee has noted the great political popularity of Community Schools, but has also noted apparent abuses of Program funds by some ~~schools~~ administrators.

University of Alaska Research Programs - As the industrialization of knowedge develops throughout Alaska, the role of ~~U~~ the University of Alaska as a subsidized competitor in the private knowledge market

must be fairly defined and possibly restricted if the market benefits of free enterprise are to be realized by our State.

Professional businessmen throughout the State have argued they should not have to compete with the University of Alaska for consultant planning, program evaluation, industrial, economic, and environmental analysis, and architectural and engineering, and other services. Yet many of our University's best programs flourish because of their involvement in the real competitive world of private industry. Should restrictions be placed on this involvement? Should the U. of A. be allowed to compete with private industry for State contracts? If so, under what terms? This is a public policy question of growing importance, and the Committee will work to prepare a policy recommendation.

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

TO: Rep. Terry Gardiner,
Speaker of the House

FROM: Rep. Thelma Buchholdt
HESS Committee Chair

SUBJECT: Proposed Interim Work of the HESS Committee

Traditionally, a legislator who winds up on the Health, Education and Social Services Committee is labelled a "bleeding heart" who approves, with great ease, the funding of everything that comes along, from day care to senior citizens programs, schools and numerous other social and human services needs.

During these penny-pinching times, even programs that tug at the heartstrings require as much scrutiny and justification as all others. In fact, more so than others, because historically, nobody wants to check them out for fear of treading into "sacred grounds". The H.E.S.S. Committee recognizes that in poking around for facts and public input during the interim, there will be some treading on tender, sensitive areas which will need to be addressed delicately as much as possible. But at the same time, to quote a recently-expired newspaper, "Sacred Cows make the best hamburger", and certainly, the H.E.S.S. Committee will not spare any sacred cow that cannot justify its existence.

The H.E.S.S. Committee proposes to work on certain bills presently in committee and others that will be introduced next session. Additionally, work topics will include, but will not be limited to, the following:

HEALTH AND SOCIAL SERVICES ISSUES

Alcoholism programs - review of local agencies and educational programs. (HB-219)

Senior Citizens Programs:

Multipurpose Senior Citizens Center
Alternative residential facilities

The H.E.S.S. Committee will work with the Judiciary Committee in its review of the program under the Division of Corrections.

1) Police: Ethics, Recruitment, Training, Organization, Funding Source.

Because of the importance of public confidence in our policemen/state troopers, we must be sensitive to how the general public views our police. Working with respected policemen from all parts of Alaska, the Committee should review police behavior, recruitment policy, training programs and staffing, working relations of local and state officers, budgetary needs and sources.

Additionally, the Committee should become familiar with law enforcement priorities, and how such priorities get set.

2) Prison: Public policy in Alaska has historically opposed the construction of a maximum security prison, and prison classification staff has awesome power to transfer men and women to outside facilities. Is this power being used wisely? Because of the importance of public confidence in fair and just punishment, the Committee should discuss prisoner classification with respected correctional officials with a view of recommending appropriate legislative action.

The Committee should also research ways at expanding reliable alternatives to institutionalizing convicted felons, including penitential employment on public works projects.

jail, and our parole system should be reviewed by the Committee to see if it is functioning effectively as a re-entry program.

EDUCATION

1) Federal and State Funding Sources

2) Children in Grades K to 12:

   Attendance
   Basics
   Extracurricular activities
   Special Education alternatives

3) Teacher Recruitment and Pay

   Local hire first
   Outside recruitment
   (Employ the best from outside)

4) School Administration

   School Boards and Policy
   Positions and Pay Structure

5) Foundation Program (HB-126; HB-222; HB-333)

   Urban support
   Rural support

6) School Construction, Repairs and Improvement

   a) Urban schools
      Rural schools
      Problems of village school construction in the unorganized borough; in the organized borough.

   b) Review of small high schools

      Design
      Curriculum
      Staffing
      Organization and Management
      Alternatives

7) Youth Centers (HB-125)

8) Adult Basic Education

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 10, 1979

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FROM: Rep. Thelma Buchholdt
HESS Committee Chair

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educational achievement tests? Can they be trusted, or are they written to mask the failure of our schools as many feel? What do our kids think of their schools? and our truants and drop-outs -- what do they think of our schools? What do their parents think? What educational alternatives are there to help them continue their education?

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4) School Administration. There is a widely-shared perception of rapid growth of the number of educational program administrators employed in Alaska's education industry whose combined strength has weakened the role of the School Board as a moderating influence in the growth of this industry. What is the truth of these perceptions? How well are the School Boards making educational policy? Is rapid growth in the ranks of school administrators a sign of School Board weakness to resist inflationary costs? How many administrators are there? What are they paid? What do they do? How are they typically recruited, and from where? How do they relate with classroom teachers? What do classroom teachers think about the rapidly expanded corps of administrators? The Committee will focus upon educational administration as a much-complained of problem influencing educational failure in Alaska.

5) Foundation Program. The School Foundation Program has been amended to provide sharp increases of State support annually for several years. Some have suggested local governments are avoiding mill-rate increases by passing on their educational cost increases on to the State treasury. Thus, local jurisdictions have been able to appear fiscally frugal to local property tax payers, (one going as far as to even begin closing neighborhood schools), while depending upon annually-increased levels of State

foundation support. Additionally, with the creation and funding of REAA's, anticipated and extraordinary costs have contributed to State budget growth up to 10% biannually. Is the Foundation Program in need of overhaul? The Committee will seek answers to this question in an effort to make Foundation support equitable to everyone.

6) Rural School Construction, Operation and Maintenance. The Committee will undertake to study and comprehend the economic and problems of rural village school construction, operation and maintenance as it has become a major budget consideration about which too little is understood. What are the politics and economics of village high school construction? Have village school construction and Operation and Maintenance estimates proved reliable in the past? What has been the experience with cost-overruns, and what caused them? What is the real square-foot cost of village school operation and maintenance? How have village high schools stood up to wear and tear so far? What are the outstanding and most difficult operation and maintenance problems? What about heat? How will new village high schools affect rural Alaska's need for fuel? Will there be enough, or will village homes have to compete with schools for fuel? What is the life-cycle cost estimate of village schools, and what is being done to try to reduce it? Why are these schools so important to rural Alaska? How is a village school used? Against the background of perceptible political reaction against capital expenditure for new village high schools, the Committee will try to determine their real monetary cost, as well as the costs to be incurred if the schools are not built and operated as planned.

7) Small High School Programs. The Committee will respond to growing criticism that Alaska's small high school program operated by our new REAA School Boards are providing substandard high school educations, and turning out graduates unable to read or write properly. How are small village high schools designed, and for what are they designed? How is curriculum designed and used, and how relevant are small high school curricula to community needs? How are these small high schools staffed? How are teachers and administrators recruited, and from where? How do they perform? How are they regarded by their communities? How long do they stay? How much are they paid? How well are small schools organized and managed? What alternatives exist for rural high school students who do not want to attend small village high schools? What do small high school students and their parents think of

their experience? Many Alaskans feel the small high school program produced the world's most expensive high schools and the most poorly educated high school students fluent and literate in neither English or their Native languages. The Committee will determine how true this may be, but it will also seek to learn what is good about the small high school program, and how it can be improved.

8) Youth Centers. The Committee will respond to the continuing requests for a State-supported youth center program. Many communities throughout Alaska, both urban and rural, feel the need for stability and direction -- it is felt a good youth center program could provide to increasingly unemployed and unemployable young people both in and out of school. Youth Centers are being advanced more as community education and guidance programs rather than as merely recreation and social centers. At a time when Alaska must sharply restrict budget growth, what is the proper policy we should adopt regarding State support of community youth center construction and operation? The Committee will seek to determine if Alaska's social and education investment should provide for community youth centers.

9) Adult Basic Education. Increasing educational program failure produces increased need for adult basic education, an activity now shared between the University of Alaska and several non-profit corporations especially in rural Alaska. The Committee will review Adult Basic Education in Alaska to determine how it might be improved to mitigate increasing failure to properly educate children. It may be that we must face up with the necessity to provide for local District ABE programs.

10) Community Schools Program. Slated for termination as a State-funded program, the Community Schools Program proved to have a large and effective constituency able to convince this Committee to extend the program's support one more year, with the understanding the Legislature would study the Community Schools Program to make recommendations about its future. The Committee has noted the great political popularity of Community Schools, but has also noted apparent abuses of Program funds by some administrators.

11) University of Alaska Research Programs. As the industrialization of knowledge develops throughout Alaska, the role of the University of Alaska as a subsidized competitor in the private knowledge market must be fairly defined and possibly restricted if the market benefits of free enterprise are to be realized by our State. Professional businessmen throughout the State have argued they should not

have to compete with the University of Alaska for consultant planning, program evaluation, industrial, economic, and environmental analysis, architectural and engineering, and other services. Yet many of our University's best programs flourish because of their involvement in the real competitive world of private industry. Should restrictions be placed on this involvement? Should the University of Alaska be allowed to compete with private industry for State contracts? If so, under what terms? This is a public policy question of growing importance, and the Committee will work to prepare a policy recommendation.

VII APPENDIX

TABLE I - SUMMARY OF STATE LEGISLATIVE OPTIONS TO EXPAND COMPREHENSIVE HEALTH CARE COVERAGE

	Program	Who It Would Cover	State Administrative Tasks	Estimated Annual Premium Costs To The State*	Other Payers
1.	Universal State sponsored coverage	All state residents without federal health coverage (267,500)	Verification of residency, enrollment, accounting, and financing	$87 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
2.	State sponsored coverage for the uncovered	All state residents not covered under other public or private plans and their dependents (56,000-71,000 estimated)	Eligibility determination, enrollment, accounting, and financing	$27 - $41 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
3.	State sponsored coverage for non-wage earners without coverage from public sources	The unemployed, self-employed, and the non-labor force and their dependents (60,000 estimated)	Eligibility, determination, enrollment, accounting, and financing	$25 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
4.	Income tax credit	All residents filing tax returns (124,000 estimated) and their dependents	Negligible	$21 million (assuming a flat $250 credit)	Taxpayers and subscribers
5.	Medicaid medically needy program	Categorically needy with income above the public assistance level (1,580 estimated)	Eligibility determination, enrollment, accounting, and financing	$1.1 - $1.4 million (cost savings in GRM not included)	Federal government, federal taxpayers, and Alaska taxpayers
6.	Mandatory employer coverage	All non-agricultural wage and salary employed people, and their dependents (200,000 estimated)	Regulation of Employers	$0 (state cost sharing optional)	Employers and their clients (optional cost sharing with subscribers)
7.	High risk reinsurance pool	People who are unable to obtain health insurance at a reasonable premium due to health conditions	Investigation on a complaint basis	$0 (state cost sharing optional)	Subscribers, insurance companies and their clients
8.	Health insurance regulation	Better coverage for current subscribers; possible decline in the number of low-income subscribers	Regulation of carriers	$0	Subscribers (including employers and other sponsors)

* These estimates are based on estimates of the current extent of coverage. Presumably alternatives 2, 3, & 4 would provide incentives for increasing health coverage, and therefore the state's premium costs would tend to rise over time.

Prepared by Legislative Affairs Agency Research Division 2/17/78

TABLE II ESTIMATED PREMIUM COSTS OF STATE-WIDE HEALTH COVERAGE WITH BENEFITS EQUIVALENT TO THE STATE EMPLOYEE HEALTH PLAN

Total FY '77 Civilian Population	398,000
U. S. Public Health Service Eligibles	(70,000)
CHAMPUS Eligibles	(55,000)
Medicaid Eligibles (excluding USPHS)	(5,500)
Eligible Population	267,500

	19 and Under (32.5%)	Over 19 (67.5%)
Number eligible	86,900	180,600
Premium Rate	$12.40	$34.10
Monthly Premium	$1,078,000	$6,158,000

ESTIMATED ANNUAL PREMIUM $86,800,000

TABLE III ESTIMATED RANGE OF INITIAL[1] PREMIUM COSTS OF HEALTH COVERAGE FOR THE UNCOVERED POPULATION

	High	Low
Uncovered Population	71,000	56,000
19 and Under (32%)	23,000	18,000
Premium Rate[2]	$22.00	$19.00
Monthly Premium	$506,000	$342,000
Over 19 (68%)	48,000	38,000
Premium Rate [2]	$60.00	$51.00
Monthly Premium	$2,880,000	$1,938,000
ESTIMATED ANNUAL PREMIUM	$41,000,000	$27,000,000

1. These costs would approach the cost of universal coverage over time, as private subscribers opt for state subsidized coverage.

2. The estimated premium rate for state wide coverage, +50 to 75%. See Blue Cross memo which follows.

TABLE IV ESTIMATED RANGE OF PREMIUM COSTS OF HEALTH COVERAGE FOR NON-WAGE EARNERS AND DEPENDENTS WITHOUT HEALTH COVERAGE FROM PUBLIC SOURCES

Unemployed	18,300
Self-employed	15,000
Non-labor Force	244,000
Wage earner dependents	(105,000)
CHAMPUS eligibles	(46,000)
Medicaid eligibles	(14,800)
U. S. Public Health Service Eligibles	(31,500)
TOTAL	60,000

	High (+20%)	Low (+20%)
19 and Under (32.5%)		19,500
Premium Rate	$16.12	$14.88
Monthly Premium	$314,000	$290,000
Over 19 (67.5%)		40,500
Premium Rate	$44.33	$40.92
Monthly Premium	$1,795,000	$1,657,000
TOTAL ANNUAL PREMIUM	$25,300,000	$23,400,000

TABLE V ESTIMATED COST OF INCOME TAX CREDIT FOR PRIVATE HEALTH COVERAGE

Tax Returns Filed	124,000
Filers with Private Health Coverage (68.5%)	85,000
Annual Tax Credit	$250.00
TOTAL	$21,000,000

Blue Cross®
of Washington and Alaska

John M. Hopkins
Vice President, Marketing

15700 Dayton Avenue North/P O Box 327
Seattle, Washington 98111
206/361-3586

November 30, 1977

Ms. Sharman Haley
Research Analyst
Legislative Affairs Agency
State of Alaska
Pouch Y, State Capitol
Juneau, Alaska 99811

Dear Sharman:

On September 29, you requested information concerning projected costs of a Blue Cross medical package for various classifications of State residents.

Three alternative approaches were requested in your letter. The attached proposal is applicable only for the first alternative, "coverage for all residents". The second alternative, to cover "all residents not currently covered under comprehensive group health plans", would present problems in defining and administering eligibility and in developing a controlled risk. Rates for the second alternative would probably be 50% to 75% higher than the rates for the first alternative.

The third alternative, to cover "the unemployed, the temporarily or seasonally employed, and the self-employed (mandating employer-sponsored coverage for all regular employees and their dependents)", would present fewer problems in controlling risk but would still require rates 20% to 30% higher than the first of the three alternatives and probably would have the least economic impact on the State's health care system.

We recognize that you may have many questions concerning the information contained in this letter. Please give me a call and we will try to help in any way we can.

Sincerely,

John M. Hopkins

JMH:bc

EXHIBIT 'A'

Blue Cross medical coverage extended from the Alaska State Employees to eligible residents of Alaska, given the following assumptions:

I. A resident is a person whose primary residence has been within the State of Alaska for a continuous period of at least six months.

II. An eligible resident is a resident not eligible for medical care benefits available through the following entities:

a. Federal Employee Health Programs
b. United States Armed Forces
c. CHAMPUS
d. Medicaid
e. United States Public Health Service

III. Healthcare benefits would be provided as primary coverage, with the sole exception that the Program be coordinated as secondary coverage to Medicare. Any persons eligible for Medicare and not enrolling in the Medicare Program will receive the same coordinated benefits had they been covered under Medicare.

IV. The State of Alaska would identify all eligible residents and submit necessary eligibility data to the Blue Cross Plan monthly on a computer tape in order that an updated eligibility file could be maintained for the Program. Administration and enforcement of eligibility rules would be the responsibility of the State of Alaska.

V. The State of Alaska would remit, monthly, funds due the Plan based on the eligibility file and contract rates.

VI. At the end of each contract year the Plan would provide a summary of Income, Incurred claims and administrative expenses under the Program. Any surpluses would be refunded to the State of Alaska. Any deficits would become due and payable to the Plan by the State of Alaska. The Plan would provide monthly reports to the State of Alaska during each contract year, itemizing year-to-date income and expense data.

VII. During the initial years of the Program it is likely that abnormally high rates of inflation and increases in utilization of healthcare services will occur. In an attempt to control these anticipated trends and their effects on the cost of the Program, it would be desirable for the State of Alaska to enact legislation to control the expansion of healthcare facilities and to set reasonable limits on the rate of return healthcare providers may be allowed.

continued . . .

VIII. If the first contract year is from 7-1-78 through 6-30-79, one of the following options could be used in determining the monthly funds due to the Plan:

A. Rates by eligible resident-

1. Adult (age 19 and over) = $34.10/month
2. Child (under age 19) = $12.40/month

B. Rates by type of family unit-

1. Single Adult = $34.10/month
2. Husband & Wife = $68.20/month
3. Husband,Wife & one or more Children = $96.70/month
4. Husband,or Wife and one or more Children = $62.60/month

C. Rate for any Family Unit = $71.40/month
Each family unit would coincide with one of the categories itemized in section VIII, B., above. Children must be unmarried and meet the IRS definition of a dependent to be considered an eligible member of any covered family unit.

The above rates assume all eligible residents will participate in the Program.

IX. To minimize the chance of duplicate coverage and benefit payments each eligible resident should be assigned a unique membership number under the Program. This procedure would also facilitate computerized surveillance of medical utilization under the Program. Surveillance programs could be used to detect abnormal utilization of benefits by covered members and abnormal patterns of service by healthcare providers.

X. The Program should provide coverage for services rendered within the State of Alaska. For services outside the state, coverage should be limited to emergencies and to referrals by Alaska physicians for conditions that, in the opinion of the attending physician, cannot be adequately treated in the State's healthcare facilities.

MINUTES
House HESS Committee Meeting
3/31/80

Members present:

All members were present at the start of the meeting.

758 The Chair stated that the Committee would be hearing testimony on HB 977, providing comprehensive health care in the state, for most of the week. The first witness would be John Ingrassia, from Minnesota, to talk about how the Minnesota plan resembles one part of HB 977. A Mr. Ching from Hawaii would be with the Committee tomorrow to discuss another section of the bill (he was originally scheduled to come before the Committee today but was unable to get here on time).

802 John G. Ingrassia, Supervisor, Life and Health, Insurance Division, Dept. of Commerce, State of Minnesota

Mr. Ingrassia described the Minnesota health insurance for the Committee. He began his testimony by stating that the most important part of the Minnesota plan that is included in HB 977 is the creation of an association to control expenses incurred through the provision of catastrophic illness coverage. All health insurance carriers would participate in the association and thereby share the risks of the plan. The state would cover the losses of the carriers by allowing them to deduct any losses taken from their tax liability to the state.

