SB

227

6/9/1986

SB 227: See also ~~H~~HESS files on "STATE HEALTH INSURANCE".

Jeanie Henry

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M March 29, 1979

SUBJECT: CSSB 227, relating to alcoholism and drug dependence insurance

TO: Senator Mike Colletta

FROM: John B. Chenoweth, Legislative Counsel

I do not want to belabor the explanation you requested of this bill. The one-page summary provided by the insurance division seems more than adequate. I did question Don Koch concerning the distinctions among the several types of policies mentioned or referenced in lines 11-13 of page 1 of the bill, and thought I would share that informaton with you.

The subsection mentioned speaks to

(1) "group insurance policies providing coverage on an expense-incurred basis"; and

(2) "group service or indemnity type contracts issued by a non-profit corporation."

(1) identifies the contracts normally issued by private insurance contracts. Private corporation contracts are typically indemnification contracts, by the terms of which the insurance company agrees to reimburse the insured for covered expenses. These contracts are usually one of three types: the "specified sickness" policy, the "flat rate" policy (paying so much per day for hospitalization for whatever the reason), and the "expense-incurred" policy (reimbursing for certain expenses designated in the policy). This bill addresses only the "expense-incurred" policy, the insurance division spokesman says, for this is the type of policy usually written by companies for the benefit of employees, and is more nearly related to the kind of coverage for hospitalization and outpatient services than other kinds of company-written policies. By the term of the bill, only group policies must provide for the coverage.

(2) above -- the service or indemnity-type policy -- is typically the kind of coverage written by carriers providing direct subscription coverage. In a service contract, payment is made by the carrier to the hospital or health facility (and in some states to physicians) for medical services provided to persons covered. In Alaska, Blue Cross of Washington/Alaska is the principal carrier of service contracts for health care coverage. My understanding of the explanation is that only nonprofit corporations are able to enter into service contract relationships directly with hospitals and health facilities. The reference to "indemnity-type" contracts in this line extends the mandatory coverage for alcoholism and drug dependence to nonprofits who indemnify insureds as well as to those whose business follows the service approach.

I trust this helps to explain the differences in the types of coverage. From the explanation, it appears certain that the intended alcoholism and drug dependence coverage does reach all providing coverage on an expense-incurred basis, including, of course, "profit-seeking" insurance corporations writing this type of coverage.

JBC:nem

PROBLEM

THE PROBLEM IS THAT CURRENTLY IT IS NOT REQUIRED BY LAW THAT ALL GROUP INSURANCE PLANS INCLUDE COVERAGE FOR PERSONS WITH ALCOHOL OR DRUG DEPENDENCY PROBLEMS, YET STATISTICS INDICATE THAT;

1. 5% OF THE POPULATION ARE PROBLEM DRINKING EMPLOYEES
2. 15% OF HEALTH MONEY IS SPENT ON THE PROBLEM DRINKING EMPLOYEE
3. ALCOHOL IS RELATED TO 1/3 OF ALL SUICIDES, 1/2 OF ALL MURDERS 1/2 OF ALL TRAFFIC ACCIDENTS, 1/4 OF ALL ACCIDENTAL DEATHS
4. 70% OF THE PROBLEM DRINKING EMPLOYEES CAN BE REHABILITATED.

COST/BENEFITS

'AN EMPLOYER CAN EXPECT SIGNIFICANT HEALTH INSURANCE COST SAVINGS BY PROVIDING EMPLOYER HEALTH INSURANCE FOR ALCOHOLISM' ::

1. PROBLEM DRINKING EMPLOYEES USE $3 IN HEALTH BENEFITS TO $1 FOR THE AVERAGE EMPLOYEE
2. IF AN EMPLOYER PROVIDED ADEQUATE COVERAGE FOR ALCOHOLISM AND ONLY 20% OF PROBLEM DRINKING EMPLOYEES WERE REHABILITATED, THIS MINIMAL NUMBER ALONE COULD SAVE THE EMPLOYER AROUND 2% OF TOTAL CLAIMS PAID.

:: FROM THE REPORT 'INSURANCE COST SAVINGS DUE TO ADEQUATE ALCOHOLISM HEALTH BENEFIT' FROM THE BLUE CROSS MAGAZINE PERSPECTIVE, WINTER 1978

BRIEF SUMMARY OF CSSSSB 227

" AN ACT RELATING TO INSURANCE FOR ALCOHOLISM AND DRUG DEPENDENCE"

THIS BILL MAKES IT REQUIRED FOR GROUP INSURANCE POLICIES TO PROVIDE COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. THE MINIMUM REQUIREMENTS FOR THIS COVERAGE ARE DESCRIBED IN THE BILL AND INCLUDE:

1. 14 DAYS OF INPATIENT DETOXIFICATION CARE PER YEAR
2. 30 DAYS OF INPATIENT TREATMENT PER YEAR
3. 30 VISITS OF OUTPATIENT TREATMENT PER YEAR

ALL OF THE ABOVE MINIMUM REQUIREMENTS AS OUTLINED IN THE BILL ARE TO BE ADMINISTERED IN A/OR BY A

1. STATE APPROVED TREATMENT FACILITY
2. LICENSED HOSPITAL
3. LICENSED PHYSICIAN
4. STATE CERTIFIED PROFESSIONAL SUBSTANCE ABUSE COUNSELOR

THE INSURANCE AS REQUIRED BY THIS BILL WOULD INCLUDE BENEFITS FOR DEPENDENTS REGARDLESS OF AGE,SEX OR STATE OF ILLNESS.
HOSPITAL MEDICAL SERVICE CORPORATIONS IE. BLUE CROSS (THE LARGEST INSURANCE COMPANY WITH ALASKA) ARE REQUIRED BY THIS BILL TO INCLUDE ALCOHOLISM AND DRUG DEPENDENCE INSURANCE.

THIS BILL INSURES THAT ALL PERSONS COVERED BY A GROUP INSURANCE POLICY ARE COVERED FOR ALCOHOLISM AND DRUG DEPENDENCE WHETHER OR NOT SPECIFIED IN THE POLICY. (THE REASONING FOR THIS IS THAT SOME POLICIES ORIGINATE OUT OF STATE THERFORE THE POLICY MIGHT NOT SPECIFY ALCOHOLISM AND DRUG DEPENDENCE COVERAGE, SO THIS WOULD CHANGE THE LAW MAKING IT AUTOMATIC FOR ALASKAN EMPLOYEES COVERED BY INSURANCE.)

CSSSSB 227 PROVIDES FOR AN EFFECTIVE DATE OF NOVEMBER 1,1979 IN ORDER FOR INSURANCE COMPANIES TO COMPLY WITH THE NEW LEGISLATION.

SECTION ANALYSIS SS for SB 227 FROM THE DIVISION OF I''SURANCE

Sec 1 AS 21.42

Requires that all group health insurance policies issued by insurance companies and all service or indemnity type contracts issued by non-profit corporations such as Blue Cross, provide as a minimum, specified coverages related to alcoholism and drug dependence.

COVERAGES are:

A. not less than 14 days detoxification benefit at a rate equal to other benefits provided in the policy.
B. not less than 30 days inpatient treatment benefit
C. not less than 30 visits to specified outpatient treatment facilities.

Alcoholism and drug dependence coverage is to be provided for all persons covered under the group policy without regard to age, sex, state of illness, or pre-existing condition.

Section 1 also provides key definitions of alcoholism and drug dependence.

Section 2 Amends AS 21.87 347 to provide that Hospital Medical Service Corporations ie. Blue Cross, are also subject to the provisions of AS 21.42 as created by this bill.

Section 3 Specifies that coverage for alcoholism and drug dependence shall automatically apply to all persons covered by a group policy issued for delivery, delivered or renewed in this state after the effective date of the act; whether the policy wording specifically provides coverage or not.

Section 4 Provides for an effective date of November 1, 1979 in order for insurance companies to amend policies and adjust rates prior to the effective date.

Blue Cross®
of Washington and Alaska

Armand B Hoppel
President

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3389

April 11, 1979

Representative Thelma Bucholdt
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Bucholdt:

You are aware that Committee Substitute for Sponsor Substitute for Senate Bill 227 (CSSSSB 227) is before you for consideration.

This bill is designed to combine the resources from providers, business/industry, and third party payors from the private sector in an attempt to combat, through recognized treatment programs, the problem of alcoholism and drug abuse.

The proposed legislation does have a price tag and we estimate this to be between three percent and five percent of existing health insurance premium. However, there is strong evidence that this cost will ultimately be offset by a decrease among the alcoholic population in the incidence of other conditions and a reduction in loss-of-time benefits paid by employers.

Although the concept of mandating benefits is offensive to many, we believe that it is appropriate in this case in order to guarantee the availability of services. In this respect, we would also encourage your support on Committee Substitute for Senate Bill 228 amended (CSSB 228 am).

Overall I believe CSSSSB 227 is a sound piece of legislation and I would urge your support.

Sincerely,

Armand B Hoppel

Armand B Hoppel

ABH:eb
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file under SB 227

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

SB 227-HEALTH INSURANCE FOR TREATMENT OF
ALCOHOLISM AND DRUG DEPENDENCE

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

Our member companies are very much concerned about the problems of alcoholism and drug dependence. We have been leaders in developing insurance coverage for these conditions, and in encouraging the establishment of effective programs for early detection, diagnosis, and treatment. We have learned that an effective program requires much more than just some group insurance coverage. Where an employer does nothing more than furnish the coverage, little use is made of it.

One essential of an effective program is an employer who is willing to encourage the use of the treatment program, and who has specially trained supervisors and a medical department which participate in the program. Forcing unwilling employers to furnish insurance coverage is the worst possible approach.

SB 227, as it passed the Senate, takes this latter approach. It would require all group hospital and medical expense policies to include certain specified benefits for treatment of alcoholism, drunkenness (detoxification), and drug abuse. The required coverage differs in several important respects from coverage now being furnished by insurers, either in Alaska or in other states. We think it would be unwise to take an untested plan of insurance and mandate it for all policies.

The additional costs of this plan are estimated at 3 1/2% to 5% for those policies that already cover alcoholism and drug abuse, and would be considerably higher for one that does not. This will be in addition to the increases in premiums that will be needed to cover the rapidly rising costs of health care covered under other policy benefits.

While additional costs concern everyone, they hurt most employees who have to contribute to the cost of their group insurance, retired persons who pay for coverage under a group plan, and small employers.

Your House HESS committee, at our suggestion, recommended a substitute bill which would not mandate benefits for all policies, but would test the Senate plan of benefits by including it in the State employees insurance program. Blue Cross-Blue Shield is willing to provide the coverage. We think this is the place to test it, where costs and results can be most closely monitored.

This approach will not disrupt our existing plans of alcoholism and drug addiction coverage, which many groups already have and which can be purchased on a voluntary basis.

We urge you to support your HESS committee's substitute bill.

April 27, 1979

Charles D. Kuhnen, Counsel

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE 586-6442
JUNEAU, ALASKA 99802

File under SB 227

APR 25 PM 5 14

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32261 ANCHORAGE ALASKA 105 04-25 244P AST

PMS THELMA BUCHHOLDT, CHAIRMAN

HOUSE HESS COMMITTEE POUCH V

JUNEAU AK 99811

ON BEHALF OF THE PARTICIPATING EMPLOYERS OF THE KETCHIKAN RETAILERS HEALTH AND WELFARE TRUST AS WELL AS MANY OTHER EMPLOYERS WE STRONGLY URGE THAT SENATE BILL 227 IF PASSED DOES NOT CONTAIN A MANDATORY PROVISION REQUIRING ALCOHOL AND DRUG COVERAGE. SUCH SHOULD BE A MATTER OF FREE CHOICE AND BARGAINING AND SHOULD BE A MATTER OF FREE CHOICE AND BARGAINING AND SHOULD NOT BE FORCED ON AN EMPLOYER OR AN EMPLOYEE. BOTH SHOULD BE FREE TO NEGOTIATE TYPES OF COVERAGE. A MANDATORY PROVISION WOULD BE INFLATIONARY AS WELL. FOR FURTHER INFORMATION PLEASE CONTACT THE WRITER. P.S. WITH THE EXCEPTION OF BLUE CROSS ALL OTHER INSURANCE COMPANIES OF WHICH THE WRITER HAS KNOWLEDGE. SUPPORT THE FOREGOING POSITION.

