STATE

HEALTH

ISURE.

#2

Consumer Director of Insurance
Kim Moore
Not advised I was coming

TESTIMONY PREPARED
for
HOUSE OF REPRESENTATIVES
COMMITTEE ON HEALTH EDUCATION & SOCIAL SERVICES
ALASKA STATE LEGISLATURE

March 31, 1980

I apologize publicly to him for this breach of protocol

It is indeed a pleasure for me to appear before you today to discuss legislation which I believe will promote the health of residents of your great state and this great country. I am very pleased that a state legislature is seriously considering enactment of a bill which will guarantee citizens' access to third party payment for health care. It is also very comforting for Minnesotans who have championed this sort of legislation to know that Minnesota is not out of step in fighting for this enlightened program.

I have come a long way to be with you today. It is an awesome responsibility to represent the State of Minnesota, our Governor, Al Quie, and our Insurance Commissioner, Michael D. Markman. I also feel I represent the hundreds of people who toiled for many months before and after the enactment of our law. We had great cooperation from our local insurance people and although the insurance industry continues to be assaulted from many quarters, this is one area in which some of the industry can be justifiably proud.

What success our law has had in promoting access to comprehensive health care to Minnesotans lies in the willingness of the State and the insurance people within that state to join forces to effect the goal of the legislation. Although I could not bring the experts who have made our program work smoothly with me, I did bring some of their work product which I shall leave with you with the hope that it will ease the implementation of the bill upon enactment.

My role here today as I see it is to share with you the experiences and knowledge gained in four years of working with our legislation which is similar to your proposed legislation. The provisions which are similar or nearly identical will of course, lend themselves to a recitation of historical fact. Those that ar unique to your bill will require a forecast.

(2) QUALIFIED MEDICARE SUPPLEMENT PLAN 21 50 040

STATE PLAN PREMIUM 21 50 050

125% of the 5 LARGEST
INSURERS FOR QUALIFIED PLANS

HMO ONLY — GEN ACCEPTED
ACTUARIAL PRINCIPLES.

DUTIES OF DIRECTOR 21 50 060

SAME AS MINN.

COMPREHENSIVE HEALTH ASSOCIATION 21 50 070

INSURERS
SELF INSURERS
FRATERNALS
HMO'S

BOARD (9) ELECTED BY
WEIGHTED VOTE

MANDATORY MEMBERSHIP AS A CONDITION OF
DOING BUSINESS.

ASSOCIATION MAY EXERCISE POWERS (SAME AS MINN

INCLUDES PROVISION
FOR REINSURANCE SAME AS MINN

21 50 110 ENROLLMENT BY ELIGIBLE PERSON

NO PRESUMPTIVE CONDITIONS

6 MONTH WAITING PERIOD ON
90 DAY PRE EXISTING CONDITIONS

21 50 120 SOLICITATION OF ELIGIBLE PERSONS

DISSEMINATE INFO

PUBLIC AWARENESS

25% REFUSALS

NOTIFICATION BY INSURER OF
EXISTANCE OF STATE PLAN UPON
REJECTION FOR COVERAGE

21 50 130 CONVERSION PRIVILEGES

POLICIES WRITTEN OR RENEWED IN
THIS STATE (NOT EXTRATERRITORIA

RIGHT TO CONVERT FOR ANY REASON

~~DISCOUNT~~

INDIVIDUAL COVERAGE MUST BE
QUALIFIED PLAN. (NO CHOICE?)

OPERATION OF STATE PLAN 21 50 080

PROVIDES FOR ENROLLMENT BY ELIGIBLE PERSON

EMPLOYER MAY PAY DIRECT TO W/C

87½ MIN TO PAY CLAIMS
12½ MAX TO W/C

MEMBERS SHARE LOSSES DUE TO CLAIMS EXPENSES.

ADMINISTRATION EXPENSES?

WHY CALL IT REINSURANCE PAYMENTS?

PAYMENTS ASSESSED MAY BE OFFSET BY INCOME TAX OR PREMIUM TAX

21 50 090 MINIMUM BENEFITS OF STATE PLAN

#1 #2 & QUALIFIED MED SUPPLEMENT

HMO WHERE AVAILABLE

(ACTUARIAL EQUIVALENT NOT OFFERED IN MINNESOTA)

21 50 100 ADMINISTRATION OF PLAN

PROPOSED PLANS MAY BE SUBMITTED
(PROTOTYPE OR AE)

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

21 March 1980

MAR 26 1980

To All Parties Interested in Health Care Coverage:

Hearings for legislation dealing with various health care issues are scheduled for March 31, April 1 and April 2 before the House Health, Education and Social Services Committee.

We are interested in your comments on this important piece of legislation which is presently in draft form. Therefore, we felt that it was necessary to prepare the following summary of the issues contained in the legislation to aid in the preparation of your testimony.

We expect that the legislation will be introduced in the House on March 25 or 26. The bill will be available at Legislative Information Offices throughout the state on the following day.

On March 31 and April 2, the Committee will be hearing testimony in Room 112 of the Capitol at 1:30 pm. On April 1 we will be holding teleconference hearings from Anchorage and Fairbanks from 7:00 - 9:00 pm Juneau time (5:00 - 7:00 pm Anchorage and Fairbanks time) and from all other sites from 1:30 - 3:00 pm Juneau time.

We regret that the bill is not available in its final form at this date. However, we would like to stress that all of the information necessary to formulate comments/testimony is included in the attached summary. Thank you for your cooperation.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
Chair, House HESS Committee

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

SUMMARY OF HEALTH CARE LEGISLATION

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

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

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

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

Section two of the bill establishes state standards for "qualified" health insurance plans, and requires insurance carriers to offer qualified plans to all eligible applicants. The bill does not prohibit the offering or sale of unqualified plans. Qualified plans must include benefits for the following: hospital services, professional services rendered by a physician or at his or her direction, prescription drugs, nursing home services, home health agency services, radium, oxygen, anesthetics, prostheses, medical equipment, x-rays and laboratory tests, oral surgery , physical therapy services, medically necessary transportation, well baby care, routine physical exams, multiphasic screening, and other diagnostic testing. The plan must cover at least 80% of the usual and customary charges for covered services, must limit out-of-pocket expenses at least to $3,000 per person annually, and may provide a limit on maximum lifetime benefit of not less than $250,000. A number three qualified plan may have an annual deductible not exceeding $150 per person or $450 per family. A number two qualified plan may have an annaul deductible not exceeding $500 per person or $1500 per family. A number three qualified plan may have an annual deductible not exceeding $1,000 per person or $3000 per family. A qualified Medicare supplement plan must provide coverage of at least 50% of the Medicare deductible and co-payment, provide at least 80% coverage of the services required in a qualified plan which are not covered by Medicare, limit out-of-pocket expenses to no more than $1,000 per person per year, and provide for a maximum lifetime benefit of not less than $100,000. The director has authority to upgrade minimum benefit standards by regulation.

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

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

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

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

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

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

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

Proofed 3-21

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the health of residents of the state; and providing for an effective date."

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

* Section 1. AS 18 is amended by adding a new chapter to read:

CHAPTER 12. PREPAID HEALTH CARE.

Sec. 18.12.010. COVERAGE OF REGULAR EMPLOYEES BY GROUP PREPAID HEALTH CARE PLAN. (a) An employer who pays to a regular employee monthly wages amounting to 86.67 times the minimum hourly wage established in AS 23.10.065 shall provide coverage for the employee with a prepaid group health care plan or combination of plans which have been certified under AS 21.50.040 as a number two qualified plan including coverage for dependents with a prepaid health care plan contractor in accordance with this chapter.

(b) If the plan of health coverage does not meet the requirements of AS 21.50.040 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan.

Sec. 18.12.020. CHOICE OF PLAN TYPE AND OF CONTRACTOR. (a) An employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall determine whether coverage is provided by

(1) a plan which obligates the prepaid health care plan contractor to furnish the required health care benefits;

(2) a plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care; or

(3) ~~a plan which complies~~ plans under both (1) and (2) in compliance with AS 18.12.030(a).

(b) The election made under (a) of this section is binding for one year.

(c) Whether the employer elects a plan type described in (a)(1) or (2) of this section, the employer may elect the particular contractor but the employee is not obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the state.

(d) The employer shall provide coverage with the prepaid health care plan contractor selected under (c) of this section for all his employees in the state electing the type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement and except as provided in AS 18.12.110.

Sec. 18.12.030. DUAL OPTION. (a) An employer who employs 100 or more persons in the state on the average during a calendar quarter other than employees engaged in seasonal employment, shall, upon the next renewal of the health benefits plan contract, offer his employees an option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if fewer than 25 employees select that option.

(b) An employer may make the offers through an insurer, a health maintenance organization or on a self-insured basis. If an offer is made on a self-insured basis, the accident and health insurance type of coverage or health maintenance organization type of coverage shall meet

the requirements of the laws of the state as to the services covered or benefits provided but is not required to be approved by the director.

(c) An insurer may not make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. A health maintenance organization may not make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. An offer to provide the accident and health insurance policy and the health maintenance organization contract may not combine the two offers in a single price package.

Sec. 18.12.040. LIABILITY FOR PAYMENT OF PREMIUM AND FOR WITHHOLDING. (a) Unless an applicable collective bargaining agreement provides otherwise, an employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance. The employee may not be required to contribute more than 1.5 percent of his wages. If the amount of the employee's contribution is less than one-half of the premium, the employer is liable for the remaining portion of the premium.

(b) The employer shall withhold the employee's share from his wages.

Sec. 18.12.050. COMMENCEMENT OF COVERAGE. The employer shall provide the coverage required by this chapter for any regular employee who has been in his employ for four consecutive weeks at the earliest time after the fourth week at which coverage may be provided with the prepaid health care plan contractor selected in accordance this chapter.

Sec. 18.12.060. CONTINUATION OF COVERAGE. If an employee is prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amount paid

by the employer toward the premium before the employee's sickness for the period that the employee is prevented by sickness from working. The obligation established by this section may not exceed a period of three months following the month during which the employee became disabled from working or the period for which the employer has paid regular wages to the employee, whichever is longer.

Sec. 18.12.070. LIABILITY OF SECONDARY EMPLOYER. An employer who has been notified by an employee on a form prescribed by the commissioner that he is not the principal employer is relieved from the duty to provide coverage required by this chapter until he is notified by the employee under /S 18.12.090 that he has become the principal employer. A secondary employer shall notify the commissioner on a form prescribed by the commissioner that he is relieved from the duty of providing coverage and of any change in that status.

Sec. 18.12.080. EXEMPTION OF CERTAIN EMPLOYEES. (a) In addition to the exemption granted by AS 18.12.070, an employer is relieved of his obligations under AS 18.12.010 to an employee who has notified him on a form specified by the commissioner that the employee is

(1) protected by health insurance or a prepaid health care plan established under a law of the United States;

(2) covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;

(3) a recipient of public assistance or covered by a prepaid health care plan established under the laws of the state governing medical assistance.

(b) An employer receiving notice of a claim of exemption under this section shall notify the commissioner of the claim on a form prescribed by the commissioner.

Sec. 18.12.090. TERMINATION OF EXEMPTION. (a) If an exemption

claimed by an employee under AS 18.12.080 terminates the employee shall notify the principal employer promptly of the termination of the exemption and the employer shall provide coverage as required by this chapter.

(b) If a principal employer becomes a secondary employer or a secondary employer becomes the principal employer because of a change in the employment situation of an employee or a redetermination by an employee under AS 18.12.100, the employee shall promptly notify the employers affected of the change and the new principal employer shall provide coverage required by this chapter.

Sec. 18.12.100. PRINCIPAL AND SECONDARY EMPLOYERS. (a) If an individual is concurrently a regular employee of two or more employers, the principal employer is the employer who pays him the most wages. If the employer who does not pay the most wages employs the regular employee for at least 35 hours per week, the employee shall determine which of the employers is his principal employer and his other employers are secondary employers. An employer designated as the principal employer remains the principal employer for one year or until change of employment, whichever occurs first.

(b) If an individual is concurrently a regular employee of a public entity which is not an employer under this chapter and of an employer under this chapter, the latter is a secondary employer.

(c) An employer who directly or indirectly interferes with or coerces or attempts to coerce an employee in making a determination under this section is guilty of a class B misdemeanor.

Sec. 18.12.110. FREEDOM OF COLLECTIVE BARGAINING. (a) This chapter may not be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs of the coverage. A collective

bargaining agreement may provide that the employer will provide the health care specified in an agreement.

(b) If certain employees are not covered by the health care provisions of an applicable collective bargaining agreement to which their employer is a party, this chapter applies to them. An employer or group of employers has complied with this chapter if the employer or group of employers undertakes to provide health care services under a collective bargaining agreement and the services are available to all employees not covered by the agreement.

Sec. 18.12.120. INDIVIDUAL WAIVERS PROHIBITED. An employee as an individual may not waive the required health care benefits or agree to pay a greater share of the premium for the benefits than is required by this chapter.

Sec. 18.12.130. JOINT PROVISION OF COVERAGE. For the purpose of providing prepaid health care protection under this chapter for their employees, employers may form associations with the contractors authorized to provide coverage in the state.

Sec. 18.12.140. POWERS OF THE COMMISSIONER. The commissioner may adopt regulations necessary for the administration and enforcement of this chapter.

Sec. 18.12.150. PENALTIES. (a) An employer who fails to comply with AS 18.12.010 - 18.12.040 shall pay a penalty of not less than $25 or of $1 for each employee for every day during which the failure continues, whichever is greater. The penalty shall be assessed under regulations adopted by the commissioner under the Administrative Procedure Act (AS 44.62) and shall be collected by the commissioner and paid into the general fund. The commissioner may, for good cause shown, remit all or a part of the penalty.

(b) An employer, employee, or prepaid health care plan contractor

who wilfully fails to comply with this chapter or a regulation adopted under it may be fined not more than $200 for each violation.

Sec. 18.12.160. ENTITLEMENT TO PREMIUM SUPPLEMENTATION. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to the employees under AS 18.12.010 is entitled to premium supplementation if the employer's share of the cost of providing the coverage as determined under AS 18.12.040 and 18.12.060 exceeds 1.5 percent of the total wages payable to the employees and if the amount of the excess is greater than five percent of the employer's income before taxes directly attributable to the business in which the employees are employed.

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

Sec. 18.12.170. CLAIM OF PREMIUM SUPPLEMENTATION. 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. 18.12.180. EXISTING PLANS. This chapter may not be construed to interfere with or diminish protection already provided under collective bargaining agreements or employer-sponsored plans more favorable to the employees benefited by them than the protection provided by this chapter.

Sec. 18.12.190. TERMINATION OF CHAPTER. This chapter terminates on the effective date of federal legislation that provides for voluntary prepaid health care for the people of this state in a manner at least as favorable as the health care provided by this chapter or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of this state.

Sec. 18.12.~~1~~2~~5~~50. DEFINITIONS. In this chapter

(1) "commissioner" means the commissioner of labor;

(2) "employer"

(A) means an individual or any type of organization, including a partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment

(B) does not mean

(i) the state, a municipality of the state or an instrumentality of the state or its municipalities;

(ii) the United States government or an instrumentality of the United States;

(iii) another state or municipality or instrumentality of another state or municipality;

(iv) a foreign government or instrumentality wholly owned by a foreign government, if the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality of the United States, and the United States Secretary of State certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption for similar service performed in the foreign country by employees of the United States government and instrumentalities of the United States;

(3) "employment"

(A) means service, including service in interstate

commerce, performed for wages under a contract of hire, written or oral, expressed or implied, with an employer, either inside or both inside and outside the state if:

(i) the service is localized in the state; or

(ii) the service is not localized in any state but some of the service is performed in the state and the individual's base of operation, or, if there is no base operation, the place from which the service is directed or controlled, is in the state; or the individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in the state;

(B) does not mean service

(i) performed by an individual in the employ of an employer who, under the laws of the United States, is responsible for care and cost in connection with the service;

(ii) performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of 21 in the employ of his father or mother;

(iii) performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sickness, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if admission to membership in the association is limited to individuals who are officers or employees of the United States government, and no part of the net earnings of the association inures (other than through such payments) to the benefit of a private shareholder or individual;

(iv) performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all the service performed by the individual for the employer is performed for remuneration solely by way of commission;

(v) performed by an individual for an employer as a real estate salesman or as a real estate broker, if all the service performed by the individual for the employer is performed for remuneration solely by way of commission;

(4) "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;

(5) "premium" means an amount payable to a prepaid health

care plan contractor as consideration for his obligations under a prepaid health care plan;

(6) "prepaid health care plan" means an agreement by which a prepaid health care plan contractor undertakes in consideration of a stipulated premium

(A) to furnish health care, including hospitalization, surgical, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or

(B) to defray or reimburse, in whole or in part, the expenses of health care;

(7) "prepaid health care plan contractor" means

(A) a medical group or organization which undertakes under a prepaid health care plan to provide health care;

(B) a nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or

(C) an insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care;

(8) "regular employee" means a person employed in the employment of any employer for at least 20 hours per week;

(9) "wages"

(A) means cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to an individual by a customer of the employer; if the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $200 a month in tips,

the combined amount received by him from his employer and from tips is considered to be at least equal to the wage required by AS 23.-10.065 or a greater sum as determined by regulation of the commissioner;

(B) does not mean the amount of a payment

(i) specified in AS 23.20.530(b);

(ii) received for nonoccupational sickness or accident; or

(iii) received as workers' compensation.

* Sec. 2. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. COMPREHENSIVE HEALTH INSURANCE.

Sec. 21.50.010. DUTIES OF INSURERS. (a) For each type of qualified plan described in AS 21.50.030, an insurer or fraternal issuing individual policies of accident and health insurance in the state other than group conversion policies shall develop and file with the director an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in the state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

(b) An insurer or fraternal issuing Medicare supplement plans in the state shall develop and file with the director a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in the state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

(c) For each type of qualified plan described in AS 21.50.040, an insurer or fraternal issuing group policies of accident and health

insurance in the state shall develop and file with the director a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in the state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

(d) Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more in a calendar year for services covered under AS 21.50.030(a), benefits shall be payable, subject to any copayment authorized by the director, up to a maximum lifetime limit of $250,000.

(e) A policy of accident and health insurance may not be issued or renewed in the state after January 1, 1981, by an insurer or a fraternal which has not complied with this section.

(f) An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in its own name and reinsuring the risk and administration of the coverages with the association in accordance with AS 21.50.030(g)(5) and (6).

(g) This section does not require an insurer or fraternal to offer or issue a policy to a person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Sec. 21.50.020. CERTIFICATION OF QUALIFIED PLANS. On application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of AS 21.50.010 - 21.50.130 the director shall determine within 90 days whether the plan is qualified. Each plan of

health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. A qualified plan shall indicate whether it is a number one, two, or three coverage plan.

Sec. 21.50.030. MINIMUM BENEFITS OF QUALIFIED PLAN. (a) A plan of health coverage shall be certified as a number three qualified plan whether or not the policy is issued in the state if it meets or exceeds the following minimum standards:

(1) The minimum benefits for a covered individual shall, subject to the other provisions of this subsection, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which may not exceed $150 per person, or $450 per family. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than $250,000. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(A) hospital services;

(B) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

(C) drugs requiring a physician's prescription;

(D) services of a nursing home for not more than 120 days in a year if the services begin within 14 days following confinement of at least three days in a hospital for the same condition;

(E) service of a home health agency up to a maximum of 180 visits per year;

(F) use of radium or other radioactive materials;

(G) oxygen;

(H) anesthetics;

(I) prostheses;

(J) rental or purchase, as appropriate, of durable medical equipment;

(K) diagnostic x-rays and laboratory tests;

(L) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(M) services of a physical therapist;

(N) medically necessary transportation.

(2) Covered expenses for the services and articles specified in this subsection do not include the following:

(A) a charge for care for an injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation law or for which benefits are payable under another policy of accident and health insurance or Medicare;

(B) a charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(C) a charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

(D) that part of a charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided;

(E) a charge for services or articles the provision of which is not within the scope of authorized practice of the in-

stitution or individual rendering the services or articles.

(3) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in (a)(1) of this section, benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(A) well baby care;

(B) physicians' services for routine checkups and annual physicals when prescribed by a physician;

(C) multiphasic screening and other diagnostic testing.

(b) The director shall prescribe by regulation reasonable limits on the reimbursement required for the services specified in (a) of this section.

(c) A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of the state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed $500 per person. or $1500 per family

(d) A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of the state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed $1,000 per person. or $3000 per family

(e) A health maintenance organization which provides the services required by (a) of this section is providing a number three qualified plan.

Sec. 21.50.040. QUALIFIED MEDICARE SUPPLEMENT PLAN. A plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 50 percent of the deduc-

tible and copayment required under Medicare and 80 percent of the charges for covered services described in AS 21.50.030(a) which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $100,000.

Sec. 21.50.050. STATE PLAN PREMIUM. (a) The association shall establish the following premiums to be charged for membership in the state plan:

(1) The premium for the number one qualified plan may not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in the state.

(2) The premium for the number two qualified plan may not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in the state.

(3) The premium for a qualified Medicare supplement plan may not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified Medicare supplement plan.

(4) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

(b) The schedule of premiums for coverage under the state plan shall be designed to be self-supporting and based on generally acce actuarial principles.

Sec. 21.50.060. DUTIES OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.140 and may adopt regulations under the Admin

tive Procedure Act (AS 44.62) to carry out AS 21.50.010 - 21.50.140.;

(2) adopt regulations revising minimum benefit standards under AS 21.50.010 - 21.50.040 as may be appropriate due to inflation or changes in prevailing industry standards;

(3) supervise the establishment of a comprehensive health association within the limits described in AS 21.50.050;

(4) approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged;

(5) appoint advisory committees;

(6) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(7) contract with the federal government or another unit of government to ensure coordination of the state plan with other governmental assistance programs;

(8) undertake directly or through contracts studies or demonstration programs to develop awareness of the benefits of AS 21.50.010 - 21.50.140, so that the residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.070. COMPREHENSIVE HEALTH ASSOCIATION. (a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternals, and health maintenance organizations licensed or authorized to do business in this state.

(b) The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director. To select the initial board of directors and to initially organize the association, the director shall give notice to all members of the time and place of the organizational meeting. In

determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based on the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the previous calendar year, as determined by the director. If the board of directors is not selected within 60 days after notice of the organizational meeting, the director may appoint the initial board. In approving or selecting members of the board, the director shall consider, among other things, whether all types of 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 may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) Members shall maintain their membership in the association as a condition of doing business in the state. The association shall submit bylaws and operating rules to the director for approval.

(d) Meetings of the association, its board, and committees of the association shall comply with AS 44.62.310.

(e) Members shall enter into a contract with the association according to terms specified in AS 21.50.080. The contract of reinsurance shall be executed for a period of one year and may be renewed annually. A company which ceases to do business in the state remains liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members are exempt from the provisions of AS 45.52.

(g) The association may

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions including the functions provided for in (5) and (6) of this subsection;

(4) establish administrative and accounting procedures for the operation of the association;

(5) provide under (h) of this section for the reinsuring of risks incurred as a result of issuing the coverages required by AS 21.50.010 and 21.50.120 by members of the association;

(6) provide under (i) of this section for the administration by the association

of policies which are reinsured under (5) of this subsection.

(h) Each member which elects to reinsure its required risks under (g)(5) of this section shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (1) individual qualified plans, excluding group conversions; (2) group conversions; (3) group qualified plans with fewer than 50 employees or members; and (4) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks may not be less than 11 percent of the total anticipated expenses incurred by the association

for the reinsurance.

(i) Each member electing to reinsure one or more categories of coverage in the association under (g)(6) of this section may elect to have the association administer the categories of coverage on the member's behalf under (g)(6) of this section. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

see page 37 discussion

Sec. 21.50.080. OPERATION OF STATE PLAN. (a) Upon certification as an eligible person under AS 21.50.110, an eligible person may enroll in the state plan by payment of the state plan premium to the writing carrier.

(b) An employer which has in its employ one or more eligible persons enrolled in the state plan may make all or a portion of the state plan premium payment to the state plan directly to the writing carrier.

(c) Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims and not more than 12.1/2 percent shall be used for the payment of agent referral fees authorized in AS 21.50.120(c) and for payment of the writing carrier's direct and indirect expenses, as specified in AS 21.50.100(g).