There would be three different categories of plans that employers could provide. Insurance carriers could develop several different options for employers to chose from within each category. However, an employee could not pick and choose which items he or she would like his insurance to cover, rather, he or she would have to choose one of the preplanned packages that the insurance company or the employer would present to him. $250,000 would be the maximum life time benefit.

Mr. Ingrassia stated that Alaska might want to consider mandating that all plans include "chemical dependency" coverage as well as coverage for alcoholism. The plans cover treatment for "conditions" such as pregnancy, obesity, etc., as well as coverage for illnesses and diseases.

There would also be a state plan providing minimum benefits that an individual could pay for if he could not find someone to cover him because he had a heartattack or some other serious illness that no one wished to provide further insurance against.

1300 Rep. Miles left the Committee.

The self employed would be covered because they would also qualify for the state plan since they would not be getting a plan from their employer in the private sector.

There would also be a provision in the Act that would allow employees to receive coverage when they are in a period of unemployment.

Mr. Ignassio stressed the point that everyone could get coverage through one form or another, even those who traditionally are not able to because they are high risk investments.

There were several questions from the Committee members on the above subjects. In addition, Rep. Chatterton asked if the Minnesota law was not presently embroiled in a court battle to have its constitutionality determined. Mr. Ingrassia explained that this was indeed the case.

new tape
00 Rep. Munson stated that the Minnesota plan did not require employers to provide insurance but that it required employers to make insurance available.

Mr. Ingrassia stated that there has not been a major influx of people into Minnesota to profit from the Act. This had been a fear before enactment that has never materialized.

There were other questions, and the meeting was eventually adjourned for lack of further time to carry on the discussion.

Mr. Ching stated that he was not very optimistic about national health insurance legislation passing Congress because there are too many diverse geographical interests to resolve. Rather, he feels that states should attack the problem on their own and that if a plan does develop that would benefit the country as a whole, then that plan can be lobbied for on a national level. He reiterated his earlier point that maybe the Alaska plan will develop into a prototype for national legislation, or for implementation on a statewide basis in other states. He stated that only time would tell, however, if administrative and other problems would develop.

Mr. Ching stated that the Committee was very likely to run into opposition from insurance companies and that he did not think that there was any way to avoid it.

The Chair asked if there were any people about on the teleconference network that would like to ask a question of Mr. Ching. A person from Nome asked why state employees were exempted from the Act. Mr. Ching stated that they are already covered under a program designed especially for state employees.

1000 Rep. Hurlburt left the Committee room.

Mr. Ching stated that if there was any further assistance that the State of Hawaii could offer in the area of administration of the program or in any other area, it would be forthcoming.

The Chair asked if there was anyone in the audience in Juneau who wished to testify. Since no one responded, the meeting was adjourned.

MINUTES
House HESS Committee
4/1/80

Members present:

Buchholdt, Chair
Munson
Chatterton
Miles
Beirne
Hurlburt

00 The Chair brought the meeting to order. The meeting consisted of a hearing on HB 977, comprehensive state health insurance, that was broadcast over the teleconference network.

95 Donald Ching, Hawaii State Legislator

Mr. Ching came from the State of Hawaii to talk about the similarities and the differences between the existing Hawaii statute and HB 977. He prefaced his remarks by stating that HB 977 was comprehensive and "far reaching" and that it could represent an answer to the people's problems regarding health insurance. He stated that the following provisions were what made the bill comprehensive and more complete than the Hawaii statute: (1) coverage for employee dependents, (2) medicare coverage, (3) coverage for the uninsurable, (4) the establishment of a joint underwriting association, and (5) the allowance of deductibles.

Mr. Ching explained that the Hawaii statute was currently under litigative attack by Standard Oil Company. That suit is presently before the 9th Circuit Appeals Court.

He noted that Hawaii had set up a supplementation fund to pay premiums for employees unable to meet that obligation. He stated that that fund had hardly been touched and that through its investments it had made over $800,000 for the State of Hawaii. He used this as an example of how little money the Hawaii statute was costing the state. He stated that employers pay the biggest chunk of the health insurance costs in Hawaii.

There was a discussion about the fact that around 97% of Hawaii's population is covered by some type of health insurance.

Rep. Hurlburt asked if natives would be able to opt out of the Alaska plan due to existing coverage by the Indian Health Service. Mr. Ching stated that it was his understanding that that would be a "political and social" decision that the Alaska legislature would have to make and that costs would need to be taken into account. The Chair explained that native groups had indicated that they would introduce an amendment to the Act to have the Act treat them as individuals, not as members of a racial group, so that they could receive coverage under it.

Rep. Chatterton asked about dependent coverage. Mr. Ching explained that employees who wish to have dependents covered must pay for the additional premiums themselves. However, he noted that most employers will pick up this tab for their employees.

80C Rep. Miles left the Committee room.

Rep. Beirne asked if Mr. Ching thought that Alaska, given its oil wealth, should pick up 100% of the cost of the bill. Mr. Ching cautioned that the legislators should provide as much as they could, but that they should not get themselves into a position that they could not extricate themselves from without extreme political costs. He stated that they should provide a level of funding that they could support in the bad times as well as the good. "Don't pay too much of the tab in the beginning...", he stated, "you can still be heroes further down the road."

Angie Hague, National Association of Social Workers

She stated that she did not have sufficient time to review the bill but that she supported timely reimbursement of payments to providers of services, dental, prenatal and high risk coverage, coverage for the medically needy, and buying private insurance with medicaid funds.

Penny Hladna, Anchorage

Ms. Hladna supports provisions for the medically needy, alcoholism treatment, routine exams, high risk, cash advance and interest. She also stated that doctors routinely refuse to handle medicaid patients.

Gordon DePew, Fairbanks Life Underwriters Association

Mr. DePew was angry that he had not been informed about the bill; he stated that he received the legislation summary by accident. He said that it was the most inflationary piece of legislation that he had even seen and that it called for coverage exceeding mandatory coverage in six states. He said that the bill woud bankrupt employers. He said that mandatory coverage in a state with so little population would mean that many insurers would leave the state and that small companies would go under.

Bernie Barr, International Rehabilitation Association, Anchorage

Mr. Barr was curious about what coverage for rehabilitation services would be provided. Debby Behr, from H&SS answered that she thought that physical therapy and similar services would be covered.

Gil D'Ihnorente, Anchorage

Mr. D'Ihnorente complained about the short notice given for the hearing. He stated that insurance rates would rise by $100-150 per person.

Candice Berry, Welfare Rights Organization, Anchorage

Ms. Berry voiced her support for the bill. She stated that uninsured poor women currently suffer the most and that only 6% of ob-gyns accept medicaid patients.

Pudge Kleinkoff, National Association of Social Workers

Ms. Kleinkoff supported coverage for poor and otherwise needy people. She stated that she would like to receive a copy of the bill's fiscal note. She also questioned whether coverage for the medically needy would elimiate their coverage under General Relief Medical.

Frank Austin, CEJ, Black Caucus, Anchorage

Mr. Austin endorsed the concept of the bill and stated that he would try to write a position paper for the Committee.

Susan Johnson, Chris Billington, NOW

The witnesses voiced their support for the bill.

Nancy Lander, WPA

Ms. Lander expressed support for the bill. She stated that it should include coverage for mental health problems.

1437 The meeting was adjourned.

MINUTES
House HESS Committee
4/1/80
evening session

Members present:

Buchnoldt, Chair
Munson
Miles
Beirne
Chatterton
Barnes

1219 The meeting consisted of a teleconference on HB 977, an Act providing comprehensive health insurance for the state.

1264 Bill Weimer, Anchorage

Mr. Weimer proposed comprehensive health and dental programs that each citizen would be enrolled in. The programs would be subject to competitive bid proceedings and the state could pay monthly premiums. If there was an adverse impact on employers, state could provide some form of supplementation. This would be a way to distribute the state's wealth equally. Processing of the bill in Alaska would provide more jobs.

There was discussion between the members, the audience and the witness about how much oil wealth the state really has, and how much of it should be spent on health insurance.

Nick Noll, Fairbanks Eye, Ear, Nose & Throat Clinic

Mr. Noll stated that he hadn't had enough time to review the bill.

The Chair asked if he could send written comments, when he has time, especially regarding the proposed medicaid plan and how that would effect the present payment system.

Donald Thieman, Fairbanks Medical Association

Mr. Thieman stated that he had so little notice on the bill that he hadn't had time to prepare any comments.

Chris Beardsly, Providence Hosp., Anchorage

Ms. Beardsley stated that she had just received the bill but she made several comments anyway. She said that it seemed that some employers' liability for premium and withholding payments would be greater than others because of the discrepancy in wage levels. She also stated that the Medicaid sections would reward the physicians and that further work was needed to improve this section. She made several other comments and stated that these would be incorporated into a position paper which she would present to the Committee.

David Mather, Tanana Chiefs Conference

Mr. Mather stated that he had only had time for a cursory review of the bill, but that he very definitely supported its goals.

new tape

Margaret Wolfe , Anchorage

Ms. Wolfe noted that the bill would exclude outpatient mental health care coverage. She also stated that small employers would be severely impacted by the bill. She said that she supports a penalty for late payment of premiums.

page two.

He said that there may be a problem finding enough domestic carriers in the state to provide enough competition to bring about reasonable insurance rates for employers.

new tape 00 There would also be problems with having outside carriers, in terms of getting immediate payments to providers.

There would be cost problems with this outside carrier situation, and also cost problems for the employers.

He concluded his remarks by stating that there may also be other conflicts of law which called for further research, including the possibility that Blue Cross could be excluded from providing coverage in Alaska if HB 977 was enacted.

200 Rep. Miles left the Committee room.

Mr. Koch provided testimony for the Committee that consisted of a section-by-section analysis of the bill. He noted several areas of proposed language change and suggested several interpretations for policy changes that the bill would bring about. He was unable to complete his analysis because of time constraints, and so the Chair asked him to come back and continue his analysis at another hearing. He completed comments on Section 1 of the bill, only.

1350 The meeting was adjourned.

MEETING
House HESS Committee
4/2/80

Members present:

Buchholdt, Chair
Chatterton
Munson
Miles

The meeting consisted of a public hearing on HB 977, an Act providing comprehensive health insurance on a statewide basis.

1442 Don Koch and Jim Jordan, Division of Insurance, Dept. of Commerce

Mr. Koch stated that the Division is not in favor of the bill although it applauds the concept of providing health insurance for all Alaskans. He stated that though the bill was like Hawaii's and Minnesota's legislation, combining those two states' plans and adding a new "Alaskan" section made the bill entirely different from either states' plans and allowed for very little comparison between the other states' plans and HB 977. He stated that the experience of the other two states would not be the same as what would happen in Alaska if HB 977 were enacted.

Mr. Jordan then made several statements to the Committee, addressing several problem areas of the bill from the Division's point of view. He stated that litigation pending against the Minnesota and Hawaii statutes involved issues that were also addressed in HB 977. This would mean that if enacted, HB 977 could also be subjected to litigation. The Hawaii suit centers around who can be considered a self insurer and therefore exempt from the law.

Mr. Jordan brought up two areas of statutory conflict that would be created by enactment of the bill. He said that creation of an underwriting association would conflict with existing law that states that a group may not form for the purpose of becoming insured. The other area of conflict involves the proposed provision to give the director 90 days to certify qualified plans. This conflicts with an existing statute stating that the director can have only 30 days to complete filing of forms.

He further stated that the provisions for determining amounts of employers' contributions to pay for the health insurance are discriminatory. Also, the method of making a determination would be cumbersome, time consuming and costly for the employer.

He said that there could be a problem with a couple that could receive dual coverage. One partner could work for the state and get coverage and the other could work for a private employer and also get coverage. Since coverage in both instances would include dependents, both people would be covered twice. They could conceivably get 100% of their health costs paid under dual coverage, instead of the 80% allowed. They would have to pay double premiums, but conceivably this could be worth it to them if they would get all their health care costs paid.

He stated that the term "prepaid health care" as used in the bill should be changed to provide more specific language to better mesh with the provisions that the phrase is currently found in. The same comments were made about "defray or reimburse".

He asked how employers would be able to comply with the President's wage guidelines and comply with HB 977.

He noted several problems with the premium supplementation section of the bill. He stated that the section may provide payments too late and that there was not enough data to know how often and how much supplementation would be necessary.

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

SUMMARY OF HEALTH CARE LEGISLATION
HB 977

The first section of the bill requires employers to provide health coverage for their regular employees and to pay at least 50% of the premium cost of such coverage. The health coverage must meet or exceed the standards for a "number two qualified plan" as established in the second section of the bill, and must cover the employee's dependents as well. The employer may choose the type of health plan (insurance, self insurance, medical service contract, etc.) and the carrier, provided that employers with 100 or more employees offer each employee a choice of an insurance type plan or a health maintenance organization contract, where a health maintenance organization exists. The employee's share of the premium is automatically withheld from his or her paycheck and may not exceed the amount the employee would have paid if the employer had chosen the most prevalent type of health care plan in the state. The employer is obligated to continue paying his or her share of the premium even if the employee is sick and unable to work, for up to three months or the period for which the employer must continue to pay wages, which ever is larger. Any employee who works for at least twenty hours per week on the average, and has been employed for at least four consecutive weeks, is to be covered. If the employee has health coverage from another source, such as another employer, a government program, or coverage as a dependent under someone else's health plan, the employer is not liable for health coverage for that employee. The bill specifically provides that employees retain the freedom to bargain collectively for health benefits which may differ from those provided under this legislation.

A small employer who can demonstrate undue financial hardship resulting from the mandatory health coverage is entitled to premium supplementation from the state. To qualify (1) the employer must employ fewer than eight employees, (2) the premium for which the employer is liable must exceed 1.5 percent of the total payroll, and (3) the amount that the employer's cost exceeds 1.5 percent of the payroll must exceed five percent of the employer's income from that business, before taxes. A qualifying employer is entitled to subsidy in the amount that his or her costs exceed these standards.

Employers who cover their Alaska employees in a group plan in which the majority of the covered employees are out-of-state and not covered by the act, are given, in section eight of the bill, an additional year to bring the coverage of their Alaska employees up to the standards mandated in the act.

The law mandating employer sponsored coverage would terminate when it is superseded by federal health insurance legislation.

Section two of the bill establishes state standards for "qualified" health insurance plans, and requires insurance carriers to offer qualified plans to all eligible applicants. The bill does not prohibit the offering or sale of unqualified plans. Qualified plans must include benefits for the following: hospital services, professional services rendered by a physician or at his or her direction, prescription drugs, nursing home services, home health agency services, radium, oxygen, anesthetics, prostheses, medical equipment, x-rays and laboratory tests, oral surgery, physical therapy services, medically necessary transportation, well baby care, routine physical exams, multiphasic screening, and other diagnostic testing. The plan must cover at least 80% of the usual and customary charges for covered services, must limit out-of-pocket expenses at least to $3000 per person annually, and may provide a limit on maximum lifetime benefit of not less than $250,000. A number one qualified plan may have a deductible not exceeding $150 per person or $450 per family. A number two qualified plan may have a deductible not exceeding $500 per person or $1500 per family. A number three qualified plan may have a deductible not exceeding $1000 per person or $3000 per family. A qualified Medicare supplement plan must provide coverage of at least 50% of the Medicare deductible and copayment, provide at least 80% coverage of the services required in a qualified plan which are not covered be Medicare, limit out-of-pocket expenses to no more than $1000 per person per year, and provide for a maximum lifetime benefit of not less than $100,000. The director has authority to upgrade minimum benefit standards by regulation.

The act also offers health insurance coverage to high risk "uninsurable" clients under the state plan. The state plan provides number one, number two, and Medicare supplement qualified plans at premium rates which may not exceeed 125% of the average premium for a normal risk individual. To qualify, a person must present evidence that they have been refused coverage which is available to a person of standard risk by at least two carriers. The person is not covered for a preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days preceeding the filing of an application.

All health insurance carriers in the state are required to participate in a joint underwriting association to pool the risk of the state plan, to publicize the state plan, and to reinsure other coverage mandated by the act. Losses incurred by the association due to the state plan are to be covered through assessments on association members proportional to their volume of health insurance business in the state. Assessments on members may in turn offset the income tax or premium tax payable by that member to the state. Thus the state is ultimately liable for the losses incurred by the operation of the state plan. The association selects one carrier to act as its agent in writing and issuing each type of state plan insurance for a period of at least three years, and reimburses the carrier or carriers for their expenses.

The act requires that all group health insurance policies written in the state include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions, regardless of the reason for leaving the group. It also requires that individual policies include a provision that covered dependents may continue coverage following the death of the primary insured, under that or a different contract, without additional underwriting restrictions.

The remaining sections of the bill amend the state's medical assistance programs. The bill provides that the Department of Health and Social Services will purchase health care services for its clients through health insurance policies or through health care service contracts which provide some or all of the services covered by state medical assistance programs.

The bill authorizes the Department to pay a cash advance to providers who serve a large volume of state medical assistance clients. It also requires the state to pay interest on unpaid bills which have been presented by providers which satisfy program requirements for payment. If payment of the bill is delayed more than thirty days from the date it becomes payable, interest is charged at the rate of one percent per month. If payment of the bill is delayed more than six months from the date it becomes payable, interest is charged at the rate of two percent per month.

The bill extends Medicaid coverage to all optional eligible groups under the federal program and expands covered services to include prescription drugs, adult dental care, dentures, physical therapy, prosthetic devices, chiropractors' services, private duty nursing, podiatrists' services, and other optional services under the federal Medicaid program. Eligibility for Aid to Families with Dependent Children and Medicaid is expanded to cover unborn children.

The bill establishes a medically needy program under the state General Relief program. The monthly income threshold for eligibility is set at 150 percent of the poverty guidelines for Alaska, and includes a spend down provision such that a person who is over income qualifies when the amount of their excess income has been spent on medical bills.

LIMITS ON EMPLOYEE SHARE OF PREMIUM COST

Hourly Wage	Gross Monthly Wage (172 hrs.)	Maximum employee share (HB 977) 1.5%	2%	3%
$3.60	$619	$9.29	12.38	18.57
4.00	688	10.32	13.76	20.64
6.00	1032	15.48	20.64	30.96
8.00	1376	20.64	27.52	41.28
10.00	1720	25.80	34.40	51.60
15.00	2580	38.70	51.60	77.40
20.00	3440	51.60	68.80	103.20

WRITTEN COMMENTS TO HOUSE BILL NO. 977

Presented by: Denise L. Knapp, Executive Director
Delta Dental Plan of Alaska

April 10, 1980

First of all, I would like to mention that I was informed of the bill and the teleconference at 5:08 p.m. on Tuesday, April 1, the time of the teleconference. I, therefore, did not have time to prepare a formal testimony. The next day I checked with the Alaska State Dental Society to see if they had received any information on the bill or the hearing, and their response was negative.