A FRED MILLER, ATTORNEY FOR KETCHIKAN
RETAILERS HEALTH AND WELFARE TRUST

Name	Address	Organization	Bill No.
Matt Felix	210 Admiral Way	Alcoholism - Drug Abuse Control Agency	SB. 227

6529
Chenoweth

Original sponsors: Colletta, Stimson and Hohman

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to insurance for alcoholism and drug dependence; and providing for an effective date."

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

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.347. REQUIRED PROVISION OF COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) Group health insurance policies providing coverage on an expense-incurred basis and group service or indemnity type contracts issued by a nonprofit corporation

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a

licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 per cent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to an employer, as the policyholder, for the purpose of insuring his employees only if the employer employs 15 or more employees.

(c) In this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 2. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.42.347.

* Sec. 3. The provisions of this Act apply to group policies or contracts delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for persons in this state delivered, issued for delivery, or renewed after the effective date of this Act shall be considered to provide the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 4. This Act takes effect November 1, 1979.

approval of the Advisory Board on Alcoholism. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available or could reasonably be made available to the applicant.

(d) Money used by the applicant to qualify for state money may be from any source other than the state. The cost of developing an application is not reimbursable from the grant. The value of real property to be used directly in conjunction with the grant may be used in calculating the required amount of community money, as allowed by regulations of the department. (§ 2 ch 101 SLA 1970; am § 1 ch 126 SLA 1975)

Effect of amendment. — The 1975 amendment, in subsection (c), substituted the language beginning "except that in communities" and ending "10 per cent community money" for "for the purpose of providing staff, and in the ratio of 75 per cent state money and 25 per cent community money" in the first sentence, inserted "staff and" in the second sentence, and substituted "percentages" for "percentage" in the third sentence.

Sec. 47.30.477. Grant-in-aid program regulations. The department shall adopt regulations implementing § 475 of this chapter. The regulations shall provide for the method of application, the time for consideration of applications, the processing of applications, the type of record keeping, the requirements for reporting the progress and statistics regarding the program, the notification of the applicant as to the action taken on the application, and the issuance of licenses for facilities receiving grants-in-aid under § 475 of this chapter. The department shall also establish the necessary forms of application and may adopt other regulations considered necessary to meet the requirements of health and safety and the orderly administration of the grant-in-aid program. (§ 2 ch 101 SLA 1970)

Sec. 47.30.480. Judicial notice. The superior courts of this state may take judicial notice of the fact that an alcoholic is suffering from an illness and is in need of proper medical, advisory or rehabilitative treatment. (§ 2 ch 163 SLA 1966)

Sec. 47.30.490. Acceptance of funds. The department may accept on behalf of the state and deposit, apart from other public funds, grants from the federal government or gifts or contributions from other sources to assist in carrying out the purposes of § 470 of this chapter. (§ 2 ch 163 SLA 1966)

Sec. 47.30.500. Definitions. In §§ 470—490 of this chapter

(1) "department" means the Department of Health and Social Services;

(2) "alcoholism" means a condition related to alcohol and concerns a physical compulsion which exists, coupled with a mental obsession;

(3) Repealed by § 2 ch 207 SLA 1972.

Sec. 47.37.270. Definitions. In this chapter

(1) "alcoholic" means a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered, or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in § 140(a) of this chapter and approved under § 140(c) of this chapter;

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under § 130(g) of this chapter and meeting the standards prescribed in § 140(a) of this chapter and approved under § 140(c) of this chapter;

(4) "commissioner" means the commissioner of health and social services;

(5) "coordinator" means the coordinator of the office of alcoholism;

(6) "department" means the Department of Health and Social Services;

(7) "emergency service patrol" means a patrol established under § 230 of this chapter;

(8) "incapacitated by alcohol" means a person who is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment, as evidenced objectively by extreme physical debilitation, physical harm or threats of harm to others or chronic inability to hold regular employment;

(9) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling. (§ 1 ch 207 SLA 1972)

Quoted in Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Chapter 40. Purchase of Services.

Name	Address	Organization	Bill No.
Mike Thomas	Box 1211 Juneau 99802	Am Council of Life Ins.	SB 227
Charles Kuhnen	332 S. Michigan Ave, Chicago Ill. 60604	Health Insurance Association of America	SB 227
ROBERT L. COLE	819 G. ROBERT JUNEAU 99811	Office of ATG/DA	SB 227
DON KOCH	POUCH D 99811	DIV. OF INSURANCE	SB 227

Proofed 4-30

Original sponsors: Colletta, Stimson and Hohman

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health insurance for employees in the state; and providing for an effective date."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. ~~AS 21~~ COMPREHENSIVE HEALTH CARE PLANS

Sec. 21.50.010. INDIVIDUAL AND GROUP COMPREHENSIVE HEALTH CARE PLANS. (a) A carrier offering individual health insurance in the state shall, as a condition of transacting health insurance, make an individual comprehensive health care plan described in AS 21.50.040 available to each resident of the state who is not eligible for Medicare. An individual shall have a choice of the low option, the middle option, or the high option deductible described in AS 21.50.020(b). Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in accordance with AS 21.50.050 or a residual market association, in accordance with AS 21.50.060. The premium charged for a plan which is not insured by or through the Health Reinsurance Association or ~~another~~ residual market association may not exceed the premium which is applicable through participation in a residual market association. The premium charged for a plan insured by or through the Health Reinsurance Association is the premium established for the particular classification under the Health Reinsurance Association.

(b) A self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan described in AS 21.50.040 available under a conversion privilege to each insured person

covered by the plan who is a resident of the state, who is not eligible for Medicare, and whose coverage under the self-insured plan ceases as a result of layoff, death, or termination of employment. An individual shall have the choice of the low option, the middle option, or the high option deductible described in AS 21.50.020(b). The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association under AS 21.50.050. The premium charged for a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for a plan which is insured by or through the Health Reinsurance Association is the premium established for that particular classification under the Health Reinsurance Association.

(c) Each carrier offering group health insurance in the state shall, as a condition of transacting health insurance, make a group comprehensive health care plan described in AS 21.50.030 available to every resident employer of three or more eligible employees. An employer shall have the choice of the low option, the middle option, or the high option deductible described in AS 21.50.020(b). Group comprehensive health care plans may be made available to resident employers of between three and 25 eligible employees through participation in the Health Reinsurance Association under AS 21.50.050 or the residual market association under AS 21.50.060. The premium charged for a plan on groups of between three and 25 eligible employees which is not insured by or through the Health Reinsurance Association or a residual market association may not exceed the premium which is applicable through participation in a residual market association. The premium charged for a plan which is insured by or through the Health Reinsurance Association is the premium established for that particular classification under the Health

Reinsurance Association.

(d) ~~Except as provided in AS 21.50.070(c)~~ This chapter does not preclude the right of a carrier to transact another kind of insurance or another kind of health insurance which it is authorized to transact.

(e) This chapter does not require a carrier to make coverage available under a group or individual comprehensive health care plan to a person or group already covered under a plan.

Sec. 21.50.020. MINIMUM STANDARD BENEFITS. (a) Individual and group comprehensive health care plans shall include minimum standard benefits described in this section. Except as provided in (b) and (c) of this section, minimum standard benefits are benefits, including coverage for catastrophic illness, with a lifetime maximum of $1,000,000 per insured person for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred for the following health care services rendered to an ~~individual~~ insured person covered by a plan for the diagnosis or treatment of nonoccupational disease or injury;

(1) hospital services;

(2) professional services which are rendered by a physician or at his direction, by a registered nurse, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions as defined in regulations of the director during the year by one or more physicians on other than an inpatient basis or, at their direction, by their staffs of registered nurses up to a yearly maximum benefit of $1,000;

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a calendar year if the services begin within 14 days follow-

ing a confinement of at least three consecutive days in a hospital for the same condition;

(6) home health agency services, as defined in regulations of the director

(A) up to a maximum of 180 visits in a calendar year if the services begin within seven days following confinement in a hospital or skilled nursing facility for at least three consecutive days for the same condition;

(B) in the case of an insured person diagnosed by a physician as terminally ill with a prognosis of six months or less to live, home health agency services may begin even if the thresholds of (A) have not been met;

(7) medical social services not to exceed $200 in a calendar year;

(8) use of radium or other radioactive materials;

(9) oxygen;

(10) anesthetics;

(11) non-dental prosthesis;

(12) rental of durable medical equipment which has no personal use in the absence of the condition for which it is prescribed;

(13) diagnostic x-rays and laboratory tests as defined in regulations of the director;

(14) oral surgery for

(A) excision of partially or completely unerupted impacted teeth; or

(B) excision of a tooth root without the extraction of the entire tooth;

(15) services of a licensed physical therapist, rendered under the direction of a physician;

(16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury;

(17) other medically necessary services in the treatment or diagnosis of an illness or injury as defined in regulations of the director;

(18) confinement in a facility established primarily for the treatment of alcoholism and licensed for care of alcoholics by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least 45 days in a calendar year.

(b) Minimum standard benefits may include one or more of the following provisions:

(1) subject to (3) of this subsection, a plan may require deductibles. The low option deductible is $100 per person, the middle option deductible is $500 per person, and the high option deductible is $1,000 per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when the service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an insured person's deductible for the year shall be applied to the insured person's deductible in the following calendar year. The $100 maximum, the $500 maximum and the $1,000 maximum shall be adjusted yearly by the director in regulations adopted by him to correspond with the change in the medical care component of the consumer price index. The base year for the computation is the first full year of operation of the plan.

(2) subject to the provisions of (3) of this subsection a plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible and 50 percent for

services listed in (a)(3) of this section in excess of the deductible.

(3) the sum of the deductible and copayments required in a calendar year under an option may not exceed a maximum limit of $1,000 per covered individual or $2,000 per covered family except ~~that~~ O.K. ~~(A)~~ covered expenses incurred after the applicable maximum limit has been reached are paid at the rate of 100 percent; and (B) expenses incurred for treatment of mental and nervous conditions may be paid at the rate of 50 percent under (a)(3) of this section. The $1,000 and $2,000 maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the commissioner.

(4) the plan may limit lifetime benefits to a maximum of not less than $1,000,000 per insured person.

(5) a plan may not exclude coverage of a preexisting condition unless (A) the condition first manifested itself within the period of six months immediately before the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately before the effective date of coverage; or (C) the condition is pregnancy existing on the effective date of coverage. A policy may not exclude coverage for a loss due to preexisting conditions for a period greater than 12 months following the effective date of coverage. An individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self insured group shall credit the time covered under the group health insurance toward an exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for a charge for

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject to a workers' compensation or similar law; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered;

(3) travel other than medically necessary transportation as defined in regulations of the director;

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that it exceeds the reasonable charge in the locality for the service;

(6) services or articles which are determined not to be medically necessary;

(7) services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for or reimbursed directly by or under a law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care ~~of~~ or designed primarily to assist an insured person ~~or person's~~ in meeting his activities of daily living;

(10) services which would not have been made if no insurance existed or for which the insured person ~~or person's~~ is not legally obligated to pay;

(11) eyeglasses, contact lenses or hearing aids, or the

fitting of them;

(12) dental care not specifically covered by this chapter; and

(13) services of a registered nurse who ordinarily resides in the insured ~~person or~~ person's home, or who is a member of the insured ~~person or~~ person's family or the family of the spouse.

(d) If an insured person who receives benefits for an injury possesses a right of recovery, a carrier that has paid benefits to or for the insured person is subrogated to a right of recovery to the extent of its payments.

(e) The minimum standard benefits of an individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense-incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

Sec. 21.50.030. ADDITIONAL REQUIREMENTS AND ELIGIBILITY UNDER GROUP COMPREHENSIVE HEALTH CARE PLANS. (a) A group comprehensive health care plan shall cover each regular employee and the dependents of the employee.