(d) Income in excess of the costs incurred by the association in providing reinsurance or administrative services shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

(e) Each member of the association shall share the losses due to claims expenses of the state plan according to the terms of the individual reinsurance contracts executed by the association with each

member in accordance with AS 21.50.070(e). Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of state residents as divided into the total cost of self-insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges, received by all association members from or on behalf of state residents, as determined by the director. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within 30 days after each renewal date of the re-insurance contract. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association is grounds for termination of the member's membership. Net gains from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

(f) The assessed reinsurance payment levied against a member may be offset against the income tax or the premium tax payable under this title by the member payable under AS 43.20 for the year in which the payment is assessed. The commissioner of revenue shall report not later than the 10th day of a regular session to the legislature the total amount of income tax or premium tax offset claimed by members during the preceding calendar year.

Sec. 21.50.090. MINIMUM BENEFITS OF STATE PLAN. The association through its state plan shall offer policies which provide the benefits

of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan. It shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Sec. 21.50.100. ADMINISTRATION OF PLAN. (a) A member of the association may submit to the director the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the state plan. The time and manner of the submission shall be prescribed by regulation of the director.

(b) On the director's approval of the policy forms and contracts submitted under AS 21.50.070, the association shall select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based on criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

(c) The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. The failure to approve or deny a request to terminate within 90 days of its receipt constitutes an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing

carrier. The association shall select a writing carrier for the following three-year period under (b) of this section.

(d) The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate which contains a clear and easily understandable statement as to the insurance protection to which he is entitled, with whom claims are to be filed, and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

(e) The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association before the effective date of the state plan.

(f) All claims shall be paid by the writing carrier under the provisions of AS 21.50.010 - 21.50.140 and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(g) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses include but are not limited to a pro-rata reimbursement for the portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

(h) The writing carrier is an agent of the association and the director with civil liability subject to the provisions of AS 09.50.250 09.50.300 when carrying out its duties under AS 21.50.010 - 21.50.140.

(i) Premiums received by the writing carrier for the state plan are exempt from the requirements of AS 21.50.130(c).

Sec. 21.50.110. ENROLLMENT BY ELIGIBLE PERSON. (a) The state plan is open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier which provides:

(1) name, address, age, and length of time at residence of the applicant;

(2) name, address, and age of spouse and children, if any, if they are to be insured;

(3) evidence of rejection, or a requirement of restrictive riders, or a preexisting conditions limitation on a qualified plan by at least two association members within six months of the date of the certificate, the effect of which is to reduce coverage substantially from that received by a person considered a standard risk;

(4) a designation of the coverage desired.

(b) Within 30 days of receipt of the certificate described in (a) of this section, the writing carrier shall either reject the application for failing to comply with the requirements in (a) of this section or forward the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt of the first month's state plan premium and shall be retroactive to the date of application if the applicant otherwise complies with the requirements of AS 21.50.010 - 21.50.140. An eligible person may not purchase more than one policy from the state plan.

(c) A person who obtains coverage under this section is not

covered for a preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application.

Sec. 21.50.120. SOLICITATION OF ELIGIBLE PERSONS. (a) The association shall disseminate appropriate information to the residents of the state under a plan approved by the director regarding the existence of the state plan and the means of enrollment.

(b) The association shall maintain public awareness of the provisions of AS 21.50.010 - 21.50.140 and shall administer this chapter in a manner which encourages public participation in the state plan.

(c) The writing carrier shall pay an agent's referral fee of $25 to each insurance agent who refers an applicant to the state plan if the application is accepted. Selling or marketing of qualified state plans may not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

(d) Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the appplicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Sec. 21 50.130. CONVERSION PRIVILEGES. (a) Each program of self-insurance and each policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in the state shall include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions regardless of the reason for leaving the group. A person leaving the group may exercise his right to conversion within 30 days of leaving the group.

(b) Plans of health coverage shall include a provision which, upon the death of the individual in whose name the contract was issued, permits an individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

Sec. 21.50.200. DEFINITIONS. In this chapter,

(1) "accident and health insurance policy" or "policy"

(A) means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care;

(B) does not mean coverage which is

(i) limited to disability or income protection coverage,

(ii) automobile medical payment coverage,

(iii) supplemental to liability insurance,

(iv) sold by fraternals and provides payments on a per diem, daily indemnity or nonexpense-incurred basis;

(2) "association" means a comprehensive health association established under AS 21.50.070;

(3) "dependent" means a spouse or unmarried child under the age of 18 years, a child who is a student under the age of 25 years and financially dependent upon the parent, a dependent child of any age who is disabled, or a household member who is financially dependent on the primary insured;

(4) "director" means the director of insurance;

(5) "eligible person" means an individual who is a resident of the state and meets the enrollment requirements of AS 21.50.110;

(6) "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with AS 21.84;

(7) "gross income" means income under AS 43.20;

(8) "health benefits" means benefits offered to employees on an indemnity or prepaid basis which pays the costs of or provide medical, surgical, or hospital care;

(9) "health maintenance organization" means a nonprofit corporation organized and operated under 42 U.S.C. sec. 300e;

(10) "insurer"

(A) means a company offering, selling, issuing or renewing policies or contracts of accident and health insurance;

(B) does not mean health maintenance organization;

(11) "Medicare" means Part A and Part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. sections 1394, et seq;

(12) "Medicare supplement plan" means a plan of insurance protection which provides benefits for the costs of medical, surgical, or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare;

(13) "plan of health coverage" means a plan or combination of plans of coverage, including combinations of self-insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract;

(14) "qualified expense" means a charge incurred for a health service which is included in the list of covered services described in AS 21.50.040(a) and for which no third party is liable;

(15) "qualified Medicare supplement plan" means a health

benefit plan which has been certified by the director as providing the minimum benefits required by AS 21.50.050 or the actuarial equivalent of those benefits;

(16) "qualified plan" means those health benefit plans which have been certified by the director as providing the minimum benefits required by AS 21.50.040 or the actuarial equivalent of those benefits;

(17) "self-insurance" means a plan of health coverage offered by a self-insurer;

(18) "self-insurer"

(A) means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer;

(B) does not mean an employer engaged in the business of providing health care services to the public who provides health care services directly to his employees at no charge to them;

(19) "state plan" means policies of comprehensive health insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier under this chapter;

(20) "state plan premium" means a premium determined under AS 21.50.060;

(21) "third party" means a person other than the eligible person or his dependents;

(22) "writing carrier" means an insurer or insurers and a hospital or medical service corporation or corporations selected by the association and approved by the director to administer the comprehensive health insurance plan.

* Sec. 3. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. INSURANCE AND SERVICE CONTRACTS.

Sec. 47.07.100. 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 care service contracts or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically or the medically needy.

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

(1) to provide medical and remedial care and services of the type and according to the standards prescribed under AS 47.07.030;

(2) to pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges, and costs established under AS 47.04.030 except as to medical or hospital service contracts issued by a hospital association which employs a method of accounting or payment on other than a fee for service basis;

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

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

Sec. 47.07.110. RATES ON INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall establish uniform areawide rates for the payment on policies of insurance or service contracts from available medical assistance funds.

(b) The commissioner may not pay a premium or other periodic charge on a policy of insurance, health care service contract, or

hospital service contract unless the insurer or contractor issuing the policy or contract is authorized to do business in the state.

Sec. 47.07.120. 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 under this chapter. Payment shall be made under AS 47.07.030.

(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.

Insert. Pick up Secs. 130 & 150 from page 32

* Sec. 4. AS 47.07.0~~X~~0 is amended to read:

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, podiatrist services chiropractic services, private duty nursing, physical therapist services occupational therapy services, dental services and dentures, personal care services, prosthetic services, prescribed drugs, inpatient psychiatric hospital, skilled nursing and intermediate care facility services 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, inpatient, skilled nursing, and intermediate care facility services for persons 65 years of age or older, clinic services, treatment of speech, hearing and language disorders, diagnostic, screening, prevention, and rehabilitation services and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

Sec. 47.07.130. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.07.100 - 47.07.130 when the commissioner determines that comparable benefits at equal or less cost than direct payments by the department to the providers of medical assistance.

Sec. 47.07.150. DEFINITIONS. In AS 47.07.100 - 47.07.150

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

(2) "department" means the Department of Health and Social Services.

* Sec. 5. AS 47.07.070 is amended by adding a new subsection to read:

(b) In providing reimbursement to providers of services under (a) of this section, the state shall pay

(1) interest on unpaid ~~medical~~ Medicaid bills presented by providers at the rate of one percent per month when payment is delayed more than 30 days after presentation of the billing; and

(2) interest on unpaid ~~medical~~ Medicaid bills presented by providers at the rate of two percent per month when payment is delayed more than six months after presentation of the billing.

* Sec. 6. 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 departmen'; and

(2) a medically needy person who has incurred medical expenses which equal or exceed the difference between the person's monthly income and 150 percent of the current Federal Community Services Administration poverty income guidelines for Alaska (45 C.F.R.,sec. 1060.2).

* Sec. 7. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.175. INTEREST ON LATE PAYMENTS. In providing reimbursement to providers of medical services under AS 47.25.120 - 47.25.300, the state shall pay

(1) interest on unpaid medical bills presented by providers at the rate of one percent per month when payment is delayed more than 30 days after presentation of the billing; and

(2) interest on unpaid medical bills presented by providers at the rate of two percent per month when payment is delayed more than six months after presentation of the billing.

* Sec. 8. ADJUSTMENT OF EMPLOYER-SPONSORED PLANS. When employees subject to the requirements of AS 18.12 enacted in sec. 1 of this Act are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the state and the majority of the employees are not subject to the requirements of AS 18.12, the benefits applicable to the employees covered by AS 18.12 shall be adjusted within one year after the effective date of this Act so as to meet the requirements of AS 18.12.

* Sec. 9. This Act takes effect January 1, 1981.

"CHAPTER
PREPAID HEALTH CARE ACT
PART I. SHORT TITLE; PURPOSE; DEFINITIONS

Sec. -1 **Short title.** This chapter shall be known as the Hawaii Prepaid Health Care Act.

Sec. -2 **Findings and purpose.** The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto.

Sec. -3 **Definitions generally.** As used in this chapter, unless the context clearly requires otherwise:

(1) "Department" means the department of labor and industrial relations.

(2) "Director" means the director of labor and industrial relations.

(3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment. "Employer" does not include:

(A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;

(B) The United States government or any instrumentality of the United States;

(C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision.

(D) Any foreign government or instrumentality wholly owned by a foreign government, if (i) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (ii) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemp-

n with respect to similar service performed in the foreign ..untry by employees of the United States government and of instrumentalities thereof.

(4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections -4 and -5.

(5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for his obligations under a prepaid health care plan.

(6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:

(A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or

(B) To defray or reimburse, in whole or in part, the expenses of health care.

(7) "Prepaid health care plan contractor" means:

(A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or

(B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or

(C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

(8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes seasonal employment.

(9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $20 a month in tips, the combined amount received by him from his employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386.

Sec. -4 **Place of performance.** "Employment" includes an individual's entire service, performed within or both within and without this State if:

(1) The service is localized in this State; or

(2) The service is not localized in any state but some of the service is performed in this State and

(A) the individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or

(B) the individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State.

Sec. -5 **Excluded services.** "Employment" as defined in section -3 does not include the following services:

(1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service.

(2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his father or mother.

(3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if

(A) admission to membership in the association is limited to individuals who are officers or employees of the United States government, and

(B) no part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.

(4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.

(5) Service performed by an individual for an employer as a real estate salesman or as a real estate broker, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.

(6) Service performed by an individual who, pursuant to the Federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation.

Sec. -6 **Principal and secondary employer defined; coercion, interference, etc. prohibited.** If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the employee shall deter-

mine which of the employers shall be his principal employer. His other employers are secondary employers. The determination by the employee of his principal employer is binding for one year or until change of employment, whichever is earlier.

If an individual is concurrently is regular employee of a public entity which is not an employer as defined in section -3 and of an employer as defined in section -3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection -33(b).

Sec. -7 Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section -12(a) (1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section -11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

(i) Room accommodations;

(ii) Regular and special diets;

(iii) General nursing services;

(iv) Use of operating room, surgical supplies, anesthesia services, and supplies;

(v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:
(i) Covering use of out-patient hospital;
(ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:
(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
(B) After-care visits for a reasonable period;
(C) Anesthesiologist services.

(3) Medical benefits:
(A) Necessary home, office, and hospital visits by a licensed physician;
(B) Intensive medical care while hospitalized;
(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals.

PART II. MANDATORY COVERAGE

Sec. -11 Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section -7 with a prepaid health care plan contractor in accordance with the provisions of this chapter.

Sec. -12 Choice of plan type and of contractor. (a) Every employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

(1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or

(2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

His election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a) (1) or in subsection (a) (2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section -20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all his employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section -19(b) first sentence.

Sec. -13 Liability for payment of premium; withholding. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director.

Sec. -14 Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapte

Sec. -15 Continuation of coverage in case of inability to earn wages. If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of his regular wages in such case, whichever is longer.

Sec. -16 Liability of secondary employer. An employer who has been notified by an employee, in the form prescribed by the director, that he is not the principal employer as defined in section -6 shall be relieved of the duty of providing the coverage required by this chapter until he is notified by the employee pursuant to section -18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status.

Sec. -17 Exemption of certain employees. (a) In addition to the exemption specified in section -16, an employer shall be relieved of his duty under section -11 with respect to any employee who has notified him, in the form specified by the director, that the employee is:

(1) Protected by health insurance or any prepaid health care plan established under any law of the United States;

(2) Covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;

(3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director.

Sec. -18 **Termination of exemption.** (a) If an exemption which has been claimed by an employee pursuant to section -17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section -6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new principal employer shall provide coverage as required by this chapter.

Sec. -19 **Freedom of collective bargaining.** (a) In addition to the policy stated in section -2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement.

Sec. -20 **Adjustment of employer-sponsored plans.** Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter.

Sec. -21 **Individual waivers prohibited; additional withholding for dependents.** An employee may not waive individually all or part of the required health care benefits or agree to pay a greater share of the premium for such benefits than is required by this chapter.

Subject to section -7(b), an employee may consent to pay a greater

share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself.

Sec. -22 **Exemption of followers of certain teachings or beliefs.** This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means.

Sec. -23 **Joint provision of coverage.** Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State.

PART III. ADMINISTRATION AND ENFORCEMENT

Sec. -31 **Enforcement by the director.** Except as otherwise provided in section -7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees.

Sec. -32 **Rule making and other powers of the director.** The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof.

Sec. -33 **Penalties.** (a) If an employer fails to comply with sections -11, -12, -13, or -15 he shall pay a penalty of not less than $25 or of $1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section -41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who wilfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than $200 for each such violation.

PART IV. PREMIUM SUPPLEMENTATION

Sec. -41 **Establishment of special premium supplementation fund.** There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the

fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter.

Sec. -42 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depositary bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depositary bank. Such moneys shall be secured by the depositary bank to the same extent and in the same manner as required by the general depositary law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37.

Sec. -43 Disbursements from the fund. Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director.

Sec. -44 Investment of moneys. With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations.

Sec. -45 Entitlement to premium supplementation. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section -7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such coverage as determined by sections -13 and -15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's

income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a).

Sec. -46 **Income directly attributable to the business.** (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

(1) Compensation of officers;
(2) Salaries and wages, except wages paid by an individual proprietor to himself;
(3) Repairs;
(4) Taxes on business and business property;
(5) Business advertising;
(6) Amounts contributed to employee benefit plans;
(7) Interest on business indebtedness;
(8) Rent on business property; and
(9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

(1) Bad debts;
(2) Contributions or gifts, other than those listed under subsection (a) (6);
(3) Amortization and depreciation; or
(4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section -45.

Sec. -47 **Claim of premium supplementation.** An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing his entitlement."

SECTION 2. This Act shall take effect upon its approval, except that the coverage by group prepaid health care plans required by this Act and the payment of premiums for such coverage shall commence January 1, 1975; provided that this Act shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in a manner at least as favorable as the health care provided by this Act, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii.

(Approved June 12, 1974.)

ACT 211 H.B. NO. 3018-74

A Bill for an Act Relating to Mental Health Services for Children and Youth.

Be It Enacted by the Legislature of the State of Hawaii:

51 Amend.

SLH 1975

rial is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 9. This Act shall take effect upon its approval.

(Approved May 6, 1975.)

ACT 51 H.B. NO. 419

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-6, Hawaii Revised Statutes, is amended to read:

"**Sec. 393-6 Principal and secondary employer defined; coercion, interference, etc. prohibited.** If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays him the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be his principal employer. His other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b)."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 6, 1975.)

ACT 52 H.B. NO. 442

A Bill for an Act Relating to Taxation of Banks and Other Financial Corporations.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 241-4, Hawaii Revised Statutes, is amended by amending subsection (b) to read:

*Edited accordingly.

and may be leased by it as provided in chapter 171, Hawaii Revised Statutes, or may be retained for management by the department.

Any lease by the board of land and natural resources of Hawaiian home lands hereafter entered into shall contain a withdrawal clause, and the lands so leased shall be withdrawn by the board of land and natural resources, for the purpose of this Act, upon the department giving at its option, not less than one nor more than five years' notice of such withdrawal; provided, that the minimum withdrawal-notice period shall be specifically stated in such lease.

In the management of any retained available lands not required for leasing under section 207(a), the department may dispose of such lands to the public, including native Hawaiians, on the same terms, conditions, restrictions and uses applicable to the disposition of public lands as provided in chapter 171; provided, that the department may not sell or dispose of such lands in fee simple except as authorized under section 205 of this Act.

(3) The department shall not lease, use, nor dispose of more than twenty thousand (20,000) acres of the area of Hawaiian home lands, for settlement by native Hawaiians, in any calendar five-year period.

(4) The department may, with the approval of the governor and the Secretary of Interior, in order to consolidate its holdings or to better effectuate the purposes of this Act, exchange the title to available lands for land, publicly owned, of an equal value. All land so acquired by the department shall assume the status of available lands as though the same were originally designated as such under section 203 hereof, and all lands so conveyed by the department shall assume the status of the land for which it was exchanged. The limitations imposed by section 73(1) of the Hawaiian Organic Act and the land laws of Hawaii as to the area and value of land that may be conveyed by way of exchange shall not apply to exchanges made pursuant hereto. No such exchange shall be made without the approval of two-thirds of the members of the board of land and natural resources."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. If any portion of this Act is declared invalid, the remaining portions of this Act shall not be affected thereby.

SECTION 4. This Act shall take effect upon its approval.

(Approved April 28, 1976.)

ACT 25 H.B. NO. 2194-76

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

*Edited accordingly.

SECTION 1. The legislature finds that alcoholism and drug problems are the medical problems most disruptive of family life and employment, with alcoholism ranking, in addition, as the third highest medical cause of death in the United States today. Alcoholism and drug addiction are illnesses, and like other illnesses, their treatment should be uniformly covered by prepaid health care plans. The legislature further finds that such inclusion in prepaid health care plans will provide visibility to alcoholism and drug addiction benefits, and as a result, may encourage more accurate diagnosis of health problems related to alcoholism and drug addiction, because of health plan coverage. Moreover, employees may be encouraged to seek early diagnosis and treatment because of such coverage. Effective treatment will reduce substantially the great economic loss to employers. The purpose of this Act is to ensure adequate treatment for alcoholism and drug addiction by requiring its inclusion in prepaid health care plans, including coverage for appropriate detoxification and treatment facilities.

SECTION 2. Section 393-7, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:
  (A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:
    (i) Room accommodations;
    (ii) Regular and special diets;
    (iii) General nursing services;
    (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
    (v) Drugs, dressing, oxygen, antibiotics, and blood transfusion services.
  (B) Out-patient care:
    (i) Covering use of out-patient hospital;
    (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:
  (A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
  (B) After-care visits for a reasonable period;
  (C) Anesthesiologist services.

(3) Medical benefits:
  (A) Necessary home, office, and hospital visits by a licensed physician;
  (B) Intensive medical care while hospitalized;
  (C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the

prepaid health care plan for nine months prior to the delivery.

(6) Substance abuse benefits:

(A) Alcoholism and drug addiction are illnesses and shall receive benefits as such. In-patient and out-patient benefits for the diagnosis and treatment of substance abuse, including but not limited to alcoholism and drug addiction, shall be specifically stated and shall not be less than the benefits for any other illness, except as provided in this subsection. Medical treatment of substance abuse shall not be limited or reduced by restricting coverage to the mental health or psychiatric benefits of a plan. However, any psychiatric services received as a result of the treatment of substance abuse may be limited to the psychiatric benefits of the plan.

(B) Out-patient benefits provided by a physician, psychiatrist, or psychologist, without restriction as to place of service; provided that health plans of the type specified in section 393-12(a) shall retain for the contractor the option of:

(i) Providing the benefits in its own facility and utilizing its own staff, or

(ii) Contracting for the provision of these benefits, or

(iii) Authorizing the patient to utilize outside services and defraying or reimbursing the expenses at a rate not to exceed that for provision of services utilizing the health contractor's own facilities and staff.

(C) Detoxification and acute care benefits in a hospital or any other public or private treatment facility, or portion thereof, providing services especially for the detoxification of intoxicated persons or drug addicts, which is appropriately licensed, certified, or approved by the department of health in accordance with the standards prescribed by the Joint Commission on Accreditation of Hospitals. In-patient benefits for detoxification and acute care shall be limited in the case of alcohol abuse to three admissions per calendar year, not to exceed seven days per admission, and shall be limited in the case of other substance abuse to three admissions per calendar year, not to exceed twenty-one days per admission.

(D) Prepaid health plans shall not be required to make reimbursements for care furnished by government agencies and available at no cost to a patient, or for which no charge would have been made if there were no health plan coverage."

SECTION 3. New statutory material is underscored. In printing this Act, the revisor of statutes need not include the underscoring.*

SECTION 4. This Act shall take effect on July 1, 1976; provided that prepaid health care contracts due for renewal after July 1, 1976 may defer

*Edited accordingly.

inclusion of these substance abuse benefits until such renewal date, or January 1, 1977, whichever occurs earlier.

(Approved April 28, 1976.)

ACT 26 H.B. NO. 2533-76

A Bill for an Act Relating to Day Care Centers.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 346-19, Hawaii Revised Statutes, is amended to read:

"**Sec. 346-19 Day care centers defined.** A "day care center" is defined as a place maintained by any individual, organization, or agency for the purpose of providing care for a child or children with or without charging a fee during any part of a twenty-four hour day. The term day care center includes any place where group care is provided for six or more children, and any family home providing care for two to five children.

Nothing in sections 346-18 to 346-25 shall be construed to include an individual person caring for a related child, a neighbor or friend caring for a child or children if the person does not regularly engage in such activity, a kindergarten or school conducted solely for educational purposes or specialized training, or an organization established to conduct athletic or social group functions."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. This Act shall be effective July 1, 1976.

(Approved April 28, 1976.)

ACT 27 H.B. NO. 2880-76

A Bill for an Act Relating to the State Environmental Policy.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The purpose of this Act is to propose an amendment to Section 344-4 of the Hawaii Revised Statutes to provide for guidelines relating to solid wastes.

SECTION 2. Section 344-4 (2) is amended to read as follows:

"(2) Land, water mineral, visual, air and other natural resources.

(A) Encourage management practices which conserve and fully utilize all natural resources;

*Edited accordingly.

ACT 78 Amend.

SECTION 3. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 4. This Act shall take effect upon its approval.

(Approved , 12, 1976.)

ACT 78 S.B. NO. 1820-76

A Bill for an Act Relating to the Prepaid Health Care Act.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-3, Hawaii Revised Statutes, is amended by amending the definition of "Wages" to read:

"(9) "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer, and the cash value of all remuneration in any medium other than cash.

The director may issue regulations for the reasonable determination of the cash value of remuneration in any medium other than cash.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $20 a month in tips, the combined amount received by him from his employer and tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

ACT 79 S.B. NO. 1832-76

A Bill for an Act Relating to Civil Service and Exemptions.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 76-16, Hawaii Revised Statutes, is amended to read:

"**Sec. 76-16 Civil service and exemptions.** The civil service to which this part applies comprises all positions in the state service not existing or hereafter established and embraces all personnel services performed for the State, except the following:

*Edited accordingly

brackets, the bracketed material, or the underscoring.*

SECTION 10. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

ACT 81 S.B. NO. 2225-76

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-21, Hawaii Revised Statutes, is amended to read as follows:

"**Sec. 393-21 Individual waivers; additional withholding for dependents.** (a) An employee may waive individually all of the required health care benefits pursuant to this chapter by:

(1) Requesting the waiver by a writing submitted to the employer; and

(2) Receiving approval of the waiver from the director upon the director determining that the employee has other coverage under a prepaid health care plan which provides benefits that meet the standards prescribed in section 393-7.