I would like to respond to the bill wearing not only the hat of Executive Director of a small company with 6 full-time employees (over 32 hours a week) and four part-time employees (under 32 hours a week but paid more than the minimum hourly wage), but also that of a prepaid dental service corporation (and therefore a member of the insurance industry).

Section 18.12.010. The last sentence of this section indicates the "Number two qualified plan" includes coverage for dependents, but I was unable to find any further reference in the bill as to who is to pay the cost for dependent coverage. This perhaps should be clarified.

Section 18.12.030. This section seems to benefit the part-time, lower paid employee and discourage the incentive of an employee to be full-time and earn a higher salary. Under the approach in the bill, the way I read it, a full-time employee due to the fact of working longer hours, or a long-time employee having worked several years, would be paying a higher portion of the premium than a part-time or new employee. Where then is the incentive for employees to want to stay with a company for a long period of time if they are penalized by paying more premium for the same benefits as a newcomer? As an example,

	Example I Part-time Employee	Example II Full-time Employee
Salary	$5.05/hr.	$7.50/hr.
Number of hours	x 32	x 40
Weeks a year	x 52	x 52
Yearly Salary	$8403.20	$15,600
Bill Percent	x 1.5%	x 1.5%
	$ 126.05	$ 234
Insurance Yearly Premium	$ 457.56	$457.56
One-half	$ 228.78	$228.78
Employee's Portion	$ 126.05	$228.78

Section 18.12.040. Under Delta's present program, there is a 90-day waiting period for eligibility for medical, life, and A,D&A benefits. Changing the eligibility period to four weeks would encourage an individual to join a company just to get medical benefits, and then quit once treatment was completed. In the past few months, Delta has had two employees terminate after two months with the firm. They would not have been eligible for benefits under Delta's program, but we would have been paying for them under your bill, and most likely they would have taken advantage of the benefits and cost the insurance company more money.

Section 18.12.050. By your provision of continuing coverage if prevented from working by sickness, Delta could be paying up to three months for any employees who worked only one and one-half months and up to six years if an employee worked six years before becoming ill. Wouldn't it be better to have the employee transfer to the State risk-plan fund or Medicaid if without sufficient funds to continue self-paying?

Section 18.12.060. Perhaps the decision of which company is prime should be left up to the present insurance industry rule; i.e., whichever company has employed the individual the longest. Is this really the type of decision which should be left up to an employee?

Section 18.12.070, paragraphs (2), (3), and (4). Clarification is needed as to what types of employees are included under this paragraph. Would this be natives covered under the Indian Health Service, or those employees eligible and presently receiving Medicaid coupons? Are State of Alaska employees exempted by this paragraph?

Section 18.12.100. Not all employees wish medical coverage presently under Delta's program; one, because her husband is in the military and another because she says she cannot afford even her share of the premiums. Would this bill make it mandatory for these two cases?

Section 18.12.140. (Do we qualify under 1 and 2?)

Section 18.12.200, paragraph (3) (B) (i). Does this mean that employees treated by the Indian Health Service may not bill for services provided?

Section 18.12.200, paragraph (6) (A). Perhaps the term "restorative appliances" should be clarified. Does this mean dentures and partials? What is meant by the ability to charge a "nominal per services charge"? Is this charged to the patient by the provider, or does this mean an additional charge can be made if the company wishes to add "restorative appliances" as a covered benefit?

Section 21.50.010 (d). If an applicant (I presume applicant is an employer rather than an individual employee) elects not to offer major medical coverage to its employees, would the employees be able individually to obtain major medical at their own cost or by applying to the State "high risk" plan? This is not clear.

Section 21.50.030 (a). Mention is made for the first time of "number three qualified plan". Is this a typographical error, since the employer, as I read the bill, is only required to offer the "number two" or "number one" plan.

Section 21.050.030 (a) (1) (I). Would "prostheses" include dental prosthesis such as dentures, partials, or bridges? Typically the medical insurance carrier would not cover such services under its program.

Section 21.50.030 (a) (1) (L). Oral surgery of the "gums and tissues of the mouth" would mean periodontal surgery to Delta. Is this what is intended? Normally in the insurance industry, this type of service is not covered by the medical carrier. It would only be included in dental insurance coverage.

Section 21.50.030 (a) (3) (B) and (C). Inclusion of coverage for annual physicals and multiphasic screening would raise the insurance rates to an extraordinary level, which would be beyond the reach of most employers to pay and most insurance companies to pay, and still keep rates down.

Section 21.50.050. The section on the State Plan Premium could use further clarification of definitions and intent. It is confusing as to whether all employers will be members of the "association" and pay premiums directly to the State Plan instead of an individual insurance carrier. From your "summary", it would appear this State Plan is only for "high-risk" employees; however, I did not get that from reading the bill itself.

Section 21.50.070 (b). Lines 6-10 on page 19 appear to be contradictory. On the one hand, the members of the board may be reimbursed for expenses incurred, but must pay for the costs of conducting meetings themselves. Would they be reimbursed for transportation mileage, hotel plus a per diem? This section needs clarification.

Section 21.050.070 (h). On lines 22-25 of page 20, I question why the "Association" should be allowed to make a 110% profit on expenses of "reinsuring". Perhaps I don't understand the intent of this paragraph, but this is the way I interpret it. Perhaps it needs to be clarified.

Section 21.50.080. Again, I find this section very confusing. Is the "State Plan" an alternative choice for the employer to dealing through a private insurance company directly, or is it only for "high-risk" employees? What about individuals who do not qualify under an "employer" group? Would self-insured individuals be eligible for the State Plan? This is unclear in my reading of the bill.

Under paragraph (e) of this section, are all employers required to join the State Plan even if they have no "high-risk" employees and required then to share the risk for companies who happen to hire "high-risk" employees?

Section 21.50.100 (c). If the writing carrier is to agree to provide these services of administrative and claims payment functions for a period of three years, would there be any provision in the contract for review of the administrative fee paid for these services, or would the carrier be held to one rate for three years?

Section 21.50.110 (a) (2). Again, it is unclear whether only high-risk individuals may enroll dependents under the "State Plan" or whether any employee eligible under the employer group could elect to enroll his/her spouse and children and at what cost to the employee or employer.

Section 21.50.130 (b). This paragraph is unclear. If an individual dies, why would his medical coverage be passed on to his beneficiary, or why would he need extended coverage? If this refers to the life coverage, perhaps it should be spelled out that way?

Section 21.50.200 (3). Definition of dependent includes "a household member who is financially dependent on the primary insured." Is the intent of this to cover a non-related individual who happens to be living in the household of another? This paragraph could be interpreted to mean the "old lady" or "old man" (the popular terminology for the live-in boyfriend or girlfriend) or any friend of the opposite or same sex who happens to be living in the household of the insured. Also, would the employer be required to pay for this dependent, or is this only on "high-risk" individuals?

Section 47.05.070 (a) and (b). Is the intent of this section to have employers with employees presently on medical assistance receive the employee's portion of the premium from the State? If the employer is paying for a portion of the medical benefits for a Medical Assistance eligible person, does that mean the individual who is working will no longer be on Medical Assistance? If they can continue receiving free benefits through the Medical Assistance coupon, what is the purpose of having the employer cover them also through a private carrier?

Section 47.05.090. As the fiscal intermediary for the dental portion of the State Medicaid and General Relief Medical programs, we applaud this section. However, in Delta's case, we would like to see the State consider paying interest to Delta when Delta is not reimbursed within 30 days of its billings to the State.

Section 47.07.030. Benefits added include "dental services and dentures" and "prosthetic devices". Does this mean the same dental services presently available to children under the Medicaid program, except with the addition of dentures? Or, does it mean all "dental services"? We personally feel partial dentures should be covered, but not porcelain/gold crowns or fixed bridges. Also, periodontal surgery and orthodontic services should be limited to only the most severe cases. If all the aforementioned services were included in a State funded program, it could bankrupt the State and the taxpayers.

Overview - Mandatory health insurance is a good concept and it is evident a lot of thought and time have gone into this bill. However, mandatory health insurance, to the extent written into this bill, will jeopardize the free enterprise system in that many companies would be unable to afford to provide this maximum coverage. May we suggest a minimum benefits coverage excluding some of the services written into the bill. If the employer wishes to offer more, he could do so. If the employee wished to purchased additional coverage, it would be optional, but could be handled through payroll deduction by the employer and require one-year's signup.

Apr. 11, 1981

Dear Rep. Buchholdt:

If this letter is in time to be made a part of the public testimony concerning HB 977, I would like for the paragraphs marked to be entered. If not, I hope you'll take a few minutes to read the letter and the enclosed article.

Thank you,
Eileen Herring

April 10, 1980
Anchorage

Rep. Bill Parker
Bouch V
99811

Dear Bill;

Thank you for taking the time to tell me about HB977 and for soliciting my comments. It is an area of great concern to me, as you know, and I welcome the opportunity to opine.

I think that the measure is well-intended but poorly conceived. Insurance is not the way to improve health care because the problem goes much deeper than that. The reason that health care is so expensive is that it is controlled, almost monopolized, by a single profession, that of the M.D.'s, who have a strong political organization, the A.M.A. The A.M.A. runs doctors, runs medical schools, collaborates with pharmaceutical companies to lobby Congress, collaborates with insurance companies, and generally acts to keep power within the M.D. profession. Until this conglomerate is dealt with in some way, health care will not improve.

You're probably aware that there's a growing grass-roots movement, loosely known as the holistic health field, making a vigorous, though uphill, struggle to provide viable and professional alternatives to the power monopoly in health care. A person wanting to improve health care for the public would do well to support this movement, especially since the holistically-oriented treatments are often much cheaper and more effective than those of the medical establishment.

HB977 unfortunately plays right into the hands of the power maniacs. Insurance policies only cover certain "acceptable" modes of treatment, administered in the usual manner by the usual "acceptable" M.D.'s. Giving a whole lot of people a chance to get the standard treatments for free or cheap will just send a lot more business and money their way. It will leave chiropractic and naturopathy and some other struggling professions out in the cold, dealing them a low blow while strengthening the position of the monopoly that is getting rich on illness.

Since I'm working real hard at becoming a naturopathic physician, you can understand my absolute opposition to HB977. You might like to know that there is a group of naturopaths in Alaska who are working for the establishment of a naturopathic licensing board in this state. If you want to help get cheap and effective professional medical care to the proles, support this effort.

I am enclosing an article written by someone much more knowledegeable and articulate than me. The man's a genius, so please read it. Then sit down and figure out a new plan.

The health care problem is serious and pervasive and will not be solved by passing a bill. HB977 would do more harm than good, and I think we can do better. Thanks for listening.

Sincerely,

Eileen

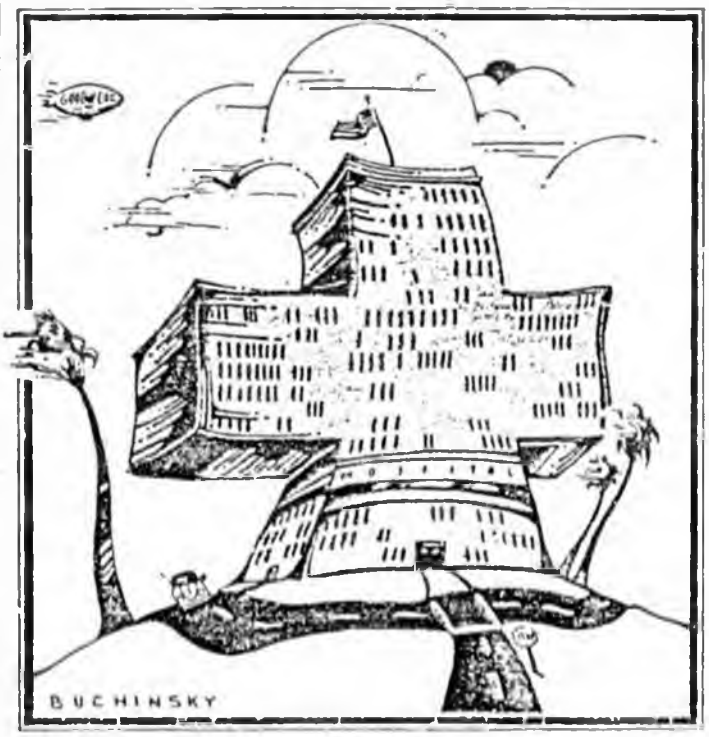
cc: Thelma Buchholdt
Mike Beirne

Eileen Herring
3407 Peterkin St. #4
Anchorage 99504

Mother's Healer

YOUR HEALTH AT TOO HIGH A PREMIUM

by Hugh Drummond, M.D.



SOME FORM OF national health insurance seems inevitable. It has been an almost sacred tenet of American liberalism since the New Deal. The Great American Center has shifted its hemorrhoidal bottom in this direction, and even organized medicine has begun to calculate the finger-lickin' goodies involved in a $60 billion-plus federal program.

Insurance is, of course, the American way of dealing with life's terror. No institution better describes a population trying to save its ass. It is a vestige of the medieval myth that moats and castle walls could keep out the plague. Insurance buildings are designed to convey immortality; steel and granite, sheathed in glass, they are meant to look like the executives who minister to them—vigorous, phallic, Apollonian. If God should break his contract with Noah, those buildings will endure the flood to pay the claims of a well-covered, if dead, constituency.

So it is inevitable that as we grow more anxious we will develop a form of universal health insurance, propped up by the federal government and its corporate underpinnings. About the only people left who are opposed to it are a few herbalists and that peculiar gaggle of paranoids on the Left and the Right, who cannot believe that anything compassionate or rational can emerge from the heart of this nation.

I have great respect for paranoia. So let me count myself among the crazies this time and suggest that, like the massive public housing projects that were another vision of American liberalism, national health insurance as currently conceived will someday be subjected to euthanasia.

Health insurance is really not health insurance at all, but sickness insurance. The major premise behind it is that we are all terrified by cancer and heart disease, which can be treated by such techniques as transplants, by-pass procedures and radiotherapy. These are enormously expensive technologies that the government will be expected to underwrite.

Overlooked are the pervasive diseases of the young and poor, such as lead poisoning, which affects a quarter of the kids in low-income neighborhoods, and malnutrition, which affects even more. Insurance doesn't touch these problems because their control has to do with social and environmental conditions. You can't fight hunger with pocketa-pocketa machines in medical centers.

In fact, when you get right down to it, you can't stop cancer and heart disease that way either. They are just as much social and environmental diseases as they are medical ones.

Since 1900, the ratio of cancer deaths to all deaths has increased five times; the same is true for heart disease. Together they will kill more than half of us. It is calculated by the American Heart Association and the Department of Health, Education and Welfare (HEW) that in a life of 65 years, we lose 1,300 days for being 25 per cent overweight, 1,800 days for living in a city and 3,300 days for smoking a pack a day. Yet we have virtually no information on the relative impact of bad housing, polluted air and water, Muzak and Twinkies. If we did, we would know we were losing the battle.

To really stop cancer we would need to control all industrial pollutants, such as asbestos, vinyl chloride and sulphur dioxide. The huge numbers of synthetic additives poured into our bodies every day would have to be eliminated. If we wanted to control heart disease we might have to do something about unemployment, which has been documented to increase nor-epinephrine and cholesterol excretion to murderous levels. We might also have to eat less, drink less, smoke less and drive less. If a serious effort were made in this country to prevent cancer, strokes and heart disease, the economy would collapse—a fact not lost on the pilots of the empire, many of them now supporting some form of national health insurance.

There have been amazingly few studies on the actual "outcome" of medical care in this country, but when they have been done the results are invariably depressing. A Johns Hopkins University doctor found that only 27 per cent of emergency room patients at Baltimore City Hospital received effective medical care. When the doctor's superiors insisted that the results would be radically different at a more "prestigious" hospital, namely Johns Hopkins, the doctor checked out the patients there who had gastrointestinal symptoms. He found that only 28 per cent of these Johns Hopkins patients received quality treatment. In other words, more insurance will help more people get lousy care.

With Medicaid and Medicare, the forerunners of national health insurance, the more we spent the less we got. In the first year of the programs, doctors' fees rose two and a half times as fast as the cost of living. In the last two years from September 1974 to September 1976, physicians' fees rose 23.3 per cent, while the Consumer Price Index increased by only 13.7 per cent. According to a report released in February by the Health Research Group, Medicare and Medicaid pay out more than $6 billion yearly in doctors' charges. Hospital costs have climbed even faster—a four-and-a-half-fold increase since the programs started. Where did all the extra money go?

Not to new services; there were hardly any of those. A lot of doctors got richer. There was expensive and "interesting" medical technology to utilize, such as the hyperbaric chamber at Mount Sinai, which is operated on an average of only once or twice a day. The money

spent on buying and running it could finance 20,000 outpatient visits a year, or a huge lead poisoning program in East Harlem. But that's not as much fun. Unfortunately, there is no assurance that similarly wasteful health care programs will not be funded by massive national health insurance.

Upper-level hospital personnel increased their salaries as the federal programs took hold. Hundreds of thousands of dollars were spent in efforts to prevent hospital employees from organizing unions. Much of the extra money went for outrageously expensive drugs and supplies. As long as the government was willing to underwrite the cost, the hospitals and doctors didn't care. Most of them welcomed the bucks the federal bonanza brought, no longer convinced that their salaries would decrease under the "socialized medicine" of Medicare and Medicaid.

And for the people the programs were supposed to serve? More people had access to bad health care. But one-third of Americans living below the poverty level remained untouched by Medicare and Medicaid. There was still no medical care for the poor. Enter national health insurance.

With national insurance, the $140 billion-a-year health industry could *really* rake it in. There would be the kind of guaranteed security the defense industry enjoyed during the height of the Cold War. Just think—no more people skipping out on their bills. The whole country as paying customers, and for each person, another prescription filled out, another piece of hardware needed, another disposable whatnot disposed of.

Under national health insurance, the poor still will not have quality medical attention. The health care system is not radically changed under the program, only subsidized fully. There will be no improved doctor-patient relationships, no health clinics that are community controlled. National health insurance does not mean better hospitals, with staffs responsive to the special problems of poor people. No fundamental change for the rich either. As usual, they will buy their way to priority.

We can also look forward to the government entering into some sort of alliance with private insurance companies, as it has with Medicare and Medicaid. Blue Cross is the leading contender for the job of administering a national health insurance system. That's the same Blue Cross that has allowed runaway hospital fees to multiply in the last ten years, while the average length of hospital stay has *decreased*. You might be interested in knowing that Blue Cross is controlled by the hospitals themselves. The hospitals created it during the Depression to ensure that their bills were paid, and you can be sure that with national insurance, hospital bills—no matter how ridiculously high—will be found "reasonable" by Blue Cross.

> "With national health insurance, the $140-billion-a-year health industry could really rake it in—as the defense industry did during the Cold War."