(b) A group comprehensive health care plan shall

(1) provide the option to continue coverage under each of the following circumstances until the insured person is eligible for other group insurance:

(A) layoff, leave of absence, or termination of employment, other than as a result of death of the employee, continuation of coverage for the employee and his covered dependents to the end of the 39th week following the day on which the employee lost eligibility to participate in the group;

(B) on the death of the employee, continuation of coverage for the covered dependents of the employee to the end of

the 39th week following the day on which the employee lost eligibility to participate in the group;

(C) during an employee's absence due to illness or injury, continuation of coverage for the employee and his covered dependents during continuance of an illness or injury or for up to 12 months from the beginning of the absence;

(D) on termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination continues without premium payment during the continuance of the disability for a period to 12 calendar months following the calendar month in which the plan was terminated;

(E) any continuation of coverage required by this section except (D) of this paragraph may be subject to the requirement, on the part of the individual whose coverage is to be continued, that the individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued under (A) of this paragraph but the employer is not legally obligated by this section to pay the premium if it was not paid timely by the employee.

(2) terminate the coverage of an insured person

(A) as to a child, at the end of the month following the month in which a child marries, ceases to be dependent on the employee or attains the age of 19, whichever occurs first, except that

(i) if the child is a full-time student at an accredited institution, the coverage continues while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of 23;

LA-L 20A

the 39th week following the day on which the employee lost eligibility to participate in the group;

(C) during an employee's absence due to illness or injury, continuation of coverage for the employee and his covered dependents during continuance of an illness or injury or for up to 12 months from the beginning of the absence;

(D) on termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination continues without premium payment during the continuance of the disability for a period to 12 calendar months following the calendar month in which the plan was terminated;

(E) any continuation of coverage required by this section except (D) of this paragraph may be subject to the requirement, on the part of the individual whose coverage is to be continued, that the individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued under (A) of this paragraph but the employer is not legally obligated by this section to pay the premium if it was not paid timely by the employee.

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(i) if the child is a full-time student at an accredited institution, the coverage continues while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of 23;

LA-L 20A

shall contain provisions

(1) which obligate the carrier to continue the contract until the earlier of (A) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act or under a group comprehensive health care plan or, (B) the plan anniversary date which occurs at least 60 days after the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class basis only; the carrier may reserve the right to adjust premiums by classes in accordance with its experience for policies or contracts not written by or through the Health Reinsurance Association but a premium may not exceed the premium established for the particular class by the Health Reinsurance Association;

(2) which, upon the death of the individual in whose name the contract was issued, permits every other individual covered under the contract to elect, within a period established in the contract, to continue coverage until a time when he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and

(3) under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided under a state or federal law other than Medicaid.

Sec. 21.50.050. HEALTH REINSURANCE ASSOCIATION. (a) There is created as a nonprofit legal entity the Health Reinsurance Association. Each insurer and self insurer doing business in the state, as a condition to its authority to transact the applicable kinds of health insurance defined in AS 21.50.100 is a member of the association. The association shall perform its functions under a plan of operation established and approved under (b) of this section and shall exercise its

powers through a board of directors established under this section.

(b) The board of directors of the association shall consist of seven individuals selected by participating members and subject to approval by the ~~commissioner~~ director. The director shall give notice to all members of the time and place of the organizational meeting to select the first board of directors and to organize the association. In determining voting rights at the meeting a member is entitled to vote in person or proxy. The vote shall be weighted based on the net health insurance premium derived from business in the state in the previous calendar year. If the board of directors is not selected within 60 days after notice of the meeting, the director may appoint the board. In approving or selecting members of the board, the ~~commissioner~~ director may consider whether all members are fairly represented. Members of the board may be reimbursed from the money of the association for expenses incurred by them as members but are not otherwise entitled to compensation by the association for their services.

(c) The board shall submit to the director a plan ~~of~~ of operation for the association to assure the fair, reasonable and equitable administration of the association. The plan of operation becomes effective on approval in writing by the director consistent with the date on which the coverage under this chapter must be made available. The director shall, after notice and hearing, approve the plan of operation if the plan is determined to assure the fair, reasonable and equitable administration of the association and provide for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within 180 days after its appointment or if at any time the board fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt a plan or amendments to a plan as are necessary to carry out the provisions of

this section. A plan and amendments to a plan continue in force until modified by the director or superseded by a plan submitted by the board and approved by the director. A plan of operation shall, in addition to requirements enumerated in this chapter;

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish regular times and places for meetings of the board of directors;

(3) establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the director;

(4) establish procedures under which selections for the board of directors shall be made and submitted to the director;

(5) establish procedures to amend, subject to the approval of the director, the plan of operations;

(6) establish procedures for the selection of an administering carrier and set out the powers and duties of the administering carrier;

(7) contain additional provisions for the execution of the powers and duties of the association; and

(8) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under this chapter.

(d) The association has the general power and authority granted under the law of the state to a carrier to transact the kinds of health insurance defined under AS 21.50.100 and in addition, may

(1) enter into contracts necessary to carry out the provisions of this chapter;

(2) sue or be sued and may take legal action necessary to

recover an assessment for, on behalf of, or against a participating member;

(3) take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association;

(4) establish with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments which may not be unreasonable in relation to the coverage provided and the operational expenses of the association not to exceed the limits set under (e)(3) of this section;

(5) administer a reinsurance program for participating members;

(6) pool risks among participating members;

(7) issue policies of insurance in its own name or on behalf of participating members on an indemnity ~~of~~ or provision of service basis providing the coverage required by this chapter;

(8) administer separate pools, separate accounts or other plans considered appropriate for separate members or groups of members;

(9) operate a combination of plans, pools, reinsurance arrangements or other mechanisms considered appropriate to accomplish the fair and equitable operation of the association;

(10) set limits on the amounts of reinsurance which may be ceded to the association by its members; and

(11) appoint from among participating members appropriate committees necessary to provide assistance in the operation of the association.

(e) Each member of the association shall participate in the association under the following provisions of this subsection:

(1) A participating member shall determine the particular

risks it elects to have written by or through the association.

(2) A member shall designate which of the following classes of risks it shall underwrite in the state, from which it may elect to reinsure selected risks:

(A) individual, excluding group conversion;

(B) individual, including group conversion; and

(C) groups of between three and 25 employees or members.

(3) A member or employer may not select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except under rules established by the association.

(4) Rates for coverage issued by or through the association may not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age apply for individual risks and group risks. Group rates may be adjusted for area variations in provider costs but individual rates may not be adjusted for area variations in provider costs. Premium rates shall consider the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of 10 lives. The rate for a given classification or group may not be more than 125 percent of the average group rate charged for the classification or group at standard risk with similar characteristics under a policy covering 10 lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed

with the director and may be disapproved within 60 days from the filing if the director determines that the rates are excessive, inadequate, or unfairly discriminatory.

(f) Following the close of a fiscal year, an administering carrier shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. A net loss shall be assessed to participating members of the association in proportion to their respective shares of the total health insurance premiums earned in the state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on another equitable basis provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by 85 percent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(g) A net loss to the association represented by the excess of it actual expenses of administering policies issued by the association ove the applicable expense allowance shall be separately assessed to participating members who do not elect to administer their plans. Assessments shall be on an equitable formula established by the board.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the director for his review and the association is subject examination by the director under AS 21.06.

(i) Policy forms issued by the association shall conform to prot

type forms developed by the association and to the requirements of this chapter and shall be approved by the director. The director may disapprove a form if it contains a provision which is unfair or deceptive or which encourages misrepresentation of the policy.

(j) The association may not issue comprehensive health care plan coverage for a person who is covered under an individual or group comprehensive health care plan, who is eligible for Medicare, or who is not a resident of this state.

(k) Benefits payable under a comprehensive health care plan insured by or reinsured through the association are paid net of all other health insurance benefits paid or payable through another source and net of all health insurance coverages provided by or under another state or federal law including Title XVIII of the Social Security Act, Medicare but not including Medicaid.

(l) No liability and no claim arises against a carrier or its agents or its employees, the association or its agents or its employees or the residual market mechanism established under AS 21.50.060 or its agents or its employees, or the director for any action taken by the director in the performance of his duties under this chapter. This subsection does not apply to the obligations of a carrier, a self-insurer, the association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

(m) A carrier may credit an assessment paid to the association under (f) of this section against its income tax payable under AS 43.20 or its premium tax payable under this title for the year in which the assessment was paid. If a carrier's total assessment exceeds its tax liability for the year, the commissioner of revenue shall directly reimburse the carrier in the amount of the excess.

Sec. 21.50.060. HOSPITAL AND MEDICAL SERVICE CORPORATIONS;

RESIDUAL MARKET MECHANISM; DIRECTOR'S POWERS CONCERNING MECHANISMS. (a) A hospital ~~and~~ or medical service corporation may elect to meet the obligations of AS 21.50.010 by participating in the association either as a full member or by making comprehensive health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism similar to the association.

(b) If a hospital ~~and~~ or medical service corporation forms a separate residual market mechanism, the director has the same regulatory powers over the residual market mechanism as he has over the association and the residual market mechanism has the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association but rates established by the residual market mechanism shall be approved by the director. The director may adopt regulations to implement this section.

(c) If a hospital ~~and~~ or medical service corporation does not participate in the association, it is required to make an individual comprehensive health care plan available to every resident of the state who is not eligible for Medicare and whose coverage under a group or individual contract issued by the hospital or medical service corporation has terminated. The coverage may be made available through a separate residual market mechanism established under this section.

Sec. 21.50.070. POWERS OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.060 and may adopt regulations under the Administrative Procedure Act (AS 44.62) to carry out the provisions of AS 21.50.010 -21.50.060;

(2) adopt regulations upgrading minimum benefit standards under AS 21.50.020 - 21.50.040 as may be appropriate due to inflation or

changes in the prevailing standards of the industry;

(3) supervise the establishment of the association under AS 21.-50.050 or a residual market mechanism under AS 21.50.060;

(4) approve the selection of the administering carrier by the association and approve the association's contract with the administering carrier including the comprehensive health care plan coverage and the premiums to be charged;

(5) adopt by regulation reasonable limits on administrative expenses of the administering carrier which may be paid from comprehensive health care plan premiums, and minimum standards for the proportion of comprehensive health care plan premiums to be paid out in claims;

(6) appoint advisory committees;

(7) conduct audits to assure the general accuracy of the financial data submitted by the administering carrier and the association;

(8) contract with the federal government or with another unit of government to ensure coordination of the comprehensive health care plan with other governmental assistance programs;

(9) undertake directly or through studies or demonstrations programs to develop awareness of the benefits of AS 21.50.010 - 21.50.060 so that residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.080. APPLICATION TO NEW OR RENEWED GROUP HEALTH POLICIES AND CONTRACTS (a) Group health policies or contracts delivered or issued for delivery or renewal in the state on or after January 1, 1981, shall, subject to the provisions of (c) of this section, contain the provisions established under AS 21.50.030(b).

(b) The commissioner shall within 180 days after January 1, 1981,

adopt regulations under the Administrative Procedure Act (AS 44.62) covering group coverage discontinuance and replacement.

(c) Nothing in this section alters or impairs existing group policies or contracts which have been established under an agreement which resulted from collective bargaining and the provisions required by this section are effective on the next regular renewal and completion of the collective bargaining agreement.

Sec. 21.50.090. PREMIUM SUPPLEMENTATION. (a) A resident employer who employs 10 or less regular employees who are provided with health insurance coverage as an employee benefit is entitled to premium supplementation if

(1) the employer's share of the cost of providing the coverage exceeds 1.5 percent of the total wages payable to regular employees; and

(2) the amount of the excess under (1) of this subsection is greater than four percent of the employer's income before taxes directly attributable to the business in which the regular employees are employed.

(b) The amount of the supplementation shall be 80 percent of that portion of the employer's share of the premium cost which exceeds the limits specified in (a)(2) of this section.