(b) The employer who receives from an employee a written request for a waiver under this section shall transmit to the director a copy of the waiver, on a form prescribed by the director, and a copy of the prepaid health care plan on the basis of which the waiver is requested.

(c) A waiver under this section is binding for one year and is renewable for subsequent one-year periods.

(d) An employer who, directly or indirectly, coerces or attempts to coerce an employee in making a waiver under this section shall be subject to the penalty provided under subsection 393-33(b).

(e) An employee may not agree to pay a greater share of the premium for such benefits than is required by this chapter.

(f) Subject to section 393-7(b), an employee may consent to pay a greater share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

*Edited accordingly.

ACT 206 Amend.

brackets, the bracketed material, or the underscoring.*

SECTION 4. This Act shall take effect upon its approval.

(Approved June 7, 1976.)

ACT 206 S.B. NO. 1821-76

A Bill for an Act Relating to the Prepaid Health Care Act.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-13, Hawaii Revised Statutes, is amended to read:

"Sec. 393-13 Liability for payment of premium; withholding; recovery of premium. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director.

If an employee separates from his employment after his employer has prepaid the employee's share of the cost of providing health care coverage, the employer may deduct an amount not to exceed one-half of the premium cost but without regard to the 1.5 per cent limitation, from the last salary or wages due the employee, or seek other appropriate means to recover the premium."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved June 7, 1976.)

ACT 207 S.B. NO. 1899-76

A Bill for an Act Relating to the Establishment of an Office of Children and Youth.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The legislature finds that securing the well-being of all of Hawaii's children should continue to be a policy concern of the highest order for state government. Hawaii has long been a leader among the states in the development of innovative undertakings in behalf of children and youth as evidenced, in part, by the enactment of Act 294, Session Laws of Hawaii 1949, which estab-lish-

*Edited accordingly

SOME ANSWERS TO HAWAII PREPAID HEALTH CARE LAW

FOR EMPLOYERS AND EMPLOYEES

STATE OF HAWAII
Department of
Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

Form No. HC-2 10M

INTRODUCTION

This leaflet has been prepared in question-and-answer format to help employers and employees understand the Hawaii Prepaid Health Care Law. The new law sets up a compulsory health insurance program for the workers of Hawaii. Since every employer has a major role in the program, it is hoped that the information contained herein will enable employers to implement the law with minimal difficulty. For detailed information of this new program, refer to the law.

WHAT IS THE HAWAII PREPAID HEALTH CARE LAW?

This landmark legislation (the first in the nation) requires Hawaii employers to provide health care services for their employees, thus assuring them of needed protection against the high costs of hospital and medical care.

WHEN WILL THIS NEW LAW TAKE EFFECT?

The law took effect on June 12, 1974, but the required coverage by group prepaid health care plans and the payment of premiums for such coverage will not commence until January 1, 1975.

WHEN DOES AN EMPLOYER BECOME SUBJECT TO THE LAW?

An employer becomes subject to the law when he has one or more regular employees. A regular employee is one who works twenty or more hours per week and is paid a monthly wage of at least 86.67 times the prevailing Hawaii minimum hourly wage. A regular employee does not include a person employed in seasonal employment (e.g., harvesting and canning of pineapples) or one who works less than twenty hours a week. The Federal, State and County governments are excluded from the law.

ARE THERE EMPLOYEES EXEMPT FROM COVERAGE?

Yes, besides employees working in seasonal employment, employers need not cover insurance and real estate salesmen or brokers paid solely on commission basis, parent working for son/daughter, wife/husband working for spouse, son/daughter under twenty-one years of age working for father/mother, and others specifically exempted by the law. Also exempt are employees who are covered as dependents under another health care plan.

CAN A REGULAR EMPLOYEE WORKING CONCURRENTLY FOR TWO OR MORE EMPLOYERS HAVE COVERAGE FROM ALL EMPLOYERS?

No.

WHO HAS TO PROVIDE COVERAGE IN ABOVE CASE?

The employee is required to name which of the two or more employers is the principal employer and which the secondary employer(s) on the employee notification form (HC-5). The principal employer is required to provide coverage. An employee's determination of principal employer is binding for one year or until change of employment occurs. A secondary employer can buy out the principal employer if the employee so chooses or if the employee no longer holds two or more jobs concurrently. The employer is prohibited from coercing, interfering or influencing an employee in making a determination.

WHEN IS AN EMPLOYER A PRINCIPAL OR SECONDARY EMPLOYER?

An employee is required to complete Form HC-5 for the purpose of naming his principal and secondary employers, or when ever he chooses to make a change with respect to the status of each employer. The employer and employee each retains a copy, with the original going to the Department of Labor.

MUST AN EMPLOYER COVER AN EMPLOYEE WHO IS ALREADY COVERED AS A DEPENDENT UNDER A HEALTH CARE PLAN?

No. Besides such dependents, others who are exempt are employees protected by health insurance or any prepaid health care plan established under any law of the United States and recipients of public assistance or those covered by a State-legislated health care plan governing medical assistance.

WILL AN EMPLOYER BE NOTIFIED OF AN EMPLOYEE'S EXEMPT STATUS?

Yes. An exempt employee in any of the three categories mentioned above is required to complete Form HC-5 to notify the employer of the exemption, with a copy filed with the Department of Labor. Also, when the employee terminates exemption, the employer must be notified using the same form. When an employer receives notification that the employee has terminated exemption, the employee should be covered under the employer's health care plan.

WHAT PLANS ARE AVAILABLE FOR PROVIDING HEALTH CARE SERVICES?

There are two types of prepaid health care plans: (1) A plan by which a prepaid health care plan contractor would furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances; and (2) a plan by which the contractor would defray or reimburse, in whole or in part, the expenses of health care.

WHAT IS MEANT BY PREPAID HEALTH CARE PLAN CONTRACTOR?

A prepaid health care plan contractor may fall in one of three groups. (1) Any medical group or organization which undertakes under a prepaid health care plan to provide health care benefits (e.g., Kaiser Medical Center); (2) any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care (e.g., HMSA); or (3) any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care (e.g., Aetna Life Insurance Company). Note: The names of contractors cited above do not constitute an endorsement. They are used strictly as illustrations.

WHO SELECTS THE PLAN TYPE AND CONTRACTOR FOR THE EMPLOYEES?

The employer selects the plan type and the contractor. The plan type may be either a plan which requires the prepaid health care plan contractor to furnish the required health care benefits, or a plan which requires the prepaid health care plan contractor to defray or reimburse the expenses of health care. This election is binding for one year.

IS SHARING OF PREMIUM COSTS PERMITTED?

While the employer has the option of paying the entire premium, an employee may be required to share the cost. The employer must pay at least one-half of the premium and the employee the balance. The employee's share, however, cannot exceed 1.5% of his wages. If the employee's share constitutes less than one-half of the premium, the employer must pay the entire remaining portion. The employer is permitted to withhold the employee's share from the employee's wages.

WHAT TYPES OF BENEFITS MUST BE PROVIDED IN A PREPAID HEALTH CARE PLAN?

An approved prepaid health care plan must include at least the following types: (1) hospital benefits, including in-patient care for at least 120 days of confinement in each calendar year; (2) surgical benefits; (3) medical benefits; (4) diagnostic benefits; and (5) maternity benefits if the employee has been covered by the prepaid health care plan for at least nine consecutive months prior to the delivery. Note: For detailed breakdown of above five types of benefits, see the law.

HOW SOON MUST AN EMPLOYER COVER AN EMPLOYEE?

Any regular employee who has been employed for four consecutive weeks by an employer must be covered at the earliest time thereafter.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE IF THE EMPLOYEE IS UNABLE TO WORK BECAUSE OF DISABILITY?

If an employee is disabled and unable to work, the employer must continue the coverage by paying for the employer's share of the premium costs. The obligation is to continue the longer of the following periods: Three months following the month during which the employee became disabled, or following the period for which the employer has undertaken the payment of the employee's regular wages. An employee must keep up the employee's payments.

WHAT EFFECTS WILL THIS NEW LAW HAVE ON AN EXISTING PREPAID HEALTH CARE PLAN?

A prepaid health care plan shall qualify as a plan providing the required mandatory benefits (see above) if it provides health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health care plans specified above, or if it provides sound basic hospital, surgical, medical and other health care benefits as determined by the director after advice by the prepaid health care advisory council.

WHO DETERMINES WHETHER OR NOT A PREPAID HEALTH CARE PLAN MEETS THE LAW'S REQUIREMENTS?

This determination is made by the Director of the State Department of Labor after advice by a seven member prepaid health care advisory council consisting of representatives of the medical and public health profession, representatives of consumer interests and persons experienced in prepaid health care protection.

WHAT EFFECTS WILL THIS NEW LAW HAVE ON COLLECTIVE BARGAINING?

(1) Employees will be free to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof, or for the employer to provide the health care specified in the agreement. (2) An employer or group of employers will be deemed to be in compliance with the law if they provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement. (3) An employer will be required to provide coverage for employees not covered by the health care provisions of the applicable collective bargaining agreement to which the employer is a party.

WHAT ABOUT EXISTING EMPLOYER-SPONSORED PLANS COVERING HAWAII-BASED EMPLOYEES?

Any out-of-state employer sponsored health care plan affecting employees of this state must be adjusted by June 11, 1975, so as to meet the law's requirements.

CAN AN EMPLOYEE'S RIGHT TO BE COVERED BY A HEALTH CARE PLAN BE WAIVED?

An employee may not waive individually all or part of the required health care services.

CAN AN EMPLOYEE AGREE TO PAY A GREATER SHARE OF THE PREMIUM COST?

An employee cannot agree to pay a greater share from wages except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents ... for the same plan.

MUST AN EMPLOYEE BELONGING TO A FAITH-HEALING GROUP BE COVERED?

No.

CAN EMPLOYERS FORM ASSOCIATIONS FOR THE PURPOSE OF PROVIDING PREPAID HEALTH CARE PROTECTION?

Yes, as long as such health care protection is obtained from an authorized health care contractor.

ARE THERE PENALTIES FOR ANY INFRACTION OF THE LAW?

(1) An employer who fails without good cause to comply with the coverage provisions of the law shall be penalized not less than $25 or $1 for each employee for every day during which such failure continues, whichever sum is greater, and (2) an employer, employee or prepaid health care contractor who willfully fails to comply with any other provisions of any rules or regulations shall be fined not more than $200 for each such violation.

WHAT IS THE PREMIUM SUPPLEMENTATION FUND?

This is a special fund financed and administered by the State for the purpose of assisting certain eligible employers in paying for the cost of providing the required health care benefits.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR PREMIUM SUPPLEMENTATION?

An employer is entitled to premium supplementation if: (1) less than 8 workers are employed; (2) the employer's share of the cost of providing health care services exceeds 1.5% of the total wages payable to employees, and (3) the amount of such excess is greater than 5% of the employer's income before taxes directly attributable to the business (see below for definition).

HOW MUCH CAN AN EMPLOYER RECEIVE FROM THE PREMIUM SUPPLEMENTATION FUND?

The amount of premium supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified above.

HOW DOES AN EMPLOYER CLAIM PREMIUM SUPPLEMENTATION?

The employer must complete a prescribed claim form furnishing information that the employer's share of the premium cost exceeds the limits specified above.

WHAT IS MEANT BY INCOME DIRECTLY ATTRIBUTABLE TO THE BUSINESS?

Income directly attributable to the business means gross profits from the business minus deductions for: (1) compensation of officers, (2) salaries and wages, except wages paid by an individual proprietor to himself, (3) repairs, (4) taxes on business and business property, (5) business advertising, (6) amounts contributed to employee benefit plans, (7) interest on business indebtedness, (8) rent on business property, and (9) other expenses necessary for the current conduct of business.

WHAT DEDUCTIONS ARE EXCLUDED FROM INCOME DIRECTLY ATTRIBUTABLE TO THE BUSINESS?

These are: (1) bad debts, (2) contributions or gifts, other than those listed under 6 above, (3) amortization and depreciation, and (4) losses by fire, storm, casualty, etc.

WHAT AGENCY ADMINISTERS THE HAWAII PREPAID HEALTH CARE LAW?

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. If you need further information, please contact the following offices:

Address all inquiries to:

Dept. of Labor & Industrial Relations
Temporary Disability Insurance Division

Oahu	P.O. Box 3769 825 Mililani Street, Room 201 Honolulu, Hawaii 96812 Phone 548-7821
Hawaii	P.O. Box 671 State Office Building 75 Aupuni Street Hilo, Hawaii 96720 Phone 961-7391
West Hawaii	P.O. Box 97 Kealakekua, Hawaii 96750 Phone 322-2775
Maui	P.O. Box 580 State Office Building 54 South High Street Wailuku, Hawaii 96793 Phone 244-4322
Kauai	P.O. Box 891 State Office Building 3060 Eiwa Street Lihue, Hawaii 96766 Phone 245-4351

19 March 1980

To: Representatives Buchholdt, McKinnon, Parker, Gardiner

From: Sharman Haley
Alaska Public Interest Research Group

Subject: Policy Options in Proposed Health Legislation

The health bill which is presently being drafted at Representative Buchholdt's request is largely modeled after Hawaii and Minnesota laws. These laws do not necessarily conform in detail to the situation in Alaska nor the interests of the Alaska sponsors. This memo calls to your attention various points in the model legislation which you may wish to consider modifying for Alaska. Certain policy considerations in the proposed Medicaid amendments and medically needy program are also discussed.

Health Insurance Minimum Standards and Risk Pooling

The Comprehensive Health Insurance Act adapted from Minnesota law and published in 1980 Suggested Legislation Vol. 39, by the Council of State Governments, is the model for the minimum benefits and risk pooling portions of the proposed legislation. One section in the model bill requires health insurance carriers to offer certain kinds of conversion privilages. For example, when an individual drops out of a group plan (such as with the termination of employment) the carrier must offer an individual plan to continue coverage without the addition of underwriting restrictions. Also, when the primary insured dies, the carrier must allow other individuals covered under the plan to continue coverage. This issue was not addressed in our drafting request. You may wish to consider including language on conversion privilages in the bill.

The model legislation also contains a provision known as "dual option" which requires major employers of 100 or more employees who offer health benefits to their employees, to offer both insurance or membership in a health maintenance organization where both are available. This in part is a policy to promote HMOs. This provision was not included in the drafting request. Since Anchorage may have an HMO in the near future, you may wish to consider a similar provision in the legislation for Alaska.

The model legislation sets out standards for three types of qualified plans. You should be aware that the legislation does not require that only qualified plans can be sold; it merely requires of all carriers that qualified plans be offered to each eligible customer.

The model legislation sets numerous specific dollar amounts. Presumably these amounts will have to be periodically updated for inflation or changes in standards. You may wish to consider adding the provision that the specified amounts are applicable for the first year and subsequently the commissioner may revise and update all the dollar amounts by regualtion.

The model legislation initially sets premiums for the high risk coverage at the average premium level among the five largest carriers in the state for comparable standard risk coverage, and provides that in subsequent years the premiums are to be set such that the plan pays for itself according to actuarial principles. In Minnesota's experience however, the claims in the first 18 months were so high that they feared premiums would have to be raised 100% to cover the claims. To keep the premiums at an affordable level, the legislature amended the statute to limit the premiums to 125% of the standard risk premiums, and provided that assessments made against the carriers by the carriers association to cover the losses due to claims, could offset any income or premium taxes owed to the state by that carrier. Thus the state was made responsible for the losses incurred by the plan. You may wish to consider these amendments for the Alaska legislation as well.

The model act defines dependent as spouse, unmarried child under the age of 19, dependent child under the age of 25 who is a student and

is financially dependent on the parent, or a dependent child of any age who is disabled. You may wish to consider the addition of any household member who is financially dependent on the head of household, in order to include other relatives or non-relatives who may be members of that family unit.

The model legislation, in its itemization of minimum services covered and not covered, states that transportation costs other than ambulance are not covered, This is not well suited to Alaska, since medically necessary travel is frequent and expensive in most parts of the state.

The model legislation includes well baby care, routine physicals, and multi-phasic screening. It should be understood that since these are routine, predictable expenses, they do not fall within the central prupose of insurance -- that is, to insure against risk. Requiring coverage of basic medical care such as these in a consumer-paid plan does no service whatsoever to the consumer, since he or she will pay the full cost of routine care through higher premiums anyway, Requiring coverage of them in an employer-paid plan does offer an advantage to the consumer, of course, because it shifts the costs of these medical services from the consumer to the employer. Arguably there is a public purpose served in this requirement even for consumer-paid coverage -- namely to promote the utilization of these services in the interests of preventive medicine. Since the services have already been paid for, the consumer may as well utilize them. There are experts who claim, however, that routine physical exams, other than pap smears, blood pressure checks, or other procedures tailored to the health risks of the individual patient, are not cost effective; that overall they do not save more expense through the early detection of disease than they consume.*

Mandatory Employer Sponsored Coverage

The Hawaii Prepaid Health Care Act is the model for the mandatory employer sponsored coverage portions of the proposed legislation. The Hawaii

* One school of thought maintains that a more effective approach to preventive medicine would be promoting health education, self-awareness and self-responsibility for maintaining health among consumers. This would also promote early detection and reporting of symptoms when they do occur.

act excludes seasonal employees, in particular the pineapple pickers. The only explanation for this offered by the Hawaii program administrator was that the plantation owners had the political clout to get their employees exempted. Seasonal employees are a large component of Alaska's labor force, and often lack health coverage. You may wish to consider including seasonal employees in the Alaska legislation, or perhaps some form of hour bank for seasonal and temporary employees similar to the union health plans in the construction trades.

The model legislation mandates coverage of the employee only, and coverage of dependants is optional (unless the plan is of lower standard than the largest plan and is approved by the commissioner). You may wish to consider making coverage of dependents mandatory in employer-sponsored plans.

The Hawaii model sets up a separate fund for premium supplementation for qualifying employers. Several sections of the bill are devoted to defining the fund and how it is to be managed. Since the fund is not going to be self-supporting and will require annual appropriations anyway, there is little apparent advantage in terms of management or oversight in establishing a separate fund. You may wish to consider making premium supplementation part of the general fund.

The Hawaii model appears to make employee participation, including payment fo the employee share of the premium, mandatory. The advantage in this is that more people will have coverage and employers cannot pressure employees to decline such coverage. The disadvantage is that employees may be required to contribute to the premium and have no choice whether or not to participate. You may wish to consider making participation voluntary on the part of the employee.

Linkage Between Hawaii and Minnesota Models

The Hawaii and the Minnesota models take two different approaches toward defining the minimum benefit standards for qualified health coverage plans. The Hawaii law is setting standards for mandatory employer coverage. In addition to meeting the very general benefit guidelines itemized in the

law, a qualified plan must meet one of two alternative benefit standards: (1) the benefits must meet or exceed the benefits of the largest plan in the state (in Alaska this would be either the Alaska State employees plan or possible the Teamsters plan); or (2) the benefits must provide a level of coverage deemed satisfactory by the Commissioner. If these benefit plans are more limited than the largest plan, the employer must pay half the premium for dependents as well as the primary insured. The bill also establishes a prepaid health care council to advise the Commissioner on benefit levels. The law is administered by the Department of Labor.

The Minnesota law is setting standards for state qualified plans which all carriers are required to offer. The law specifies the scope of required benefits as well as minimum or maximum limits, copayments, and deductibles for three levels of qualified plans. The law is administered by the Division of Insurance.

While there is no direct conflict between these two laws which are proposed for Alaska, there is some duplication. Since the Alaska Department of Labor has no expertise in the arena of health insurance benefits, you may wish to consider centralizing all responsibility for benefit standards under the Division of Insurance, and leave only the employer compliance responsibilities with the Department of Labor. You should be aware that the Alaska Division of Insurance is already seeking authority to regulate minimum standards for insurance of all kinds in HB882 and SB513.

Consideration should also be given to the question of what standards employer coverage should meet and how they should be set. The Minnesota model specifies the standards for three levels of qualified coverage in law, and requires that employers who offer health coverage provide at least a number two qualified plan. The Hawaii model only provides general guidelines of minimum services to be covered, and leaves the other details up to the Commissioner, or else ties the standard to the benefits provided by the largest plan in the state. The state employees plan and the Teamsters plan are both more comprehensive than the minimum standards for the number two qualified plan, but of course would also be more expensive. The Minnesota approach is much simper than the Hawaii approach and gives the legislature

greater control over the minimum standards. The standard required for employer plans does not necessarily have to be the same standard required for a qualified plan offered to individual consumers, particularly in the area of routine care for the r asons discussed in an earlier section.

Medicaid Medically Needy

Federal financial participation requirements in the Medicaid medically needy program set the maximum income threshold for medically needy program eligibility at 133% of the Aid to Families with Dependent Children income standard for a household of equivalent size. The minimum income threshold is set equal to the Adult Public Assistance standard or the AFDC standard, whichever is higher, for a household of equivilent size. Since in Alaska the AFDC standard is so much lower than the APA standard, $350 for an AFDC family of two compared to $608 for two APA elibibles, the federally mandated minimum medically needy income threshold for a family of two, $608, is higher than the federally mandated maximum income threshold of $466.55 ($350 x 1.33). These are clearly impossible criteria. The federal policy manual appears to resolve the contradiction in favor of the lower standard. The result is that for adult elibibles the Medically needy income threshold is not much higher, and for a two person household is actually lower, than the income standard for the regular Adult Public Assistnace program. (See attachment) This inconsistency could be left as is, or resolved in one of two ways: (1) the AFDC standard (which is lower than AFDC standards in many other states and a virtually impossible budget for a family in Alaska) could be raised; or (2) the medically needy income threshold could be set higher than 133% of the AFDC standard and the program could by financed entirely by the state.

Medicaid Optional Services

The Medicaid optional services included in the drafting request were the nine uncovered services most often requested by Medicaid clients and most recommended by social workers, as reported in OPTING: A Study of Medicaid Client Need. A copy of Table 2 from this report is attached. A complete listing of Medicaid optional services is attached should you wish to consider other optional services.

THELMA
BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fiscal note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commisssioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim peyments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately $ 8 million from the state's General Funds, $ 22,800 from other state funds and approximately $ 8 million in federal funds.

HCS CSSS SB 227 (HESS)

BILL SUMMARY

(revised 5/21/80)

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an ndividual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000 deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits

are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care plans must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not

assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.100 Definitions

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original CSSSSB 227 and require state employee health insurance to include coverage alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section, the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days and two percent per month after 90 days.

Sections 9 and 10 expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

FISCAL SUMMARY

HCS CSSSSB 227 (HESS)

(in thousands of dollars)

FY 81	General Funds	Federal Funds	Other	Total
Sections 1-3: Health insurance pool	99.0			99.0
Sections 4-7: Alcoholism benefits	138.6	7.8	22.8	169.2
Sections 8-12: Medicaid & GR Med	7,728.7	7,858.5		15,587.2
TOTAL	7,966.3	7,866.3	22.8	15,855.4

FY 82				
Sections 1-3: Health insurance pool	83.8		45.0	128.8
Sections 4-7: Alcoholism benefits	332.6	18.7	54.8	406.1
Sections 8-12: Medicaid & GR Med	17,003.0	17,288.7		34,291.7
TOTAL	17,419.4	17,307.4	99.8	34,826.6

Prepared by HESS staff 5/22/80

I. REQUEST

Bill/Resolution No. HCS CSSSSB 227 (HESS) SECTIONS 1-3

Title An Act relating to the health of residents of the state

Requested by Health Education and Social Services Comm Date 5/20/80

II. FISCAL DETAIL

Agency Affected Division of Insurance

Program Category Affected Public Protection

BRU, Program, or Subprogram(s) Affected Division of Insurance

(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		48.3	53.2	58.2		
200 TRAVEL		5.0	3.0	3.3		
300 CONTRACTUAL		40.9	26.8	29.4		
400 COMMODITIES		.8	.8	.9		
500 EQUIPMENT		4.0	--	--		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
Reduct. of Unrestric. tax Rcpt #019		--	45.0	99.0		
TOTAL		99.0	128.8	190.8		

FUNDING (Thousands of Dollars)

GENERAL FUND		99.0	83.8	91.8		
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduct. of Unrestric. tax Rcpt #019		--	45.0	99.0		

POSITIONS

FULL TIME Market Analyst II		1	1	1		
PART TIME Clerk Typist III		1	1	1		
TEMPORARY						

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

This note assumes a half year of implementation and a half year of operation in FY81. It assumes 10% inflation for FY82 and FY83.

prepared by HESS staff 5/20/80

PREPARED BY

FISCAL NOTE

PERSONAL SERVICES

The law in Connecticut on which this bill is based was implemented with no additional staff. Most of the substantive work was performed by the industry. One new position with clerical support may be justified, however, for drafting the regulations, reviewing the organization of the Health reinsurance Association and approving the rates and policy forms developed by the carriers for the comprehensive health plan.