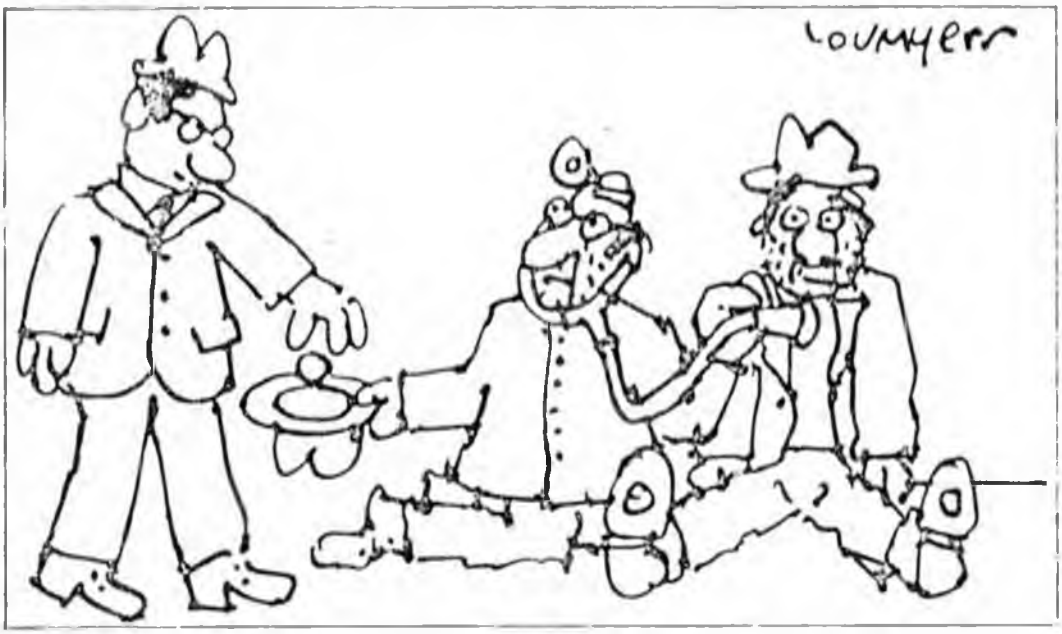
My real anxiety about national health insurance isn't only economic; it is philosophical. There is something wrong with a social policy that so irrevocably consigns to a single profession something so subtle and profound as human health. For all the wonders of Western medical science, it has no understanding of and little interest in the meaning of health. It is possible that when you set out to "conquer disease," no less than when you set out to "conquer space," you can't win. Western medicine tries to throttle its patients into well-being. It relies on the military model of technology, the invention of hammers and the subsequent search for heads to bang with them. It has only given us a new ecology of disease with the smell of progress.

I am not suggesting that we dismantle all the cobalt units, computer assisted tomographs and heart-lung machines. But national health insurance will retard a more pluralistic approach to health, which might include self-help programs, herbal remedies and even faith healing. Is it antiscientific to permit the existence of activities that may have centuries of traditional practice and pure empiricism behind them? They may be conceptualized in less mechanistic terms than we have been trained to believe truthful. However, dying empires have always insisted that their vision of the truth is eternal when their artifacts barely survive.

Do I have the courage of my own convictions? Of course not. If I awake tonight with a right lower quadrant pain, shall I not call one of my surgical confreres rather than a Navajo healer? Would I deny that preference to anyone else? No. But neither would I deny the preference of someone for a Navajo healer. Yet with national health insurance, like all the other medical programs, Navajo healers will not be licensed to accept government money. National health insurance grants access to one kind of health care, and if a bill is passed, the "right" to medical care established will be a right to bad medicine.

Think of China for a moment. It has brought health to 800 million people, who were as mutilated, starved, infected and demoralized as any who have ever lived. And in that nation, where pragmatism is almost religious, where waste is murder, they brought health to the people with as much respect for the ancient and the traditional as for the modern and innovative.

Needless to say, there were other changes.



If you have any medical or psychiatric questions you'd like Dr. Hugh Drummond to address in this column, please write Mother's Healer, c/o Mother Jones, 607 Market Street, San Francisco, CA 94105.

ESTIMATED PREMIUM COSTS FOR NUMBER TWO QUALIFIED PLANS[1]

Individual Plans - Employee Only	Minnesota Rate November 1979 (Quarterly)	Area Differential[2]	Est. Rate in Alaska (Quarterly)	Est. Rate in Alaska (Monthly)
low: Blue Cross/Blue Shield, Male age 20-24	$31.47	+12%	$35.25	$11.75
high: State Farm, Male or Female age 60-64	214.40	+ 7%	229.41	76.47
Average of 5 carriers[3], Male age 35-39	55.42	+11%	61.52	20.51
Average of 5 carriers[3], Female age 35-39	87.13	+11%	96.71	32.24
Individual Plans - Employee and Dependents				
low: Blue Cross/Blue Shield, M 20-24 + F 20-24 + children	$128.27	+13%	144.95	$48.32
high: State Farm, M 60-64 + F 60-64 + children	487.68	+ 7%	521.82	$173.94
Average of 5 carriers[3], M 35-39 + F 30-34 + children	185.80	+11%	206.24	$68.75

Group plan premiums are roughly 8% less than individual plan premiums.

1 The Minnesota minimum standards for a number two qualified plan are the same as those specified in HB 977 except that the requirements for coverage for well baby care, physical exams, and multi phasic screening have not yet taken effect in Minnesota, and Minnesota does not cover medically necessary transportation (other than an ambulance) or treatment for alcoholism or chemical dependence.

2 Derived from the area schedule of premiums of the CARE group insurance trust for all Alaska and for Anoka, Dakota, Hennepin, Ramsey, and Washington counties in Minnesota.

3 Blue Cross/Blue Shield, Prudential, State Farm, National Farmers Union, and Massachusetts Mutual. This is a straight average and not a weighted average. Since Blue Cross/Blue Shield has by far the lowest rates and covers 96% of the people covered by these five Minnesota carriers, the straight average used here is substantially higher than the weighted average would be.

a bitter pill to swallow...

Issues In Health Care Financing

MAY 8-9, 1980
NEW ORLEANS

National Conference
of State Legislatures

ISSUES IN HEALTH CARE FINANCING

MAY 8-9, 1980 — NEW ORLEANS, LOUISIANA

The National Conference of State Legislatures will hold a seminar on "Issues in Health Care Financing" at the Monteleone Hotel in New Orleans, Louisiana on May 8-9, 1980. This meeting is supported in part by a grant from the Health Care Financing Administration, U.S. Department of Health and Human Services (formerly U.S. Department of Health, Education and Welfare).

Public officials at the state level continue to face demands for action on a number of important issues in the health care field: the high rate of inflation; the provision of services to the elderly and disabled; protection against the catastrophic costs of a major illness; and access to care for the medically underserved, both rural and urban. This conference will focus on these major issues and some solutions that the states have developed to deal with them. Key legislators and administrators involved in the enactment, operation and oversight of these programs will serve as seminar faculty.

This program promises to be a useful tool of assistance for legislators as they deal with these and other important health financing issues.

The NCSL has reserved a block of rooms at the Monteleone Hotel, located in the New Orleans French Quarter at 214 Rue Royale. The main hotel telephone number is (504) 523-3341 and the toll free number for reservations is 1-800-535-9595. When arranging for hotel accommodations, please indicate that you are attending the NCSL "Issues in Health Care Financing" Seminar to receive the above conference room rates. The following are rates for the block of rooms NCSL has reserved:

SINGLE ROOM: $48.00 DOUBLE ROOM $56.00

EACH PERSON IS RESPONSIBLE FOR CONTACTING THE HOTEL AND MAKING NECESSARY ARRANGEMENTS FOR HOUSING. RESERVATIONS MUST BE MADE NO LATER THAN APRIL 16, 1980 AND WILL BE HELD ONLY UNTIL 4:00 P.M. ON THE DAY OF ARRIVAL. If you do not plan to arrive by 4:00 p.m., you must guarantee your room for late arrival. If you guarantee your room and do not arrive or fail to cancel your reservation, you will be responsible for payment of one night's stay. NCSL can not be responsible for any guarantees.

Registration Fee: $ 75.00—Legislators and Legislative Staff
$150.00—Non-Governmental Persons

The registration fee is payable in advance of the seminar or due at registration. NCSL cannot bill you or your legislature without advance approval. Expenses of attending an NCSL seminar are deductible for income tax purposes if the "taxpayer is benefiting or advancing the interests of his trade or business by such attendance."

For additional information contact Russ Hereford or Susan Ponder with NCSL, 1405 Curtis Street, 23rd Floor, Denver, Colorado 80202—(303) 623-6600.

AGENDA

Thursday, May 8

8:45-9:00 am	**Welcome and Introduction**
9:15-9:45 am	State Legislatures' Interest in Health Care Financing
10:00-12:00 am	Approaches to Health Care Cost Containment: Competition vs. Regulation
12:00-2.00 pm	Luncheon and Luncheon Address: The Federal Role in Health Financing
2:15-4:15 pm	**TRACK A:** Long Term Care: Nursing Home Reimbursement; Alternatives to Institutional Care
	TRACK B: Catastrophic Health Insurance: Overview of Issues; State Approaches

Friday, May 9

9:00-9:15 am	**Introduction to Day's Activities**
9:15-11:45 am	**TRACK A:** State Hospital Cost Containment Programs: Overview of Efforts; State programs
	TRACK B: Health Manpower: Federal Activities Impacting on the States; State Programs
12:00-2:00 pm	Luncheon and Luncheon Address: Congressional View of Health Financing
2:00-3:00 pm	**Closing Session**

The National Conference of State Legislatures, the official representative of the country's 7,600 state legislators and their staffs, works to help lawmakers meet the challenges of the complex federal system. Headquartered in Denver, Colorado with an office of state-federal relations in Washington, D.C., the NCSL is a nonpartisan organization funded by the states and governed by a 43-member Executive Committee.

The NCSL has three basic objectives:

To improve the quality and effectiveness of state legislatures.

To assure states a strong, cohesive voice in the federal decision making process.

To foster interstate communication and cooperation.

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Earl S. Mackey
Executive Director

Please reserve accommodations as indicated

NAME _____

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BUSINESS MAILING ADDRESS _____

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BUSINESS PHONE (Area Code) _____ NUMBER _____

Reservations must be received no later than April 16th and will be held only until 4:00 p.m. on the day of arrival. Later arrivals must have first night's deposit. (Checkout time is 1:00 p.m.)

DATE ARRIVING _____ HOUR _____ AM PM

DATE DEPARTING _____ HOUR _____ AM PM

☐ SINGLE—$48.00 ☐ DOUBLE—$56.00

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MAY 8-9, 1980

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HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO NEW YORK WASHINGTON

LEGAL DEPARTMENT
Charles D. Kuhnen, *Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 322-0800

April 15, 1980

The Honorable Thelma Buchholdt
Chairman, House Health, Education and
Social Services Committee
Alaska House of Representatives
State Capital
Juneau, Alaska 99811

Dear Representative Buchholdt: Re: Alaska H.B. 977

We wish to thank you for sending us a copy of this bill, which arrived only last week because of its recent introduction.

Portions of this bill are of vital interest to health insurance companies. I would be there to testify on the bill, but for a recent injury which temporarily prevents me from traveling. I am sorry to miss the pleasure of visiting Juneau again, and of testifying again before your committee, as I did last year in connection with a bill on another subject.

I would appreciate your including the attached HIAA Statement on H.B. 977 in the record, and, if possible, providing copies of it to committee members.

Sincerely,

Charles D. Kuhnen
Counsel

CDK/erc
enclosure

STATEMENT
of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
concerning
ALASKA H. B. 977 ESTABLISHING
A STATE MAJOR MEDICAL INSURANCE PLAN

The Health Insurance Association of America is a trade association consisting of 311 insurance companies which write 85% of the health insurance written by insurance companies in the United States.

We are opposed to this bill, which is badly conceived and poorly drafted. We believe that its enactment would have serious adverse effects on the Alaska business of insurance companies, causing many insurance companies to stop writing health insurance in Alaska, to the detriment of Alaska residents.

Our remarks are directed to Sections 1, 2, and 8 of the bill, which are the sections affecting insurers. We understand that your Insurance Department has prepared a detailed analysis of the bill's section-by-section defects, and so our remarks will mostly be of a more general nature.

GENERAL PLAN

The general plan of the bill is to require employers of one or more regular employees in Alaska to provide at least a specified level of medical expense benefits, through a prepaid health care plan contractor, to employees and their dependents, with the costs shared by the employees (Section 1 of the bill). Health insurers would be required to make available to employers (if the insurers write group health insurance) and to individuals (if the insurer's write individual health insurance), three specified ("qualified") plans of major medical expense insurance, and must add to any health insurance policy which is not a "qualified" plan a fourth plan of specified benefits, unless the "applicant" declines it (Section 2 of the bill). There is a fifth standard plan for qualified Medicare supplements. There would also be a State Plan for persons not otherwise insurable at standard rates for qualified plan benefits, under a pooling arrangement funded by health insurers and self-insurers, with a tax offset for the inevitable losses of the pool (Section 2 of the bill).

The purpose of these sections of the bill seems to be to provide more major medical insurance to Alaska residents, by requiring all health insurers to furnish major medical insurance, by requiring certain employers and their employees to purchase it, and by requiring a pool for substandard risks.

GENERAL COMMENTS

Section 1 of the bill is derived from a Hawaii law. That law, together with a premium tax differential between insurance companies on the one hand, and Blue Cross-Blue Shield and the Kaiser HMO (Health Maintenance Organization)

plans on the other, makes it virtually impossible for insurance companies to compete for qualified plan business. There is likewise a substantial premium tax differential in Alaska between insurance companies and Blue Cross-Blue Shield. Alaska has no HMO's.

Section 2 of the bill is derived from a Minnesota law, which is the subject of several lawsuits and is on its way to being declared unconstitutional. One case has been tried and the Federal Magistrate who tried the case has, in an 85-page opinion, found the law to be unconstitutional on at least five different grounds. Among other things, the Magistrate's opinion says:

> "The Court is convinced that, in spite of exemplary effort by able counsel, no one knows what the Legislative intended or what this Act really means. . ." Insurers' Action Council Inc. et al. v Heaton et al., U.S. District Court, District of Minnesota, c.v. No. 3-76-440 (p. 84 of the Magistrate's decision dated October 1, 1979).

Some provisions of the law are so impractical that they are being ignored in administering it. Other provisions are confusing. Some qualified plan benefits are so expensive that the Minnesota legislature just recently passed a bill modifying or eliminating them.

Many insurance companies have either writhdrawn from Minnesota, or have stopped or limited their writing of health insurance in that State. Unless the law is finally held invalid, more companies can be expected to do so.

Because of its poor design and drafting the Minnesota law has resulted in much difficulty for the insurance department, insurers, and the courts. The law has never been fully implemented. The State Plan is operating partially (it is not reinsuring insurers or administering qualified plans for them), and incurring substantial losses. That it operates at all is due to the presence in the State of several large domestic insurers, and to the ready availability of qualified people from out-of-State compaines. This ready availability of insurer help is not the case in Alaska, since Blue Cross-Blue Shield has its principal office in Seattle and all the other large Alaska writers have their principal offices even further away.

SECTION 2

1. No law is needed to make major medical insurance available in Alaska. Coverage in a wide variety of plans is already available from a sufficient number of insurers. This includes some plans with higher policy maximums than the $250,000 of HB 977's "qualified" plans.

Most Alaskans are already covered by some type of major medical protection. Persons age 65 or over are covered by Medicare or other government programs.

Of the under-age-65 civilian, noninstitutionalized population, my own rough projection is that about 70% have some form of major medical coverage from insured and noninsured plans. Some of the remainder have government plan coverage (Medicaid, Public Health Service, etc.), a small number are uninsurable as individuals not covered under group plans, and a larger number just plain can't afford it. We think that the subsidy plan in Section 1 will make only a dent in the affordability problem.

2. The insurers which do not write major medical coverage do not have the knowledge or assets to write this broadest, most complex, and costly of health insurance coverages, or have chosen other health insurance coverages as their proper products, or both. If, HB 977 is enacted, any of them writing coverage for hospital, surgical, or medical care will be forced out of the health insurance business in Alaska. We cannot think of a single valid reason for the bill requiring these companies to write major medical insurance.

3. All of the five plans of insurance which section 2 would require health insurers to write are nonstandard -- the three "qualified" major medical plans, the supplementary major medical plan to be added to existing policies, and the "qualified" Medicare supplement plan. While some companies can get by with some of their standard plans on an equivalency test, there seems to be no good reason to disrupt the health insurance business by requiring nonstandard plans of benefits. The bill's major medical plans will not even be the same as Minnesota's, in view of the latter state's recent amendment to the law. Using nonstandard forms just adds unnecessarily to administrative costs, which are reflected in premium rates.

4. The required plans are too expensive.

5. The method of determining State Plan rates is impractical. The corresponding Minnesota statutory provision is not followed by the Minnesota State Plan.

Charging 125% of standard rates for the substandard persons in the State Plan is inadequate, and will always produce losses, as Minnesota discovered. The provision that rates are also to be self-supporting is illusory.

The Minnesota State Plan, together with the costs of the Association governing body, lost $1,000,000 in 1979. We do not know how much in additional costs insurance companies incurred in attempting to comply with the law.

SECTION 1

1. Whoever drafted this section does not know what a prepaid plan is. Insurance companies do not write them, except for a few companies that market

prepaid dental or vision care plans. As a result, insurance companies do not qualify, under the section 1 definitions, as "prepaid health care plan contractors" from which employers can purchase qualified plans. Neither do employers, which cannot self-insure under the provisions of this section.

2. The dual option of proposed section 18.12.030 is impractical in Alaska, because there are no HMO's in the State. Before employers are asked to offer such an option you need a sufficient number of good operating HMO's in appropriate locations in the State.

Self-insurance by employers of HMO benefits is mentioned in paragraph (b) of that proposed section. This is impossible, except for an employer that is an HMO.

If, in the future, you do get a sufficient number of operating HMO's in Alaska so that you then want an HMO option, the requirement should be drafted to be in accord with the amended Federal law on this subject.

3. It seems to us that eligibility for premium supplementation may also be needed by employers of more than seven employees.

4. Where the legislature sets minimum standards for "qualified" plans, these tend to be the standard plans employers provide for their employees (absent a collective bargaining agreement calling a different plan). Insurance companies cannot compete on premium costs with Blue Cross-Blue Shield on standardized benefits where Blue Cross-Blue Shield has substantially lower premium taxes to pay. In Alaska, the premium tax is 3% of health insurance premiums for out-of-State insurance companies (there are no or few Alaska companies which write health insurance). Whereas Blue Cross-Blue Shield pays 6% on the difference between premiums and claims. It is a reasonable guess that major medical claim payments are about 90% of premiums, with a resulting effective tax rate for Blue Cross-Blue Shield of six-tenths of one percent of premiums (.06 times 10% of premiums). This is more than sufficient differential to make insurance companies noncompetitive on premiums which must be charged on standardized major medical plans.