(c) An employer entitled to premium supplementation may file a claim in the manner provided by regulation of the commissioner. The employer has the burden of establishing his entitlement.

Sec. 21.50.200. DEFINITIONS. In this chapter,

(1) "association" means the Health Reinsurance Association established under AS 21.50.050;

(2) "carrier" means an insurer, hospital service corporation or medical service corporation, or fraternal benefit society;

(3) "commissioner" means the commissioner of commerce and economic development;

(4) "dependent" means

(A) a spouse;

(B) an unmarried child under the age of 19 years;

(C) a child under the age of 23 years who is a full-time student and is financially dependent on the parent;

(D) a child of any age who by reason of mental retardation or physical handicap is incapable of self-sustaining employment and is chiefly dependent on the parent for support and maintenance; and

(E) a household member who is financially dependent on the primary insured;

(5) "director" means the director of the division of insurance in the Department of Commerce and Economic Development;

(6) "family" means the primary insured and his covered dependents;

(7) "health insurance"

(A) means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, and self-insured or self-funded employee health benefit plans;

(B) does not include accident only policies, disability income policies or casualty insurance coverages subject to regulation under AS 21.39;

(8) "home health agency" has the same meaning as "home health agency" as defined in 42 U.S.C., sec. 1395x;

(9) "hospital" has the same meaning as "hospital" as defined in 42 U.S.C., sec. 1395x;

(10) "income directly attributable to the business"

(A) means gross profits from the business less deductions for

(i) compensation of officers;

(ii) salaries and wages, except wages paid by an individual proprietor to himself;

(iii) repairs;

(iv) taxes on business and business property;

(v) business advertising;

(vi) amounts contributed to employee benefit plans;

(vii) interest on business indebtedness;

(viii) rent on business property; and

(ix) other expenses necessary for the current conduct of business;

(B) does not mean

(i) bad debts;

(ii) contributions or gifts, other than those listed under (A)(vi) of this paragraph;

(iii) amortization and depreciation; or

(iv) losses by fire, storm, casualty, or theft;

(C) means zero for organizations with a nonprofit tax status under ~~section~~ O.K. 501(c) of the Internal Revenue Code;

(11) "insurer" means an insurance company licensed to transact accident and health insurance business in the state;

(12) "medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to

(A) assessment of the social, psychological and family

4-L 20A

(B) appropriate action and utilization of community resources to assist in resolving such problems;

(C) participation in the developments of the treatments for ~~the~~ the insured person;

problems related to or arising out of an insured person's illness and treatment; (B) see above

(13) "physician" means a licensed practitioner of medicine, osteophathy, acupuncture, chiropractic, podiatry, psychology, and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry;

(14) "psychologist" means a person who is licensed or certified as a clinical psychologist and has a doctoral degree and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center;

(15) "regular employee" means, with respect to an employer, an employee who either is a full-time employee, or who is expected to work at least 20 hours a week for at least 26 weeks during the next 12 months or who has actually worked at least 20 hours a week for at least 26 weeks in a continuous 12-month period;

(16) 'resident employer"

(A) means a person, partnership, association, trust, estate, corporation, whether foreign or domestic or the legal representative, trustee in bankruptcy or receiver or trustee of one of these, or the legal representative of a deceased person, including the state and a municipality of the state which has in its employ one or more individuals during a calendar year;

(B) refers only to an employer with a majority of employees employed in the state;

(17) "self-insurer"

(A) means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or a part of the cost of covered hospital or medical expenses for covered individuals;

(B) does not include an employee welfare benefit fund or plan established before January 1, 1981, by an organization which is exempt from federal income taxes under the provisions of sec. 501 of the Internal Revenue Code and amendments to it except an organization described in section 501(c)(15) of the Internal Revenue Code;

(18) "skilled nursing facility" has the same meaning as "skilled nursing facility" under 42 U.S.C., sec. 1395x;

(19) "totally disabled" means the inability of an employee because of an injury or disease to perform the duties of an occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of the same age and sex in good health.

* Sec. 2. AS 39.30.090(1) is amended to read:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance. alcoholism and drug dependency insurance, or other medical care insurance.

* Sec. 3. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) The group insurance policy required by AS 39.30.090(1)

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and profes-

sional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 per cent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to provide coverage for employees of the state and may apply to contracts for the benefit of employees of other participating governmental units only if the governing body of the governmental unit elects to have the provi-

sions apply.

(c) In this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially

(B) appropriate action and utilization of community resources to assist in resolving such problems;

(C) participation in the development of treatment for the insured person;

impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 4. AS 39.30.100 is amended to read:

Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-30.090]

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee, and

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a borough, municipal corporation, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts.

* Sec. 5. The provisions of secs. 2 - 4 of this Act apply to group policies or contracts delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for eligible employees in this state delivered, issued for delivery, or renewed after the effective date of this Act shall be considered to provide the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 6. AS 47.05 is amended by adding new sections to read:

Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health maintenance organization service contracts or medical or hospital service contracts that provide one or more ~~the~~ of the medical services available under state medical assistance programs.

(b) The policy of insurance or the contract must by its terms guarantee

(1) to provide the medical services allowed under Alaska law;

(2) to provide medical services under policies of insurance or contracts in compliance with applicable laws and regulations;

(3) to provide the statistical data, records, and reports relating to the provision, administration, and costs of providing medical services as required by the commissioner.

Sec. 47.05.080. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND SERVICE. (a) The commissioner may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and

remedial care and services available under medical assistance for services rendered and supplies furnished by them.

(b) A contract under this section shall

(1) oblige the contractor to make payments under the contract promptly and not later than 30 days after receipt of the proper evidence of the claim; and

(2) provide data, records, and reports required by the commissioner.

Sec. 47.05.090. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.05.070 - 47.05.100 when the commissioner determines that comparable benefits are available at equal or less cost than direct payments by the department to the providers of medical assistance.

Sec. 47.05.100. INTERIM PAYMENT. The department may make an interim payment before receipt of billing for service to providers who serve a large volume of state medical assistance clients under regulations of the department.

Sec. 47.05.110. INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the state shall pay

(1) interest at the rate of one percent per month when payment is delayed more than 30 days after presentation of the clean claim;

(2) interest at the rate of two percent per month when payment is delayed more than 90 days after presentation of the clean claim; and

(3) a full months interest entitlement if the claim is not paid by the 15th day of a calendar month.

Sec. 47.05.120. DEFINITIONS. In AS 47.05.070 - 47.05.120

(1) "clean claim" means a claim for payment which 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;

(2) "commissioner" means the commissioner of health and social services;

(3) "department" means the Department of Health and Social Services;

(4) "medical assistance" means Medicaid (AS 47.07), general relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and crippled children's and maternal and child health programs (AS 18.05.-010).

* Sec. 7. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

* Sec. 8. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

* Sec. 9. AS 47.25.120 is amended to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE UNDER THE CONDITIONS IN THIS STATE,] to

(1) a needy person who is eligible under the regulations of the department; and

(2) a medically needy person whose income is less than the medically needy income standard or who has incurred medical expenses

which equal or exceed the difference between the person's monthly income and the medically needy income standard; the medically needy income standard is 150 percent of the current Federal Community Services Administration poverty income guidelines for Alaska (45 C.F.R., sec. 1060.2).

* Sec. 10. AS 47.07.020(d) is repealed.

* Sec. 11. Sections 1, 7 and 9 of this Act take effect January 1, 1981.

* Sec. 12. Sections 2 - 6, of this Act take effect July 1, 1980.

Here's a quiz on "drinking and working" . . . and the answers:

Questions	Answers
• What percentage of an employee population are problem drinkers?	5%
• How many more company dollars in health benefits does a problem-drinking employee use than the average employee uses?	3 to 1
• What share of employee health claims are by problem drinkers?	15%
• What can be done about problem-drinking employees?	Rehabilitation
• What percentage of problem-drinkers can an employer expect to rehabilitate successfully?	70%
• At what cost to the employer?	None?

Large employers such as Scovill, Economics Laboratory, Illinois Bell, the Philadelphia Fire Department and Kennecott Copper have an edge on most readers. They knew the answers even before PERSPECTIVE provided them. That's because these five employers helped contribute the data.

But Kenneth Sarvis, insurance consultant to the Florida Department of Health & Rehabilitative Services, brought the facts into focus.

His report, INSURANCE COST SAVINGS DUE TO AN ADEQUATE ALCOHOLISM HEALTH BENEFIT, makes four major contentions borne out by employer data:

1. "Problem drinkers utilize a disproportionately high portion of health benefits."
2. "There is a high rehabilitation rate for problem-drinking employees."
3. "There is a significant reduction in the utilization of health and sickness benefits by rehabilitated problem drinkers."
4. "An employer can expect significant health insurance cost savings by providing employees health insurance for alcoholism."

Sarvis' data to support each of these contentions are considerable.

THE TOLL . . .

The U.S. Department of Health, Education & Welfare has issued a report on alcohol abuse. It says:

- An estimated 10 million Americans are either problem drinkers or alcoholics.
- Drinking may be to blame for as many as 205,000 deaths a year.
- The economic toll from alcohol problems was about $43 billion in 1975 (lost production, medical bills, other expenses).
- Alcohol may be involved in: up to one-third of all suicides, half of all murders, half of all traffic deaths, one-fourth of all other accidental deaths.
- Alcohol is "indisputably involved" in causing cancer.

But . . .

- Programs to treat problem drinkers and alcoholics increased from 500 in 1973 to nearly 2,400 in 1977.

CONTENTION NO. 1:

"Problem drinkers utilize a disproportionately high portion of health benefits."

Sarvis says:

"Employee health is considerably affected by problem drinking."

He cites work done by Dr. Wilton Maxw , studying a sample of employees with sickness or injury absence of eight days or more for which sickness payment was made. Each eight-day absence is called a "case" in the following tabulation:

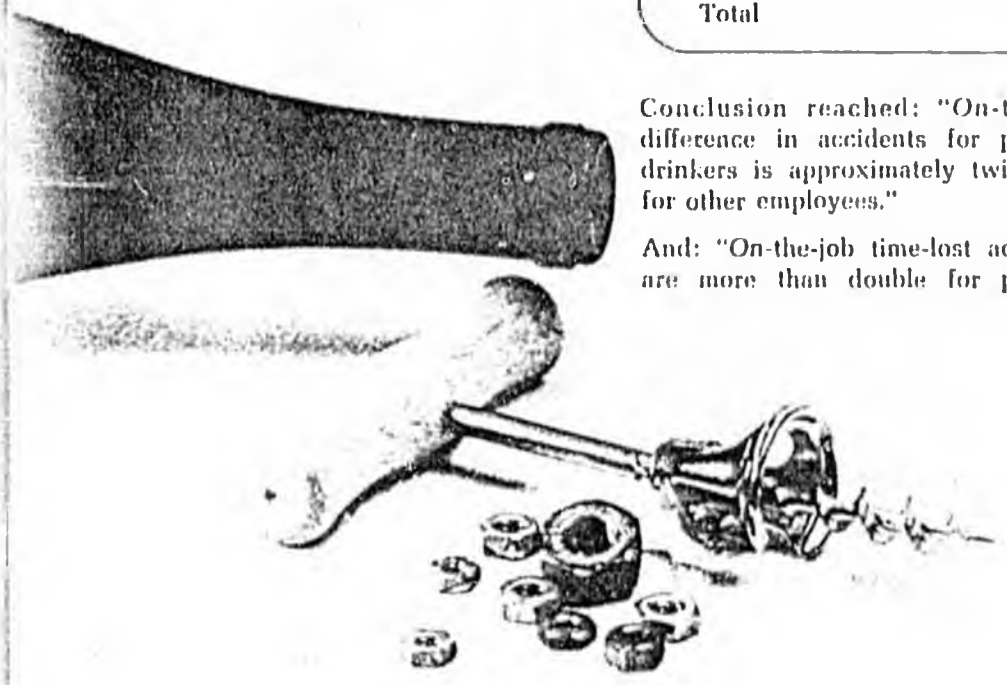
Description	Problem Group	Control Group
Number of cases	364	149
Average number of cases per employee	7.6	3.1
Total days absent	11,672	4,648
Average number of days absent per employee	243.2	96.8
Total sickness payments	$108,495	$36,862
Average sickness payment per employee	$ 2,260	$ 768

Conclusion reached: *"The average and total sickness payments indicate alcoholics cost employers three times the sickness payments of other employees."*

Moreover: "The problem group's total days absent is 2½ times that of the control group, indicating a tremendous loss in production time to the employer."