Market Analyst	III	Range 18A	12 months	$29,580
Clerk Typist	III	Range 8A	half-time, 12 months	8,162
				$37,742
			benefits (.1529)	5,771
			FICA (.0665 x 8162 + 1985)	2,528
			health insurance (127 x 1.5 x 12)	2,286
				$48,327

TRAVEL

Travel to Connecticut and Minnesota and to Health Reinsurance Association board meetings	$ 5,000

CONTRACTUAL

Rent 2 positions x 150 sq. ft. x $1.70 x 12 mo.	$ 6,120
Phone (80 install + 600 local + 3,000 long distance)	3,680
Postage	1,000
Printing and Xerox	2,000
Equipment Rental (typewriter)	2,500
Consulting	25,000
Other	600
	$40,900

COMMODITIES (1.5 x 500)

$ 750

EQUIPMENT

desks, chairs, bookcase, filing cabinet, caculator, etc.	$ 4,000

PREMIUM TAX OFFSET

Total Comprehensive Health Plan Premiums in Connecticut for 1979: $2,785,367

Total HMA Assessment since April 1, 1976: $ 80,000

Alaska population*/Connecticut population* = 395,000/2,746,000 = .144

Alaska rates/Connecticut rates: 1.35

Factor for change in deductions: 1.05

Factor for change in pregnancy benefits: 1.05

Factor for change in transportation benefits:? fudgefactor: 1.20

Loss factor: (135% - 125%)/135% = .074

Inflaction factor '79 - '81: 1.21

$2,785,367 x .144 x 1.35 x 1.05 x 1.05 x 1.20 x .074 x 1.21 + ($80,000/345) = 87,402

This estimating procedure will tend to overestimate the costs. Nevertheless, there are many difference between Connecticut and Alaska which we cannot account for, and the margin for error is large. Rounding up to an even $90,000 should produce a safe high estimate of the tax loss to the state in a full year of operation. Since FY '81 includes only a half year of operation, only half that amount would be claimed in FY '82.

* Civilian noninstitutionalized population under age 65.

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HCS CS for SS Senate Bill 227 (HES) Sections 4-7

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

Summary Sheet

House CS for CS for Sponsor Substitute for Senate Bill No. 227
(In thousands of dollars) SECTIONS 8-12

		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

[NOTE: THESE AMOUNTS PREPARED BY THE DEPARTMENT ARE FOR A FULL YEARS'S OPERATION. THE SUMMARY SHEET PREPARED BY HESS STAFF ASSUMES A HALF YEAR OF OPERATION IN FY81 AND 10% INFLATION FOR FY82. --HESS STAFF]

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

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 (11-20-79)

Approval DHSS Mgt. & Bdgt: _____ Date: _____

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

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 amount 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.

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)

Approved DHSS Mgt. & Bdgt: _____ Date: _____

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

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				
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: _____

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

Title An Act relating to the health of the 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		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)

HCS CSSS SB 227

BILL SUMMARY

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. Every self-insured employer group is required to make an individual comprehensive health care plan available as a conversion privilege to each group member. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000

deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or was apparent and should have been diagnosed or treated within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses.

AS21.50.030 Group comprehensive health care plans must also cover dependents and must include the privilege to continue coverage for a specified period of time upon leaving the group by reason of layoff, leave, termination, death or illness. Unmarried children remain eligible as dependents as long as they are under 19, under 23 and a full-time student, or disabled. Spouses and resident household members who are financially dependent on the employee are also covered as dependents up until they become elegible for Medicare. Group members must also be provided the privilege to convert to an individual plan immediately on the termination of group coverage.

AS21.50.040 Individual comprehensive health care plans must provide the privilege for dependents to continue coverage after the death of the primary insured until the coverage would have otherwise ceased.

AS21.50.050 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of directors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.060 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the

Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.070 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.080 The conversion privileges required for group comprehensive health care plans under AS21.50.030 are also required for all group health policies issued in the state after January 1, 1981.

AS21.50.090. A voluntary health premium supplementation program is established for employers who choose to provide health benefits for their employees and meet certain financial hardship criteria. Premium supplementation is at the rate of 80% of the premium cost which exceeds 1.5% of the payroll plus 4% of the employer's income before taxes from that business. This section is modeled after Hawaii law.

AS21.50.200 Definitions.

Sections 2 through 5 of the bill amending AS39.30 comprise the original CSSSSB 227 and require group health insurance to include coverage for alcoholism and drug dependence. Minimum benefits are defined to include inpatient detoxification,

inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 6 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days, and two percent per month after 90 days.

Section 7 and 8 expand the state's Medicaid program to include all services qualifying for federal financial participation.

Section 9 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

IMPACT ON INSURANCE CARRIERS

Minnesota Experience

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

Out of

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

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

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

17 carriers that withdrew had a combined volume of

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

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

$428,000 in accident and health premiums.

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

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

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

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

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

The carriers which might find compliance with HB 977 most difficult perhaps are those who write only accident or illness indemnity policies with fixed reimbursement rates (for example, $50 per day for every day in the hospital). These companies are not set up to handle claims based on expenses incurred as required of a qualified plan under HB 977. The largest carrier of this type in Alaska has a premium volume of $723,000. It is not known how many other carriers of this type there are, nor what their premium volume might be. While it is perhaps undesirable to adversely affect any Alaska business with this legislation, it is notable that those for whom compliance with HB 977 would be most difficult are precisely those carriers who specialize in limited types of accident and health coverage which afford the least financial and medical protection to consumers.

POSITION PAPER
ON
HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (FINANCE)

"An Act relating to the health of residents of the State; and providing for an effective date."

1. Departmental Overview of House CS for CS for SS for SB 227 (Finance)

The Department of Health and Social Services will primarily reserve its comments to Sections 5-15 of the bill, as the earlier sections are concerned with health insurance. It is our understanding that these issues are planned to be addressed by the Division of Insurance in the Department of Commerce and Economic Development.

The Department, in general, believes that House CSCSSSSB 227 (Finance) takes a multi-faceted approach to a complex problem. It appears to move in too many directions and at too rapid a time frame, which could potentially jeopardize the accomplishment of the goals that the bill seeks to obtain. We recommend that all sections of the bill, except for Sections 5-8, be studied further during the interim to insure that the plan on which the insurance section of the bill is modeled is workable, affordable, and in the best interest of clients and the insurance industry. Sections 5-8 (pilot project for alcoholism insurance coverage for state and other participating government employees) which were the body of CSSSSB 227 (HESS) and the result of over a year's planning. That pilot project concept is supported by state government and the insurance companies that serve Alaska. We, therefore, recommend that the pilot project sections of the current committee substitute be addressed separately in their original piece of legislation. We are concerned that the fiscal impact of the expansion of the Medicaid program and the uncertainities of the health insurance section may outweigh serious consideration of the pilot project for alcohol insurance, which has been studied for a significant period of time.

The Department is also concerned about the massive increase to the Medicaid and General Relief-Medical programs, if House CSCSSSSB 227 (Finance) were to pass. The bill would increase the budgets of these programs by over 50% (if implemented for a full fiscal year) and would require a monumental effort on the part of our Division of Public Assistance to gear up for implementation by the January, 1981 effective date. We are concerned that the current Medicaid service program might suffer during the transition period as a result of such a significant increase. We would, therefore, recommend that if new options to Medicaid or General Relief-Medical were to be added that they be phased-in, rather than adding all remaining services and eligibility groups at a single time. Each service could be evaluated on its own merits, rather than in mass, to determine whether it is cost effective to do so at that time. If options are to be added, the Department is interested in exploring the coverage of the AFDC-unborn child under Medicaid and a limited medically needy program under General Relief-Medical. We are also interested in exploring the addition of prescription drugs to the list of covered Medicaid services, if it can be determined to be cost effective.

We also support in concept the purchase of health insurance policies or contracts for our current Medicaid or other state medical assistance clients when the Department determines that such a purchase would be cost effective. The purchase of such insurance or contracts would allow our clients to be integrated into the normal mainstream of the health delivery system, rather than be stigmatized by having to reveal his or her welfare status each time a medical assistance coupon is presented as payment in the medical provider's office.

II. Departmental Comments on Sections 5-8 (Mandatory State and Other Participating Government Employee Alcoholism and Drug Dependence Coverage)

Sections 5-8 of the bill are essentially the contents of CSSSSB 227 (HESS) which passed from House HESS Committee on April 26, 1979. Sections 5-8 were the result of over a year's work involving insurance companies which serve Alaska, the Division of Insurance, and the Department's Office of Alcoholism and Drug Abuse. The sections authorize a limited pilot project to mandate health insurance coverage for the diagnosis and treatment of alcoholism and drug dependence for state and other participating government employees. The Department of Health and Social Services continues to support this concept. The Department of Administration in 1979 estimated the cost of such coverage for state employees to be $338,400 for FY 81.

Authorization of such a pilot project would allow for the testing of the cost effectiveness and merits of mandatory employee alcoholism and drug dependence treatment coverage on a statewide basis. The project will test if coverage were available, would state employees in need of such services would seek them earlier in illness and thus potentially reduce costs for later medical care. The benefits to the employer through the early diagnosis and treatment of alcoholism or drug dependence could be increased employee productivity, reduced absenteeism, decreased sick leave utilization, fewer disability benefit payments, and reduced cost for hospitalization for injury- or disease-related problems.

We support Sections 5-8 of the bill.

III. Specific Department Comments on 9 Through 10 (Medical Assistance)

Section 9 - AS 47.05.070(a) - (Page 9, line 18)

The Department, as mentioned earlier in the position paper, is in favor of purchasing services through health insurance policies or contracts for medical assistance clients only if such purchase is more cost effective than traditional methods. The Department has no problem with the mandatory nature of the language in this section, but notes that there is currently no statutory prohibition against such purchase. Therefore, although these sections would facilitate the purchase of insurance for medical assistance clients, it is not absolutely essential to authorize it.

Section 9 - AS 47.05.110 - (Page 10, lines 24-29 and page 11, lines 1-4)

Under present Medicaid law, the Department is required to pay 90% of "clean claims" within 30 days of receipt, and 99% of "clean claims" within 90 days of receipt. The Department supports the idea that medical providers should not suffer financially because of payment delays after a reasonable period. We would though recommend that payment of interest commence at 60 days rather than 30 days after presentation of "clean claims." This is generally considered reasonable turnaround in Alaska by health providers for payments from private insurance carriers due to uncertainty of mail deliveries. Also, we have been informed by the federal Medicaid program that federal funds are not available for interest payments on late Medicaid claims.

Section 9 - AS 47.05.120 - (Page 11, lines 5-19)

Add definitions for "remedial care," "non-exclusive contract," and "health care service contracts."

Section 10 - AS 47.07.020(b) - (Page 11, lines 20-23) and Section 13 - (Page 12, line 13)

This section would amend Medicaid law to provide coverage for all optional groups not currently entitled to Medicaid benefits in Alaska, primarily the unborn child group, the unemployed fathers, and the medically needy group.

Also, Section 13 removes the requirement that future additions of optional eligible groups to Alaska's Medicaid program must be approved by the Alaska State Legislature. Therefore, when Congress authorizes a new Medicaid optional eligibility group in the future, Alaska statutes do not require revision in order for the State to be required to automatically begin covering the groups.

The Department recognizes the value of the addition of the unborn child group to Medicaid to assist in proper health and development of children to low income women through access to necessary pre-natal care. We believe the addition of this group to Medicaid will have little impact on the program's expenditures. We can see the need for health care coverage to the medically needy and to the unemployed fathers under Medicaid but the cost of these options would be substantial and would be covering a greatly expanded group of clients. The Department supports the concept of a limited medically needy program under General Relief-Medical including only the aged, blind, and disabled until such time that we can fully assess the monetary and administrative costs of more expanded coverage.

Section 11 - AS 47.07.030 - (Page 11, lines 24-28)

This section as amended would change Medicaid law to dramatically expand medical services offered under the Medicaid program. It also removes the requirement that future additions to Alaska's Medicaid services must be approved by the Alaska State Legislature. Therefore, when Congress authorizes a new Medicaid optional service in the future, the Alaska statutes need not be amended in order for the State to be required to automatically offer the service.

Legislative Affairs Agency Department of Health and Social Service

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

Section 12 - AS 47.25.120 - (Page 11, line 29 and Page 12, lines 1-12)

This section as amended would add broad medically needy coverage under the State General Relief-Medical program. The Department supports the concept of a more limited medically needy program including only the aged, blind, and disabled until we can gain some experience regarding monetary and administrative burdens.

Section 14 - (Page 12, lines 14-15 and Page 12, line 16)

Sections 10-12 would add all remaining optional eligibility groups and services to Medicaid and add a broad medically needy program to General Relief-Medical. The bill provides for an effective date of January 1, 1981 for these sections. In light of the size of these additions (over $31 million for a full fiscal year), we would recommend a phase-in model over a period of years, beginning July 1, 1981, in order to administratively prepare for these changes with the minimum of adverse impact during the transition period to clients and providers.

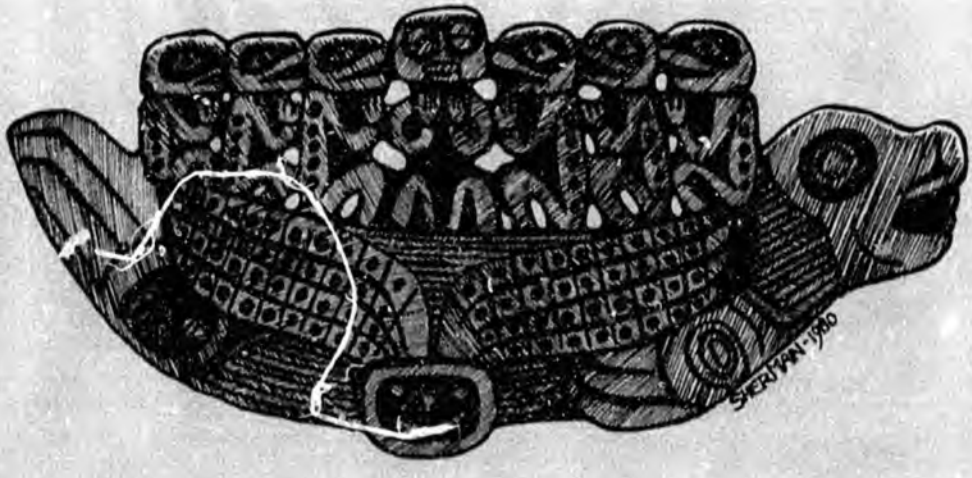
Approved by: _____ 5/30/80
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

POSITION PAPER/Department of Health & Social Services


Medical
Diagnosis
information

MEDICAID PROGRAM

in Alaska



Administered by:

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

Jay S. Hammond, Governor Helen D. Beirne, Commissioner

The Medicaid Program pays medical expenses for eligible, low-income people. Under agreement with the U.S. Department of Health, Education, and Welfare, the Alaska Division of Public Assistance runs the program through its local offices and fee agents. This booklet explains the rules, and tells you how to apply for and use Medicaid coupons. For more information, ask your local public assistance office or village fee agent.

1 FILE AN APPLICATION FORM

* To be eligible for Medicaid you must usually be eligible for the:

  Aid to Families with Dependent Children Program (AFDC)
  OR
  Adult Public Assistance Program (APA)
  OR
  Supplemental Security Income (SSI)

* Certain people not eligible to receive benefits under the AFDC, APA, or SSI programs may still be eligible to receive Medicaid. This special group of people includes:

  1. Juveniles who are in the protective custody of the Department of Health & Social Services whose available financial resources do not exceed the AFDC need standard for a single person;

  2. Persons in health care facilities on an inpatient basis whose income does not exceed 300 percent of the current SSI payment standard;

  3. All individuals under age 21 who would be, except for age or attendance requirements, dependent children under the AFDC program;

  4. Certain families who become ineligible for AFDC payments due to increased earnings;

  5. Those reasonably classified individuals under age 21 who are in an intermediate care facility for the mentally retarded or persons with related conditions;

  6. Those reasonably classified individuals age 21 and under who are receiving active treatment in an inpatient psychiatric facility;

  7. Individuals under age 18 who meet the SSI eligibility requirements.

* The public assistance office or village fee agent will give you an application for either AFDC or APA. Your local federal Social Security Administration office or their traveling representative will help you apply for SSI. Addresses for Social Security offices are listed in Section 13 of this booklet.

* If you qualify for AFDC or APA, you will be mailed a check and Medicaid coupons within approximately 30 days from the date the office received your application.

* If you qualify for SSI, you must still apply separately at the public assistance office for APA cash benefits and for Medicaid coverage.

* You can apply for food stamps at the same time you apply for AFDC or APA and Medicaid.

2 AFDC, APA, AND SSI

* Aid to Families with Dependent Children (AFDC) is a program which gives money for children of eligible low-income families who are deprived of one or both of their natural or adopted parents.

* Adult Public Assistance (APA) is a program that includes three categories of eligibility (Old Age Assistance, Aid to the Blind, and Aid to the Disabled) and provides a supplemental payment to low-income adults whose income is not enough to provide for their own basic needs. All adults who qualify for APA must be either blind, OR 65 or older, OR physically or mentally disabled.

* Supplemental Security Income (SSI) is a federal program for low-income adults who are either blind, OR 65 or older, OR physically or mentally disabled. It also provides cash assistance for low-income children who are either blind or disabled.

3 HAVE AN INTERVIEW

* When you turn in your application, a worker will usually hold a confidential interview with you.

* At the interview, the worker will explain the program rules and go over the information on your application. The worker will help you complete any of the application form you have not been able to fill out. Ask the worker to explain anything that you do not understand. It's important that you understand the rules.

* Interviews are held at the public assistance office or at the fee agent's location. If no one in your household can go the interview, an adult friend or relative who knows your circumstances may go to be interviewed for you.

* If you are disabled or are unable to go to the interview and no one can go for you, let the office know. It may be possible to arrange an interview at your home or by telephone.

* If you live too far from an office or a fee agent, if you are ill, or if you do not have any transportation to an office, you won't have to have an interview.

4 MEET ELIGIBILITY RULES AND PROVIDE PROOF THAT YOU ARE ELIGIBLE

When you apply, you must show the Division of Public Assistance certain papers and give them information to prove you are eligible. Papers you need for proof may include birth certificates, paycheck stubs, fish tickets, recent income tax returns or other proof of your age, relationship, and income.

You should also be prepared to list your resources (property other than your home) such as cars, boats, savings accounts, and other valuables.

If you have trouble getting the documents or information you need, the division will help you. If the papers are not available, you may give the name of someone outside of your household and family, such as employer, who can confirm your statements.

Eligibility rules and proofs you may have to provide to support your application are different for each type of assistance. Your eligibility worker or fee agent will tell you what documents and information are necessary.

5 RECEIVE A NOTICE THAT THAT TELLS YOU IF YOU QUALIFY

* After reviewing your application, the public assistance office will send you a Notice of Finding.

* If you do not qualify, the Notice will explain why.

* If you do qualify, the Notice will explain when your cash and Medicaid benefits will begin. It's possible that your bills from past months may also be paid by Medicaid.

* If you think your application has been wrongly denied, you should tell the public assistance office. If they do not agree, you can ask for a fair hearing. For more information about fair hearings, see Section 10.

6 RECEIVE YOUR MEDICAID COUPONS

* If the office finds that you are eligible, you will get your Medicaid coupons no later than 30 days from the date you first applied.

* Medicaid coupons are either handwritten or printed by machine. Both types of coupons are equally valuable.

* You will receive five Medicaid coupons. They will be printed with the names of everyone in your household who is eligible for Medicaid. Everyone listed can legally use the coupons.

* Medicaid coupons are dated for one month and can only be used to pay for medical care received during that month.

* If you need more Medicaid coupons, you can request them from the public assistance office.

* Medicaid is a "last pay" program. This means that Medicaid will only pay your health provider for the part of his bill that isn't paid by your private or union health insurance, by Medicare, (see Section 13) or other insurance programs. When you apply for Medicaid, you must list any other sources of medical payments you have. You should also tell your doctor, hospital, etc. about them when you get service.

* To use your Medicaid coupons you must give them to the doctor, hospital, or other health care provider when you receive medical care. It is very important to remember to give your Medicaid coupon to your health care provider. The coupon tells the doctor, clinic, etc. that you are eligible for that month for Medicaid benefits. Without the coupon, your bill cannot be correctly submitted for payment.

7 USE YOUR MEDICAID COUPONS

Most health care providers in Alaska participate in the Medicaid program. This means you can usually choose the doctor you would like to visit. If you are eligible for both Public Health Service and Medicaid, you also have the choice of going to the local Alaska Area Native Health Service (AANHS) or a private doctor.

If the medical treatment you need is not available in your area, payment for transporation may be provided to the nearest location where you can receive the necessary medical care.

When you are Medicaid-eligible and receive a Medicaid-covered service from a doctor or other health practitioner who is enrolled in the Medicaid program, he cannot ask you to pay for all or for any part of that service--even if Medicaid and any other health coverage you have doesn't pay all of his charges. If he bills the Division of Public Assistance, he must accept the Medicaid fee as the total payment for your bill.

Medicaid doesn't pay for every kind of medical and psychological care. If you want to be sure that Medicaid will pay for the services you want or need, your medical provider can tell you. The following list of services are paid by Medicaid:

1. hospital--inpatient and outpatient
2. skilled nursing facility
3. intermediate care facility
4. intermediate care facility for mentally retarded persons and persons with related conditions
5. laboratory and X-ray services
6. physician services
7. visual care services and dispensing
8. opthalmic materials
9. medical transportation
10. speech, hearing, and language services
11. psychiatric facility services (if you are under 21 or over 65)
12. home health care services
13. community mental health clinics
14. family planning services
15. outpatient surgical care centers
16. rural health clinics
17. early periodic screening, diagnosis, and treatment (EPSDT) of individuals under 21 years of age

Payment of service is made directly to doctors, hospitals, and other providers of health care based on invoices submitted by the provider. Invoices must be accompanied by a coupon which you must surrender at the time service is provided.

8 SERVICES NOT COVERED BY MEDICAID

Most Medicaid-eligible people automatically qualify for coverage under the General Relief-Medical program (GRM). Payment is available through the GRM program for all Medicaid-eligible people for the medical services and supplies listed below when those services are not otherwise available under the Medicaid program :

(1) dental care-limited to emergency treatment for relief of pain and acute infection;

(2) family planning services;

(3) pharmaceuticals and over-the-counter drugs;

(4) physical and occupational therapy;

(5) prosthetic devices and medical supplies.

More information about the GRM program is provided in Section 13 of this booklet.

It is your responsibility to pay for any medical treatment not covered by Medicaid or GRM.

The following services are NOT covered by Medicaid :

(1) Any medical expense which is not reasonably necessary for the diagnosis and treatment of illness or injury or for the correction of an organic system;

(2) Items and services not properly prescribed or determined necessary by a health care practitioner;

(3) Expenses incurred for evaluative or periodic check-ups, examinations, or immunizations in connection with the participation, enrollment, attendance, or accomplishment of a program or activity not related to your physical or mental health or rehabilitation which does not meet the criteria of (1) above, is not provided as part of an EPSDT screeening (see Section 12), or is not a physical examination required by the Division of Public Assistance for the purpose of determining eligibility :

(4) Any expense which is for or in connection with cosmetic therapy or cosmetic surgery, except that Medicaid coverage is available when required for repair of accidental injury, for the improvement of the functioning of a malformed body member, or for the correction of a visible disfigurement which would materially affect your acceptance in society, and when performed within the normal course of treatment or otherwise beginning no later than one year after the event which caused the need for that corrective action;

(5) Any expense which constitutes a non-medical charge imposed by a friend or relative, except when payment is made for medical transporation ;

(6) Any medical expense which is for persons who are in the care and custody of federal, state, or local penal facilities, including juveniles in detention facilities.