UNCONSTITUTIONALITY

The Federal Magistrate in the case cited earlier involving the Minnesota law found that law to be unconstitutional on several grounds, all but one of which apply to HB 977. Section 1 of this bill, which does not appear in the Minnesota law, may raise additional constitutional questions.

The Federal Megistrate found the Minnesota law to be unconstitutional on these grounds: (1) it violates the due process clause of the constitution by requiring insurers to write major medical coverage, which many of them do not or can not do; (2) it violates the Constitutional provision prohibiting impairment of

the obligation of contracts, by requiring insurers to add major medical coverage to existing policies unless the policyholder declines such coverage; (3) it violates the commerce clause of the Constitution by attempting to regulate policies validly issued outside the State; (4) it is vague and ambiguous and unconstitutionally delegates legislative authority to the insurance commissioner; and (5) denies the required equal protection of the law, because of an amendment (not in HB 977) concerning the pool. The Magistrate also found that there was, as yet, too little experience under the law to determine whether the law was unconstitutionally confiscatory.

The validity of the Minnesota law is also in question on other grounds in other lawsuits which have not yet reached trial.

CONCLUSION

The foregoing critical comments, together with the more detailed ones we expect you will receive from others, should be sufficient indicators that HB 977 is contrary to the public interest and should not be enacted.

Charles D. Kuhnen
Counsel

/erc

April 28, 1980

Mr. Dale Strowbridge
State Liaison Officer
DHEW, Region X
Arcade Plaza Building
1321 Second Avenue
Seattle, Washington 98101

Dear Dale:

I appreciate all your efforts assisting the Department in obtaining HEW comments on relevant pending legislation. I am in need of receiving further clarification regarding the scope of the Medicaid option - diagnostic, screening, prevention, and rehabilitation services. In particular, House Bill 977, if passed would add that option to the State's Medicaid program (see page 33 of the enclosed bill). I have received correspondence from International Rehabilitation Associates, Inc. inquirying whether they would be covered under that Medicaid option. The letter is enclosed for your reference and outlines that organization's services and the background of its employees. Would you please have your Medicaid Bureau review this material to determine whether that new option would cover International Rehabilitation Associates, Inc.?

I appreciate your assistance in this matter. If you need additional information on this inquiry, please do not hesitate to contact me. I would appreciate a response by May 7, 1980.

Sincerely,

Deborah E. Behr
Special Assistant to
the Commissioner

cc: International Rehabilitation Associates, Inc.
Representative Thelma Buchholdt

DEB:lar
bcc: Rod Betit, Division of Public Assistance
Bob Tanna, DHEW

ANHC
ANCHORAGE NEIGHBORHOOD HEALTH CENTER
1217 EAST 10TH AVENUE · ANCHORAGE, ALASKA 99501 · 907-279-9586

April 21, 1980

Thelma Bucholdt
House HESS
State Capital Bldg.
Juneau, Ak 99811

Dear Thelma:

I've been meaning to respond to HB 977 in more detail as it has been on my mind ever since I received the copy of the bill. While I generally agree with the intent of the bill, I've had this uneasy feeling about it and have finally realized the source of my concerns.

The major deterrent to good health care in the United States, as I see it, is the fee-for-service philosophy, which rewards the doctor for performing more as well as more expensive procedures.

Physicians engage in benevolent (for them) price fixing. They set their fees high enough to make a sizable profit, then agree as a group not to let the factors of supply and demand interfere.

Physicians (and hospitals) have institutionalized this practice via the creation of health insurer intermediaries, who have grown so powerful in the health industry that even Senator Kennedy has retracted in the face of their opposition.

In the health field, the federal government (and to a degree, state governments) has legitimized restraint of trade (by allowing physicians to control supply and access), price fixing (by reimbursing providers at the prevailing rates) and boycotts (by allowing physicians to refuse to see Medicaid patients).

While HB 977 has noble intentions, i.e., the mandatory insurance for high risk patients, employees, etc., it institutionalizes:

1) The health insurance industry and creates the potential for a greater political alliance by creating a

mechanism to further their power (The Association) while giving them a cause to rally around (more government regulations).

2) Price fixing. By reinforcing the fee-for-service mechanism, physicians will continue to set fees at a high profit level and health insurers will continue to ally with their clients (the physicians) as opposed to the State's clients (the patients).

3) Boycotts. HB 977 sanctions the present physician boycott of Medicaid patients by placing the blame on the State bureaucracy. There are very few physicians around whose medical school or education is not subsidized by the federal government. It is unconscionable, to me, for them to refuse to treat Medicaid patients.

I oppose the payment of interest or advance payments to physicians to treat Medicaid patients. The money should be put into the State Medicaid office. After my visit with the State Medicaid people in March, I'm convinced that the problem will not be resolved for another 6 - 9 months, in spite of claims to the contrary by the legislature and the Commissioner. They are still understaffed and 6 months behind in their reimbursements.

I feel that the State of Alaska has a chance to really excell in the area of health policy. I think that HB 977 is a very progressive attempt to do just that. However, I think that we can do better and would take the liberty of making a few suggestions.

1) That the legislature proceed with a study (such as HB 793) to investigate new and innovative methods of health care financing. Further, this study should be international in scope, with regards to determining true alternatives to the present methods of financing health care in the United States.

2) That Section 47.05 070 of HB 977 be studied further. While the HMO concept has many inherent limitations, there are a few successful consumer controlled HMO's that may be successful in Alaska (with State subsidy). Certainly Anchorage is a potential candidate and the situation at Alaska Hospital suggests some interesting alternatives. It is my hope that within a year, the Anchorage Neighborhood Health Center will be a candidate for such a program, and potentially a model for attempting alternative sources of health care financing.

Again, I want to emphasize that I basically support the intent of the bill.

I realize that my comments may not be politically palatable, but I still have the hope that Alaska can take an innovative lead in the health policy arena. It is in the spirit of this optimism (and my high regard for you) that I have made these comments.

I know that you will weigh their merit (if any) and political acceptability, and I thank you for the opportunity to respond to the bill.

Sincerely,

Don Bantz
Executive Director

DB/jw

THE UNIVERSITY OF MICHIGAN

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF HEALTH PLANNING AND ADMINISTRATION

ANN ARBOR, MICHIGAN 48109

March 24, 1980

Richard L. Block, Director
Division of Insurance
Department of Commerce and Economic
Development
State Office Bldg.
Pouch D
Juneau, Alaska 99811

Dear Mr. Block:

Please find enclosed a reprint of an article describing a new approach to the structuring of Health Insurance Policy Information. The article describes an information frame based on seven major issues or goals (Table 1, p. 129). There is a preliminary listing of program options to pursue these goals (Table 2, pp. 136-157) as well as identification of problems related to these program options relevant to the other issues. A limited range of possible solutions to these problems so far identified are suggested.

The proposed information frame aims at eventually establishing a health insurance policy information base. It is postulated that when completed, the comprehensive information frame alone would provide a qualitative tool for policy analysis.

Before proceeding with further development of the information frame, I consider it desirable to explore its potential utility. I would therefore appreciate your completing the attached very short questionnaire and returning it as soon as possible. I will arrange for you to receive a compilation of the replies to this questionnaire.

In addition, I would appreciate your comments on the enclosed article once you have had time to go over it. I would particularly like to know whether you might be interested in participating in a review of a first draft of the information frame and, at a later stage, in contributing to the information base.

Yours sincerely,

J. L. de Vries, M.D.

JLdV:jsk
Enclosures

Socio-Econ. Plan. Sci., Vol. 13, pp. 127-140
Pergamon Press Ltd., 1979. Printed in Great Britain

A SYSTEMS APPROACH TO HEALTH INSURANCE POLICY INFORMATION

A PRELIMINARY TAXONOMY OF HEALTH INSURANCE ISSUES, PROGRAM OPTIONS, PROBLEMS AND SOLUTIONS

J. L. DE VRIES and B. H. PERRY
Department of Health Planning and Administration, University of Michigan School of Public Health, Ann Arbor, MI 48109, U.S.A.

(*Received* 20 *August* 1978; *received for publication* 15 *January* 1979)

Abstract—A methodology is proposed for assisting health insurance policy analysts by developing a systems approach to health insurance information and literature. The general approach is to supply a link between the quantitative and qualitative information available, and the analytic needs of policy analysts. There is a great deal of information available, but traditional cataloging and indexing techniques do not adequately meet the policy researcher's and analyst's information needs. The most important of these once goals and limitations are identified, is knowledge of the interrelationships between program options in terms of expected results (problems, solutions) in a wide range of settings.

The key element of the approach used is the concept of an information frame, based on considering health insurance as systems of issues, program options, problems, and solutions with interrelationships explicitly defined. This approach would provide initially qualitative identification of these interrelationships and make them available via a machine readable taxonomy of the components. With substantiating literature references, preliminary work on the building of the taxonomy is based on seven major health insurance issues, and over 70 program options, 325 problems, and 350 solutions so far identified for 170 of the problems. The implementation of this methodology would provide analytically structured information for policy analysts in a format not presently available. The multi-country information to be included would allow consideration of alternatives which might otherwise be neglected. The result would improve an important element of the analytic process, and reduce the lead time required for inquiries by health insurance policy analysts, legislators, health planners and administrators.

1. INTRODUCTION

In a rational model, policy analysis, as a search for ways of determining preferred policies, should be able to consider as many options as possible. Recognition of the desirability of expanding the range of policy options as a means to more rational policy outcomes has led to an increasing interest in cross-national studies. The number of such studies has greatly increased in the past decade and shows every indication of continuing to do so[1]. A recent publication by HEW and NSF indexes some 4000 selected books and articles on the effectiveness and efficiency of alternative programs in health and social welfare[2]. The growing amount of information available in health insurance and health system programs is, however, inadequately structured for easy access particularly with regard to actual experience with various program options.

Thus, the policy analyst is still faced with the task of having to make decisions based on whatever information he is able to assimilate. To the extent that the information can be systematically structured his burden can be lightened. Jay Forrester has maintained that without an integrating structure, information remains a hodge podge of fragments. "When a structure and governing principles for systems have been accepted, they should go far to explain the contradictions, clarify the ambiguities and resolve the controversies in the social sciences"[3].

Faced with the challenge to review health insurance in an extremely concise manner, one of the writers developed for teaching purposes a conceptual listing of health insurance issues, problems and solutions in early 1975. Subsequently this approach was encouraged as well as assisted by the academic environment† of the authors and expanded into a project to establish a systematic information frame for eventual indexing of literature and other reports relevant to health insurance. The usefulness of the information frame was tested by collecting a set of references for application of program options and solutions in several European countries and linking them to the information frame. Eighty-five of these earlier generated solutions were thus verified in practice in various European countries. This trial run proved encouraging as a potentially useful method for structuring information about alternative approaches in health insurance policy in the countries examined. This paper describes an attempt to apply this basic concept of a systematic structure to the organizing of information on comparative health insurance policies. While specific to a particular substantive area, the framework should also be generally applicable to comparative policy analysis.

Comparative policy analysis provides material for evaluating alternatives among possible choices by looking at their recorded or probable effects. Comparative research many times will reveal what is possible under certain conditions rather than what is explicitly desirable

†Special thanks are due to Dean Wilbur J. Cohen and Prof. R. N. Grosse for major contributions to the conceptual development.

or transportable directly to another social setting. The overall goal of the present activity is to improve the decision making process by improving on one important input to the analytic process—comparative information on alternative solutions and problems in health insurance policy. The detailed objectives of the project are as follows:

(1) To establish a computer stored taxonomy of major issues, program options, problems, and potential solutions involved in health insurance policy decisions.

(2) To establish a capacity to identify for health insurance policy analysts qualitative interdependencies among issues, program options, problems and solutions.

(3) To establish a comprehensive identification of actual applications of program options and potential solutions by health insurance systems, within the U.S. and abroad.

(4) To establish a selective listing of references from published literature and annual and other reports of health insurance systems linked to a taxonomy created and coded to indicate the type of information contained therein (e.g. resource requirements, program outcomes, theoretical references, etc.).

2. BACKGROUND

One of the most important health and social policy questions today in many countries is that of the choice of the preferred mode of financing and delivering health care to the population. In the broadest view a country's health insurance scheme is a projection of its overt and covert social goals in all the modes of financing and delivering health and medical care and health related activities, as contributions to overall social welfare. A range of societal goals is involved which often conflict with each other in actual implementation, such as the trade-off between equity and efficiency. While Roemer and Axelrod considered four possible combinations of modes of financing and delivery for *broad* policy consideration[4], many more alternatives could be generated for purposes of mapping a new health insurance system and its actual application.

While some issues and several program options are determined by the social-political environment, other issues and many program options are compatible with different yet related social-political systems, particularly with regard to equity considerations and to incentives and disincentives for both providers and consumers. Furthermore, the commonality of problems encountered in implementing program options and solutions to cope with such problems is probably greater than often recognized, possibly because of the lack of comparative studies.

Because of the close interdependencies among the various possible options and their resultant positive or negative effects, health insurance or health care financing policies which address a single problem, for example easing the financial burden of hospital care only, may fail to achieve these objectives or may even have counterproductive results[5, 6]. Nor can health insurance policy be considered in isolation from many other social service needs and provisions, such as care for the elderly, workmen's compensation benefits, child day care facilities, etc., extending the interdependencies beyond health insurance per se.

The issues, encompassing a complex range of concerns, vary among countries and often within one country. Major obstacles in implementing or managing a health insurance program can arise from neglected differences in socio-political values among sub-groups in a particular society. It is often overlooked that while it is technically possible to impose a uniform health insurance program on a society in which diverse social values are held, value conflicts among competing interest groups may remain unresolved. These latent conflicts are likely later to lead to unplanned consequences of implemented programs (e.g. Medicaid's excessive cost-escalation [7], Canada's growth of hospital beds and their costs over the past two decades[8]). Unanticipated consequences of the sort experienced in the U.S. and Canada are less likely to occur when a very strong, centralized governmental authority imposes one set of values on all. (China[9], U.S.S.R.[10]).

If the need of the policy analyst is correctly postulated as particularly directed to the interrelatedness of program options and their effects, then the scope of much of the available literature does not address itself to that specific need. There are many comprehensive studies of a descriptive nature (Roemer[11], Simanis[12], Fry and Farndale[13], Fulcher[14], Van Langendonck[15], U.S. Congressional Studies[16], K. Davis[17]), while others endeavor to explore interrelationships of a range of issues and program options Donabedian[18], Berki[19], M. Feldstein[20], Somers[21]). However, the problem of the interdependence of health insurance activities has not been adequately addressed from a comprehensive systems point of view. The complexity of health insurance problems *per se* and the considerable interrelationships among health insurance options and other social programs and systems make health insurance systems well beyond individual investigation[22].

Thus, health care system analysis requires a considerable amount of manpower time to explore sources of information for each policy issue at the varying levels of decision making--federal or central, state, county and city. Many approaches to analysis are used. In health and social planning, it has been common to look extensively at data collected from within one's own country and, by modifying or adjusting for different assumptions about such variables as population mix, incomes, age distributions, use rates, etc. to make rational decisions about the preferred course action[23].

A recent approach, proposed by some as an improvement over merely attempting to extrapolate from existing data to reach rational conclusions, is the controlled field experiment or special study. The experimental model approach has been used in the United States in attempts to estimate the probable effects of income maintenance programs[24], and of housing allowances[25]. The experimental model has even been proposed as a useful tool for evaluating national health insurance proposals[26]. However, the use of controlled experiments as tools for social planning has been criticized since so many of the necessary criteria and assumptions of controlled experiments are violated in complicated social action and health related programs[27]. In fact, some maintain that the modern techniques in policy analysis which have been pursued with such great optimism in the areas of public housing, manpower training, etc have had few if any striking successes, partially due to a failure of the analysts to appreciate the complexity of the tasks they were facing[28]. The complexity arises because, inevitably, goals, the resultant programs and their results are all highly interrelated and interdependent. Levin, Roberts

and Hirsch in a more recent approach to policy analysis, applied the theory of systems dynamics to complex social problems, in particular to the specification of the U.S. heroin problem in terms of a closed, or feedback, dynamic system[29].

Useful information has come from the above approaches in some settings, however, they primarily focus on activities and observations within a single society or section of the country. Improved generation of alternatives could result from the consideration of a wider range of possible alternatives, particularly those which tap cross-national experience. The proposed methodology not only would offer more observations than are currently available to the above approaches, but would include qualitative and descriptive evaluative data collected for a wide range of alternative activities. This, along with qualitatively determined interrelationships between the alternatives will serve to complement and assist the above and other approaches, adding alternatives and relationships for testing and scrutiny.

A central component for this process is the development of a systems framework for health insurance issues, program options, problems and solutions on which to build an information base containing structured data elements on a broad range of alternative activities, derived from literature searches and other sources.

3. A SYSTEMS CONCEPT FOR A HEALTH INSURANCE POLICY INFORMATION FRAME

The essence of the presented activity lies in the recognition of two important factors: (1) the need to recognize the interactions that characterize health insurance as a system, and (2) the need for analysts and decision makers to try to consider as many reasonable alternative activities as possible. A principle rationale behind the present attempt at defining health insurance as a system relates to the importance which Forrester gives to systems as the building blocks for understanding complex dynamic behavior by way of the theory of system dynamics[3].

In this view of health insurance the dynamics of the system are initially set in motion by the broad health insurance goals determined by the social values and political will of a society. A health insurance goal here is a category of concerns less specific than the term objectives as used in the usual planning and evaluation context, but yet more operational than a mere statement of societal values. Seven areas or issues have been used to define goals within the current project and are intended to be the basic categories for the major grouping of alternative activities which aim toward the ultimate goal of a healthy society. These goals are listed in Table 1.

The primary means by which attainment of a society's health insurance goals is attempted is by implementation of various program options. The health insurance goals can be thought of as requiring program options aiming at their fulfillment. On the other hand, the very existence of certain programs may serve as a controlling or guiding factor in terms of which broad goals are pursued and with what degree of intensity. In this way there is a kind of synergism between program options and goals so that in most cases neither can be looked at separately, and it may become very difficult to separate out which force has brought a certain set of program options into being. The program options are broad sets of activities, and in the context of this project, may also include many activities not necessarily already in existence.

From the program options, we can project subsequent outcomes either empirically or hypothetically. Some of the outcomes will, it is hoped, be positive and to that extent some attainment of the major goal is achieved. Because all social programs have a variety of impacts, however, the results of any one of them may be felt in areas other than the specific one initially intended. The consequences of a program may be beneficial and expected, but with most activities, because it is inherently impossible for one activity to be all things for all segments of a population, some of the consequences of a program may be undesirable and these undesirable effects may need to be counteracted or corrected by other activities. The undesirable consequences are grouped under the broad category *problems*, and the various attempts at their correction, under *solutions*. There is an interaction between each of these levels of activities—the issues and program options affecting each other, while program options and "problems" shape each other, equally as do problems and the solutions tried to correct them. The success or failure of the solutions affect in turn the continued or modified pursuit of the original and other goals. Desirable effects of a program option often constitute a solution to a problem inherent in some other program option. A few examples may illustrate the concept.