Maxwell, a PhD in sociology, also studied how frequently accidents happened to members of the two study groups:

Accident Class	Problem Group	Control Group
On job (no time lost)	29	16.0
On job (time lost)	26	11.5
Off job (eight days or more lost time)	44	0.0
Total	99	27.5



Conclusion reached: "*On*-the-job difference in accidents for problem drinkers is approximately twice that for other employees."

And: "*On*-the-job time-lost accidents are more than double for problem drinkers, indicating that the type of accident attributable to problem drinkers is more costly to the employee than other non-alcohol related accidents."

Worst of all: "*Off*-the-job accidents numbered 44 for the problem-drinking group, zero for the control group."

Overall: "The problem-drinker accident rate was 3.6 times that of other employees, a distinctive cost differential to the employer."

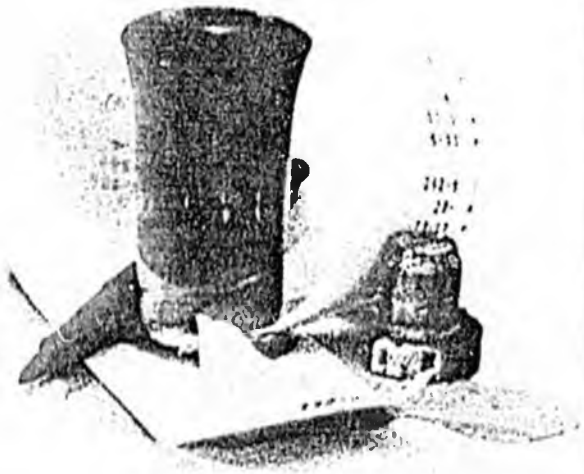
Maxwell explored the question of "how many hospital stays are attributable to problem drinking?" He cites the work of S. Pell and C.A. D'Alonzo in establishing frequency rates by type of illness or injury:

Selected Digestive Disorders		No. of Absences	Frequency Rate %
Gastrointestinal upsets	A	167	21.9
	C	66	7.6
Cirrhosis of liver	A	6	0.8
	C	0	0.0
Peptic ulcer	A	18	2.4
	C	13	1.5
Hernia	A	11	1.4
	C	4	0.5
Gall bladder disease	A	6	0.8
	C	7	0.8
Other digestive disorders	A	7	0.9
	C	13	1.5
Total	A	215	28.1
	C	103	11.9

A = Alcoholics C = Controls

Selected Respiratory Infections		No. of Absences	Frequency Rate %
Upper respiratory infection	A	173	22.6
	C	116	13.4
Influenza	A	71	9.3
	C	51	5.9
Bronchitis	A	35	4.6
	C	24	2.8
Pneumonia	A	15	2.0
	C	4	0.5
Total	A	294	38.5
	C	194	22.5

Selected Musculoskeletal Disorders		No. of Absences	Frequency Rate %
Arthritis	A	18	2.4
	C	5	0.6
Rheumatism	A	15	2.0
	C	7	0.8
Low back disorders, cause unspecified	A	22	2.9
	C	7	0.8
Bursitis	A	17	2.2
	C	5	0.6
Disc disorders	A	14	1.8
	C	2	0.2
Muscular strain	A	16	2.1
	C	6	0.7
Other	A	9	1.2
	C	14	1.6
Total	A	111	14.5
	C	46	5.3



Conclusion reached: "*The frequency rate of alcoholics is about three times that of other employees* for digestive and musculoskeletal disorders, and about two times that of other employees for respiratory infections," replicating other findings.

Sarvis comments: "These and similar studies indicate that problem-drinking employees are sick people who use a disproportionately high portion of employee group health insurance, contributing to high group insurance costs."

CONTENTIONS NO. 2 & 3:

"There is a high rehabilitation rate for problem-drinking employees."

"There is a significant reduction in the utilization of health & sickness benefits by rehabilitated problem drinkers."

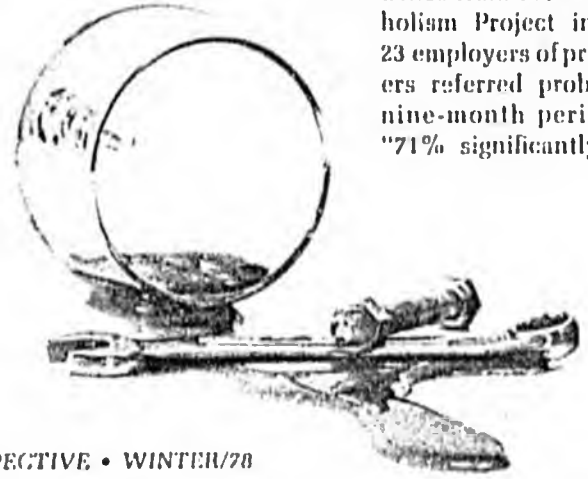
Sarvis finds "the success rate for rehabilitation of problem-drinking employees" to be "very high," indicating that "the possibility of job loss is an incentive for employees to seek rehabilitation."

He also finds that, "after problem drinkers are rehabilitated, there is a great reduction in their utilization of health and sickness benefits," thereby "significantly decreasing the cost of group health insurance."

He cites five employers who have proven track records at rehabilitating problem-drinking employees through a formal mechanism for early identification and referral:

Employer	# of Employees	"Processed"	% Rehabilitated	Savings
Scovill Mfg. Co. Waterbury, Conn.	6,500	180 in 3 years	78%	$186,550
Economics Laboratory, Inc. St. Paul, Minn.	3,500	N/I	80% for employees; 50% for dependents	Not indicated; but treatment costs were cut as much as 65% by using non-hospital facilities, such as alcoholism treatment centers.
Illinois Bell Telephone Co. Chicago, Ill.	N/I	402 in 5 years	72%	46% reduction in sickness disability and "a tremendous decrease in utilization of insurance plans."
Philadelphia Fire Department	3,410	N/I	N/I	55% decrease in sick leave for referred cases; 67% reduction in injuries; "a significant decrease in health insurance utilization."
Kennecott Copper Corp. New York City	N/I	N/I	N/I	After a year, costs for hospital, medical and surgical care were reduced 55%; alcoholics vs. other employees cost 5-to-1 for all sickness & accident activity, 3-to-1 for hospital, medical & surgical care.

N/I = not indicated



Sarvis also cites equally pointed evidence from the DePaul Industrial Alcoholism Project in Milwaukee, where 23 employers of primarily factory workers referred problem-drinking over a nine-month period. Their findings: "71% significantly improved, 46% of them reporting total abstinence and 26% 'essential' abstinence."

The consultant concludes that "*an employer can expect a high rehabilitation success rate for problem-drinking employees* — 70% is average — and a tremendous decrease in the utilization of health benefits." Savings are "maximized when an employer couples a formal mechanism for early identification and referral with appropriate health insurance coverage for alcoholism."

CONTENTION NO. 4:

"An employer can expect significant health insurance cost savings by providing employees health insurance for alcoholism."

Sarvis quotes some key numbers:

- *"5% of an employee population are problem drinkers."* (Source: National Institute on Alcohol Abuse & Alcoholism)
- *"A problem-drinking employee uses $3 in health benefits to $1 for the average employee."* (Source: Dr. Maxwell)
- "An employer can therefore estimate that problem-drinking employees are responsible for 15% of claims paid *annually*" . . . by multiplying the 5% times the 3 in the 3-to-1 ratio.
- If all problem drinkers could be rehabilitated and it could then be "assumed that alcoholism did not exist in an employee group, the employer would pay 10% less in claims" . . . reducing the 15% above by the difference between the numbers in the 3-to-1 ratio to arrive at the use by non-problem-drinkers.
- "It is impractical to believe that 100% of such savings could be achieved. Some can. If an employer provided adequate coverage for alcoholism and only 20% of problem-drinking employees were rehabilitated, this minimal number alone could save the employer around 2% of total claims paid" . . . multiplying the maximum 10% savings by the 20% rehabilitated.

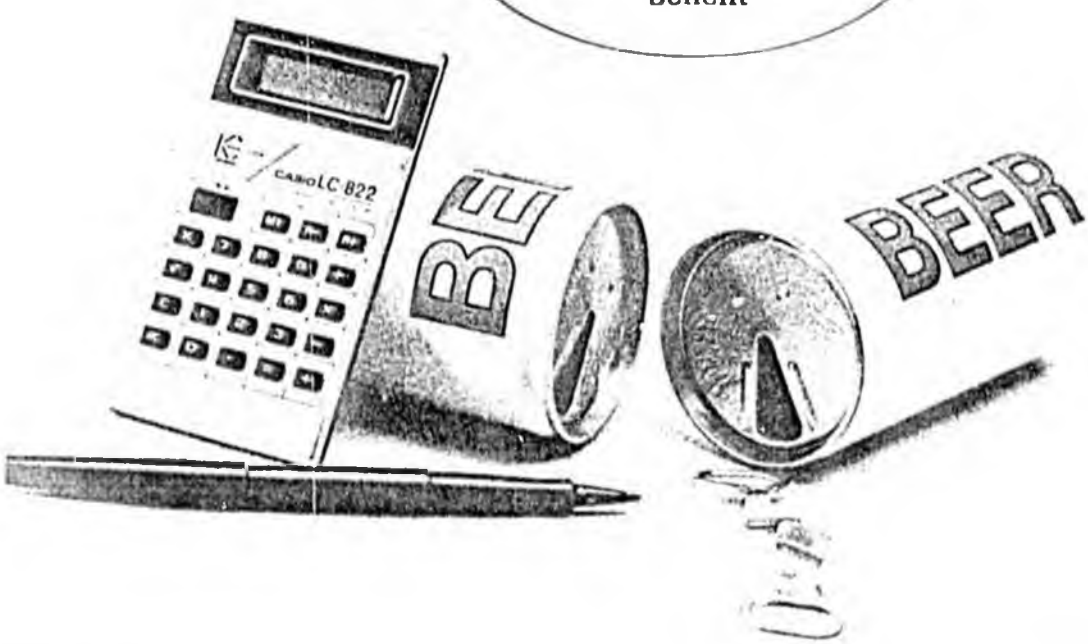
Sarvis then addresses four types of employer situations and presents evidence of savings from each.

A.
With an employee assistance program, *and* an alcoholism health benefit

B.
With an employee assistance program *but not* an alcoholism health benefit

C.
With an alcoholism health benefit, *but not* an employee assistance program

D.
With *neither* an employee assistance program nor an alcoholism health benefit



PROBLEM DRINKERS

Savings depend on the use of the following data:

Expected REDUCTION IN CLAIMS PAYMENTS As A Percent Of Total Claims Payments*

Problem Drinkers Referred As Percent Of Total Employee Population	Percent Increase In Total Premiums Due To Cost Of Alcoholism Benefit				
	0.5%	1.0%	1.5%	2.0%	2.5%
1.0%	1.0%	0.5%	0.1%	—	—
2.0%	2.4%	1.9%	1.4%	1.0%	0.6%
3.0%	3.7%	3.2%	2.8%	2.3%	1.9%
4.0%	5.1%	4.6%	4.2%	3.7%	3.3%
5.0%	6.5%	6.0%	5.6%	5.1%	4.7%

* Problem-drinking employees should have been rehabilitated for at least one year to achieve the expected reduction in claims payments.