* The services of the following practitioners are NOT covered under the Medicaid program in Alaska :

(1) chiropractors;

(2) Christian Science practitioners or theological healers;

(3) naturopaths;

(4) podiatrists;

(5) private psychologists;

(6) any other licensed or unlicensed practitioners not enrolled in the Medicaid Program as providers.

9 YOU MUST REPORT CHANGES IN YOUR CIRCUMSTANCES

* You must report changes promptly.

* You can report changes by contacting the public assistance office or your fee agent. However, it is better to fill out the change report form included with your AFDC or APA check and mail it to the office.

IT IS EXTREMELY IMPORTANT THAT YOU REPORT CHANGES, SO THAT YOUR HOUSEHOLD RECEIVES THE RIGHT AMOUNT OF BENEFITS.

Changes that you must report include :

- Changes in mailing or residence address;
- Movement of a related person into or out of the household;
- Increase, decrease, or change in source of income in the household;
- Any change in resources of the household;
- Any change in the costs of rent, mortgage payment, taxes or insurance;
- Change in eligibility status of any household member for other benefits;
- Death of a household member;
- Change in marital status of any household member;
- Change in school attendance of any household member;
- Placement of a child in the custody of the Department of Health & Social Services;
- Improvement in the condition of a blind or disabled person;
- Refusal to accept vocational rehabilitation services;
- Departure from the state, the United States, or both;
- Refusal to accept treatment, or discontinuing treatment for drug addiction or alcoholism; and
- Admission to or discharge from a public institution, hospital, or nursing home.

10 YOUR RIGHTS

YOU HAVE THE RIGHT TO.....

* Apply for or request information about any assistance payments program or social service available from the Department of Health & Social Services including the following:

  — Family Planning
  -- Child Protection
  --- Alcoholic Rehabilitation
  -- Family Counseling
  -- Homemakers
  --- Day Care
  -- Information and Referral Supportive Services for Children.

  (You are eligible for family planning services for three months from the date of your application for AFDC even if you are found ineligible.)

* Receive courteous and fair treatment with no discrimination because of race, color, creed, religion, political belief, marital status, national origin, age, or sex.

* Receive a prompt written decision of your eligibility.

* Receive help from the department in obtaining child support for your children, if you are requesting assistance for children.

* Receive free, regularly scheduled physical examinations, diagnosis, and treatment for most medical problems for all children and adults under 21 who are eligible for Medicaid, under a program called EPSDT.

* Understand that information you give to the Division of Public Assistance will not be disclosed or used for purposes other than those connected with the administration of the public assistance laws of Alaska.

* Request a hearing by a fair and impartial person if you are dissatisfied by a delay or with the decision on your eligibility or the amount of assistance provided to you.

At a fair hearing you can explain to a hearing official why you disagree with an action the public assistance office has taken on your case.

If the hearing official decides you are right, you will continue to receive, or will begin to receive, the correct amount of benefits. If the official decides the public assistance office is right, you will be asked to repay the value of any assistance you were not entitled to receive.

You can ask the public assistance office for a fair hearing in writing, in person, or over the phone.

You can ask a friend or a representative from Alaska Legal Services or anyone else to help you prepare for the hearing and to attend the hearing with you.

The hearing will be scheduled at a time and place that are reasonably convenient for you.

11 YOUR RESPONSIBILITIES

YOU HAVE A RESPONSIBILITY TO.....

* Provide correct and complete information on your application and on all other forms related to your application and your eligibility for assistance.

* Cooperate in providing information about absent parents who are responsible for the children in your care.

* Accept any medical examinations necessary to determine your eligibility.

* Cooperate with the Division of Public Assistance in verifying your situation and the information you provide.

* Register for the Work Incentive Program when your youngest child reaches six years of age.

* Never allow anyone to use your Medicaid coupons or ID card, unless the person is named on the card or coupon as an eligible recipient.

* Apply for and make use of any benefits which you, or those for whom you want help, may be eligible, such as Unemployment Compensation, Social Security, Veteran's Benefits, etc.

* Tell the Division of Public Assistance promptly as changes in your situation occur which may affect your eligibility or the amount of assistance you are paid.

* Advise the Division of Public Assistance of any settlement in your favor as a result of an accident, and grant permission to the State of Alaska, Division of Public Assistance to file a claim against the settlement for medical bills paid in your behalf.

12 EARLY AND PERIODIC SCREENING, DIAGNOSIS & TREATMENT

EPSDT is part of the Medicaid Program and is mainly a preventive health program for children. The goal is to find children who have diseases or abnormalities and to prevent or correct handicaps by giving them medical treatment and rehabilitation as early as possible.

EPSDT services are available to all persons under 21 who are receiving, or are eligible to receive, Medicaid benefits.

EPSDT offers all the coverage available under Medicaid as well as the following special services :

1. physical exam and diagnosis
2. dental care
3. prosthetic devices (leg braces, wheel chairs, etc.) and medical supplies
4. physical therapy
5. immunizations
6. health and nutrition counseling.

13 OTHER MEDICAL PROGRAMS

GENERAL RELIEF-MEDICAL (GRM)

The General Relief-Medical Program (GRM), which is administered by the Division of Public Assistance, is a 100% state-funded program that provides for the payment of providers of medical and emergency dental care for eligible low-income Alaskans.

GRM is considered a "last resort" assistance program. AFDC and APA recipients are automatically eligible for Medicaid and are therefore eligible for GRM benefits only for services not covered by Medicaid.

Applications for GRM are available at State Division of Public Assistance offices.

CATASTROPHIC ILLNESS PROGRAM

The Catastrophic Illness Program,which is administered by the Division of Public Assistance and a committee appointed by the Governor's Office, is a 100% state-funded program that pays providers of medical services.

The purpose of the program is to financially assist residents of Alaska who have suffered and received treatment for a catastrophic illness or injury. A catastrophic illness or injury is one which results in medical expenses of over $1000 during a period of not more than 12 months–after all other sources of medical payment (insurance, etc.) have been used.

Applications for the Catastrophic Illness Program can be obtained at State Division of Public Assistance offices or by writing to:

Catastrophic Illness Program
Division of Public Assistance
Pouch H-07D
Juneau, Alaska 99811

Medicare is a federal health insurance program for certain kinds of individuals regardless of the amount of their income and resources :

-- the aged (65 and older)
-- the blind
-- the disabled
-- persons with certain permanent kidney failure

Although the name of the program "Medicare" is very similar to the name of the program "Medicaid" which is administered by the state Division of Public Assistance, Medicare is a completely separate and different program, administered by private health insurance companies.

Medicare is a two part program. Part A, available to all Medicare beneficiaries without charge, provides coverage for inpatient hospital services. Part B, which is available for a small monthly charge, provides coverage for outpatient and physician services. Detailed information about the Medicare program is available at any Social Security Administration office. In Alaska, Social Security offices are located at the following addresses :

Social Security Administration
P.O. Box 5837
Ketchikan, Alaska 99901

Social Security Administration
P.O. Box 1327
Juneau, Alaska 99802

Social Security Administration
P.O. Box 2600
Anchorage, Alaska 99510

Social Security Administration
P.O. Box 1449
Fairbanks, Alaska 99701

Information about Medicare can also be obtained by calling these toll-free numbers :

Juneau.....Zenith 5000

Anchorage.....Zenith 7777

Fairbanks.....Zenith 8888

14 DIVISION OF PUBLIC ASSISTANCE OFFICES

ANCHORAGE . . . . . .4th and Gambell
Anchorage, Alaska 99501
Phone: 274-6524

ANIAK . . . . . .Box 63
Aniak, Alaska 99557
Phone: 675-4351 (Fee Agent)

BETHEL . . . . . .Box 365
Bethel, Alaska 99559
Phone: 543-2686

DILLINGHAM . . . . . .Box 221
Dillingham, Alaska 99576
Phone: 842-5961

FAIRBANKS . . . . . .675 7th Street, Section F
Fairbanks, Alaska 99701
Phone: 452-1637

FORT YUKON. . . . . .Box 149
Fort Yukon, Alaska 99740
Phone: 662-2327

GALENA. . . . . .Box 239
Galena, Alaska 99741
Phone: 656-1260

JUNEAU. . . . . .419 Sixth Street
Juneau, Alaska 99811
Phone: 465-3551

KENAI . . . . . .Box 3613
Kenai, Alaska 99611
Phone: 283-3124

KETCHIKAN. . . . . .222 NBA Building
Ketchikan, Alaska 99901
Phone: 225-2135

KODIAK. . . . . .Box 2515
Kodiak, Alaska 99615
Phone: 486-3783

KOTZEBUE. . . . . .Box 41
Kotzebue, Alaska 99752
Phone: 442-3451

NOME. . . . . .Box 221
Nome, Alaska 99762
Phone: 443-2237

PALMER. . . . . .Box 901
Palmer, Alaska 99645
Phone: 745-4217

PETERSBURG. . . . . .Box 1089
Petersburg, Alaska 99833
Phone: 772-3565

SITKA . . . . . .Box 1069
Sitka, Alaska 99835
Phone: 747-8234

UNALAKLEET . . . . . .Box 40
Unalakleet, Alaska 99684
Phone: 624-3601

VALDEZ. . . . . .Box 750
Valdez, Alaska 99686
Phone: 835-2535

In rural communities where there isn't a district office, the Division of Public Assistance has paid volunteers, called fee agents, who can assist people to apply for Public Assistance Programs.

ABOUT THE COVER:

Antler was used for this spirit canoe in the shape of a sea lion. The seven figures represent people who were drowned when their boat was seized by an octopus. Among Salish groups, shamans performed a ceremony in which they paddled a spirit canoe to the land of the dead to bring back the soul of a person who had become ill because he had lost his soul.

Tlingit design. from the Museum of the American Indian, Heye Foundation. From THE ART OF THE NORTHWEST COAST INDIANS by Shirley Glubok

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CURRENT STATUTE

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

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 a 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

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

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

CURRENT STATUTE

(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. 1634. For report on ch. 105, SLA 1974 (CSSB 355), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 762.

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)

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

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

Selection of Medicaid Optional Services by States *

Top 10 States With Most Number Of Optional Services

States	# of Optional Services Maximum = 32
1. Wisconsin	32
2. Minnesota	31
3. California	
4. Massachusetts	28
5. West Virginia	28
6. New Jersey	27
7. Kansas	26
8. Montana	26
9. Nebraska	26
10. Connecticut	24

Top 10 States with Least Number of Optional Services

States	# of Optional Services Minimum = 0
1. Wyoming	5
2. Delaware	9
3. Georgia	9
4. Mississippi	9
5. Alaska	10
6. Oklahoma	10
7. Rhode Island	10
8. Texas	10
9. Alabama	12
10. South Carolina	12

* Arizona currently does not participate in the Medicaid Program.

Most Selected Medicaid Optional Services
Not Included in Alaska's Medicaid Program

	Optional Service	No. of States, Terr., and Protectorates Selecting the Option. Maximum = 53
1.	Prescription drugs	51
2.	Prosthetic devices	45
3.	Podiatrist's services	38
4.	Physical therapy	36
5.	Dentures	33
6.	Dental services	30
7.	Other practioners' services	30
8.	Private duty nursing	30
9.	Mental treatment in ICF for person aged 65 or older	28
10.	Occupational therapy	27
11.	Rehabilitation service	27
12.	Chiropractic services	26
13.	TB treatment in inpatient hospital for persons aged 65 or older	26
14.	Mental health treatment in SNF for persons aged 65 of older	25
15.	Diagnostic services	23
16.	Prevention services	20
17.	Christian science sanitoria	18
18.	Screening	14
19.	Personal care	11
20.	TB treatment in SNF for persons aged 65 or older	11
21.	TB treatment in ICF for persons aged 65 or older	10
22.	Christian science nursing	6

Services provided only under the mandatory portion of the screening and treatment programs for individuals under 21 are not shown on this chart.

welfare offices and State Medicaid agencies.

CN[2]

Both CN and MN[3]

Optional services in State Medicaid programs

FMAP[1]	BASIC REQUIRED MEDICAID SERVICES SEE ABOVE		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in Tit Institutions A. Inpatient Hospital Ser.	B. SNF Services	C. ICF Services	Services for Age 65 or Older in Mental Inst. A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	For Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services
73		Alabama																																	13
70		Alaska																																	10
61		Arizona																																	
72		Arkansas																																	21
50		California																																	23
54		Colorado																																	14
50		Connecticut																																	14
50		Delaware																																	9
50		D.C.																																	13
57		Florida																																	5
72		Georgia																																	12
50		Guam																																	1
50		Hawaii																																	21
74		Idaho																																	13
50		Illinois																																	21
55		Indiana																																	14
62		Iowa																																	16
53		Kansas																																	15
70		Kentucky																																	17
70		Louisiana																																	14
50		Maine																																	14
50		Maryland																																	16
50		Massachusetts																																	19
50		Michigan																																	22
50		Minnesota																																	7
74		Mississippi																																	9
		Missouri																																	15
51		Montana																																	21
50		Nebraska																																	16
50		Nevada																																	20
50		New Hampshire																																	24
50		New Jersey																																	21
70		New Mexico																																	17
50		New York																																	21
65		North Carolina																																	14
51		North Dakota																																	14
		Ohio																																	7
71		Oklahoma																																	16
57		Oregon																																	23
50		Pennsylvania																																	13
50		Puerto Rico																																	6
57		Rhode Island																																	16
70		South Carolina																																	14
54		South Dakota																																	13
53		Tennessee																																	14
51		Texas																																	17
79		Utah																																	10
50		Vermont																																	15
50		Virgin Islands																																	9
57		Virginia																																	16
52		Washington																																	21
70		West Virginia																																	23
53		Wisconsin																																	14
63		Wyoming																																	5
	25	States	14	13	9	10	6	13	8	11	9	8	19	22	16	11		3	4	9	8	2	2	13	9	12	23	22	10	1	6	16	17	2	
	25		24	22	17	20	14	25	22	25	18	21	32	11	25	25	18	11	10	18	18	9	8	27	16	16	26	25	23	5	12	24	23	9	
Total	50	Total	38	35	26	30	19	42	30	36	27	29	51	33	45	36	23	14	14	27	26	11	10	43	25	28	49	47	32	6	18	42	40	11	

[1]FMAP Federal Medical Assistance Percentage. Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.

[2]Categorically needy. People receiving federally supported financial assistance.

[3]Medically Needy. People who are eligible for medical but not for financial assistance.

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* STATE HEALTH INSURANCE

The first three sections of the bill establish a state comprehensive health plan and a premium supplement program. The comprehensive health plan is a major medical insurance policy offered by a private carrier under contract with the state to any resident who does not have public or group health coverage. The premium program provides state premium supplements on a sliding scale basis to residents who purchase qualifying individual major medical insurance policies.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDY

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately $8 million from the General fund and $8 million in federal funds for FY81.

House HESS Committee Hearings on
State Health Insurance

Teleconference Witnesses

Bill Weimar, Anchorage
Nick Noll, Eye, Ear & Nose Clinic, Fairbanks
Donald Thieman, Fairbanks Medical Association
Chris Bearsly, Providence Hospital, Anchorage
David Mather, Tanana Chiefs Conference, Fairbanks
Margaret Wolfe, Anchorage
Angie Hague, National Association of Social Workers, Anchorage
Penny Hladna, Anchorage
Gordon DePew, Fairbanks Life Underwriters Association
Bernie Barr, International Rehabilitation Association
Gil D'Innocente, Anchorage
Candice Berry, Welfare Rights Association, Anchorage
Pudge Kleinkoff, National Association of Social Workers, Anchorage
Frank Austin, Black Caucus Council for Economic Justice, Anchorage
Susan Johnson, Chris Billington, NOW, Anchorage
Nancy Lander, Women for Political Action, Anchorage
Rose Palmquist, Anchorage
Donna Hayes, Norton Sound Health Corporation, Nome
Herb Berkowitz, Anchorage
Mason Preston, Bethel
Rosy Porter, Bethel

Other Witnesses

Don Koch - Division of Insurance, Dept. of Commerce and Economic Development
Jim Jordan " " " " " " " " "
Donald Ching- Dept. of Regulatory Agencies, State of Hawaii
John Ingrassia - Life and Health Section, Insurance Division, State of Minnesota
Joan Gaumer - Director, Government Relations, Blue Cross of WA and AK
Dr. Helen Beirne - Commissioner, Dept. of Health and Social Services
Bob Ogden - Chief, Medical Assistance, Dept. of Health and Social Services

The House HESS Committee held a total of 12 hearings on HB977/SB227

THELMA
BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fis al note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commisssioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim peyments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standar become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately $ 8 million from the state's General Funds, $ 22,800 from other state funds and approximately $ 8 million in federal funds.

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 [illegible]

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act all[illegible] optional medical coverage qualifying for federal financial participat[illegible] are eligible for medical assistance.

CURRENT STATUTE

(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 CS-SB 56), see 1972 House Journal, p. 1641. For report on ch. 105, SLA 1974 (CSSB 465), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

Sec. 17.07.030. 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)

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 11. 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 Security Act.

Selection of Medicaid Optional Services by States *

Top 10 States With Most Number Of Optional Services

States	# of Optional Services Maximum = 32
1. Wisconsin	32
2. Minnesota	31
3. California	29
4. Massachusetts	28
5. West Virginia	28
6. New Jersey	27
7. Kansas	26
8. Montana	26
9. Nebraska	26
10. Connecticut	24

Top 10 States with Least Number of Optional Services

States	# of Optional Services Minimum = 0
1. Wyoming	5
2. Delaware	9
3. Georgia	9
4. Mississippi	9
5. Alaska	10
6. Oklahoma	10
7. Rhode Island	10
8. Texas	10
9. Alabama	12
10. South Carolina	12

* Arizona currently does not participate in the Medicaid Program.

Most Selected Medicaid Optional Services
Not Included in Alaska's Medicaid Program

	Optional Service	No. of States, Terr., and Protectorates Selecting the Option. Maximum = 55
1.	Prescription drugs	51
2.	Prosthetic devices	45
3.	Podiatrist's services	38
4.	Physical therapy	36
5.	Dentures	33
6.	Dental services	30
7.	Other practioners' services	30
8.	Private duty nursing	30
9.	Mental treatment in ICF for person aged 65 or older	28
10.	Occupational therapy	27
11.	Rehabilitation service	27
12.	Chiropractic services	26
13.	TB treatment in inpatient hospital for persons aged 65 or older	25
14.	Mental health treatment in SNF for persons aged 65 of older	25
15.	Diagnostic services	23
16.	Prevention services	20
17.	Christian science sanitoria	18
18.	Screening	14
19.	Personal care	11
20.	TB treatment in SNF for persons aged 65 or older	11
21.	TB treatment in ICF for persons aged 65 or older	10
22.	Christian science nursing	6

under 21 are not shown on this chart.

welfare offices and State Medicaid agencies.

CN[2]

Both CN and MN[3]

Optional services in State Medicaid programs

FMAP[1]	BASIC[4] REQUIRED MEDICAID SERVICES SEE ABOVE		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in TB Institutions A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Services for Age 65 or Older in Mental Inst. A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services
73		Alabama																																	12
60		Alaska																																	10
51		Arizona																																	
52		Arkansas																																	21
50		California																																	23
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60		Georgia																																	13
50		Guam																																	9
50		Hawaii																																	23
64		Idaho																																	13
50		Illinois																																	28
52		Indiana																																	14
52		Iowa																																	16
52		Kansas																																	25
73		Kentucky																																	17
73		Louisiana																																	14
50		Maine																																	22
50		Maryland																																	16
50		Massachusetts																																	29
55		Michigan																																	22
50		Minnesota																																	21
76		Mississippi																																	8
55		Missouri																																	15
61		Montana																																	21
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50		Nevada																																	20
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50		New Mexico																																	17
50		New York																																	1
65		North Carolina																																	16
50		North Dakota																																	24
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51		Wyoming																																	5
	20		14	13	9	10	6	13	8	11	9	8	19	22	10	11		3	4	9	8	2	2	13	9	12	23	22	10	1	6	13	17	2	
	33		24	22	17	20	14	29	22	26	18	21	32	11	23	25	18	11	16	19	18	9	8	27	16	16	28	25	22	5	12	24	29	9	
[total]	53	Total	38	35	26	30	19	42	30	38	27	29	51	33	45	36	23	14	20	27	26	11	10	40	25	28	49	47	32	6	18	42	45	11	

[1]FMAP Federal Medicaid Assistance Percentage. Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.

[2]Categorically Needy. People receiving federally supported financial assistance.

[3]Medically Needy. People who are eligible for medical but not for financial assistance.

National Conference of State Legislatures

Headquarters Office
(303) 623-6600

1405 Curtis Street
23rd Floor
Denver, Colorado
80202

President
George B. Roberts, Jr.
Speaker, New Hampshire
House of Representatives

Executive Director
Earl S. Mackey

January 28, 1980

Jan Sorice
House Committee on Health, Education
and Social Services
Pouch V
State Capitol
Juneau, Alaska 99801

Dear Ms. Sorice:

Enclosed, as you requested, is some information on state catastrophic health insurance programs.

Maine, Minnesota, Rhode Island, Connecticut, Hawaii and New York, in addition to Alaska, have enacted catastrophic health insurance legislation. Extensive analysis of these programs has not been performed, however.

Mr. Van Ellett at the Intergovernmental Health Policy Project is in the preliminary stages of preparing a background issue paper on catastrophic programs. He has indicated that he will be glad to offer further assistance in this area. Mr. Ellett can be contacted at:

The Intergovernmental Health Policy Project
Suite 505
1919 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
(202)872-1445

I hope this information is useful. If I can be of further assistance, please feel free to call me.

Sincerely,

Russ Hereford

Russell W. Hereford
Project Director
Health Care Cost Containment

RWH/sep

enclosure

GR-MEDICALLY NEEDY PROGRAM

* 50% of all tax returns in Alaska for individuals and families reported 1978 Adjusted Gross Incomes of less than $20,000.

* 30% reported incomes less than $10,000; less than $833 per month on the average for 1978.

* Many more Alaskans do not file tax returns at all.

These statistics suggest that for a large number of Alaskans, medical care for age, illness or injury would be unaffordable without health insurance or medical assistance while some of these people may have group insurance or be eligible for Medicaid, Medicare, or Alaskan Native Health Service, many are not eligible for any third party health benefits. The medically needy program created by HCSCSSSSB 227 would be an important medical resource for these people.

The income threshold for the medically needy program is set at 150% of the poverty guidelines for Alaska for 1979, the poverty guidelines were as follows:

Non-farm poverty income guidelines

Family size	Annual	Monthly	150%
1	$4,270	356	534
2	5,640	470	705
3	7,010	584	876
4	8,380	698	1047
5	9,750	813	1219
6	11,120	927	1390

A person or family which is over income becomes eligible for medical assistance under this program if their income in excess of the threshold is spent on medical bills. Essentially, this provides a form of catastrophic coverage for all families, as well as a form of basic coverage for low-income families. The department estimates the new program would serve approximately 2,800 families and individuals.

ADJUSTED INCOME OF ALASKA TAXPAYERS FILING 1978 RETURNS

annual income	average monthly income	percent of taxpayers earning this much or less
$5,000	$ 416	16.5%
10,000	833	29.2
15,000	1,250	40.2
20,000	1,667	49.5
25,000	2,083	57.8
30,000	2,500	65.6

MEDICAID ELIGIBLES *

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent or other caretaker relative

Child over 18 but under 21 who is school

All children in foster homes or institutions

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

Eligibles added by HCSCSSSSB 227

Child deprived of support of father due to unemployment

Spouse of disabled parent

Spouse of unemployed father

Pregnant woman and unborn child

All other financially eligible children

Caretaker relative of child over 18 but under 21 and not in school

Individuals who would be eligible for AFDC except for child care costs

Individuals who meet categorical criteria and whose incomes, less medical bills, are below 133% of the need standard (medically needy)

* In addition to these categorical criteria, persons must be financially needy.