There are many different kinds of problems that arise when implementing programs for health insurance goals. A restricted categorization of them would be deficiencies, negative results and constraints. A deficiency would be a structural inadequacy resulting in failure to obtain fulfillment of an objective because of neglect or exclud-

Table 1. Seven major goals of health insurance

1) Promote access to medical care.
2) Contain indirect financial burden of illness on the individual consumer.
3) Contain direct financial burden of illness on the individual consumer.
4) Promote efficient remuneration of providers.
5) Containment of overall cost of medical care.
6) Secure appropriate medical care.
7. Promote preventive health care.

ing a segment of the population or area of concern. For example, lack of coverage of the unemployed is a deficiencies in health insurance schemes linked to employers. Negative results are process outcomes resulting from implementation of a program option, e.g. some undesirable impacts either directly or indirectly to some segment of the target population or area of concern, or with respect to some other issue under consideration in this activity. An example would be excessive laboratory or surgical procedures resulting from expanded coverage. One class of problems more difficult to identify without ambiguity would be program constraints. These would be limitations in the environment of a program option, which imply the need for avoidance of compensation. Problems in this category may flow from such social factors as regional or cultural patterns of health care utilization and health behavior practices which may constrain access or stimulate overutilization of services.

Problems, and indeed solutions as well, can be defined only in the context of an existing set of criteria for their classification and identification. These criteria depend almost totally for their definition on the social values and priorities of the society. The criteria of equity, efficiency and illness cost risk sharing have been proposed for the current project. Identification of health insurance system components in the above format, along with literature references linked to them, form the basis for a health insurance information base to serve as an important but currently lacking input into the policy analysis process.

Figure 1 shows a summary of the proposed health insurance project, emphasizing that the analytic process is served by the project rather than subsumed within it.

Obviously the boundaries in any attempt at a systems view can not always be formulated definitively, and in social policy even less so. In health promotion many other social activities play a crucial, if not overriding role, the contribution of medical services to overall health status being increasingly questioned[8]. Yet health insurance's main concern is medical care, even preventive care being often totally or partially provided by public health activities. Many important preventive activities are partly or completely outside the reach of medical care in different areas of social action, be it the behavior of the individual or family, the compliance with immunization provisions, the use of destructive weapons in inter-personal conflict, the safety at work, the protection of the environment, etc. all of which can affect health and the cost of medical care and health insurance considerably. From this point of view it becomes all the more apparent that medical care is but one of the contributors to social welfare (Margot Jeffereys[31]) and that the socio-political values entertained by any society are basic to health behavior and health care. This paper does not pretend to extend its boundaries into these manifold areas of social concern, yet does not intend to neglect their existence. A projection of the interdependencies of these various social concerns with health insurance policy design is provided in Fig. 2.

The uniqueness of the present approach lies in the existence of well defined cross linkages among the four elements within the formulated system. Indeed, not only can an activity appear as a "solution" for many "problems", but in some cases an activity may be a valid program option under consideration of one issue, and the undesirable result, or problem, in another with its particular solutions.

4. PROPOSED DEVELOPMENT OF A HEALTH INSURANCE INFORMATION FRAME SCOPE

Current state of the art work in library science has developed several comprehensive multi-coordinate word indexes for many fields of study. The most elaborate of these have been prepared for the areas of medicine and biological sciences (MEDLARS, *Science Citation Index*). Word indexes also exists for the social sciences but to date are not as comprehensive as those for the exact sciences[32]. These extensive data collections may be based on multiple keywords from previously written abstracts, title keywords, or subject content of the current literature. Such abstracting and indexing, while immensely worthwhile and essential in medical and scientific fields for many purposes, is not what the current activity proposes to do. Rather, it is the creation and use of a taxonomy of health insurance issues, options, problems, and solutions that forms a key element of the proposed information frame.

It is clear that the development of consistent typologies in the social and political sciences lags far behind such development in the natural sciences. This is no doubt related to the difficulty of trying to relate complex social problems and solutions to a clearly categorized indexing scheme. Also, the time frames for problem solving, policy analysis, and decision making in the highly politicized social structures is considerably shorter than in such academic disciplines as mathematics, statistics, or biology, discouraging the considerably time-demanding efforts in this direction.

Establishing a taxonomy of categories of knowledge is a laborious endeavor in any field, and for health insurance problems as a part of the social sciences possibly more so than in some other sciences. On the other hand the first application of a discipline to a field so far untouched usually appears more complex than already existing applications, without necessarily being so, since the earlier applications have partly lost their image of complexity and laboriousness as a result of work already accomplished.

The establishment and maintenance of indexed reference collections is labor intensive and costly, due to the tremendous volume of information indexed. However, as emphasized earlier, comprehensiveness in the mode of indexes such as MEDLARS and Scientific Citations Index is not envisaged here. Rather only articles and reports containing information relevant to the information frame or for expanding this frame would be selected. As a result it is expected that the information base will be much smaller in size than those currently in use and maintained for the more conventional library searchers. In contrast to conventional indexes, the coding of the information will require more careful attention and understanding of the contents of the references found, since the aim is not to create merely a keyword reference, but to identify the kind of information contained in the reference (e.g. type of political system, resources identified, quantitative results) and link it logically to the information frame (see Fig. 3).

It is expected that such indexing will require more specially trained indexers than normally used for abstracting of articles, etc. and that extra attention will have to be given to the crucial problems of inter-coder reliability. Much use will be made of the existing multi-coordinate indexed systems, but this will by no means be the only source of input to the information base. Actual experience with health insurance options is not always

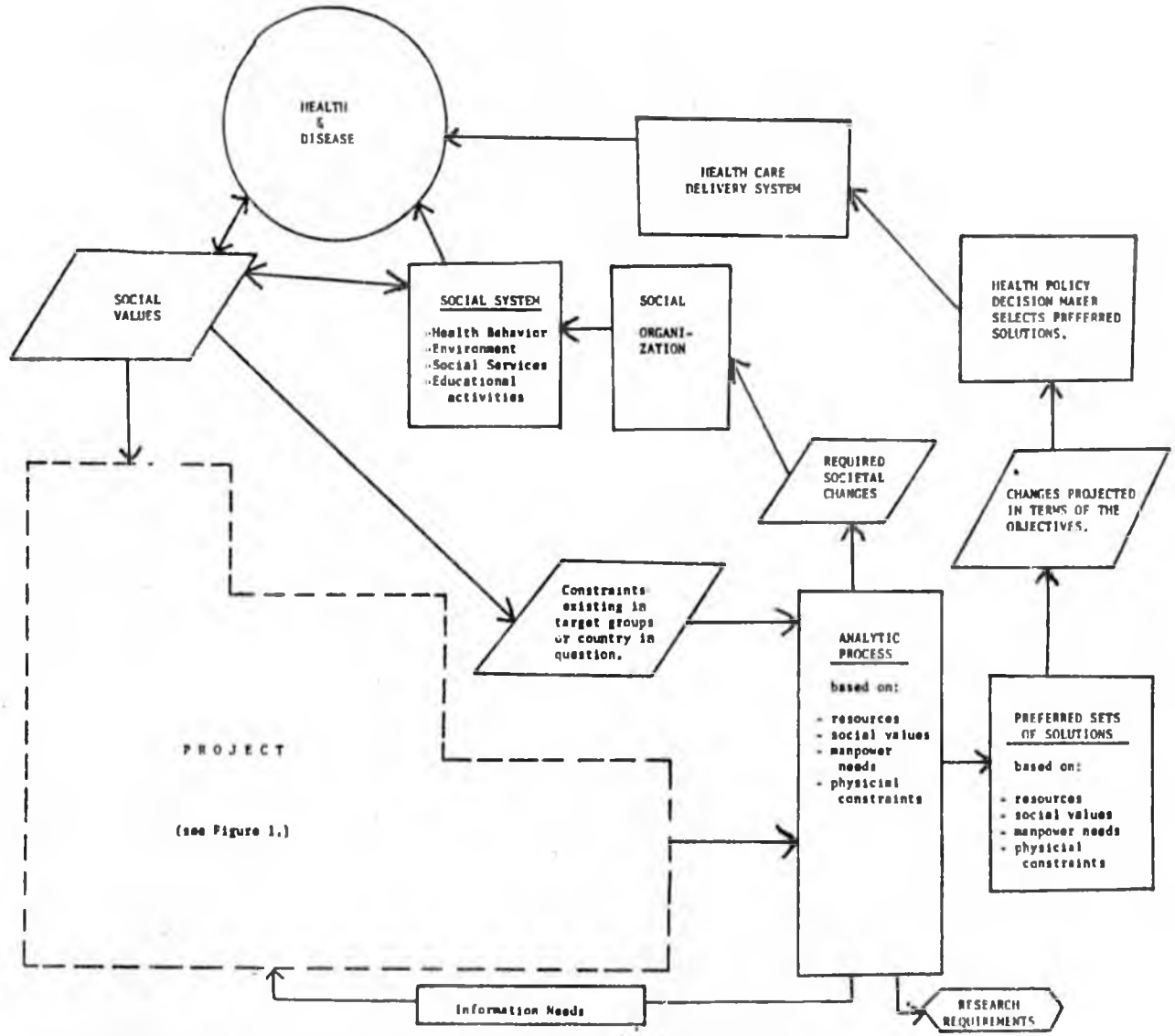

Fig. 2. A systems appraoch to health insurance policies: Delineation of project boundaries within total system of health and disease.

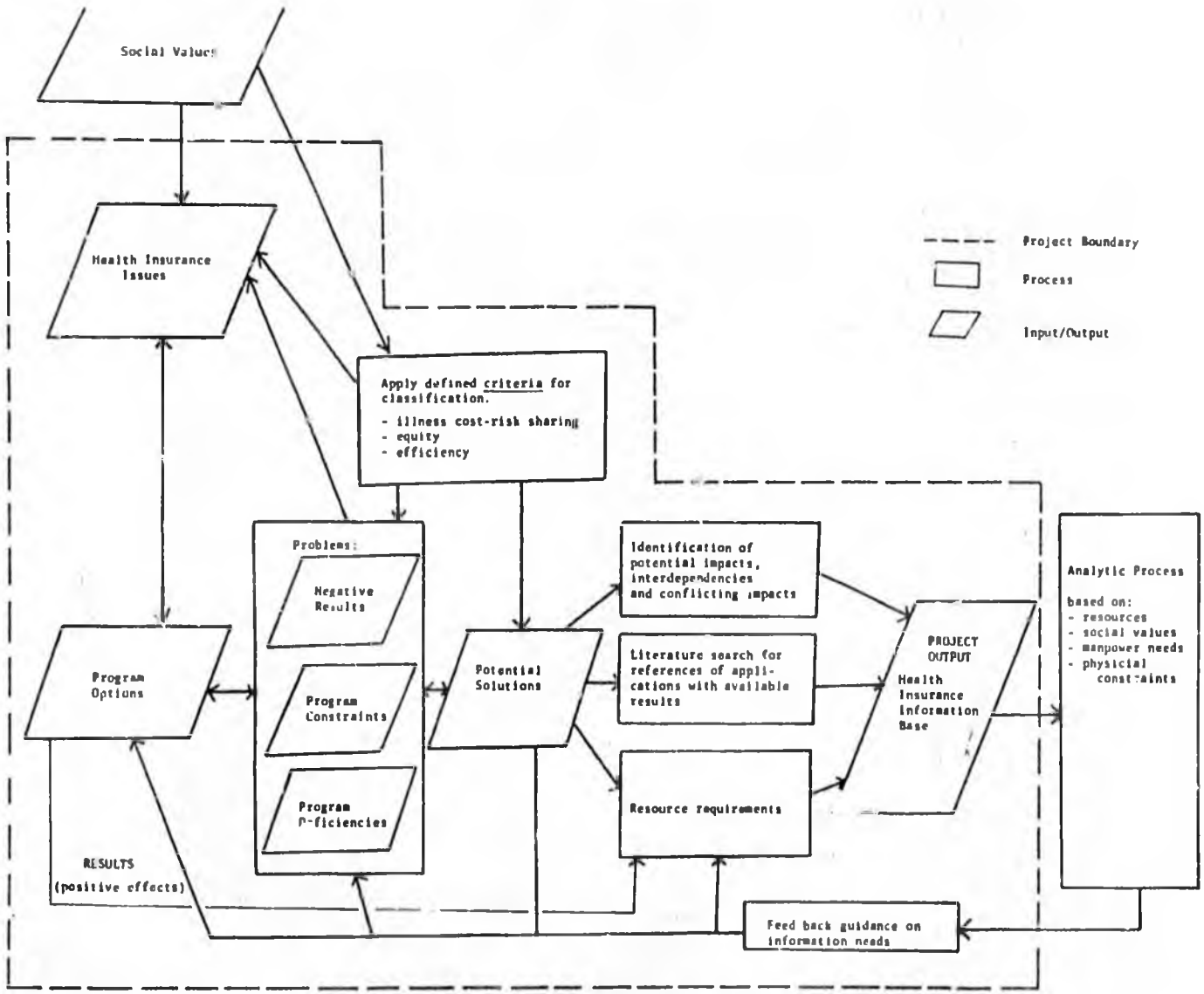

Fig. 1. Systems approach to health insurance policy analysis information.

1.8.3.2
Ombudsmen

U.S. Congress. House. Committee on Ways and Means. National Health Insurance Resource Book. Washington, D.C.: U.S. GPO, 1974
Part III, Chapt. 5: United Kingdom - Appendix II p. 397

kind of information contained in this reference

1) Type of ref.: theoretical | X applied | legislative | regulatory

2) Country & system: Britain -- National Health Service

3) Resources: X Manpower | Investment Cost | X Operating Cost | Facility

4) Results:

	Quantitative Outcomes	Postulated Outcomes	Positive Results	Negative Results
Health				
Other _____				

5 Financing mechanism: NHS financing - general taxation & contributions

6) Additional information:

Fig. 3 Example of coding card for summarizing references.

readily available from publications normally included in multi-coordinate indexed systems and is more likely to be found in internal documentation of health insurance systems both in the U.S and abroad. These normally unpublished sources would be a significant source of much of the information for the proposed health insurance information base.

The exact costs of establishing and maintaining the information base can only be approached after the information frame has been evolved to a workable degree. The test for the workability of the frame lies in the use of the frame for exploring qualitatively interrelationships among issues, program options, problems and solutions. It is postulated that the capacity to explore such qualitative relationships within this information frame is adequate justification for further developing and using the proposed systems approach to health insurance.

Methods

(1) *Initial exploration.* The activity reported now has been pursued by the authors, assisted through occasional review by colleagues at the School of Public Health in Ann Arbor. An information frame was internally generated using only the three categories—issues, problems and solutions. The listings for these three categories were subsequently partly confirmed as well as expanded through literature search. Further development of the concept led to the recognition of the need to identify program options for the selected issues and to clearly specify criteria for identification of problems and solutions. This recognition led to the outline of the information frame as shown in Fig. 1, using as the basis for the taxonomy the hypothesized operational sequence—issues, program options, problems and solutions. Figure 4 shows the format for listing the program

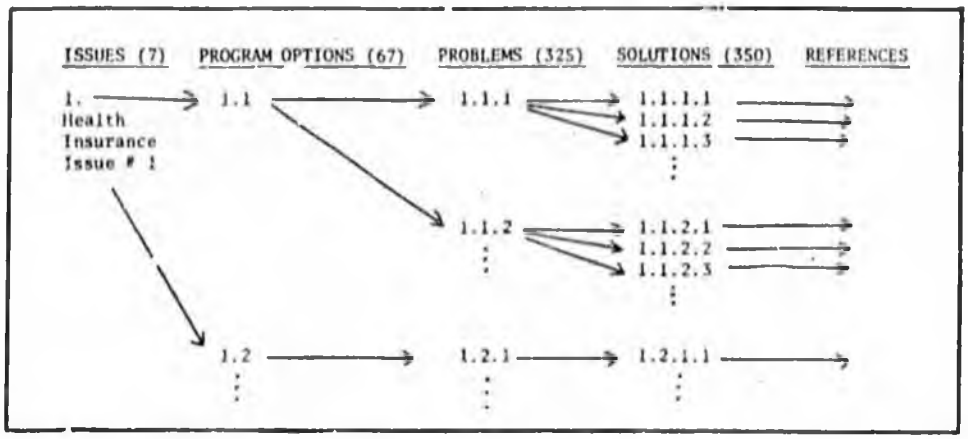

Fig. 4. Format for listing of health insurance taxonomy.

options, problems and solutions based on the proposed taxonomy. The sixty-seven program options so far generated for the postulated issues are provided in Table 2. An example of the worksheets using this format for one problem, under one program option, under Issue 1, *Promote Access to Medical Care*, is shown as Fig. 5. This example lists the codes for problem class (reference Fig. 1) and for the criteria used for identification of the individual problem and solution. It is anticipated that this identification will provide one of the tools to explore qualitative interrelationships between solutions and problems and issues. Also an attempt is being made to identify for each solution one or more of the seven levels assumed for most health care systems at which the solution is directed. Known applications of solutions are linked to these levels of care by country of application with references.

The relevancy of generated program options, problems and solutions should be tested by submitting the preliminary frame, once completed, to a larger group of health insurance experts here and abroad. It is likely that this testing process will generate a considerable number of additional program options, problems and solutions easily incorporated in the established data file. The design for a computerized information base using the health insurance information frame as described has been done with the anticipation of easy expansion resulting from such tests[33].

(2) *Access to an interrelated taxonomy.* To establish data manipulation capability the list of health insurance issues, program options, problems and solutions is used as a starting point. From this list a single file of raw data consisting of two types of records, identification records and reference records, has been constructed.

The identification portion of the files contains one set of data (one record) for each program option, problem and potential solution. The reference records would be made up of one additional data record for each country where, for a given program option or solution, an application reference or a literature reference(s) to a theoretical application was found. The exact contents of these two kinds of records is flexible, however, the basic format is as shown in Fig. 6. The machine readable data base has been described in more detail elsewhere[33].

Identification of individual problems and solutions is done by use of a computer generated word index for each relevant term in the program option, problem, and solution description. This facilitates initial location of specific elements of the taxonomy without requiring prior knowledge of the structure.

It is probable that explicit definitions of levels of care and areas of impact, both from the provider and client perspective, can be used with concepts from set theory to provide a framework to structure analyses of the interdependence problem. The procedure to be followed involves identifying additional variables for each solution based on their expected outcomes with regard to other issues of the health insurance system. The inter-linkage would be identified at two levels—the first level will be the impact, beneficial or otherwise, of each solution on each of the other major issues, the second level will be the identification of solutions which may be incompatible with other specific solutions for this same objective. Each solution can effect the other issues positively, negatively, or not at all, and this gives enough classification to define an additional categorical variable for each solution.