Expected REDUCTION IN PREMIUMS As A Percent Of Total Premiums*

Problem Drinkers Referred As Percent Of Total Employee Population	Percent Increase In Total Premiums Due To Cost Of Alcoholism Benefit				
	0.5%	1.0%	1.5%	2.0%	2.5%
1.0%	0.8%	0.3%	—	—	—
2.0%	2.2%	1.7%	1.1%	0.6%	0.0%
3.0%	3.5%	3.0%	2.4%	1.9%	1.3%
4.0%	4.9%	4.4%	3.8%	3.3%	2.7%
5.0%	6.3%	5.8%	5.2%	4.7%	4.1%

* An actual reduction in total premiums from one year to the next could be expected only if overall insurance program costs did not increase.

Here's what the tables tell an employer with 1,000 employees whose total premium is $1,200,000 a year ($100 a month x 12 months x 1,000 employees) and whose total claims payment is $1,080,000 — a 90% claims ratio (claims as a percentage of total premium):

If PROBLEM-DRINKING EMPLOYEES were referred at the rate of:	If the ALCOHOLISM BENEFIT increased total annual insurance premiums by:	These decreases would occur in		For net savings of				
		CLAIMS PAYMENTS	PREMIUMS PAID	CLAIMS PAYMENTS		PREMIUMS PAID		TOTAL
				%	Dollars	%	Dollars	Dollars
2% a year	1%	1.9%	1.7%	.9%	$ 9,720	.7%	$ 8,400	$18,120
5% a year	2.5%	4.7%	4.1%	2.2%	$23,760	1.6%	$19,200	$42,960

The two tables also alert employees to these facts:

Employer "A" — with both referral program and benefit — can determine the percent of problem drinkers who need to be referred vs. the cost of the alcoholism benefit to reach the cost savings he desires.

Employer "B" can determine what it will cost to add an alcoholism health benefit in order to achieve desired insurance cost savings.

Employer "C" can determine how the cost of establishing an employee assistance program in order to increase problem-drinking referrals would net out insurance cost savings.

Employer "D" can determine the cost of both referral program and benefit to produce desired insurance cost savings. ◻

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS for SS Senate Bill 227

Title Insurance for Alcoholism and Drug Dependence

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement and Benefits

Program Category Affected Retirement and Benefits (OTHER BENEFITS)

BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	TRS STATE MATCH						
100	BENEFITS		282.0	338.4	406.1	487.3	584.8
	TOTAL		282.0	338.4	406.1	487.3	584.8

FUNDING (Thousands of Dollars)

GENERAL FUND	230.8	277.1	332.6	399.2	478.9
FEDERAL FUNDS	13.0	15.6	18.7	22.4	26.9
VETERAN'S FUND	0.6	0.7	0.8	1.0	1.2
FISH & GAME FUND	1.7	2.0	2.4	2.9	3.5
HIGHWAY FUND	3.7	4.4	5.3	6.3	7.6
AIRPORT FUND	8.2	9.8	11.8	14.1	17.0
CAPITAL FUND	24.0	28.8	34.5	41.4	49.7
PERS					
TRS					

POSITIONS NONE

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. Approximately 8,900 State employees are currently covered under the State Group Health Care Plan.

2. The cost to implement the provisions of this bill will be $2.64 per employee per month.

3. Estimate that the cost to provide continued coverage will increase 20% each year for the immediate future. However, an effective alcoholism/drug dependency program should help to reduce overall health care claim experience in the future.

4. Cost for coverage of political subdivisions (approximately 50 subdivisions) participating in group insurance not included; recommend that the Alaska Municipal League, 204 Franklin St., Juneau, AK 586-1325, be contacted for input.

Paul B. Arnoldt

IV. DATE 3/30/79 PREPARED BY Paul B. Arnoldt, Director

AGENCY Division of Retirement & Benefits

PHONE 465-4460

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) Senator Colletta & Senate HESS

Health

(Albany, N.Y.) Times-Union, May 2, 1978

Blue Cross insuring alcoholism treatment

By [illegible] FAIRFIELD

Pioneering insurance coverage for alcoholism treatment will be provided later this year by Blue Cross of Northeastern New York, which is hosting a two-day Albany conference on the plan with other Blue Cross systems in the state.

The Slingerlands-based Blue Cross group will be the first to provide the coverage in New York state, and among the first in the nation.

But other Blue Cross groups may not be far behind, and they sent representatives to the Quality Inn Monday to discuss the design and introduction of alcoholism coverage for every region in the state.

Coverage now exists for hospital treatment of alcoholics in the acute final stages of the disease. The sort of coverage planned by the local Blue Cross group will dramatically expand the availability of treatment programs.

The coverage will include 30 days of "intermediate care" in a residential facility; 30 outpatient visits per individual, and 15 outpatient visits for the individual's family.

These options would be available to a patient during a 365-day period; he can renew them once. He is then entitled to 30 visits during the rest of his life.

The present hospital acute care only coverage "really does not get at the drinking behavior itself," explained James M. Stewart, community consultant to Blue Cross of Northeastern New York.

[illegible] ded by the [illegible], however, [illegible] Blue Cross [illegible] the coverage in the [illegible] areas of the country have found that [illegible] alcoholics who need help still don't seek it, partly because many don't recognize the problem, according to Howard Dallowitz of the Blue Cross and Blue Shield Associations in Chicago.

To counter that expected problem Stewart says the local Blue Cross will actively market the expanded coverage, which may become available as early as October.

It will initially be available to [illegible] employer groups which comprise 50 percent of Blue Cross' membership. Blue Cross covers 13 counties, "50 percent of the citizens here," said Dr. Clifton C. Thorne, Blue Cross president.

Stewart couldn't provide specific figures on the added cost of the coverage to subscribers, but said "relatively speaking, as new benefits go," it is "modest."

Among the speakers Monday at the conference, which concludes today, was State Sen. Dale M. Volker, chairman of the Senate Subcommittee on Alcoholism.

He described the high cost of alcoholism to society and its prevalence, even stating it was a problem at the Capitol. He said if the problem were examined there, or in "any pressure place" or "any state capital . . . you might come up with some frightening results."

50:E7

Health

(Albany, N.Y.) Times-Union, May 14, 1978

Blue Cross to sell alcoholism coverage

By JOHN FAIRHALL

Blue Cross' "hardest marketing job" ever will begin locally this fall when its salesmen start knocking on subscribers' doors with comprehensive alcoholism insurance plans.

The first Blue Cross group in the state to announce the added coverage, Blue Cross of Northeastern New York has its work cut out.

Unlike insurance benefits such as general hospital coverage, which obviously are necessary, alcoholism has long been an underestimated problem.

"Only in the last decade" has the problem been viewed as a disease, points out James M. Stewart, community consultant to the 13-county Blue Cross group.

He thinks "of the Dick Van Dykes who only in the last few years have come forward and said 'I am an alcoholic' or the Betty Fords who make public acknowledgement."

So although alcoholism is "the third largest health problem confronting American society after heart disease and cancer," according to one area expert, Blue Cross believes it will have to add community education to its marketing efforts.

"It is perhaps the hardest marketing job we've ever taken on," Stewart says.

What Blue Cross will be selling, as early as October, is alcoholism insurance beyond the hospitalization coverage already provided. An alcoholic suffering from organic problems caused by the disease or in need of detoxification can under present policies get inpatient hospital treatment, according to Stewart.

What he can't get, but will soon be offered, is a package providing 30 days of "intermediate care" at a residential facility; 30 outpatient visits per individual, and 15 outpatient visits for the individual's family.

These are available during a 365-day period and be may be repeated once. A patient is then entitled to 60 other visits during the rest of his life.

This treatment will get at "the drinking behavior itself," which is not addressed in present hospital care.

The insurance, which initially will be provided to Blue Cross groups totaling 70 percent of its subscribers, will eliminate the financial barrier now separating many alcoholics from treatment.

But at the outset Stewart doesn't expect a rush to buy the added protection, which he says will come at a relatively "modest" cost. Part of the reason is that the disease is so little acknowledged, even by its victims.

If there were a sudden and large demand, it would probably overwhelm treatment programs available in the area. There is no "intermediate care" residential center now available in the area, Stewart says.

But Blue Cross believes the insurance coverage will stimulate growth of treatment programs.

Wilmington (Del.) Evening Journal, January 24, 1978

Blue Cross Stops Funds, Dooming New Center for Alcoholics

By IDA KOSCIESZA

Blue Cross says it won't pay for treatment at Delaware's only private alcoholism rehabilitation center, and the people who run the center say that means Delaware won't have a private alcoholism treatment center.

The board of Blue Cross and Blue Shield of Delaware yesterday voted not to extend a contract to Harbour House, a 33-bed facility in Milford.

And James F. Edwards, director of Harbour House, said the decision probably means the end of the 6-month-old center.

"I would assume we will close tomorrow," Edwards said bitterly.

Occupancy at Harbour House, described as "excellent' three months ago, has fallen sharply since word got out that Blue Cross might not pay for care there, Edwards said. There are six patients at the center now, he said.

Blue Cross officials said the decision against paying for the Harbour House program was a "cost containment" measure, but both Edwards and M.T. "Ted" Lassiter, director of the Delaware Alcoholism Council, charged that the health plan picked alcoholism for its economy move because of the "stigma" attached to the disease.

"That's typical. Nobody cares about alcoholics," Edwards said.

Blue Cross had been studying the Harbour House issue since mid-August. Charles R. Richards, vice president for provider and professional relations, said Blue Cross staff recommended against paying for the program because: Blue Cross's resources are limited, alcoholism has not been designated a priority by federal or state authorities, and the region has adequate alcohol treatment facilities.

"When it comes to providing money, [alcoholism] may not be a priority," said Lassiter. "But as far as problem areas, it is one of the largest in the country."

Two doctors on the Blue Cross board agreed.

"Alcoholism is a national problem. Why it's not a priority I don't know," said Dr. John M. Levinson.

Dr. Alfred Lazarus suggested that Blue Cross, which has recently been pushing the idea of preventive health care, is going back on its commitment by refusing to pay for alcoholism treatment. Lazarus added, however, that he has had no trouble finding a bed in a treatment facility for his own alcoholic patients.

"If the bed situation is adequate, let's say so . . . not that alcoholism is not a priority," he said.

Delaware residents currently can be treated for alcoholism at private facilities in Maryland, Pennsylvania and New Jersey. There is a one-to-two-week waiting period for these centers, Richards said. The Delaware Blue Cross plan will pay for treatment at these out-of-state rehabilitation facilities.

Harbour House officials claim Blue Cross would save money by paying for the Delaware facility because Harbour House's $1,712 charge for its 28-day program is lower than rates at the out-of-state rehabilitation centers.

But Blue Cross president William E. Flaherty said that is not the case. Harbour House will not substitute for the out-of-state facilities, but will add to them, Flaherty said.

"When you add facilities they get filled," he said.

With alcoholism facilities both in and out of state, Blue Cross would wind up paying for both, Flaherty predicted.

In any case, Blue Cross does not pay the full charges of the Maryland and Pennsylvania facilities, Flaherty said. It pays on a cost basis that works out at about $55 a day, he said.

Two recent Blue Cross cost containment initiatives, a fee cap negotiated with the state's doctors and an improved budget review process with the hospitals, have achieved savings of $400,000 to $550,000 a year, Flaherty said. A contract with Harbour House would cost Blue Cross more than $400,000 a year and would completely wipe out the other savings, he said.

The state's health planning agencies approved Harbour House last year. In the past Blue Cross has gone along with the decisions of these planning groups, but Richards said planning criteria for alcoholism rehab[illegible] centers are "weaker than [illegible] other facilities."

Harbour House is [illegible] by [illegible] Health [illegible] a non-profit [illegible]. It [illegible] from [illegible] Harbour House, which is own[illegible] [illegible] a [illegible] of [illegible] care [illegible].

(Newark, N.J.) Star-Ledger, September 20, 1978

Dispute slows health plan for alcoholics

By VINCENT R. ZARATE

The program that was supposed to aid thousands of alcoholics through added benefits from Blue Cross and Blue Shield has barely gotten off the ground, even though the law ordering it is more than a year old.

The Star-Ledger has learned the Department of Insurance and Blue Cross have been wrangling for months on language in new policies to provide those extra benefits.