Currently Covered Services

Hospital-Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (ICF)

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

Laboratory and X-ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

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

Community Mental Health Clinics

Family Planning Services

Outpatient Surgical Care Centers

Rural Health Clinics

* Accessible through General Relief-Medical

Services Added By HCS CSSSSB 227

Podiatrist Services

Chiropractic Services

Private Duty Nursing

Personal Care Services

* Physical Therapy

* Occupational Therapy

* Prescribed Drugs

Dentures

* Prosthetic Devices and Medical supplies

Other Diagnostic, Screening, Preventive & Rehabilitative Services

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

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

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

Clinic Services-other than Community Mental Health Clinics

Services by Christian Science Nurses

Services by Christian Science Sanatoria

House HESS Committee Hearings on
State Health Insurance

Teleconference Witnesses

Bill Weimar, Anchorage
Nick Noll, Eye, Ear & Nose Clinic, Fairbanks
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Other Witnesses

Don Koch - Division of Insurance, Dept. of Commerce and Economic Development
Jim Jordan " " " " " " " " "
Donald Ching- Dept. of Regulatory Agencies, State of Hawaii
John Ingrassia - Life and Health Section, Insurance Division, State of Minnesota
Joan Gaumer - Director, Government Relations, Blue Cross of WA and AK
Dr. Helen Beirne - Commissioner, Dept. of Health and Social Services
Bob Ogden - Chief, Medical Assistance, Dept. of Health and Social Services

The House HESS Committee held a total of 12 hearings on HB977/SB227

*Section 1. AS 18 is amended by adding a new chapter to read:

CHAPTER 27. STATE HEALTH INSURANCE.

Sec. 18.27.010. STATE COMPREHENSIVE HEALTH PLAN

(a) The state comprehensive health plan shall be established by the Commissioner of Administration as provided in AS 18.27.030. The Commissioner shall provide for the underwriting and administration of the state plan through competitive bid. The state plan shall be made available to the public no later than July 1, 1981.

(b) A resident of the state is entitled to enroll in the state plan if:

(1) The resident is not eligible for Medicare or covered under a state or federal health program;

(2) The resident is not covered by a group health insurance plan.

Sec. 18.27.020. STATE HEALTH PREMIUM PLAN (a) A resident of the state is entitled to participate in the state health premium plan if:

(1) The resident is enrolled in the state comprehensive health plan or an individual health insurance policy which is certified by the director of the division of insurance as meeting or exceeding the benefit standards of the state plan; and

(2) the resident is not enrolled in a group health insurance policy or covered under a state or federal health program;

(3) the resident qualifies for a supplement under the formula in subsection (b) of this section.

(b) The amount of the supplement is equal to 80 percent of the monthly premium less 8 percent of the monthly premium for every $100 of the insured's adjusted gross income, as defined in regulation, over $1000 per month. The premium cost of the state plan is the maximum amount of monthly premium which may be used in the calculation of the supplement. The $1000 per month of adjusted gross income used in the calculation shall be adjusted periodically by the commissioner by regulation to correspond with the change in the consumer price index.

Sec. 18.27.030. The commissioner shall:

(a) hold statewide public hearings to determine the major medical insurance needs of Alaskans;

(b) determine the number and characteristics of persons currently not covered by a group health plan or federal or state health program, and estimate the number of persons eligible to participate in the state health premium plan;

(c) conduct an actuarial study to determine the cost of providing insurance covering the services in subsection (a), for the group in subsection (b);

(d) present state health insurance plan to the legislature by January 1, 1981 including:

(1) services to be covered in the state health insurance plan;

(2) the cost of the services to be provided;

(3) the estimated number of Alaskans eligible to purchase the plan and the estimated number of Alaskans eligible to participate in the state health plan; and

(4) the estimated cost of the state health premium plan;

(5) a plan of operation for the state health premium plan which provides for:

(i) eligibility determination;

(ii) prompt payment of premium supplement entitlements to eligible residents or to their insurer;

(iii) reasonable protection against fraud; and

(iv) public awareness of the benefits provided under this chapter.

(6) recommendations for amendments of this chapter;

AS 13.27.040 DEFINITIONS. In this chapter

(1) "commissioner" means the commissioner of administration;
(2) "state plan" means the state comprehensive health plan established under AS18.27.010;

Health Care Survey: Doctors and Medicaid

A survey of 113 Anchorage doctors was conducted in order to determine the percentage of Anchorage physicians presently accepting Medicaid recipients as patients. The surveyors, posing as prospective patients, called each physician's office in an attempt to schedule an appointment. After it had been determined if the physician had any openings available, the method of payment was discussed. The conversation was specifically structured this way, in order to provide an indication of the extent to which the method of payment altered accessibility to health care.

The results of the survey are delineated in the accompanying chart. The percentage break-down is as follows: Pediatrics 40% of the doctors will accept Medicaid coupons, 60% will not; OB/GYN 6% will accept, 94% will not; Family Practice 27% will accept, 73% will not; internal 52% will accept, 48% will not; cardiology 100% will not accept; radiology 100% will accept. The chart clarifies the results, for example, cardiologists are not accepting Medicaid coupons, but they will accept as little as $1.00 per month as payment.

The survey clearly shows the existence of a problem for Medicaid recipients seeking medical care. The brunt of the problem falls on women and children, not only because fewer pediatricians, obstetricians and gynecologists accept Medicaid patients, but also because most Medicaid patients are women and children. For example, in November 1979, 8,418 adults were eligible for Medicaid in Alaska; 6,193 of the total were women. The total number of Medicaid eligible children was 9,998.

There are no existing public facilities in Anchorage which provide prenatal care. There are no OB/GYN's in Anchorage who accept new Medicaid recipients needing gynecological care as patients; only one Anchorage OB/GYN will accept new Medicaid patients for obstetrical care. It has been suggested that those women in need of, and without access to, OB and/or GYN care elicit the assistance of a family practitioner. Presently 73% of the family practitioners will not accept coupons as the method of payment.

It has further been suggested that poor people use the emergency room as a recourse to health care. This is a non-solution; the function of an emergency room is crisis-oriented, it is not designed to provide on-going care. At Providence Hospital, business personnel estimate that up to 30% of the patients using the emergency room are Medicaid recipients. Reportedly, the number of recipients using the emergency room has incrementally increased as the number of doctors willing to accept coupons has decreased.

Physicians who have elected to exclude patients from health care base their refusal on claims that they receive unsatisfactory payment for their services from Medicaid and that the reimbursements they do receive are untimely. It is also felt that the state requires excessive amount of paperwork before reimbursements approved. Doctors further claim that they owe no ethical obligation to the poor.

Although the state has encountered numerous difficulties in making timely Medicaid payments, the recent implementation of a new computer system has succeeded in processing the vast majority of all pending claims.

Poor people, still waiting in long lines at the welfare office to procure Medicaid coupons, continue to lack accessible health care. As one recipient complained to a staff person at the welfare office, coupons in hand, "What am I supposed to do with these, if no doctors in town will take them?"

Availability of Health Care to Medicaid Recipients: Jan./Feb. 1980 Telephone Survey

I Will accept all forms of payment including medicaid	II Will not accept new medicaid patients/info on established caseload n/a	III Will not accept new medicaid patients; but carries an established medicaid caseload	IV Not accepting any new patients
OB/GYN			
Eastburn, Lydia	Gills, Raymond E. Nist, Richard Ekvall, David L. Ivy, William 1/ Ferucci, Leonard 1/ Newton, Burrit 1/ Orren, Jerry Wallner, Charles Stransky, George Curtis, Richard	Hanson, Hedric Erkman, John Renn, Claire Gibson, Sam	Compton, William
PEDIATRICS			
Keller, R. Tower, John C. Witt, Marian Zartman, Harvey P. Martin, Sarah	Lillibridge, Clinton Nesbitt, James Jr. Roberts, Dion Schriever, Gerry Hatton, Elizabeth Patterson, James Larson, William 1/	Kiehl, Phyllis Wallington, Joanne	

FAMILY PRACTICE

Agnew, Mark
Myers, Robert C.
Sydnam, Nancy E. 2/
Manwiller, Charles
Jones, Warren 3/
Billings, Robert
Feirtag, Mary
Martin, Asa
Lindhal, James
Sutherland, Richard

Arbow, Donald
Jones, Leland
Laufer, Kenneth
Kiessling, Bruce
Taylor, Richard
Cates, Vernon
Romig, Howard C.
Monlux, George
Mosley, Charles
Persons, Jean C.
Jackson, Marcell
Burgess, Joan
Bryan, Harold
Cormack, Allan
Nolan, Patrick
Smith, John
Colyar, A. B. 1/
Morgan, Royce 1/
Olsen, Harry 1/
Lang, Thomas 1/

St. John, Charles
Bosveld, Robert
Foland, Mary Ann
Wieland, Tyron

INTERNAL MEDICINE

Watson, III, James
Webb, Dale 4/
Ames, John
Hemry, David
Fish, Winthrop
Burtis, Buffington
Sonneborn, David
Armstrong, Michael
Ragle, William
Wilkins, Robert
Archer, Gary
Beechman, Sherman
Austin, Stanley
Stewart, George

Behymer, G. W.
Steer, Paul
Hall, Robert
Peach, David
Morris, Ann
Morris, Gerald
Princiville, Thomas
Blankinship, Gilbert 5/

Whaley, Robert

Buchanan, Richard
Schlosstein, Lee
Brownsberger, Keith 6/
Witt, Richard 6/
Wilson, Rodman 6/

RADIOLOGY

Gibbons, John
Hall, Randolph
Hendrics, Zeke
Pister, James
Coyle, Maurice J.
Kottra, John
Sternhagen, Charles

CARDIOLOGY

Baldauf, James 5/
Bustad, Leo 5/

Footnotes:
1/ Cash only
2/ Limited amount
3/ Will not take coupons for O.B. care
4/ For cancer patients only
5/ Will not accept medicaid coupons; will accept minimal monthly cash payments (i.e.: $1.00/mo.)
6/ Does have established medicaid caseload

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* HIGH RISK INSURANCE POOL

People who have high risk medical conditions often are considered "uninsurable" and cannot purchase comprehensive health insurance. Section one of the bill establishes a high risk insurance pool to be administered by the largest carrier in the state. Premiums would be limited to reasonable levels and the carrier would be allowed to pass excess claims losses from this coverage on to the state through the tax system.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDY

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately $8 million from the General fund, $23 thousand from other state funds and $8 million in federal funds for FY81.

THELMA
BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fiscal note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commisssioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim peyments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately $ 8 million from the state's General Funds, $ 22,800 from other state funds and approximately $ 8 million in federal funds.

HCS CSSS SB 227 (HESS)

BILL SUMMARY

(revised 5/21/80)

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000 deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits

are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care plans must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each asscaition member must designate the classes of r. which it elects to have written by or reinsured by the a 'ation. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the assocaition by an actuarial committee.

Losses of the assocaition are assessed to members. Members in turn may credit the assessed claims losses, but not

assissed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.100 Definitions

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original CSSSSB 227 and require state employee health insurance to include coverage alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a spearate section, the department is authorized to make interim apyments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days and two percent per month after 90 days.

Sections 9 and 10 expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

payments from public assistance, social security, unemployment and workmen's compensation, strike benefits from union funds, veterans benefits, training stipends, alimony, child support and military family allotments or other regular support from an absent family member or someone not living in the household; government employee pensions, private pensions and regular insurance or annuity payments; and income from dividends, interest, rents, royalties or income from estates and trusts. For eligibility purposes, income does not refer to the following money receipts, any assets drawn down as withdrawals from a bank, sale of property, house or car, tax refunds, gifts, one-time insurance payments or compensation for injury; also to be disregarded is non-cash income, such as the bonus value of food and fuel produced and consumed on farms and the imputed value of rent from owner-occupied farm or non-farm housing.

(2) *A Farm Residence.* Is defined as any dwelling on a place of 10 acres or more with $50 or more annual sales of farm products raised there; or any place less than 10 acres having product sales of $250 or more.

Poverty Income Guidelines for All States Except Alaska and Hawaii

	Non-farm family	Farm family
Size of family unit:		
1	$3,400	$2,910
2	4,500	3,840
3	5,600	4,770
4	6,700	5,700
5	7,800	6,630
6	8,900	7,560

For family units with more than 6 members, add $1,100 for each additional member in a non-farm family and $930 for each additional member in a farm family.

Poverty Guidelines for Alaska

	Non-farm family	Farm family
Size of family unit:		
1	$4,270	$3,650
2	5,640	4,810
3	7,010	5,970
4	8,380	7,130

Poverty Guidelines for Alaska—Continued

	Non-farm family	Farm family
5	9,750	8,29[illegible]
6	11,120	9,45[illegible]

For each family unit with more than 6 members, add $1,370 for each additional member in a non-farm family and $1,160 for each additional member in a farm family.

Poverty Guidelines for Hawaii

	Non-farm family	Farm family
Size of family unit:		
1	$2,930	$2,[illegible]
2	5,190	4,[illegible]
3	6,450	5,[illegible]
4	7,710	6,[illegible]
5	8,970	7,[illegible]
6	10,230	8,[illegible]

For family units with more than 6 members, add $1,260 for each additional member in a non-farm family and $1,070 for each additional member in a farm family.

[44 FR 26476, May 7, 1979]

Subpart 1060.3—Limitation on Benefits to Those Voluntarily Poor (CSA Instruction 6004-2)

§ 1060.3-1 Applicability of this subpart.

This subpart applies to all agencies receiving funds under Titles I-D, II and III-B of the Economic Opportunity Act for programs administered by OEO in which income criteria are used as admission standards (with the exception of Head Start and Upward Bound programs).

(Sec. 602, 78 Stat. 503; 42 U.S.C. 2942)

[34 FR 2419, Feb. 20, 1969]

§ 1060.3-2 Policy.

(a) Section 611 of the Economic Opportunity Act provides as follows:

The Director shall take such action as may be necessary to assure that, in determining a person's eligibility for benefits under this Act on account of his poverty such person will not be deemed to meet the poverty criteria if his lack of income results from his refusal, without good cause, to seek or accept employment commensurate with his health, age, education, and ability.

MEDICAID OPTIONAL SERVICES--INCLUDING THOSE NOT CURRENTLY COVERED BY THE ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

(1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.

(2) Optometric services. Covered under Alaska Medicaid.

(3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.

(4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.

(5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.

(6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

OPTIONAL SERVICES

OPTIONAL SERVICES	ALASKA	IDAHO	OREGON	WASHINGTON
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
POUCH H 01 – JUNEAU 99811

April 9, 1980

Ms. Thelma Buchholdt
Chairperson, House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Document# 68-80

Dear Ms. Buchholdt:

At the recent teleconference on House Bill 977, your Committee requested further information regarding the definition of the "other diagnostic, preventative, and rehabilitative services" option to the Medicaid program. The definition included in federal Medicaid regulations for this option is as follows:

§440.130 Diagnostic, screening, preventive, and rehabilitative services.

(a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

(b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

(c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to--

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

(d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

As you can see the federal definition is quite general. The Medicaid program allows state flexibility to define optional services for operational purposes. Seven states currently have selected to include this service option in their Medicaid programs. These states have defined this option as follows:

1. California - Rehabilitation center outpatient services. Included are physical, occupational, and speech therapy and audiology. One visit in a six-month period is allowed, without prior authorization, for evaluation purposes and preparation of an extended treatment plan. The treatment plan must be signed by a physician. Subsequent visits are subject to prior authorization. A maximum of 30 visits may be authorized at any one time. Authorizations are valid for up to 120 days.

2. Idaho - The following are the core medical rehabilitative services provided on a statewide basis through facilities comparable to adult/child development centers: medical/social and psychological evaluations, speech and hearing evaluations, psychological therapy, patient centered psychological consultation, speech therapy, and patient centered psychological consultation, speech therapy, and patient centered development deficiency services related to particular diseases or health deviations.

3. Nevada - Limited to inhalation therapy prescribed by a physician and provided by a Certified Respiratory Therapist subject to the same limits that apply for Medicare. Prior authorization by the Medical Care Section is required.

4. North Carolina - Limited to diagnostic, preventive, and rehabilitative services when provided by mental health centers.

5. Oklahoma - Limited to blood. For inpatients, payment is made to blood banks for blood and blood fractions when the cost of blood is not included in the hospital per diem cost. For outpatients, payment is made for blood and blood fractions on behalf of an eligible recipient who is suffering from a congenital or acquired disease of the blood which requires the use of blood or blood fractions. Specifically eliminated is gammaglobulin, both the pooled and specific types. Payment may be made to physicians, clinics, out-patient hospitals or blood banks. Blood claims are screened through the computer stream against eligibility files to assure that no payment is made beyond the scope of the program.

6. Wisconsin - Includes psychotherapy provided or supervised by a psychiatrist or psychologist in the provider's office, the outpatient office of a hospital, an outpatient facility, a nursing home, a licensed child-caring institution, a school, or the recipient's home or foster home. A diagnostic examination and a physician's written prescription for therapy must be furnished before therapy is begun (a prescription is not needed for emergency treatment but must be obtained within 48 hours). Prior authorization is required for all therapy.

7. Washington - Diagnostic services - covered as needed and approved. Preventive services - (a) Rabies shots; (b) Fluoride painting; and (c) Immunizations when not otherwise available. Rehabilitative services - (a) Physical medicine and rehabilitation as requested and approved; (b) Alcohol detoxification limited to 3 days in certified facilities which may be within the physical location of a general hospital - however, narcotic detoxification is not covered; (c) Chemotherapy and consultation for drug addiction are provided in clinics approved to provide to services; and (d) Adult Day Health Care as provided and periodically reviewed.

I hope this clarifies your concerns. Alaska, if it choses to add this option, could define the option in a similar ways to those noted above, subject to federal approval in order to be eligible for federal financial participation.

If you have additional questions on this matter, please do not hesitate to contact the department at 465-3030.

Sincerely,

Deborah E. Behr

Deborah E. Behr
Special Assistant to
the Commissioner

Alaska State Legislature

House

JUNEAU ALASKA

To: Representative Thelma Buchholdt
Chair, House HESS

From: Jan Sorice, A.A.

Re: CSSSSB 227

Section One of CSSSSB 227,which creates a Health Reinsurance Association of all carriers in the state, is based on Connecticut's Health Care Act of 1975. Travelers Insurance Company is the administering carrier for Connecticut's Health Reinsurance Association.

According to Tim Lyons of Travelers Insurance Company in Connecticut, the law serves a positive public purpose and does not impose an unreasonable burden on the carriers. The law offers comprehensive health insurance coverage to any resident of the state and any employer group. In addition to providing coverage for high health risk peop who are uninsurable under standard policies, the state comprehensive health care plan provides coverage to people who are temporarily lacking coverage, such as a person who is in between jobs and temporarily not eligible for group coverage, and provides many young, low-risk people an attractive health coverage plan at very modest premiums as well. Except for a

few carriers who choose to write their own comprehensive health insurance plans, the carriers act as agents to sell the comprehensive health plans written by the Health Reinsurance Association.

Mr. Lyons found no legal or administrative problems with the law, though he feels that it would be preferable to have all carriers in one residual market rather than one for insurance carriers and another for hospital/medical service corporations (Blue Cross and Blue Shield, predominately). He felt that one association would provide a more equitable sharing of the costs of high risk coverage among all carriers and would avoid duplication of administrative overhead.

Blue Cross of Connecticut does not participate in the Health Reinsurance Assocaition, but instead chooses to operate a separate residual market mechanism and offer a competing comprehensive health plan as mandated by the law. Blue Cross' comprehensive health plan is offered at two-thirds the premium cost and has five times the enrollment of the comprehensive plan offered by the Health Reinsurance Association. Blue Cross prefers to operate a separate program because as a non-profit hospital/medical service corporation, they run their business a little differently than insurance companies do. Joe Kaluzynski, Director of Market Research and Product Development for Blue Cross, saw no administrative problems or other defects in the law.

Neither Mr. Kaluzynski nor Mr. Lyons saw any potential problems generated by the fact that most carriers operating in Alaska are not located here. Only one carrier in each association, the administering carrier, needs to have regular contact with the State or its residents.

A COMPARISON OF BENEFITS UNDER HB 977 AND THREE OTHER COMPREHENSIVE HEALTH PLANS

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
deductible	$50/person; $150/family	$500/person; $1500/family	$500/person	$500/person
co-payment	10%	20%	20%	20%
out-of-pocket limit	$2000	$3000	$3000	$1000/person; $2000/family
maximum lifetime benefit	$250,000	$250,000	$250,000	$1,000,000
pre-existing conditions limit	maximum benefit limited during 1st year of plan coverage to $1000 for any pre-existing condition which was treated during the 3 months prior to enrollment in the plan	not specified	not specified	conditions manifested or treated in the 6 months prior to enrollment excluded from coverage for one year
fee basis	usual, customary and reasonable charges	usual and customary charges	usual and customary charges	may not exceed reasonable charges or rates approved by the commission on hospital and health care
COVERED SERVICES:				
hospital services	yes	yes	yes	yes
physician services	care rendered by M.D., osteopath, psychologist, chiropractor, podiatrist or Christian Science practitioner	care rendered by or at the direction of a physician	care rendered by or at the direction of a physician	professional services rendered by an M.D., osteopath, chiropractor, podiatrist, psychologist, or naturopath
private duty nursing	RN services at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered by a registered nurse at the direction of a physician

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Prescription drugs	yes	yes	yes	yes
radiation	yes	yes	yes	yes
x-ray & lab exams	yes	yes	yes	yes
oxygen	yes	yes	yes	yes
anesthetic	yes	yes	yes	yes
prostheses	yes	yes	yes	yes
medical supplies	bandages, crutches, wheel chairs, respirators, blood, hospital type beds, plasma	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment
pregnancy & childbirth	yes	yes	yes	$250 limit except for complications
travel	ambulance or commercial airline to nearest facility	medically necessary transportation	ambulance to nearest facility & mileage rate to kidney dialysis treatment center	ambulance to nearest facility
alcoholism treatment	yes, on inpatient basis, except limited to $1000 maximum if the facility does not have a contract with Blue Cross	yes	yes(required by law of all health insurance policies	yes
mental & nervous disorders	50% coverage up to $2500 maximum per year when rendered by and M.D., D.O., or licensed psychologist	____	____	50% coverage

Benefits	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Nursing home	___	120 days maximum if begun within 14 days of a hospital stay of at least 3 days	120 days maximum if it would qualify under Medicare	120 days maximum if begun within 14 days of a hospital stay of at least 3 days
home health care	____	up to 180 visits/year	if it would qualify under Medicare	up to 180 visits/year
oral surgery	yes	yes	yes	yes
physical therapist	___	yes	yes	yes
well baby care	___	yes, subject to deductibles, coinsurance and limits	effective July 1, 1980	_____
physical exams	___	yes, subject to applicable deductibles coinsurance and limits	effective July 1, 1982	_____
multiphasic screening & other diagnosis	___	yes, subject to coinsurance, deductibles & limits	effective July 1, 1982	_____
dental care	70 - 100% coverage up to a maximum of $1000 per year	_____	_____	_____
vision & optical	90% coverage for 1 exam and 1 set of lenses/year	_____	_____	_____
audio	80% coverage up to $400 over 3 years	_____	_____	_____
medical social services	_____	_____	_____	$200 limit

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
conversion privileges	yes	yes	yes	yes
dependent coverage	spouse, dependent children under 23, disabled children of any age who are financially dependent	spouse, children under 18, children under 25 who are students and financially dependent, disabled children of any age who are financially dependent and dependent household members	spouse, children under 19, children under 25 who are students and financially dependent, children of any age who are disabled and dependent	not specified

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/OF 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 INSURANCE

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.

Robertson, Montagle,

STATEMENT
of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
CONCERNING PROPOSED
ALASKA COMPREHENSIVE HEALTH CARE PLAN
(House CS for CS for SS for S.B. 227)

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

Section 1 of the proposed House Committee Substitute for this bill, now being considered by the House Health, Education and Social Services Committee, would establish a comprehensive health care plan, and would require health insurers to participate in it. Our comments will be primarily directed to Section 1.

GENERAL PLAN OF SECTION 1

The basic idea of Section 1 is to establish a pool to make three specified plans of major medical insurance available to Alaska residents, under age 65, who are uninsurable or are otherwise high risks for such coverage when furnished by individual insurers. Pooling of high-risk insureds makes the financial resources of all health insurers available to cover the large claim payments that must be made.

Because major medical insurance, with its broad coverage and high maximum benefits, is costly anyway -- and even more so for high-risk insureds -- Section 1 also limits the premium rates that can be charged for the three major medical plans to amounts that are less than are needed to pay claims and administer the program, and the State eventually pays the difference by means of a tax offset. [A State subsidy is available to certain small employers to help them pay for one of the three plans of major medical insurance for their employees.]

All health insurers (including self-insurers) would be required to be members of the Association which operates the pooled business, and to share in the losses, with one exception. Blue Cross - Blue Shield could establish its own separate pool, or could provide the three plans without participating in a pool.

Section 1 is an altered version of an existing Connecticut law, and the subsidy for small employers is an idea adapted from an existing Hawaii law.