For identification of program options, problems and solutions occurring more than once, all such solutions will be listed with an additional four level value made up of variables 1–4. For the first or primary occurrence of a solution this would be just a duplication of the first four variables: but where this solution was one repeated from a previous location, it would contain the issue, program option, problem and solution number of that solution (see Fig. 6).

Once such a data frame has been assembled, a variety of questions and comparisons can be made. A major element of flexibility arises from being able to cross reference any of the variables in the data frame. This can be done very easily without yet having all the variables defined, by using only those of most immediate concern (issue number, problem number, solution number, country and level of care) on an interactive computer system. Cross referencing would be accomplished by using packaged software (already available without immediate production of new or special computer programs), to perform sorts and/or counts of the various elements. For example, if identification of solutions applied for various problems was desired, the computer can perform a sort operation on the solution identification field which would group all occurrences of each solution, and show the different problems to which it has been applied. Similarly, counts or cross references by country, or any of the other variables, could also be obtained rapidly and inexpensively by a simple computer command. However, as additional descriptive variables (as well as other constraints) are examined special programs can then be written.

Interrelationships among the program options, problems and solutions will be explored through "signed descriptors" for the individual problem or solution qualitatively indicative of the direction of the effect on the criteria other than the one used for identifying a problem or solution as well as on the issues other than that in which the problem or solution occurs. "Signed descriptor" is used to refer to additional variables associated with each program option and solution to indicate the effect of this activity on the other issues and the other criteria. The effect is intended to be shown by giving a plus or minus *sign* or a zero to indicate the probable direction of the effect relative to that issue (positive, negative, or neutral), as for example in Table 3. The concept of a signed descriptor as an aid in the grouping of social science literature has also been observed elsewhere though not exactly in the present context[32]. For example, a program option which promoted access (Issue 1), but increased the indirect financial burden (Issue 2) and also failed to contain overall costs (Issue 5) might have three signed descriptors of +−− for these three issues.

Another means for identifying qualitative relationships is the tabulation of repeated occurrence of options as problems or solutions and vice versa. Analysis of such multiple occurrences will give some indication of the range of possible effects of the different activities. As an example, co-insurance may constitute both a program option and a potential solution in attempts to contain overall costs, but will emerge as a problem violating equity when considering the issue of promoting access to medical care. Thus it will be more easily recognized that selection of solutions to, for instance, co-insurance as a problem, mitigates negative effects on the accepted goal of equity. The power of any given solution may in this

Program Option		Problem	Problem Class	Problem Criteria		Potential Solutions	System Level	Applications
1.8 Compulsory health insurance for those with an income below a defined level. (also in: 4.7)	1.8.3	Additional charges over agreed fees in fee-for-service systems.	2	2	1.8.3.1	Supplemental insurance for increased charges (not including additional benefits). (also in: 1.9.2.1)	02 03 04	Belgium France Italy
					1.8.3.2	Ombudsmen (also in: 1.9.4.1.)	06	Sweden United Kingdom
					1.8.3.3	Press publicity on complaints of overcharging.		
					1.8.3.4	Providers association watch.	07	Sweden
					1.8.3.5	Capitation fee for G.P.'s (also in: 1.7.4.1)	02	Holland Italy United Kingdom

Codes Used:

System Level	Problem Class	Problem Criteria
01 Self-care	1 = negative result	1 = illness cost-risk sharing
02 Primary	2 = program constraint	2 = equity
03 Secondary	3 = deficiency	3 = efficiency
04 Tertiary		
05 Preventive Medical Care		
06 Social Services		
07 Administrative		

Fig. 5. Issue 1: Promote access to medical care.

Table 2.

1. Promote access to medical care.	2. Reduce indirect financial burden of illness on consumer.	3. Reduce direct financial burden of illness on consumer.
Program Options	Program Options	Program Options
1.1 Employment/occupation/ group health insurance. (also in: 3.5, 5.10)	2.1 Social security package including sickness insurance, maternity benefits.	3.1 Private health insurance. (also in: 1.9)
1.2 Insurance for persons over 65.	2.2 Voluntary sickness insurance for lost income.	3.2 Catastrophic insurance. (also in: 5.7)
1.3 Insurance for children under 6 years.	2.3 Voluntary insurance for home care.	3.3 Employment/occupation/ group health insurance. (also in: 1.1, 5.10)
1.4 Government sponsored services for pregnancy.	2.4 Voluntary agency providing home care nursing and home aids.	3.4 Prepaid group practice; HMO. (also in: 5.8)
1.5 Health insurance for entire population — National Health Insurance. (also in: 3.8, 5.15)	2.5 Local or central government funded home care services.	3.5 P.S.R.O. (also in: 5.9, 6.1)
1.6 Catastrophic health insurance administered by private insurance companies.	2.6 Volunteer home care assistance.	3.6 Medicredit health plan (tax credits to families).
1.7 Fee-for-service for all care levels. (also in: 4.1, 5.14, 6.2)	2.7 Consumer awareness programs.	3.7 Local government provided ambulance and transport service.
1.8 Compulsory health insurance for those w/income below a defined level. (also in: 4.7)		3.8 Health insurance for entire population — Nat'l Health Insurance. (also in: 1.5, 5.15)
1.9 Private (individual) h.i. (also in: 3.1, 6.8)		3.9 National health service. (also in: 5.11, 6.5)
1.10 Care for medically indigent (medicaid).		3.10 Use of co-insurance (% of cost). (also in: 5.1)
1.11 National Health Service. (also in: 3.9, 5.11, 6.5)		
1.12 Health care services available at schools.		
1.13 Health care services available at work sites.		

4. Promote efficient remuneration of providers.	5. Containment of overall cost of medical care.	6. Secure appropriate medical care.	7. Promote preventive health care.
Program Options 4.1 Fee-for-service for all care levels. (also in: 1.7, 6.2) 4.2 Capitation fee for primary care providers (including pharmacists). (also in: 5.3, 7.5) 4.3 Capitation fee for primary care providers (including pharmacists) with salaried specialists. (also in: 5.4, 7.6) 4.4 Capitation fee for primary care providers (including pharmacists) with fee-for-service specialists. (also in: 5.5) 4.5 All care level providers salaried. (also in: 5.6, 7.7) 4.6 Episode of illness payment for specialist care (within health insurance schemes). (also in: 5.12, 6.6) 4.7 Compulsory health insurance for those with income below a defined level. (also in: 1.8)	Program Options 5.1 Use of co-insurance (% of cost). (also in: 3.10) 5.2 Rate and fee regulation by state or federal government. 5.3 Capitation fee for primary care providers (including pharmacists). (also in: 4.2, 7.5) 5.4 Capitation fee for primary care providers (including pharmacists) with salaried specialists 5.5 Capitation fee for primary care providers (including pharmacists) with fee-for-service specialists. 5.6 All care level providers salaried. 5.7 Catastrophic insurance. (also in: 3.2) 5.8 Prepaid group practice; HMO. (also in: 3.4) 5.9 P.S.R.O. (also in: 3.5, 6.1) 5.10 Employment/occupation/ group health insurance. (also in: 1.1, 3.3) 5.11 National Health Service. (also in: 3.9, 6.5) 5.12 Episode of illness payment for specialist care (within health insurance schemes. (also in: 4.6, 5.12) 5.13 Insurance for persons over 65. 5.14 Fee-for-service for all care levels. (also in 1.7, 4.1, 6.2) 5.15 Health insurance for the entire population-- National Health Insurance. (also in: 1.5, 3.8)	Program Options 6.1 P.S.R.O. (also in: 3.5, 5.9) 6.2 Fee-for-service for all care levels. (also in: 1.7, 4.1, 5.14) 6.3 Health insurance regulatory control of reimbursement for appropriate medical care. 6.4 Health insurance for entire population; National Health Insurance. (also in: 1.5, 3.8, 5.15) 6.5 National health service. (also in: 1.11, 5.11, 3.9) 6.6 Episode of illness payment for specialist care (within health insurance schemes) (also in: 4.6, 5.12)	Program Options 7.1 Health education programs. 7.2 No charge MCH programs (including immunizations). 7.3 Social programs for environment: food, housing. 7.4 Environmental health programs: air, water, transport safety. 7.5 Capitation fee for primary care providers (including pharmacists) (also in: 4.2 5.3) 7.6 Capitation fee for primary care providers (including pharmacists) with salaried specialists. (also in: 4.3, 5.4) 7.7 All care level providers salaried. (also in: 4.5, 5.6) 7.8 Occupational safety regulation programs. 7.9 Disease control programs.

Program, Problem, or Solution Identification:

- one record for each									
V1 Issue Code Number	V2 Program Option Code Number	V3 Problem Code Number	V4 Solution Code Number	V5 Program, Problem, or Solution I.D.	V6 Text description of solution	V7 Potential system impacts	V8 System Level 1-2-3-4-5-6	V9 # of application refs.	V10 # of theoretical references.

Program, Problem, or Solution References:

- one record for each published literature reference (or other references) found										
								Kind of information:		
V1 Issue Code Number	V2 Program Option Code Number	V3 Problem Code Number	V4 Solution Code Number	V5 Program, Problem, or Solution I.D.	V6 Ref. Seq. Code Number	V7 Country	V8 Systems Impacts	V9 Code for theo. or applied refs.	V10 Bibliographic identifier (numeric code*)	V11 Code for type of information contained therein

*to be matched with similar numerically coded list of bibliographic citations.

Fig. 6. Record contents for implementation of a health insurance system data base.

Table 3. Signed descriptors forsolutions to Problem 1.1.1. (no coverage when unemployed) of program option 1.1. (employment/occupation/group health insurance) of Issue I (promote access to medical care)

		Issue I - access	Issue II - indirect financial burden	Issue III - direct financial burden	Issue IV - remuneration	Issue V - cost containment	Issue VI - appropriateness	Issue VII - prevention	Problem Criterion 1 - illness cost risk sharing	Problem Criterion 2 - equity	Problem Criterion 3 - efficiency
1.1.1.1	Unemployment insurance (social security) includes payment of health insurance.	+	0	+	+	+	0	-	+	+	+
1.1.1.2	Unemployed allowed to pay government health insurance (normally considerably lower than voluntary health insurance rates) from own resources.	+	0	+	+	+	0	-	+	-	+
1.1.1.3	Unemployed allowed to choose reduced coverage (catastrophic illness only) at reduced premium rates out of pocket.	+	0	+	+	+	-	+	+	-	+
1.1.1.4	Provider levels provide free care to unemployed with commensurate increase of payment to providers (primary, secondary, tertiary) by either city, state, or federal contributions.	+	0	+	+	-	-	-	-	+	-
1.1.1.5	Governmental institutions (federal, state, city) provide free care to unemployed.	+	0	+	-	+	+	-	-	+	+

way be measured by the frequency with which it addresses different problems.

Quantitative interrelationships are not intended to be produced within the policy information frame itself, but are expected to become available from literature references.

5. PRELIMINARY RESULTS

For the seven selected issues, 78 program options have so far been listed. For these 78 options 325 problems have been identified. Over 350 solutions generated earlier for the more than 75 problems at that time listed have been rearranged for the newly identified problems. So far applications in 8 European health insurance systems have been identified for 85 solutions. To test the feasibility of creating a computerized health insurance information base, the available issues, program options, problems and solutions have been transferred to computer storage according to the design provided in Fig. 6.

The first preparation of the information frame cannot at all be considered complete. Completion will require intensive collaboration from future users, particularly in government, and health insurance specialists, both in this country as well as in other countries with experience in health insurance, so as to complement and adapt the frame accordingly. In addition, the literature search, once started, is expected to provide additions to elements of the information frame, without need to change the design of the frame itself.

6. DISCUSSION

The preliminary character of this report relates to the recognition that the information frame, once worked out for all four categories, needs further testing by health insurance specialists and policy analysts for confirmation or adaptation. A structured survey of policy information-needs should form a part of such a testing phase for the project. Contributions must also be obtained from existing health insurance systems outside the U.S.A.

In addition, it is obvious that the authors by themselves can never expect to establish an adequate information frame. A search for additions and corrections and a need-survey would eventually complete a workable information frame for the purposes identified earlier. Apart from adaptation, addition to the frame will be necessary, particularly on the basis of information available through reports, including internal reports from health insurance agencies, both government and private. The information frame as designed allows for expansion within the established four categories, and also for possible expansion of the categories if considered necessary. The establishment of the information base would be a much larger endeavor, requiring considerable and long-term support or might be undertaken in another environment altogether.

7. CONCLUSION

So far the development of the information frame has been conducted in a university setting with assistance from experienced health policy analysts. But even with a relatively limited exposure, the potential usefulness of the approach has been demonstrated. The increasing importance of comparative analysis of health insurance alternatives, plus the increasing interest in international comparisons of experience, and the time saving such a resource could provide policy analysts are the justifications for the present efforts.

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QUESTIONNAIRE

1. Do you have an information framework for Health Insurance Policy Information available to you on the following issues?

	YES	NO
a) Access to medical care.	☐	☐
b) Contain in direct financial burden of illness on the individual consumer.	☐	☐
c) Contain direct financial burden of illness on the individusl consumer.	☐	☐
d) Efficient renumeration of providers.	☐	☐
e) Containment of overall cost of medical care.	☐	☐
f) Secure appropriate medical care.	☐	☐
g) Promote preventive health care.	☐	☐

2. Would an information frame with all of the above issues increase your (agency's) analytical capacity,

	YES	NO
both in scope	☐	☐
and in time efficiency? . . .	☐	☐

3. If a complete information frame was made available to you, would your organization/agency use it? (Please indicate on scale.)

Never Always

4. What factors would limit your (agency's) use of such a taxonomy?

	YES	NO
a) inadequate staff	☐	☐
b) actual policy problems do not relate to this kind of analysis	☐	☐
c) time efficiency not important enough	☐	☐
d) policy choices are not related to interdependencies among issues, program options and problems	☐	☐
e) political, administrative, and other constraints limit consideration of interdependencies	☐	☐
f) other (specify) _____	☐	☐

5. Would you expect an information frame to require

	YES	NO
a) expansion of issues	☐	☐
If yes, which? _____		
b) frequent updating	☐	☐

6) Does your agency have the resources to engage in policy analysis? ☐ ☐

If yes, please identify number of manpower in categories

(i) ____ health economists

(ii) ____ public administrators

(iii) ____ sociologists

(iv) ____ health care administrators

(v) ____ policy analysts

(vi) ____ financial analysts

(vii) ____ systems analysts

(viii) ____ actuarial specialists

(ix) ____ information systems specialists

(x) ____ health insurance experts

(xi) ____ other (specify) _____ _____

____ _____

____ _____

THE UNIVERSITY OF MICHIGAN
HEALTH PLANNING AND ADMINISTRATION
SCHOOL OF PUBLIC HEALTH
Ann Arbor, Michigan 48109

USA 15c

Dr. J. L. de Vries
Dept. Hlth. Plan. & Admin.
School of Public Health
University of Michigan
Ann Arbor, Mi. 48109

52

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3000

April 23, 1980

Representative Thelma Buchholdt
Pouch V M.S. 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

While I was in Alaska a week ago, the Health Education & Social Services Committee requested information concerning the costs for health care coverage in H.B. 977. A similar request was received by phone from Jack Kreinheder in the House Research Agency, who asked for a comparison between the $106 cost of coverage for state employees and the cost per member of coverage for all Alaskans.

I have spent a week on the project and the answer cannot be derived from our data. When coverage is figured for all Alaskans, the group makeup changes radically. For instance, a group of employees is younger than a group composed of all Alaskans since persons leave the employment group upon reaching retirement age. A group of employees is healthier since that group is composed of working people and persons who are disabled or not healthy enough to be employed would be a part of a group of all Alaskans. A group of all Alaskans would have to include all the persons who are in institutions in the state and these persons are not included in any employed group and usually have health characteristics which would result in higher utilization. Because these characteristics are different from the characteristics of an employed group and because these characteristics will have a direct effect on the utilization of benefits, the extrapolation of cost from a given cost for the state employees would be inaccurate and misleading.

The Health Education & Social Services Committee may want to consider asking that an independent consultant be employed during the interim to make an estimation of the cost of coverage. While that study will give you only an approximation of the costs, that approach seems to be the only way that a reasonable estimate will be available.

Sincerely,

Joan H. Gaumer

JHG:kg

cc: Representative Joyce Munson
Representative Vern Hurlbert
Representative Bill Miles
Representative Ramona Barnes
Representative M.F. Beirne
Representative C.V. Chatterton
Sharman Haley
Jack Kreinheder
Wes Coyner

POSITION PAPER
ON
HOUSE BILL NO. 977

"An Act relating to the health of residents of the state."

I. Departmental Overview of House Bill 977

House Bill 977 appears designed to accomplish the following reforms to health care delivery in Alaska:

a. Section 1 and 2 of House Bill 977 provides for a comprehensive plan for coverage of certain health care costs for all Alaskans who are otherwise not covered under a private or public health plan. The bill requires employers to provide health insurance coverage for their regular employees and their dependents and to pay at least 50% of the premium cost of such coverage. The Bill defines the standards and designs of the health plans including covered services and deductibles. The bill also offers health insurance coverage to high risk, "uninsurable" clients under the state plan.

b. Section 3 of H.B. 977 directs the Commissioner to use available medical assistance funds to purchase health care service through health insurance policies or contracts, if the Commissioner of the Department of Health and Social Services find them to be cost effective.

c. Section 4, 6, and 7 of H.B. 977 would expand current Medicaid and General Relief-Medical programs to cover new groups of persons specifically the unborn child group and the medically needy group.

d. Section 5 of H.B. 977 would expand covered services under Medicaid to add many of the optional services not offered under the program in Alaska.

II. General Departmental Comments/Recommendations

The Department of Health and Social Services will primarily reserve its comments to Section 3 through 8 of the bill, as the earlier sections are primarily concerned with employers and insurance and it is our understanding that these issues are planned to be addressed by the Department of Commerce and Economic Development, Division of Insurance and the Department of Labor. We do wish though to bring the Committee's attention to Section 18.12.070 on pages 4 and 5 of the bill. That section in part relieves an employer of his obligations for employees who already have health coverage through state medical assistance or state prepaid health care plan for the needy. It requires the Commissioner of Labor to notify the employer of

that fact. We find some administrative problems with the release of this information, which is generally classed as confidential under state or federal laws. We could release to the Department of Labor the names of public assistance recipients who are employed only if the individual recipient has signed a release form permitting the Department of Health and Social Services to do so. We believe this to affect only a small percentage of clients, as most public assistance clients are not employed outside of the home, due to age, disability or dependent children in the home.