Richard J. Diehl, executive director of the New Jersey Alcoholism Association Inc., charged yesterday that because of "unbelievable bureaucracy" thousands of alcoholics and near-alcoholics aren't getting the benefits unless they pay for them out of their own pockets.

The law was signed June 2, 1977, and became "effective immediately" requiring all health insurance companies, including Blue Cross and Blue Shield, to pay the cost of rehabilitation, detoxification and out-patient treatment of those suffering alcoholism.

"There's been a continuous policy of delay which is resulting in alcoholics in New Jersey slowly losing rights gained on the floor of the Legislature," Diehl said.

"All I know is we were promised in June of 1977 by the Governor and the Legislature that Blue Cross and Blue Shield would be required to give alcoholics the added benefits for treatment, and nothing has happened . . . nothing."

Diehl and Steven Blader, assistant deputy public advocate in the Division of Public Interest, have quietly been fighting for months — not only to get the program off the ground but to get government employes covered, too.

Because of an apparent "technical oversight" government employes cannot be included, Blader explained.

Blader said, "They forgot to amend the Public Health Benefits Act to include government employes, and we are now attempting to get the Public Health Benefit Commission to include them by a special order."

The sponsor of the legislation, Assemblyman James W. Bornheimer (D-Middlesex), said, "It's unbelievable" that the new benefits have not been implemented. Bornheimer said he would "push to get this whole thing rolling."

Insurance Commissioner James J. Sheeran said Blue Cross forms to amend contracts to include the added benefits have been rejected "because they do not conform to the intent of the law."

Donald Daniels, executive vice president for Blue Cross, said the nonprofit hospital insurance company has been trying to implement the program but can't until the Insurance Department approves its new contract forms.

"We have here," said Diehl. "The inability of the bureaucracy to implement the law . . . it's everybody's fault."

Gov. Brendan Byrne signed into law four bills requiring private insurance companies as well as Blue Cross and Blue Shield to, for the first time, pay for the rehabilitation of alcoholics.

• • •

While the law became effective last year, it was acknowledged then by both Blue Cross and Insurance Department officials that at least two months would be needed to spell out the regulations on how to deal with new aspects of the extended insurance coverage.

But according to Sheeran, the first regulations were not published until May, after a series of meetings with the companies involved.

Blue Cross officials blame the department for the delay, while Sheeran said, "Meetings had to be held and public hearings had to be held to cover all the points."

Blue Cross contends the program's benefits should be paid when "medically necessary," while Sheeran says they should be "therapeutically necessary."

Sheeran said if Blue Cross has its way it would

Continued

undermine the legislative intent, which was to "throw all weapons we have to combat alcoholism and treat it as a disease."

Blue Cross' attempt to restrict the added coverages to "medical necessity," Sheeran said, would limit the benefits.

Daniels said Blue Cross wants to provide the added coverage and "cooperate" with the department, denying there is a "fight between Blue Cross and the Insurance Department."

The recent newsletter of Blue Cross/Blue Shield to its subscribers heralds that both "will soon expand their coverage to include state-mandated benefits for the treatment of alcoholism."

That article states, "The new rider includes a provision to assure that all treatment is medically necessary, is provided at the appropriate level of care, and is administered by licensed professionals under a state-certified alcoholism treatment program."

An alcoholic at present gets paid full Blue Cross payments for the days spent in a hospital, but does not get paid for rehabilitation or out-patient treatment even though the law of June 2, 1977 requires it.

The alcoholism association, a public interest group based in Trenton, reports that at least one residential center has suffered $43,850 in losses because Blue Cross has refused to pay for added benefits to government employes.

Diehl said Seabrook House in Bridgeton treated 35 state employes, incurred the unpaid claims, and then had to stop admitting state employes because they are not covered under the law.

He said two other clinics, Alina Lodge in Blairstown and the Carrier Clinic in Princeton, have also had to reject government employes unless those employes paid for rehabilitation out of their own pockets.

The issue of including the thousands of government employes into the added Blue Cross benefits program for treatment of alcoholics is to be brought up today at a special meeting of the State Health Benefits Commission.

(Newark, N.J.) Star-Ledger, September 21, 1978

Alcoholic aid is ordered for state workers

By VINCENT R. ZARATE

The State Health Benefits Commission yesterday directed that an estimated 175,000 government employes be included in the health insurance program treating alcoholism.

The commission took the action in Trenton to correct an "oversight" in the law enacted 15 months ago requiring Blue Cross and Blue Shield and all other health insurance companies to pay for benefits of rehabilitation, detoxification and other out-patient treatment of alcoholics.

The government employes were inadvertently omitted from the law because the Legislature forgot to amend the State Health Benefits Act when it approved the added health benefits for alcoholics.

• • •

Attorney General John S. Degnan had in January ruled that public employes enrolled in the state health benefits program could not be included in the extended program for alcoholics because the act was not amended by the Legislature.

However, he said the three-man State Health Benefits Commission could use its discretionary power to extend the alcoholic treatment program to state employes.

William Joseph, director of pensions, said yesterday's action will bring into the program 65,000 state employes, and 110,000 employes of 17 county governments, 318 municipalities, 453 school districts and 180 public agencies enrolled in the state health program.

Riley Regan, director of the Division of Alcoholism in the State Health Department, estimated there are "at least" 10,500 state employes with alcoholic problems and they would benefit from the program.

Even though the law became effective 15 months ago, no payments for out-patient treatment, rehabilitation or detoxification have been made and the program has not been implemented for anyone.

The major reason for the delay is the fight between Blue Cross and the Insurance Department over language in riders to the Blue Cross policy on what benefits would be offered.

The Health Benefits Commission is composed of the insurance commissioner, state treasurer, and president of Civil Service.

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They were represented at yesterday's meeting by George LaPalce of the Insurance Department, Robert DeNicholas of Civil Service, and John Flynn of Treasury.

The drive to get state employes included in the program was initiated by Richard J. Diehl, executive director of the New Jersey Alcoholism Association Inc., and Steven Blader, assistant public advocate in the Division of Public Interest.

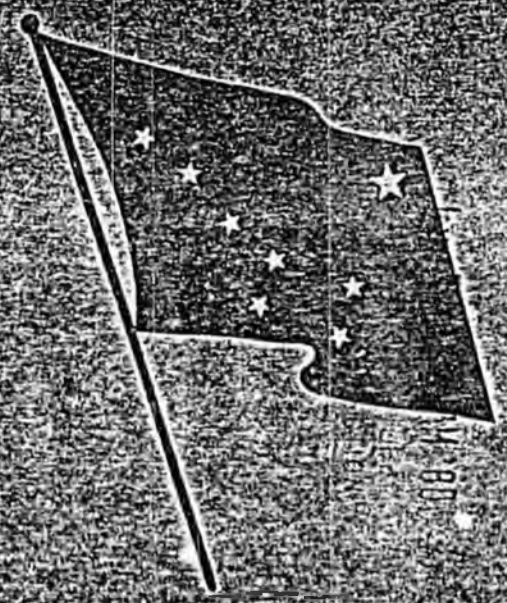
The sponsor of the legislation extending alcoholism treatment benefits to health insurance policies and pending in the Assembly is Assemblyman James Bornheimer (D-Middlesex). He was represented at the meeting by his aide, Leona Kaufman.

For information regarding claim payments for allowable charges, please call this toll-free number:

(Access Code) + 800-426-6933

The State of Alaska's Group Health Care & Life Insurance Benefits are administered by:

The Division of Retirement and Benefits
Pouch CR
Juneau, Alaska 99811
Paul B. Arnoldt, Director



State of Alaska

Group Health Care & Life Insurance Benefits

For Employees of the State of Alaska

General Government, Confidential, Peace Officers, and Employees Not Covered by Collective Bargaining

July 1, 1979

Travel/Ambulance

The following travel and ambulance costs will be paid by the Plan:

- Transportation to a hospital by professional ambulance.
- Round trip transportation by commercial airline from the place where the illness or injury occurred to the nearest place professional treatment can be obtained.

Your air transportation will be covered only if:

(a) a life-endangering situation exists that requires immediate transfer to a hospital that has special facilities for treating the condition;

(b) surgery is needed that cannot be performed locally; or

(c) a condition exists which cannot be treated locally. In that case, transportation benefits in any one benefit year will be limited to:

(1) one visit and one follow-up visit which is preauthorized as a condition requiring therapeutic treatment which cannot be provided locally;

(2) one visit for pre- or postnatal maternity care and one visit for the actual maternity delivery which cannot be treated locally;

(3) one pre- or postsurgical visit and one visit for the actual surgical procedure which cannot be provided locally; or

(4) one visit for each allergic condition which cannot be treated locally.

If you require air transportation for (b) or (c), your doctor must provide written certification and detailed medical documentation of the existing condition in advance of your trip. The Blue Cross Plan will then determine how much of the transportation charges, if any, are eligible for coverage under the plan.

If the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child will be allowed if the attending physician certifies the need for such attendance.

Transportation charges for a physician and/or registered nurse may be covered only when determined necessary by the Blue Cross Plan.

IMPORTANT: Travel benefits apply only to the conditions covered in the medical section of your Group Health Care & Life Insurance Benefits booklet. They do not apply to the audio, dental or vision section.

Travel preauthorization will not be given for diagnostic purposes or second opinion diagnosis. Postauthorization may be given after review of medical documentation for these procedures.

Travel claims submitted under items (b) and (c) will be subject to denial unless they are preauthorized.

An "Air Travel Preauthorization Application," Form 400-4868, is required in all instances that do not involve a genuine life endangering emergency. You may obtain a supply of these forms from your employer.

For travel which is not of a life endangering nature, but must be made before preauthorization can be obtained by using this form, you should call the Blue Cross travel representative, (access code) and 800-426-6933 for information and instructions.

Alcoholism Treatment Services

Your Plan will pay for treatment as an inpatient in a hospital or alcoholism treatment facility. If services are received in an alcoholism treatment facility that does not have an agreement with the Blue Cross Plan, payment will be limited to $1,000 in any benefit year.

Mental and Nervous Disorders

Physician's services for mental and nervous disorders will be covered as follows:

- 50 percent of eligible expenses.
- Care received in the hospital or physician's office.

The maximum amount of benefits available is $2,500 for each covered member in any one benefit year. Services must be provided by a M.D., D.O. or licensed psychologist.

MEDICAL EXPENSES NOT COVERED

Limitations and Exclusions

The State's Comprehensive Medical Plan does not cover any condition, ailment or injury for which you may receive:

(a) benefits from your employer's liability or Workmen's Compensation Law;

(b) benefits available under any state or federal act, even though you or your dependents waive rights to such benefits; or

(c) services provided by a hospital owned or operated by a state or federal agency.

Services provided in the following facilities are not covered:

(a) an institution which is primarily a rest home, home for the aged, nursing home, skilled nursing facility, convalescent home or any facility of like character; or

(b) convalescent or custodial services regardless where such services are provided, or any portion of a hospital stay which is primarily convalescent or custodial.

Charges for or in connection with cosmetic treatment or surgery will not be paid unless:

(a) treatment or surgery is for injuries sustained in an accident which occurs while you or your dependents are covered, and such treatment or surgery is started within 90 days of the accident; or

ARTICLE 7. MEDICAL TRANSPORTATION SERVICES.

Section
500. Prior authorization
505. Emergency transportation coverage
510. Type of transportation
515. Mortuary expenditure
520. Public rates
525. Medicare coverage
530. Definitions

7 AAC 43.500. PRIOR AUTHORIZATION. (a) All non-emergency, in-state medical transportation under $250 per person one way must have prior authorization by the division's regional office manager or his or her designee. All non-emergency, in-state medical transportation exceeding $250 per person one way and all non-emergency, out-of-state medical transportation must be authorized in advance by the medical practice review section of the division.

(b) Evidence of prior authorization must be present on the billing form before payment will be made.

(c) The division will not authorize payment to a provider of medical transportation for non-emergency medical transportation without first verifying medical need for those services.