GENERAL COMMENTS

Going to the Connecticut law for guidance results in a much better plan than in H.B. 977. The Connecticut law, unlike the Minnesota law on which H

is based, has not been a subject of great controversy or Constitutional challenge. It is, on the whole, a very workable law for that State. To be sure, it needs some alterations based on experience with it, and some additional ones if it is to be adapted for Alaska.

Before getting to that, it seems to us that the Alaska legislature should be asking, and getting answers to, some important questions:

(1) Is there a need for such a program in Alaska?
(2) How many Alaska residents can we expect to benefit from it?
(3) How much will it cost?
(4) Are the anticipated costs worth paying in view of the anticipated benefits?
(5) Would such a program work in Alaska?

These same questions should be asked and answered about any proposed health insurance program, whether it be patterned after the Connecticut law or the Minnesota law, or whether it is something untried elsewhere.

What you need, we think, is to have a thorough study made by a firm of consulting actuaries that has sufficient knowledge about State health insurance plans and access to sufficient Alaska claims data. This would be advisable for any State contemplating a program, and particularly so for Alaska which is so different from other States. Among other things are Alaska's vast area, small population, comparatively younger (and probably healthier) residents, and a large proportion of residents already covered by government health care plans.

Lacking such a study, we can only make some guesses.

Let's go to question (2), and see what we can guess from experience elsewhere about how many Alaskans who are high risks for major medical insurance might become insured under such a program. The answer to this will have some bearing on the answers to questions (1) and (4).

In Connecticut, the two pools (one "pool" operated by Blue Cross - Blue Shield, the other by insurance companies) together cover 9,680 people, which is about 35 ten-thousandths (.0035) of the under-age-65, civilian, noninstitutionalized population of about 2,746,000 people. But a large majority of the people covered by the pools consists of standard risks, who could get coverage without the program. This is primarily because Blue Cross - Blue Shield puts all of its non-group insureds, both standard and high-risk individuals, into its pool. So the Connecticut figures are not much help to us.

In Minnesota, the Association (pool) has 1,465 policies in force for people under age 65. While the records do not indicate numbers of people covered, the great bulk of the policies cover only one person each. We estimate that the pool covers

1,758 people, which is about 5 ten-thousandths (.0005) of the under-age-65, civilian, noninstitutionalized population of about 3,493,000 people. This enrollment was achieved only after a major, intensive publicity effort participated in by the Association and hospitals and other health care providers. Unlike Connecticut, only high-risk individuals are included in this figure.

Applying these Minnesota results to the estimated 395,000 under-age-65, civilian, noninstitutionalized Alaska population, we would ~~expect an Alaska~~ 2 rejections pool for high-risk individuals to cover somewhat under 200 Alaska residents. Some downward adjustment should be made for Alaska's comparatively younger and (at least partly for that reason) healthier population, and for the comparatively larger proportion of native Alaskans covered under government health care programs.

It should be kept in mind that a wide range of major medical insurance plans (including high-maximum plans) is already available from insurers to groups, and to standard and many substandard risk individuals, at premium rates that are lower than those to be charged by the pool. And Medicare, Medicaid, the Alaska catastrophic illness program, and other government programs provide coverage for many Alaskans.

The small number of people who can be expected to come into the pool is determined by a number of factors, including the small number of uninsurables, the inability of many to pay the costs of major medical insurance, the number of people already covered under major medical plans, and the number of people covered under other government programs.

COST OF PROGRAM

The Alaska Insurance Department has already given you an estimate of their anticipated costs, initially $250,000 per year we understand.

In Section 1, proposed AS Sec. 21.50.090 provides for the State to aid small employers in paying premiums for health insurance coverage for employees and their dependents. We do not have any estimate of what this may cost the State, but think that the costs may be quite substantial.

In addition, there would be a cost to the State due to the tax offset (or payment by the State to the carrier) for losses due to costs of the program which exceed the premiums on business written by the pool. The Minnesota program lost ~~$1,000,000~~ $500 in 1979, using the same limitation on premium rates that is in the proposed Alaska program. With only 10% or 11% as many insureds, but with considerable higher per person administrative costs, losses under the Alaska program might initially be $200,000, perhaps somewhat less but possibly considerably more -- the latter if a home office type operation must be established in Alaska, since no major health insurance writer has its home office in Alaska. Without a proper actuarial study, we cannot predict the range of this cost.

In addition, insurers will incur some costs for compliance with the law. The amount is unknown, but it will eventually be paid by Alaska policyholders and insureds.

COSTS TO EMPLOYERS

Proposed AS Sec. 21.50.080 would require all group "health policies" delivered or renewed in Alaska to contain the provisions called for in proposed AS Sec. 21.50.030(b). Those provisions deal principally with: (1) continuation of coverage under the group policy in specified circumstances for employees and/or dependents whose coverage would otherwise terminate; and (2) including a conversion to an individual policy, with benefits and terms at least as good as a comprehensive plan, when coverage under the group plan terminates.

Both proposed sections need careful redrafting in order not to interfere more than is intended with eligibility provisions of group policies, and to limit the conversion privilege so that it applies to the proper kinds of group policies and does not allow duplicate conversions.

After redrafting, the provisions should be considered in an actuarial study to determine the costs they will add to group plans, so that the Committee may consider whether it is avisable to add such cost burdens to employers who furnish health insurance coverage to employees under group policies or contracts.

PREMIUM RATES

An actuarial study is needed to determine the approximate premium rates that the pool will charge initially for coverage. This is essential if you are to make an informed, intelligent decision on the kinds of benefits and the amounts of benefits, including the deductibles, to be provided in the three plans. Section 1 of the proposed amendment already makes some changes in benefits from those provided under the Connecticut law. I do not know what reasons were involved in making the changes, but they have a significant effect on premium rates.

The decrease in the low option deductible to $100 from $200 will increase the premium rate for that plan by roughly 10%. The increase in the high option deductible to $1,000 from $750 will decrease the premium rate for that plan by roughly 7-1/2%. Removing Connecticut's $250 limit (and applying no limit) to the normal maternity benefit will increase the premium rate of all three plans for women of child-bearing age, by roughly 5% to 10%.

It seems to me that we should be looking for ways to lower premium rates, by decreasing some benefits, rather than for ways to increase them. We do not want to price the plans so high that even fewer people will be able to afford them.

Health insurance premium rates are already higher for Alaska residents because of the higher health care costs in Alaska. And health care costs are rising at a rapid rate generally. We know, for example, that the insurance company pool in Connecticut is about to raise its rates by 20%. We know that health care costs in Anchorage are about 35% higher than in Hartford, Connecticut.

When a small sampling of Connecticut rates for just two age groups is roughly adjusted to account for the changes inthe plans and to guess at what the pool rates might today be for Anchorage residents, and some of them indicate an annual rate, for one adult, of as much as $1,100, $1,300, or $1,500, I worry. And whatever the rates are now, they may have to be 15% or more higher by the time the program can be put into effect. per year?

After you have a proper actuarial study, you should consider what benefits the three plans should offer.

OTHER CONSIDERATIONS

1. The size of Alaska, and the distribution of its population over so large an area, create some problems, but they can be dealt with. Costs of the program will be higher, and communications (including the enrolling of individuals and payment of claims) will take somewhat longer than would be the case with Minnesota or Connecticut.

2. Because, unlike Connecticut and Minnesota, Alaska does not have within its boundaries the home office of a large insurer capable of administering the program, the Committee should investigate the practicality of having the program administered from outside the State, and the availability of insurers willing to participate as administrator and as board members of the Association.

3. The small size of the anticipated enrollment in the program does not obviate the need for a pool. It does, however, make it impractical to have more than one pool, even at the beginning of the program. The two pools under the present Connecticut law is somewhat of an historical accident, and isnot practical in the long run even with the larger enrollment in that State. The National Blue Cross-Blue Shield organization dropped its insistence on a separate pool about two years ago, and we think it is unlikely that another State will take a two pool approach.

Section 1 of the proposed amendment should be revised throughout to provide for one pool, all "health" insurers should be required to participate in it.

4. Section 1 of the proposed amendment should be amended to exempt the Association, and business written directly by insurers but reinsured in the Association, from the premium tax. This will help alleviate somewhat the higher premiums that Alaska residents will have to pay for the coverage (because of higher costs in Alaska) thus encouraging more people to participate in the plan. It will solve the problem of dealing with the premium tax differential between domestic and foreign insurance companies and service plans, and with the different manner in which the tax is computed for Blue Cross-Blue Shield business.

Because the program is certain to produce losses which the State will pay for (i.e., claims and other costs will exceed premiums), the State will wind up paying its own premium tax on this business anyway, so the premium tax exemption we suggest should not result in additional costs to the State.

5. Departures from the Connecticut law, other than those already mentioned, should be individually considered and, where appropriate, their effects on costs should be determined. Some examples are: applying the medical social services benefit to claims not involving terminal illness (proposed AS Sec. 21.50.020(a)(7); addition of a coverage for transportation other than local ambulance transportation (proposed AS Sec. 21.50.020(c)(3), omission of a coordination of benefits provision from group comprehensive plans (Conn. Ins. Law Sec. 38-374(c)); addition of household members other than spouse or child to persons who are to be covered as dependents (proposed AS Sec. 21.50.030 and .200) limiting the rate to be charged for coverage to 125% of small group rates, while Connecticut permits 125% (compare proposed AS Sec. 21.50.050(e)(4) with Connecticut insurance law Sec. 38-376(c)(3)).

6. A number of drafting corrections should be made. Examples: requiring all dependents to be covered under a group comprehensive plan, instead of just making them eligible for coverage (proposed AS Sec. 21.50.030(a)); clarying the fact that insurers may also offer other group and individual comprehensive health insurance plans to cover Alaska residents; rewriting Section 5 of the proposed substitute bill so that it clearly does not apply to plans other than the State employees' plan.

CONCLUSIONS

The proposed committee substitute bill is not, particularly as to the provisions of Section 1, ready for final action by the Committee. An actuarial study should be made to determine costs and feasibility of the program for Alaska. After such a study, the Committee will have more of the information needed to decide whether to adopt such a program and, if so, what provisions should be included in it.

Charles D. Kuhnen
Counsel

/erc

HCS CSSS SB 227 REVISED 5/16/80

BILL SUMMARY

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. Every self-insured employer group is required to make an individual comprehensive health care plan available as a conversion privilege to each group member. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000

deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care palns must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.200. Definitions.

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original SSSSB 227 and require group health insurance to include coverage for alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days, and two percent per month after 90 days.

Section 9 and 10 expand the state's Medicaid program to include all services qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

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

* 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.

Blue Cross
of Washington and Alaska

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206/361-3000

May 7, 1980

Representative Thelma Buchholdt, Chairman
Health, Education & Social Services Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

As I understand the House Committee substitute for the committee substitute for sponsor substitute for S.B. 227, the intent of this bill is to require an insurer or hospital/medical service corporation to make available in Alaska a health care plan with the comprehensive benefits outlined in this bill. An insurer would, however, be able to offer other contracts having different benefits to meet the requested coverages desired by employers and individuals in this state. This bill in no way mandates minimum coverages for all health care contracts.

In Section 21.50.020, I have several comments to make concerning some of the minimum benefits. Subsection (a)(3) concerns outpatient mental health benefits. I would hope that a maximum benefit level would be specified and that a maximum benefit would be described in this law for inpatient treatment for mental health as well. Both limits are needed to curb excessive utilization and high costs for the coverage.

Subsection (a)(6) includes home health benefits in the minimum benefits. In (6)(A) the number of visits per year is too high when you consider the limited availability of home health care in Alaska. A subscriber will be paying for a benefit which is usually not available in this state. Paragraph (6)(B) extends home health care to the terminally ill. This is usually defined as hospice services and is normally combined with the medical social services mentioned in (7). Hospice services are not available in Alaska to the best of my knowledge. This will add premium cost for services which may not be attainable.

Subsection (a)(7) adds medical social services, which are defined as being available to the patient or to his/her family. This creates a totally new category of care which may or may not be medically necessary. It is a benefit which is usually a part of home health care for the terminally ill. As a separate benefit it can be abused and can create unnecessary utilization. This benefit should be deleted.

Representative Thelma Buchholdt, Chairman May 7, 1980

Subsection (a)(16) needs to be combined with subsection (c)(3) in order to detail a benefit for medically necessary transportation which requires pre-authorization for travel and other safeguards to eliminate abuse of this benefit. I would suggest that the contract language in your benefit booklet for coverage of state employees might serve as a model. (See enclosed booklet, pages 10-12.) The existing language would seem to approve payment of air ambulance rather than payment of commercial airline transportation.

Subsection (a)(17) must be deleted. This section allows changes in benefits which can adversely affect contracts in effect when these benefits are added. It is not necessary to the bill.

The minimum benefits section does not mention pregnancy benefits. While P.L. 95-555 controls the pregnancy benefits for groups of more than 15 employees, it does not govern smaller work forces or individual contracts. Our particular concern is in individual contracts since our experience shows that these contracts are usually purchased by persons past the age of childbirth and complete coverage of pregnancy like any other illness creates an increased premium for an unusable benefit.

On page 6, subsection (b)(5)(A) speaks of exclusion for a pre-existing condition which "first manifests itself within a period of six months immediately before the effective date of coverage." While I understand the reason for this language and approve of the intent, in actuality this creates endless hassle about what is a first manifestation and whether a person prudently sought care. It makes administration difficult. I suggest you should change the language to a limitation similar to that applying to coverage for state employees. (See enclosed booklet, page 7.)

In Section 21.50.030 the state requires that a person leaving a group will have a continuation of that same coverage for 39 weeks. That will negate the ability of an insurer to set minimum group sizes and to eliminate coverage for a group which gets to be too small. With nine months continuation, you negate the factor of size in small group business.

More important, the experience of the person on continuation coverage will have to be applied to the original group. If, for instance, John Smith quits work because his wife, a covered dependent, suffers a stroke, the claims paid for Mr. and Mrs. John Smith during the continuation coverage will be credited to Mr. Smith's previous employer. That experience will affect the rates which will be charged upon renewal of the group contract. Mr. Smith is no longer an employee, but the company incurs higher cost because of his medical bills and, in theory, subsidizes the continuation program. That is a cost that should <u>not</u> be borne by business, but with continuation coverage it <u>is</u> borne by each employer.

Representative Thelma Buchholdt, Chairman May 7, 1980

The logistics of self-payments for continuation coverage from the terminated employee to the company and then to the insurer will also impact the administrative workload of the employer. Direct pay to the insurer cannot be handled because of the many different benefit plans which would be involved. Continuation coverage will be a big burden on businesses and an additional cost to them.

This bill specifies that all conversion insurance have the minimum comprehensive benefits outlined in this bill. That level of benefits is too extensive. It will intensify the adverse selection because only someone with a medical problem will purchase the conversion policy. The cost will be excessive and the healthy will "go bare" rather than pay a high premium.

In Sections 21.50.050 and 21.50.060 this bill recognizes the differences between commercial insurers and hospital/medical service corporations by providing an option for the latter in lieu of membership in the Health Reinsurance Association. The differences between for-profit and not-for-profit entities and the different methods used in claims payment, contractual agreements, and service to subscribers makes lumping the Blues and commercial insurers together unwise. This bill separates them while assuring that each provides his share of coverage to the poor risk market. This is a good feature of this piece of legislation.

However, in subsection (m) of Section 21.50.050 you allow a tax offset for those insurers who join the Health Reinsurance Association. The bill needs to be amended to add that offset in Section 21.50.060 (b) and (c) or the offset, of and in itself, destroys the viability of the option features of this bill.

Section 3 of this bill is the original committee's substitute for Senate Bill 227. The features of that alcoholism and drug dependence coverage differ from coverage provided under the minimum benefits for alcoholism and drug dependence. That difference may need to be resolved.

This bill will create additional requirements for insurers and for medical/hospital service corporations doing business in the state of Alaska. These requirements will increase costs.

This bill makes health care insurance available to any Alaskan. That insurance may not be affordable. The minimum benefits, patterned after Connecticut law, may be readily available in that state. Some of those benefits are not easily available in Alaska and the cost for them may be prohibitive. This bill could offer Alaskans a promise of help and, in reality, afford them no relief at all.

Sincerely,

Joan H. Gaumer, Director
Government Relations

JHG:eb
5B-10/11/12

Enclosure: State of Alaska Group Health Care & Life Insurance Benefits (dated July 1, 1979)

cc: Wes Coyner

January 9, 1980

Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Thelma:

The following is an assessment of possible legislation in the area of state-subsidized health insurance. Two alternatives are discussed: the first calls for universal and comprehensive coverage, the second provides for a substantial improvement in health care services, but is not a comprehensive program. I would like to emphasize at the outset that the work done on this subject was done purely on my own time and does not, in any way, represent the opinions of the Alaska Public Interest Research Group.

Some form of state-subsidy in the area of health insurance has become necessary, in large part due to a nationwide problem with the availability of health care services. As medical costs spiral ever-upwards, more and more individuals are unable to procure adequate medical care. In Alaska, the problem is magnified by a limited number of physicians and substantially higher medical costs. In addition, numerous difficulties with Alaska's Medicaid system have limited the availability of health care even to those persons qualifying for state medical assistance.

Although various forms of government-subsidized health insurance have been proposed on a national level, cost considerations and intensive lobbying against such insurance by the medical and insurance communities have served to delay adoption of a national insurance plan. Subsidized health insurance on a state level was first proposed by you in 1977, however, at that time it was felt that the costs involved were prohibitive.

Since 1977, state oil revenues have accumulated in the treasury to the extent that the State of Alaska currently has a large amount of surplus revenue. Since the primary reason in the past for not funding some type of health insurance has been cost, and the state currently possesses the moneys to fund such a program, the time is now ripe to correct some of the glaring deficiencies in the area of health care.

The first approach to a solution of this problem involves universal and comprehensive state-subsidized health insurance. Adopting such coverage would be the most equitable manner of making health services available to Alaska's residents. However, this program would be extremely expensive (probably upwards of $100 million), and could probably expect to meet with a great deal of resistance. The resistance would come not only from the extremely well-organized medical and insurance lobbies, but also from opponents of increased government services and proponents of income tax repeal. I doubt whether it is feasible to get a program of this type approved, however, you are much more aware of the political climate than am I.

The second approach, therefore, is a piecemeal solution to the health care problem. It addresses specific problems which exist in the area of health care services. It combines minimum standard benefits requirements, insurance availability to Medicaid-medically needy qualified individuals, mandatory employer sponsored coverage, and reinsurance pools.

Minimum standard benefits: There is no regulation of the levels of service covered by providers of health insurance in Alaska. Many policies are not adequate to protect those covered from financial hardship. Individuals purchasing insurance outside of a "group policy" are subject to broad exclusions for pre-existing conditions, even though such a condition may have occured twenty years in the past (e.g. a previous back injury will give rise to an exclusion for any disease, defect or injury to the back even if totally unrelated). Many policies limit reimbursements to "reasonable charges" as defined by the insurance company, regardless of actual charges and the policy holder must pay the difference. This is especially a problem in Alaska where the "reasonable charge" determination is made in insurance company headquarters located outside the state.

In response to such problems, several states have adopted minimum standard benefits for health care plans. (see enclosed legislation). In addition, the National Association of Insurance Commissioners (NAIC) has developed model state health insurance legislation for minimum standard benefits (see 13 FORUM 680 (1978)). The standards set out the minimum acceptable level of service for health insurace policies in effect in the state.

Alaska should adopt minimum standard benefits requirements.

Insurance for Medicaid/medically needy: The Medicaid problem, in particular, must be addressed this session. Doctors are unhappy with the state's Medicaid program because they are not being paid. Recipients of state medical assistance are unhappy with the state's Medicaid program because doctors will not treat them because the doctors are not being paid. Both groups are clamoring for reform.

As an alternative to medical assistnace by direct payments to providers, the state of Oregon has adopted a program (see enclosed legislation), where medical assistance funds are used to pay health insurance premiums. Thus, the state provides health insurance for defined groups of people ~~(and [redacted] the marginally employed)~~ who have no practical access to private health care coverage.

At the same time, the state should opt in to the federal "medically needy" Medicaid program. This program would extend state medical assistance to those persons whose income exceeds the income standards of current assistance programs, but who have incurred medical expenses which equal or exceed the difference between the person's monthly income and the income standard applicable under the current program. In other words, the state would provide medical assistance to persons who otherwise would not have been eligible because they make too much money. The purpose of the "medically needy" program is to allow lower-middle-income person who can not afford to shoulder the full cost of medical care the opportunity to receive needed medical assistance. Under such a program, these individuals would "spend down" to the income limits, and the state would pick up the rest. This proposal is divisible from the rest of the insurance program discussed here and should be adopted even if no other aspect of my suggestions is appropriate for legislative action.

Alaska should utilize Medicaid funds to make health insurance available to qualified individuals:

Mandatory employer coverage: Hawaii has pioneered the area of requiring certain employers to carry health insurance on all employees. The specifics of their legislation are contained in Sharman Haley's report "Third Party Health Coverage in Alaska" and I therefore will not discuss the details here. Mandating employer sponsored coverage will dose a large gap in Alaskan health care, will not involve a great deal of expense on the part of the state and will not substantially increase state bureaucracy.

Alaska should require employers to provide health insurance meeting minimum standard benefits to employees.

Reinsurance pools: At the present time in Alaska, high-risk individuals can not purchase health insurance at any price. To combat this problem and also to protect insurance companies from having to bear too great a burden in insuring such individuals, several states have developed mandatory reinsurance pools to ensure health care coverage for high-risk persons. (see enclosed legislation). This is a relatively inexpensive program to implement.

Alaska should require insurance companies to form reinsurance pools to protect high-risk individuals.

By combining the above four programs, the state would ensure that some form of health insurance is available to nearly all Alaskan citizens. The only persons left substantially unprotected are the self-employed. Although a provision could be made whereby these people could have optional health insurance with a state subsidy, this type of program would be extremely expensive. Self-employed and self-insured persons benefit from the above described program through the minimum standard benefits requirement.

I hope my review of this issue has been of some use to you, it certainly has been of great interest to me. If there is anything further I can do, please let me know (preferably after February 28 and the traumas of the bar exam are over).

Enjoy the session!

Sincerely,

Laurie Otto

SUMMARY OF 1976 COMPREHENSIVE HEALTH INSURANCE ACT
Chapter 296, Minnesota Laws of 1976
Amended by Chapter 409, Minnesota Laws of 1977

Objectives

The 1976 law consists of three articles: Article I (a) establishes minimal standards for health insurance policies and (b) creates the Comprehensive Health Association which administers a "state insurance pool" for persons who are unable to buy insurance because of existing health problems. The objective of this article is to upgrade health insurance policies and to increase the availability of health insurance.

Article II establishes a hospital rate review system. This provision requires licensed hospitals to be subject to rate review by an approved voluntary, peer review organization. The Department of Health is authorized to "publicly review and comment" on the rates charged by hospitals. The objective of this article is to reduce rates charged by hospitals by monitoring those charges via a rate review system.

Article III provides financial assistance to persons who incur high medical expenses. The Catastrophic Health Expense Program is designed to protect households from being bankrupted by medical care expenses.

Summary

Article I - Minnesota Comprehensive Health Insurance Act of 1976

Part A - Minimum benefits for health insurance coverage

Duties of Insurance Companies

All health insurers doing business in the State of Minnesota are required to offer a "qualified" health policy to applicants for insurance. The article defines three levels of "qualified" plans--number one (low), number two (standard), and number three (high). The minimum benefits of a number three plan "shall be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150." The coverage shall also include a limitation of $3000 per person on total annual out-of-pocket expenses for covered services. The maximum lifetime benefit cannot be less than $250,000. The article also itemizes the services to be covered by the "qualified" plan. The three levels of "qualified" plans vary only in the amount of deductible required: number three - $150; number two - $500; and number one - $1000. A health maintenance plan is defined as a number three qualified plan. Insurers are not prohibited from developing and selling an "unqualified" plan, however, the insurance companies must "affirmatively" offer coverage for major medical expenses to an applicant for a new "unqualified" plan. This major medical coverage shall be payable, subject to any copayment, up to a maximum lifetime limit of $250,000 for out-of-pocket expenses incurred within a calendar year, exceeding $5000.

Any insurance company issuing a Medicare supplement plan shall offer a "qualified" Medicare supplement plan to each eligible applicant. A plan is deemed "qualified" if it provides coverage of 50 percent of the deductible and copayment required under Medicare and 80 percent of the charges for "qualified plan" covered services which are not paid by Medicare. This plan includes a $1000 per person limit on annual out-of-pocket expenses.

* Note: As of July 1, 1979, covered services must include a second opinion on surgical procedures expected to cost a total of $500 or more.