However, the Department believes that H.B. 977 takes a many faceted approach to a complex problem. It appears to move in too many directions and at a too rapid time frame, which could potentially jeopardize the successful accomplishment of the worthwhile goals that H.B. 977 seeks to achieve. The Department's specific comments which follow in Part III of this Position Paper support this observation. The Department's general comments regarding Section 3 through 8 of H.B. 977 are, as follows:

1. We support in concept the purchase of health care services through health insurance policies or contracts when judged by the Commissioner of the Department of Health and Social Services to be cost-effective for Medicaid and other medical assistance programs;

2. We recognize the need for the addition of the unborn child group as eligible for cash assistance and medical services under AFDC and Medicaid respectively. The Department views this as a positive step to providing necessary medical care, food, clothing, and other necessities at a time critical to the development of the child in effort to prevent future problems. The State covered at one time unborn children under AFDC. This option was dropped by the Legislature in 1975. The Department found little cost impact to overall AFDC expenditures as a result of the addition or deletion of this option.

3. We propose that additions of new Medicaid service options (such as drugs or podiatry) should be phased in, rather than all remaining services being added at a single time. Each service could be evaluated on its own merits, rather than in mass to determine whether it is cost-effective to do so at this time.

III. Specific Departmental Recommendations on Section 3 through 8

Section 3 - AS 47.05.070 (a)

The Department is in favor of purchasing services through health insurance policies or contracts if more cost effective than traditional methods. The Department has no problem with the mandatory nature of the language in this section. "Medical assistance" should be redefined and a definition added for "remedial care".

Section 3 - AS 47.05.070 (b)(1)

Language appears to confuse the role of Commissioner, Department of Health and Social Services. Commissioner of Department of Health and Social Services purchases services under the same standards in place for all others competing for these medical services. There is nothing unique about the DHSS medical programs which would set professional standards different for them than exists for all other persons purchasing these services. Recommend 47.05.070 (b)(1) be reworded as follows: "to provide those medical and remedial care and services allowed under Alaska law."

Section 3 - AS 47.05.070 (b)(2)

Language is confusing and adds no additional authority to the Commissioner. Recommend deletion entirely or simply cross-referencing to existing state laws. Adequate safeguards exist in present law to insure fair reimbursement of medical providers.

Section 3 - AS 47.05.070 (b)(3)

No change recommended.

Section 3 - AS 47.05.070 (b)(4)

No change recommended.

Section 3 - AS 47.05.080

Recommend deletion of this section entirely. The Commissioner is not a rate setting authority in this instance. Rates are governed by competitive purchase of services on a bid basis with all competitors abiding by the same bidding principles set by Department of Administration and Division of Insurance. The only authority vested with the Commissioner is rejection of all bids which exceed the federally prescribed upper limits used by Medicare. Again, adequate safeguard and bid rules exist in this area in both federal and state regulations.

Section 3 - AS 47.05.090 (a) and (b)

No change recommended

Section 3 - AS 47.05.100

No change recommended

Section 3 - AS 47.05.110

Recommend this section be re-titled "Interim Payment." The Department is presently working towards installation of a more sophisticated claims processing system by July 1, 1981. An interim payment mechanism will be part of that new system for certain large volume providers.

Section 3 - AS 47.05.120

Under present Medicaid law the Department is required to pay 90% of "clean claims" within 30 days of receipt, and 99% of "clean claims" within 90 days of receipt. The Department supports the idea that medical providers should not suffer financially because of bill payment delays after a reasonable period. Therefore, the Department supports the intent of 47.05.120 with the following changes:

1. Interest entitlement should be limited to "clean claims" only. In Section 47.05.120 the phrase "clean claim" should be substituted for the phrase "a bill."

2. Interest entitlement should not commence until the 91st day after receipt of a clean claim. Interest entitlement should accrue in monthly increments, not in daily increments, and providers should receive a full months' interest entitlement if the bill is paid after the 15th day of any calendar month.

3. "Clean claim" should be defined in Section 47.05.130.

Section 3 - AS 47.05.130

1. Add definition for "remedial care," "non-exclusive" contract, health care service contracts.

2. Define "medical assistance" to mean Medicaid, GR Medical, Catastrophic Illness, Crippled Children's and Maternal/Child Health.

3. Define 'clean claim' to mean one that can be processed without obtaining additional information from the provider of the service or from a third party; it includes a claim with errors

originating in the department's claims processing system, but does not include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Section 4 - AS 47.07.020 (b)

This Section would amend Medicaid law to provide coverage for all optional groups not currently entitled to Medicaid benefits, primarily the unborn child group, the unemployed father, and the medically needy group. We recognize the value of the addition of the unborn child group to Medicaid to assist in proper health and low income women's development of child through the receipt of necessary prenatal care. We believe the addition of this group to Medicaid will have little impact on programs' expenditures. We can see the need for health care coverage to the medically needy and to the unemployed fathers but the cost impact of these options would be substantial and would be covering a greatly expanded group of clients. The Department supports the concept of a limited medically needy program including only the aged, blind, and disabled until such time that we can develop the monetary and administrative burdens.

Section 5 - AS 47.07.030

This section as amended would change Medicaid law to dramatically expand medical services offered under the Medicaid program. The Department recommends that each service should be evaluated on its own merit, perhaps adding only those where it appears cost-effective, in terms of saving general fund dollars, to do so. Also, all services added in mass would cause administrative problems. A phase-in model would be more appropriate if the Legislature decides to pursue this section.

Section 6 - AS 47.25.120

This section as amended would add broad medically needy coverage under the State General Relief-Medical Program. The Department supports the concept of a limited medically needy program including only the aged, blind, and disabled until such time that we can develop the monetary and administrative burndens.

Section 7 - AS 47.25.410 (3)

This section as amended would add the unborn child group under the AFDC program and entitle them to monthly cash assistance payments. Eligibility for cash payments under AFDC is a not prerequisite for the unborn child group to receive medical coverage under Medicaid.

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health and Social Services

4/4/80
(DATE)

MEDICAID SERVICES

Currently Covered Services

Hospital-Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (ICF)

Intermediate Care Facility for Mentally Retarded persons and persons with related conditions (ICF/MR)

Laboratory and X-ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

Early Periodic Screening, Diagnosis, and Treatment of Individuals under 21 years of age (EPSDT)
- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community Mental Health Clinics

Family Planning Services

Outpat[illegible] Surgical Care Centers

Rural [illegible]h Clinics

Services Added By HB 977

Podiatrist Services

Chiropractic Services

Private Duty Nursing

Personal Care Services

* Physical Therapy

* Occupational Therapy

* Prescribed Drugs

Dentures

* Prosthetic Devices and Medical supplies

Other Diagnostic, Screening, Preventive & Rehabilitative Services

Services to Individuals over 65 years of age in Institutions for Mental Diseases

Services to Individuals over 65 years of age in Institutions for tuberculosis

Non-Covered Services

Other Practitioner Services
- a. private psychologist
- b. nurse practitioner
- c. physician assistant

Clinic Services-other than Community Mental Health Clinics

Services by Christian Science Nurses

Services by Christian Science Sanatoria

* Accessible through General Relief-Medical

April 22, 1980

Dear Legislator

We are strongly opposed to House Bill 977. State health insurance would not only be very expensive, but it would crowd private insurance carriers out of the market, and therefore, greatly interfere with free enterprise. Additional information is included on second page.

Sincerely,

FREE Committee
Anchorage Woman's Club

Teddy Cartwright 7714 Penny Dr. Anch. 99502
Marlene Agajanian 1241 St. Dotthard 99504
[illegible]
Esther R. Boatman, 3616 Arlington " " 99503
Bobbye Young 3535 Hampton Dr. Anch. AK. 99504
[illegible]
[illegible]
Priscilla Johnson 2315 Lassen Dr. Anch 99503
[illegible]
Jennie Barbe Talley SRA Box 28-N Anch. 99507

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

Addendum to FREE Committe's position on House Bill 977.

We are opposed to HB 977 for the following reasons:

1. Insurance premiums will be higher than many small business people can afford.

2. History has proven that the level of care will decrease due to the increased demand.

3. We do not need another health care program in addition to Medicare and Medicaid. We have not heard patient complaints or of problems.

4. Large losses may result which the state would have to underwrite.

5. State health insurance would force insurance companies to cover even "bad" risk persons.

6. Over a period of 5-10 years all private companies will pull out of the state program because of the losses to them.

7. This is the first step towards socialized medicine because the premiums will be high; therefore there will be pressure to lower premiums so the state will pay to make up the difference.

8. The State cannot run the Medicaid program effeciently so how can they administer this program. The State had to hire an outside firm to manage Medicaid billing and the payments are still late.

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

FREE Committee Addendum HB 977 continued:

9. This bill is another form of standardization in which everyone lives in the same house, wears the same uniform, has the same insurance plan. This bill deprives the individual of his free choice.

10. An increase in the bureaucracy to administer this bill will be necessary.

11. The General Federation of Women's Clubs opposes all forms of socialized medicine.

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

FREE

Federation's Role in our Enterprise Economy

April 22, 1980

Dear Legislator

We oppose House Bill 412 relating to minimum standards for hospital care. If such a bill were enacted the cost of hospital care could rise dramatically. We feel that this bill puts an unnecessary burden on the physician as well as on the relatives of the patient.

Sincerely,

FREE Committee
Anchorage Woman's Club

Marlene [illegible]
1341 St. Gotthard 99504

Jennie Carrie Holley
SRA Box 58-W Anch. 99507

[illegible]

Priscilla J. Thorson
2315 Lakeshore Dr. Anch 99503.

[illegible] Anch. 99507

[illegible]

[illegible] 3714 [illegible]
Anch. 99502

[illegible]

[illegible] 2016 [illegible]

[illegible] Young - 3833 Hampton
Anch. 99504

[illegible]

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015
A committee of the Anchorage Woman's Club

April 23, 1980

POSITION PAPER

To: Legislators of the State of Alaska

From: FREE Committee of the Anchorage Women's Club

Re: House Bill 412 "An Ac providing for minimum standards for hospit care."

The FREE Committee of the Anchorage Women's Club opposes HB 412 for the following reasons:

1. Recruitment and retention of physicians in our rural communities could be impaired.

2. The bill appears to regulate the physicians through the hospital. Hospitals do not practice medicine, but rather provide the setting in which medicine can be practiced. Doctors work at the hospital, not for the hospital.

3. The cost of health care will rise even higher.

4. This bill appears to ignore the training of nurses who are specifically prepared to work on the intensive care ward.

5. Very few doctors will allow another doctor to interfere with his patients' care. We as patients would not like a strange "night" doctor taking over our case.

6. Malpractice insurance probl ms may result if one doctor treated another doctor's patient without permission.

7. This bill regulates and interferes even further with a profession whose primary goal is excellence in their services and relationships with their clients.

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

POUCH H-07
JUNEAU, ALASKA 99811

April 14, 1980

To: The Honorable Thelma Buchholdt
Alaska State Legislature
House of Representatives
Pouch V
Juneau, Alaska 99811

Thru: Helen D. Beirne, Commissioner
Department of Health and Social Services

Thru: Rod Betit, Director
Division of Public Assistance

From: Robert M. Ogden, Chief
Medical Assistance Section

Dear Ms. Buchholdt:

We have not been able to develop a comprehensive and complete fiscal note for HB 977. In order to adequately develop a responsive fiscal note more time is needed.

To date we have developed fiscal notes for three sections of the bill and will outline them as follows:

		Millions
a.	Dental Services and Dentures:	2,800
b.	Limited Medical Needy program for Blind, Disabled and Elderly (persons over 60):	5,600
c.	Prescription Drugs for the Elderly (65 years or older):	2,499
		10,899

These three portions are a very small part of the cost involved in the implementation of House Bill 977.

Acquiring cost figures on the many other services that would be added will take lengthy study and research and the Deaprtment has not had time to accomplish that which is required.

06-F81LH

Other services added that need cost analysis are as follows:

1. Diagnostic, Screening, Preventive and Rehabilitative Services: This type of program can be very costly if not controlled in a reasonable manner.

2. Podiatrist Services: Should not cost a great deal due to the small number of podiatrists in the State.

3. Chiropractic Services: This also could be a very costly addition.

4. Private Duty Nursing: Could in the long run with development reduce costs currently incurred in health facilities expenses.

5. Physical Therapist Services: This addition would be of moderate cost to the State.

6. Occupational Terapy: Also of moderate costs, depending upon controls of usage.

7. Personal Care Services: Costly to implement but may in the long run actually save costs.

8. Prosthetic Devices: Should be of little cost.

Greater Fairbanks

CHAMBER OF COMMERCE

FAIRBANKS
ALASKA

A RESOLUTION RELATIVE TO HEALTH INSURANCE IN THE STATE OF ALASKA

EREAS the Alaska House of Representatives Committee on Health, Education and Social Services (HESS) has introduced House Bill No. 977, and

EREAS HB 977 ignores the fact that most employers in the State of Alaska provide health insurance for their employees, and

EREAS the provisions of HB 977 place an additional cost burden on small business, both for premium and administrative cost, and

EREAS the provisions of HB 977 require additional regulations to be promulgated in large quanity by the State of Alaska, and

EREAS HB 977 would create an additional cost burden to the insurance carriers to bring their current plans into compliance with the provisions of HB 977, and this cost would be passed over to the consumer, and

EREAS these cost burdens would be a disincentive to have employees, and

EREAS currently there is a sufficient number and quality of insurance carriers licensed in the State of Alaska to provide adequate coverage as outlined in the provisions of HB 977, and

EREAS the provisions of HB 977 require the State of Alaska to add substantial additional staff to administer this local version of a "National Health Care Plan", now

EREFORE BE IT RESOLVED that the Greater Fairbanks Chamber of Commerce is opposed to HB 977 in its entirety.

ssed by the Board of Directors of the Greater Fairbanks Chamber of mmerce on April 8, 1980.

ATTEST

C.W. Baer
General Manager

Terry Palczer, President

From: Fairbanks Chamber of Commerce
Terry Palczer

FBX/L10/MW 4/9/80 [illegible]:55PM via #209 copier

Kenai Chamber of Commerce
Box 497
Kenai, Alaska 99611
(907) 283-7989

April 11, 1980

State of Alaska
House of Representatives
Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Re: House Bill 997

Dear Committee Members:

The Greater Kenai Chamber of Commerce has requested that I communicate to you in writing the Chamber's position with regard to House Bill 997. The Chamber opposes the Bill for the following reasons:

The great majority of our members carry some type of health insurance for the benefit of their employees. It therefore appears that only a relatively few regularly employed Alaskan employees would benefit from the plan.

As to those employers who do not carry insurance for their employees, there appear to be three basic types of employers. The first category of such employers are businesses who primarily employ seasonal workers, many of whom are transient. A prime example of such employers would be canneries. The canneries employ seasonal workers who would be benefited by the plan for only a month or so, and have no reasonable expectations of being insured while in the employ of the cannery.

The employers of such an industry would be saddled with the expenses of additional overhead and premium expenses with little net benefit to Alaska employees generally.

The second classification of employers who do not carry insurance are those employers, generally small businesses, who have employees who have chosen the occupation, fully aware that no health plan exists, but who have elected to stay with the job for whatever reason. They may have spouses who are covered under alternative plans; they may receive wages or bonuses in a sufficient amount to pay for their

own medical coverage; or, they may have elected to take the additional wages in lieu of insurance plans. Examples of such workers are those usually single workers whose perceived health insurance needs are not of significant concern to them, but who are in the stage of their lives where the additional income is more significant to them.

The final obvious classification is those employers, again primarily small businesses, who cannot afford to provide health care plans for their employees, but who are nevertheless able to attract employees because of other attractive aspects of the working conditions offered.

The Bill as presently written would result as noted above in a net benefit to only a small portion of the Alaska work force. The provision of the Bill which requires mandatory coverage by employers is its most objectionable feature. We question whether it is the function of the State to make such an economic decision for employers and employees. If health care is of concern to an employee, then that employee can seek employment with an organization which offers such a benefit, or can join an organization which offers a group health care plan to its individual membership. Even our Chamber of Commerce has such a plan which is available to all members and their employees.

If an employer is able to attract qualified employees for whom a health care plan is not of significant concern, then it should not be the function of the State to amend the employment contract by adding a provision which may be of little consequence to an employee, but is an added burden to an employer through increased overhead expenses.

The Bill appears to focus primarily on the small business entities of the State who are already overburdened with governmental reporting and record keeping requirements. The small benefit to the Alaskan employee from the Bill appears to be substantially outweighed by the additional costs and administrative problems with wh ch the Bill saddles the small employer.

The administrative features of the Bill make it obvious that an increased state bureaucracy is going to be required to supervise and administer the plan. This bureacracy does not seem to be justified by the limited needs which are addressed by the plan.

We view the Bill in its present form as being an unnecessary intrusion into the affairs of employers and employees, and of limited benefit generally when compared to the hardship with which it saddles the small business.

Thank you for your attention to our concerns.

Very truly yours,

C. R. BALDWIN
Director

CRB:jh

IMPACT ON INSURANCE CARRIERS

Minnesota Experience

The Minnesota Comprehensive Health Act took effect January 1, 1977. At year end, 1976, the following statistics were compiled:

Out of

751 carriers licensed to write health and accident insurance in the state,

42 carriers withdrew from the state rather than comply with the law. Of these,

25 never wrote any health insurance in the state anyway. The remaining

17 carriers that withdrew had a combined volume of

$888,000 in health insurance premiums in Minnesota (less than 0.2% of the total) or an average of

$52,200 in premiums per carrier. The largest carrier that withdrew reported a volume of

$428,000 in accident and health premiums.

Since the time these statistics were compiled, other carriers have dropped their accident and health business in Minnesota, and some that originally withdrew have resumed their accident and health line of business in the state again.

Mr. Caroll Calloway, Assistant General Counsel for the Health Insurance Association of America, discussed several reasons that carriers might have preferred to stop doing accident and health business in Minnesota rather than comply with the Comprehensive Health Act.

The first objection was that many carriers specialize in a particular type of insurance and do not underwrite comprehensive policies. The law requires them to offer comprehensive plans, and does not allow them to refuse a client for reasons other than that the client is an uninsurable risk. Another objection was that the required conversion privileges obligates a carrier that specializes in group policies to also write individual conversion policies.

Mr. Calloway stated that the insurance carriers like the Connecticut comprehensive health act, because in Connecticut the underwriting burden for the mandated coverage is not placed on the induvidual carriers, but on the association. The association in Connecticut develops and underwrites the comprehensive health plan which the carriers are obligated to make available to their clients. The Minnesota law also provides for reinsurance and administration by the association of all required types of coverage, and the association has the ability to develop prototype plans for use by any carrier which does not choose to develop and issue its own qualified plans. The Minnesota carriers association has refused, however, to reinsure lines of coverage mandated by the act, other than the state plan for high risk clients, according to Mr. Calloway. Thus it is not the provisions of the law which place an insurmountable burden on the carriers, but the practice of the assocaition, which of course is run by the carriers themselves.

The third objection was the "major medical roll on" which requires carriers to offer major medical coverage to their client with unqualified plans. They regard this as an impairment of contract. This section to which the carriers strenuously object could easily be deleted without significantly weakening the bill, in light of the requirement that carriers must offer their client a comprehensive qualified plan with major medical coverage anyway.