(d) The medical assistance coupon or identification card is not to be used as an authorization for medical transportation. Rather, the coupon or identification card is evidence of current eligibility. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.505. EMERGENCY TRANSPORTATION COVERAGE. In emergency situations, the division will assume only the necessary expenses of transporting the beneficiary to the nearest facility where the emergency medical need can be met. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.510. TYPE OF TRANSPORTATION. (a) The choice of provider of medical transportation will be determined by the beneficiary's medical condition, distance to the place of treatment, and availability of a suitable provider of medical transportation, using the least expensive conveyance consistent with these conditions.

(b) If a friend or relative will provide the required medical transportation, payment may be made as a medical expense at a reasonable rate determined by the division.

(c) When the services of more than one provider of medical transportation are available, the division will use the services of the provider with the lowest rate which can provide services appropriate to the beneficiary's medical needs.

(d) The division will not pay for ambulance service which appears to be excessive for the distance traveled and the medical needs of the beneficiary.

(e) While ambulance service may be required to transport a beneficiary to a medical provider, a less expensive mode of travel may be adequate for the return of the beneficiary.

(f) The division will work cooperatively with providers of medical transportation to schedule travel on the least busy days and during the most convenient hours during those days, and will make every effort to arrange for transport of more than one beneficiary on a single trip where appropriate. Such arrangements will reduce charges as may be agreed upon by the provider of medical transportation and the division. (Eff. 8/18/79, Reg 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.515. MORTUARY EXPENDITURE. Medical transportation services are those services provided by the carrier up to the time death is known or until the deceased beneficiary, alive at the time of pickup, reaches the source of medical care. Thereafter, transportation expense of the deceased beneficiary is a mortuary expenditure which is not covered by medicaid. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.520. PUBLIC RATES. (a) In order to qualify for payment by the division, an ambulance service must comply with the provisions of secs. 5-85 of this chapter. In addition, ambulance providers shall:

(1) file with the division a current schedule of public rates;

rates may be changed only by filing an amended public rate schedule; for medicaid purposes, original rates become effective upon filing; rate changes are effective on the first day of the first month which is at least 30 days after the date of filing the change; in no event may the effective date of the change in rates precede the date the rates are effective for the general public; all rates are subject to final acceptance, rejection, or modification by the division;

(2) customarily charge the general public at those rates specified in the public rate schedule and routinely pursue unpaid charges in anticipation of collection; i.e., a volunteer or community ambulance that operates without charge for services to the community must not charge the division for services provided to beneficiaries;

(3) be in compliance with the regulations and policies of the Division of Public Health or other local licensing body; out-of-state ambulance companies providing services to Alaska residents must be suitably licensed in the state where they operate.

(b) Charges to the division include only those services and specific charges detailed on the certification form, and may not exceed the charges to the general public for like services; any carrier may charge the division at rates less than those charged to the general public for like services. (Eff. 8/18/79, Reg.71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.525. MEDICARE COVERAGE. For those beneficiaries 65 years of age or older, or those under 65 who receive medicare coverage due to disability, every effort must be made by the ambulance company to use fully the benefits of 42 CFR 405.201--405.488 before billing the division. (Eff. 8/18/79, Reg.71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.530. DEFINITIONS. In secs.500-525 of this chapter

(1) "ambulance" means any privately or publicly owned vehicle that is regularly provided or offered to be provided for the emergency transportation of persons suffering from illness, injury or disability and licensed by the Division of Public Health or local licensing body; police, fire, funeral home, and other vehicles which serve a dual purpose, one of which meets this definition also may be considered ambulances;

(2) "emergency transportation" means that transportation necessary immediately when a sudden, unexpected occurrence creates a medical emergency;

(3) "escort" means a person who accompanies a beneficiary to or from a source of medical care; the purpose of their accompanying a beneficiary may be the result of medical necessity or may be due to the age or physical or mental capacity of the beneficiary; the accompanying person may be medically-trained but is not required; no compensation will be paid by the division to the accompanying person;

(4) "food and lodging" means meals and sleeping facilities for the beneficiary, escort, or both, while the beneficiary is receiving medical care at a facility away from the place where the beneficiary regularly resides; meals and lodging provided by friends or relatives of either the beneficiary or the escort are not included; nor are accomodations provided by hospitals or nursing homes included in this definition;

(5) "medical transportation" means transportation for medical purposes to and from any source of medical care or between medical facilities, and food and lodging incidental to such transportation for both beneficiaries and escorts when needed;

(6) "provider of medical transportation" means the owner or operator of a private automobile, municipal bus, inter-community bus, taxi, scheduled airline, ferry, wheelchair coach, train, chartered aircraft, chartered boat, or other mode of transportation commonly used to transport a person. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

CURRENT STATUTE

Chapter 07. Medical Assistance for Needy Persons.

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the federal Social Security Act. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially eligible as determined by the standards of the Federal Aid to Families with Dependent Children program;

House CS for CSSSSB227 (HESS) Revisions

* Sec. 7. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history reports. — For report on ch. 182, SLA 1972 (FCCS HCS CSSB 56), see 1972 House Journal, p. 1684. For report on ch. 105, SLA 1974 (CSSB 465), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

* Sec. 10. AS 47.07.020(d) is repealed.

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978)

* Sec. 8. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

Summary Sheet

House CS for CS for Sponsor Substitute for Senate Bill No. 227
(In thousands of dollars)

	Total	Federal	State	New Positions
1. Addition of Medicaid Services and New Eligibles	$24,194.5	$15,717.0	$ 8,477.5	17
2. Decrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligible Groups	4,471.8	-0-	4,471.8	-0-
3. State Only Medically Needy	11,169.4	-0-	11,169.4	16
4. Interest Payment	282.2	-0-	282.2	-0-
TOTAL	$31,174.3	$15,717.0	$15,457.3	33

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 277
Title An Act relating to the health of residents of the State.
Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices
Program Category Affected Health/Social and Economic Assistance
BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Determination/PAA
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		448.3				
200 TRAVEL		17.0				
300 CONTRACTUAL		175.5				
400 COMMODITIES		8.5				
500 EQUIPMENT		17.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		23,527.7				
TOTAL		24,194.5				

FUNDING (Thousands of Dollars)

GENERAL FUND		8,477.5				
FEDERAL FUNDS		15,717.0				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		17				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 3,065 new cases under the Medicaid program. Administration of program benefits would require 15 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care program which is funded at 100% federal funds. Since the bill proposes to add new coverage groups and new categories of coverage to Medicaid, there will be a reduction in General Relief Medical program expenditures as indicated on page 2. Thus, the actual increase in state General fund revenues needed for this increased Medicaid coverage is 8,477.5 - 4,471.8 = 4,005.7.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt.: _____ Date: _____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 277

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,471.8)				
TOTAL		(4,471.8)				

FUNDING (Thousands of Dollars)

GENERAL FUND		(4,471.8)				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Decrease in General Relief Medical program expenditures due to the transfer of coverage for certain service categories from state funding to coverage under the Medicaid program, and the addition of certain groups under Medicaid that are currently covered by General Relief Medical.

riginal: Legislative Finance
Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

(Rev. 12/79)
HSS (11-28-79)

Approval DHSS Mgt. & Pdgt: _____ Date: _____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

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Title An Act relating to the health of residents of the State.
Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices
Program Category Affected Health/Social and Economic Assistance
BRU, Program, or Subprogram(s) Affected General Relief Medical/Eligibility Determination/PAA
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		423.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		154.0				
400 COMMODITIES		8.0				
500 EQUIPMENT		16.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		10,551.6				
TOTAL		11,169.4				

FUNDING (Thousands of Dollars)

GENERAL FUND		11,169.4				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		16				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 2,821 new cases under a state-only medically needy program as part of the General Relief Medical program. Administration of program benefits would require 14 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is indicated as 100% state funds, but it may be possible to receive federal funding for certain individuals with income less than 133% of the state need standard for the particular eligibility categorical group to which they are related.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt.: _____ Date: _____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

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II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		282.2				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		282.2				

FUNDING (Thousands of Dollars)

GENERAL FUND		282.2				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Funding necessary to make interest payments to providers for Medicaid and General Relief Medical clean claims not processed within 30 days of receipt by the Department. Federal law requires states to process 90% of Medicaid clean claims within 30 days of receipt, however no provision is made under federal law for funds to be used to make interest payments. Thus, all interest payments must be made using state funds only.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: _____ Date: _____

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

DIVISION OF PUBLIC ASSISTANCE

BRU	FY79 ACTUAL TOTAL AS OF 11/27/79	FY80 FCC AUTHORIZATION		FY80 SUPPLE-MENTAL CURRENT REQUEST	FY80 PROJECTED TOTAL NEED		FY81 REQUEST	
			(GF)			(GF)		(GF)
GEN. POP:								
DISCRETIONARY								
Elig. Det.	$3718.3	4377.1	(2638.2)		4377.1		4695.9	(2831.0)
Staff Dev.	253.8	130.4	(40.8)		130.4		140.0	(69.1)
Quality Control	407.0	496.0	(248.5)		496.0		549.0	(274.5)
General Relief	707.1	650.0	(650.0)		650.0		650.0	(650.0)
TOTAL	5086.2	5653.5	(3577.5)		5653.5	(3677.5)	6034.9	(3824.6)
NON-DISCRETIONARY								
AFDC	21276.6	22734.5	(11367.2)	3447.9	26182.4	(13091.2)	31133.1	(15566.5)
AD	3130.2	3782.8	(3782.8)	202.7	3985.5	(3985.5)	4974.1	(4974.1)
AB	108.7	118.8	(118.8)		118.8	(118.8)	140.9	(140.9)
*OAA	2950.2	3141.4	(3141.4)	421.8	3563.2	(3563.2)	4344.9	(4344.9)
TOTAL	27465.7	29777.5	(18410.2)	4072.4	33849.9	(20758.7)	40593.0	(25026.4)
* AGED COVER PROGRAM								
HEALTH:								
NON-DISCRETIONARY								
MEDICAID								
Hospitals	6047.9	5617.7	(1160.7)	1066.7	6684.4	(1694.0)	8923.7	(2461.9)
Physicians	2872.4	2819.2	(621.9)	1217.6	4036.8	(1230.7)	5331.1	(2690.6)
Other Services	889.9	735.1	(276.[illegible])	435.8	1170.9	(494.5)	1563.1	(671.1)
EPSDT	1600.8	1711.5	(855.[illegible])	480.0	2191.5	(1095.7)	2925.7	(1462.8)
Nursing Home	12947.8	15825.6	(967.4)	1716.0	17541.6	(858.0)	21927.0	(3563.5)
Indian Health	1458.7	6557.6	-0-		6557.6	-0-	7239.6	-0-
TOTAL	25817.5	33266.7	(3882.3)	4916.1	38182.8	(5372.9)	47960.2	(10849.9)
GENERAL RELIEF MEDICAL								
Hospitals	4137.9	4147.9		1356.8	5504.7		7348.8	(7348.8)
Physicians	1443.4	1150.3		900.0	2050.3		2737.1	(2737.1)
Other	1338.0	1224.1		473.4	1697.5		2266.1	(2266.1)
Nursing Homes	328.8	683.9		231.7	915.6		1144.5	(1144.5)
Catastrophic Illness	801.8	754.2		-0-	754.2		977.3	(977.3)
Residential Nurse	-0-	166.4		-0-	166.4		166.4	(166.4)
TOTAL	8049.9	8126.8	(8126.8)	2961.9	11088.7	(11088.7)	14640.2	(14640.2)
DISCRETIONARY								
PA Admin & Support	970.4	910.9	(529.2)		910.9	(529.2)	979.8	(594.8)
Collections	42.8	44.8	(44.8)		44.8	(44.8)	47.4	(28.4)
SUBTOTAL	67432.5	77780.2	34570.8		89730.6	(41471.8)	110225.5	(54964.3)
+FEDERAL FOOD STAMPS	10400.0	14976.0			14976.0		18637.0	
+ENERGY ASSISTANCE PROGRAM	N/A	N/A			3636.7		unknown	
DIVISION TOTAL	77832.5	92756.0	34570.8		108343.3	(41471.8)	128892.5	(54964.3)