Duties of Employers

Each employer who makes available to his employees a health insurance plan must offer at least a number two plan. The employer does not necessarily have to finance the qualified plan. It can be financed from funds contributed solely by the employer or solely by the employees; or a combination thereof. For the purposes of this article, an employer is defined as employing ten or more residents of the state. The employer may supplement the existing health plan in order to meet the number two plan requirement.

The penalty for noncompliance is the exclusion of the employer's costs for health benefits as a state income deduction. A non-profit employer would lose its tax exempt status if the requirement is not met.

Any employer with 100 or more employees must offer a dual option to obtain either an accident and health insurance policy or a health maintenance organization contract, if one is available.

Conversion Privileges

The law requires group accident and health insurance policies and health maintenance organization contracts to include the right to convert to an individual coverage "qualified" plan without the addition of underwriting restrictions. The person leaving the group has 30 days in which to exercise his right to convert.

Each health insurance plan must also include a provision allowing, upon the death of an insurance holder, other individuals covered under the plan to continue coverage.

Part B - Comprehensive Health Insurance Plan

Article I also creates the Comprehensive Health Association which must offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan to individuals who cannot otherwise obtain standard insurance coverage becuase of health problems. The Association is comprised of all insurers, self insurers, fraternals, and health maintenance organizations doing business in Minnesota. These policies are referred to as the Comprehensive Health Insurance Plan or State Plan.

Comprehensive Health Insurance Plan

The Comprehensive Health Association is responsible for selecting a writing carrier to administer the Comprehensive Health Insurance Plan. The Association may select separate writing carriers for each type of "qualified" plan.

The state plan is open for enrollment at all times. An eligible person may apply to the Association or to the writing carrier. For the first 18 months of the plan's operation, premiums were determined by averaging the premium rates charged by the five largest insurers in each plan category. Subsequent premium determination will be based on actuarial experience. Not more than 12.5% of the premiums may be expended by the writing carrier for administration costs.

Each member of the Association is responsible for sharing the losses due to claim expenses of the state plan. Members shall share those costs on a pro-rated basis, determined as a ratio of premiums received by a member to the total amount of total premiums received by the Association members.

If there are any net gains from the operation of the state plan, it shall be used to offset future losses or reduce premiums.

Public Education

The Association is responsible for disseminating information to the public regarding the availability of the state plan.

Referral Fee

The writing carrier shall pay an agent's referral fee of $25 to each agent who refers an applicant to the state plan. This fee is included in the 12.5% administration expense limit.

Pre-Existing Condition Clause

An enrollee of the state plan is not covered for any pre-existing condition during the first six months of coverage if the condition was diagnosed or treated within 90 days prior to the filing of an application.

Reinsurance

A member of the Association may elect to reinsure the risks involved with being required to offer (a) individual qualified plans, (b) group conversions, (c) group qualified plans with fewer than 50 members, or (d) major medical coverage. The member would be reinsured through the Association. The Association administers the policies that are reinsured by a member. Any income in excess of the costs incurred for providing the reinsurance service shall be used to offset losses in the state plan or reduce the premiums.

Article II - Hospital Administration Act

Article II establishes a system by which hospital rates are reviewed. A licensed hospital may agree to submit its financial reports and rate schedules to a voluntary, non-profit rate review organization

for review. If the hospital does not report to this rate review organization, it will be subject to review by the Department of Health, the administrative agency for this act.

The Department of Health shall prescribe standards for purposes of approving a rate review organization. The Department is authorized to collect financial information which includes (a) a balance sheet, (b) a statement of income and expenses, (c) a copy of the most recent Medicare cost report, and (d) a schedule of rates. The Department also has the right to inspect hospital records and audits. Any modifications to a hospital's rate schedule must be reported to the Department of Health 60 days in advance of their effective date. If a hospital is subject to review by the Department of Health, the Department may conduct a public hearing on any rate increases which they consider excessive and may publicly comment on any increase.

Insurance Rates

This article also requires actuarial justification of any premium increase for a nongroup policy at the time of filing the insurance plan with the Commissioner of Insurance.

Another provision directs the Commissioner of Insurance to disapprove a filed health plan "if the proposed premium rate is excessive because the insurer has failed to exercise reasonable cost control."

Article III - Catastrophic Health Expense Protection Act

This program offers financial relief to households which incur large medical expenses. The state will pay for 90% of "qualified" expenses, for which no third party is liable, in excess of a threshold figure which is calculated by an income-related formula. "Qualified" expenses are those charges for covered services itemized as minimum benefits in the Comprehensive Health Insurance Act (Article I).

The above mentioned formula is as follows: (a) calculate 40% of household income up to $15,000, plus 50% of household income up to $25,000, plus 60% of household income in excess of $25,000; or, (b) $2,500, whichever is greater. If, for example, the household income is $10,000 the threshold figure is $4000. In this case the state would pay 90% of "qualified" expenses in excess of $4000.

Nursing Home Provision

The 1977 Legislature amended the Catastrophic Act to provide assistance to persons under the age of 65 who have resided in a nursing home for more than three years. The state will pay for all nursing home expenses which exceed 20% of household income.

Reasonableness of Rates

The Commissioner of Public Welfare is granted the authority to determine the reasonableness of provider charges. The Commissioner may also determine the "medical necessity" of a health service. In order to carry out that authority, the Commissioner may contract with a professional standard review organization to make these determinations.

Experience

Article I - Comprehensive Health Insurance Plan

The state plan went into effect on January 1, 1977. As of June 30, 1978, the plan had 1,074 policies in force. The total premiums earned for the first 18 months of the plan's operation was $441,107.73. As indicated earlier, the premium rate for this time period was based on the average of premiums charged by the five largest insurers in each category. The total claims paid for this period is $392,412.93. A reserve for incurred but not reported claims has been set at $220,000.

The 1978 State Legislature appropriated $200,000 to reimburse the Comprehensive Health Association for the first $200,000 of claims expenses incurred after June 30, 1978 which are in excess of earned premiums. The premium will be determined by generally accepted actuarial principles subsequent to June 30, 1978 except that the new premium rate cannot exceed 125% of the average premium charged by the five largest insurers in each policy category. This premium limit was enacted by the 1978 Legislature.

Article II - Hospital Administration Act

All licensed hospitals have opted to be subject to review by a voluntary, non-profit rate review organization. This is the peer review organization of the Minnesota Hospital Association. It is estimated that if the hospitals comply to the proposed budgets developed through rate review the increase in hospital charges will be between 10% to 11% compared to an historical increase of nearly 14% per year.

Article III - Catastrophic Health Expense Protection Act

This Article went into effect July 1, 1977. Eighteen million dollars was appropriated for the biennium 1978-1979 for the medical care portion of the program. $900,000 was appropriated for the nursing home section. To date there have been 148 approved applications for the medical care program for an expenditure of $441,299. For fiscal year 1978, twelve applications were approved for the nursing home expense program, totaling $55,323.65.

Georgetown University Health Policy Center
Seminar on State Health Insurance Plans
Mayflower Hotel, Washington, D.C.

September, 1977

THE POLITICAL PLANNING OF A STATE HEALTH INSURANCE PROGRAM

By Senator Donald D. H. Ching
Majority Leader
Hawaii State Senate

The concept of prepaid health care based on mandatory employment-related coverage was a brand new idea when first introduced in the Hawaii Legislature in 1971. It became law three years later as Act 210 of the 1974 legislative session.

Enactment of our Prepaid Health Care Law climaxed several years of lively discussion in the Legislature, and for many of us who supported it, Act 210 marked yet another milestone in the growing body of progressive legislation placed in our statutes since our Islands became a sovereign state in 1959.

Measured against the national background, the law represented a significant achievement in terms of social progress. Yet, while there was much discussion between introduction and enactment, the proposal was not widely viewed as politically controversial by the public at large. As a matter of fact, in my nearly 20 years of experience in our Legislature, I have seen a lot more heat generated over issues of considerably lesser public import.

To be sure, there was resistance and opposition from the traditional opponents of so-called "social legislation." But there was not the hue and cry that one might expect, considering the novelty of the concept.

This is not to say that the spectrum of political thought in Hawaii does not cover any ground to the right of center. Let me assure you we do have traditional conservative views held by many in our State, and I, for one, believe this is a healthy condition. But to the credit of those who did not adhere to the concept, their opposition was not based on the emotionalism that too often attends and distorts vital public issues of the day.

I believe the law was generally accepted by the public because of the kind of political climate we have in Hawaii and because the law was viewed as a logical extension of the kinds of programs that were already in effect at the time.

Let me briefly describe our Prepaid Health Care Law, then attempt to present an account of its chronological place in the context of Hawaii's legislative history.

The Act requires virtually every employer in the State to provide regular employees a health insurance program and to contribute at least one-half the premium cost for the employees' coverage. The major categories of employees excluded are insurance and real estate salesmen paid entirely by commissions and individuals under 21 working under a parental relationship.

The employee's contribution is limited to no more than 1.5 per cent of his monthly salary. A "regular" employee is defined as one who works at least 20 hours a week, excepting seasonal hires in Hawaii's pineapple industry.

Health plans negotiated under collective bargaining agreements are exempt because such negotiated benefits are, for the most part, more liberal in coverage or employer contributions than required under the Act.

An employer can elect to provide a plan which obligates the insurer to either reimburse the expenses of health care or to directly furnish the required health care benefits. The level of benefits provided must be equal to or medically reasonably substitutable for those benefits provided by prepaid health care plans of each type -- direct or reimbursed -- which has the largest number of subscribers in the State. In Hawaii, the standards are thus based on the Kaiser Health Foundation's Plan I, in the case of direct services, and the Hawaii Medical Service Association's (Blue Shield) Plan IV, in the case of reimbursed expenses. Both the Kaiser and HMSA plans are basic, comprehensive medical plans emphasizing ambulatory care.

Plans offered by other insurers may be provided, upon review and approval of a seven-member advisory council comprised of consumer, employer, medical profession, and health plan representatives.

What kind of coverage is required by our law? Every qualifying plan must include the following:

-- 120 days of hospital benefits, plus outpatient services.

-- surgical benefits, including anesthesiologist services.

-- medical services, including home, office, hospital visits, and intensive medical care.

-- laboratory, x-ray, and radio-therapeutic services necessary for diagnosis and treatment.

-- maternity benefits, provided an employee has been covered for nine months prior to childbirth.

-- and, under an amendment added last year, substance abuse benefits for alcoholism and drug addiction, including outpatient services and detoxification and acute care benefits.

The foregoing summarizes the basic provisions of our law.

How, then, did we come to enact what some may view as an extremely liberal mandatory health insurance program?

First, it should be noted that we have a substantial body of progressive and advanced social legislation in Hawaii. This is true of our labor laws, our educational system, our public welfare program, and in our judicial system. For instance, our minimum wage law, wage and hour law, workers' compensation, temporary disability insurance, and unemployment insurance programs all have standards comparable to the highest in the Nation. In addition, we also have a public defender program and a criminal injuries compensation law. We also have a no-fault insurance law and a medical malpractice law, the latter amended this year to remove the mandatory feature and to permit doctors the option of forming cooperative indemnity plans to protect themselves against liability judgments.

Our public assistance program is so liberal it is causing us severe financial strains -- but that's another story, and I won't digress into it, except to note that we eagerly look forward to federal reform initiatives promised by the Carter Administration.

The political foundation for eventual enactment of our prepaid health care law was further set during the mid-sixties in a program popularly labeled "The New Hawaii," adopted jointly by the legislative majorities and the Administration.

During this period, dramatic changes were advanced in terms of Hawaii's social, economic, and political conditions. Basically, the stated objective was to enact laws and programs to insure equal treatment and equal opportunities for all citizens. If this sounds simplistic, it should be borne in mind that Hawaii was pretty much the political domain of the sugar and pineapple plantation interests up until the end of World War II and that when, for the first time in our history, we elected a Democratic Governor and Democratic majorities in both houses of the State Legislature in 1962, there were not a few who thought the revolution was at hand.

But the changes we sought were achieved in orderly, not revolutionary, fashion. And there was early ferment for novel and innovative legislation to extend equal opportunity in basic human concerns to all segments of our society.

It appeared logical to move toward some form of mandatory prepaid health care law. The question then was how best to extend coverage to the uninsured working men and women

of Hawaii and thereby provide them "equal treatment" as a matter of social equity. Moreover, how could this be best achieved without any substantial added costs to the State, bearing in mind that our centralized system imposes unusually heavy financial burdens on the State?

To determine cost factors and the numbers and classes of employees in the uncovered "gap group," a study was commissioned through the Legislative Reference Bureau, the Legislature's principal research arm. Dr. Stefan A. Riesenfeld, former University of California law professor and a widely recognized authority on social legislation, now counsel to the U.S. State Department, was selected to do the research. Professor Riesenfeld had prepared an earlier report for the Legislature on temporary disability insurance, which study was extremely valuable to us in enacting our TDI law in 1969.

The Riesenfeld report, published in 1971, was a thorough and comprehensive study. Acknowledging the difficulty of precisely quantifying need, the report generally concluded that, among the State's employed, 11.7 per cent did not have hospital coverage, 13.5 per cent lacked surgical coverage, and 17.2 per cent did not have regular medical insurance.

The existence of a significant number of otherwise uncovered potential beneficiaries of the proposed legislation formed the primary policy consideration of the program. Other factors considered included the rising costs of health care and the need to assue the most practical method of ensuring the financial availability of health care for Hawaii's working men and women. Thus, the overall health of our population was the over-riding concern; without ensuring the

ready accessibility of health care, how could optimum health care be maintained?

Data compiled and analyzed in the report were very thorough. Sources outside the State included the Health Insurance Association of America, the Health Insurance Institute, the Bureau of Labor Statistics, the Social Security Administration, and the Bureau of the Census. Information from State agencies included data from the State Statistician and the Departments of Taxation, Planning and Economic Development, Social Services and Housing, and Labor and Industrial Relations. Data was also gathered from labor unions, the Hawaii Employers Council, the HMSA, Kaiser Foundation, and through questionnaires mailed to all employers covered by the Hawaii Employment Security Law.

Data used included statistics relative to the following:

-- Population by age levels, civilian and military. The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entited to Medicare.

-- Extent of prepaid health plan coverage for hospital, surgical, and medical benefits, both for subscribers and dependents.

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

As indicated by the sources of data, the full range of interest groups became involved in the process, whether employer or employee oriented.

During our legislative committee hearings, testimony was presented by representatives of the insurance industry, the health professions, the University of Hawaii Schools of Public Health and Social Work, the Comprehensive Health Planning Council, and a wide range of individual citizens.

There was very little question as to whether the plan proposed would be comprehensive or catastrophic in its approach. The Riesenfeld report recommended the comprehensive coverage plan and specifically recommended the adoption of prevailing coverages in the State, which then became the legal minimum. This reflected the health care habits and patterns of the State and set a floor without unduly disrupting the existing schedules of coverage.

The decision to make coverage mandatory was central to the legislation proposed. Before enactment of Act 210, voluntary participation was, in effect, the public policy of the State.

As to the question of affordability, the only new cost factors imposed upon the State weere founded upon the administrative requirements of the law and anticipated premium supplementation.

Administration of the new program proved to be quite easy, as it was smoothly meshed in as a responsibility of the Disability Compensation Division of the State's Department of Labor and Industrial Relations. Thus, three important employee benefits programs were placed under one umbrella: the well-established Worker's Compensation Law; the TDI law passed in 1969; and the 1974 Prepaid Health Care Act. (Incidentally,

you may have noticed that what used to be known as Workmen's Compensation is now referred to as Workers' Compensation in our State, reflecting the many similar amendments we have adopted consonant to our accepted policy on equal rights.)

Much to our pleasant surprise, the administrative expenses of Act 210 have been comparatively low. Initially, we authorized 11 new positions in the Disability Compensation Division, with an appropriation of $250,000 in General Funds to cover salaries and other expenses. Much to the division's credit, Act 210 was implemented with substantially the existing staff. The first appropriation thus lapsed, and it was renewed this year at the same annual level on the expectation that additional personnel will be recruited during the next biennium.

A feature of Act 210 is a provision for premium supplementation financed by the State to cover employer premium requirements caused by limits imposed on employee contributions. This feature subsidizing employer contributions was included to provide a cost protection for marginal small businesses. Initially, $375,000 was set aside in a trust fund for premium supplementation. Again, to our pleasant surprise, there has been little need to supplement premiums. It's estimated that, to date, only some $20,000 to $30,000 has been tapped from the trust fund in subsidies. Meanwhile, the fund is held in an interest-earning status.

What are the numbers that actually surfaced as a consequence of Act 210? The division reports that about 18,500 employers have thus far been registered. However, the extent

of newly covered workers has been difficult to establish because many of the registered employers had voluntary programs in effect before Act 210. Dr. Riesenfeld has estamated some 40,000 employees were not covered at the time he conducted his study. The Disability Compensation Division is of the opinion that actually more than 40,000 received new benefits becaus[illegible]e requirement that employers cover at least half [illegible]r the premium costs.

Of the 18,500 employers, all but some 1,000 have elected plans offered by the State's two major insurers -- HMSA and Kaiser. The approximately 1,000 employers who have opted for plans offered by other insurers are the major source of additional workload upon the division. Each submittal in this category must be reviewed by the advisory council.

The advisory council provision serves another purpose. During the course of legislative hearings on the act, public health advocates had expressed concern that the required benefits might be too rigid and unresponsive to changes in health care over the years. The Prepaid Health Care Advisory Council provisions were thus added to establish an appropriate agent to review medical equivalency of benefits.

To conclude, in light of Hawaii's experience, I believe any national health insurance plan should take into consideration the course that we have opted for. I am confident the standards we have set would meet any that a federal law would impose. As a means of encouraging other states to follow suit, or to adopt a true state plan such as Rhode Island's,

I suggest federal legislation provide support grants to at least cover administrative costs and any necessary premium supplementation expenses.

Finally, let me summarize the conditions that led to the successful adoption and implementation of Hawaii's Prepaid Health Care Act:

1 -- A political climate sympathetic to social needs.

2 -- Timeliness in terms of progressive improvements to the general body of social legislation already on the books.

3 -- A comprehensive study of a state's needs, to arm proponents with the information necessary to justify the proposed legislation.

4 -- Open discussion involving all interested elements within the public.

5 -- The last may be an element not very common to other jurisdictions, but I believe it was an important consideration in our own deliberations. This is the fact, well established in our study, that the majority of employees insured under voluntary plans or through government-employee programs were covered under plans offered by two major insurers in the State. Having a clear pattern to follow in prevailing benefits, it was easier to overcome resistance against extending similar benefits to all the State's working men and women.

I hope our experience and the foregoing thoughts presented for your discussion prove helpful to you in your own endeavors to develop plans for extending health care benefits to all others who need such coverage in our Nation.

Mahalo.

# # #

06-F1LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

REPORT AND RECORD OF CONFERENCE

Region X - Department of Health, Education and Welfare

Federal Office Complex Seattle, Washington

Tuesday, October 30, 1979

Present: Mike Street; Ed Ross; Jim Van Hoomison; Boyd Kelley, Health Care Finance Administration; Bill Knestes, Indian Health Service; Mr. Moerlin, Health Research; Frederick McGinnis, Alaska Department of Health and Social Services.

Tentative agenda for the conference was distributed and accepted as the working program for the conference this date as follows:

Tentative Agenda

I. Review developments to date on Model Health Plan for Alaska

II. Review of discussions: Center for Health Services Research, University of Washington, on October 29, 1979. Discussion of report on that conference.

III. Federal questions: Region X and Washington, D.C.

A. Waiver possibility: Title XIX, Medicaid funding, for Experimental Program in a State.

B. Technical Assistance Potential--

Region X
Washington, D.C.

C. Grant Fund Assistance: H.E.W.

IV. Conferees: Recommended: H.E.W., Washington, D.C. Week of November 1 - 7, 1979.

V. Other

Full discussions were held on a part of the outline of topics and points raised in the discussions of October 29, 1979, with representatives of the Center for Health Services Research, School of Public Health and Community Medicine, University of Washington, as follows:

A complete discussion transpired with regard to:

Alaska Medicaid Program and costs;
Alaska General Relief Medical Program and costs;
Indian Health Service Delivery System in Alaska/ Medicaid Reimbursement policies;
Alaska Catastrophic Illness Program;
Alaska Military Health Programs;
Private insurance coverages in Alaska;
Other related topics bearing on current status of Alaska health programs.

McGinnis indicated his views of some of the important next steps in developing the anticipated program:

(1) Developing a Planning Task Force;
(2) Providing an Advisory Body;
(3) Creation of small staff and Director;
(4) Developing of Data Gathering and Research Projects:

*Survey/Gathering of published data from all sources bearing on related areas of concern;

*Determination of current total costs in current plan of health services delivery:

Department of Health & Social Services;
Indian Health Services;
Military forces;
Veterans Administration;
Native Health Corporations;
Private insurance premiums and payments on plans;
Labor insurance plans;
Private insurance plans;
Other identifiable costs;
Federal Government/other.

*Determination of gaps in data needed;

*Provide for research needed to meet data needs on expenditures of health funds in Alaska;

*Provide for research to determine number of citizens without adequate health services; estimate costs of providing needed services under agreed-upon options available.

*Synthesis and interpretation of all data on hand and provided through special research tasks;

*Other research components determined necessary as planning gets underway and new needs develop.

(5) Determination of human/personnel and financial resources available from all sources to finance the project of planning:

*Within Health and Social Services Department/ State of Alaska;

1979 Fiscal Year:

Divisions related to health; State Health Planning Agency; Governor's Policy/ Planning Budget; Governor's Contingency Fund.

*Center for Health Services Research University of Washington

*Institute of Social/Government Research University of Alaska

*Possible Demonstration Grants/ Department of Health, Education and Welfare

*Alaska Legislative Appropriation

1980 Fiscal (Supplemental) Year
1981 Fiscal Year

*Private Foundation Grant(s) and other private sources

*Other sources

(6) Preparation of Budget identifying available manpower and funds for 1980 fiscal year and 1981 fiscal year.

(7) Other tasks to be developed and assigned as necessary as project develops.

(8) Determination of technical assistance needs in economics, statistics, planning, accounting, legal and other assistance, and provision for securing needed assistance, including professional services contracts as deemed necessary.

The basic information shared with the Alaska State Health Coordinating Council and Governor Hammond in memoranda of August 3, 1978 and September 18, 1979 was discussed. The conferees had copies earlier of the information in the SHCC memorandum.

In general, the Region X conferees felt that the project was worthy of development and the following points were discussed:

1. The need to determine and state exactly the goals sought in the project. This will be especially important in presenting the project to H.E.W.

2. Recommendations were made to try to contact two officials of HEW in Washington on the forthcoming visit November 1 - 6, if possible; if not possible on this visit to Washington, then in the near future:

   Mr. Ron Carlson, Park Law Building, Rockville, Maryland,

   and

   Mr. Dale Serwer, Baltimore, Maryland.

   Discussions with those men should include funding possibilities and also what they would like to see Alaska demonstrate.

3. Oregon has submitted a "Concept Paper" to Region X expressing the need and desire of that state to reorganize their health funding and programming. Mike Street will attempt to get a copy and will mail to McGinnis when received. (Note: If not received in two weeks, then Alaska should contact Oregon to secure a copy of the concept paper.)

4. It was generally agreed that assistance from the University of Washington Center for Health Services Research would likely be available through a contract with that Center for specific component(s) of the project. Desirability of competetive bidding of any contracts was discussed.

5. The working group formed for the project should give priority to writing of clear specifications of "scope of work" needed and such should be presented to all chosen to present proposals.

6. Mike Street indicated that Region X would determine the best single contact person to represent Region X in keeping in touch with progress on the project. A prospectus should be prepared on the exact services needed from contractors when that information is needed.

General summary comments were made as the conference adjourned with the understanding that the State and Region X would keep in contact on the project.

FMcG/mag

cc for information:

Commissioner Helen D. Beirne
Deputy Commissioner Allen K. Korhonen
Deputy Commissioner Catherine M. Lloyd
State Health Planning & Development Agency
Karen Cory, Governor's Office, Juneau
Fran Ulmer, Governor's Office, Juneau

of ALASKA

TO: The Honorable Terry Miller
Lieutenant Governor
State of Alaska

DATE: September 21, 1979

FILE NO:

TELEPHONE NO: 465-3030

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

SUBJECT: MODEL HEALTH DELIVERY PROGRAM FOR ALASKA

You will recall that recently Deputy Commissioner McGinnis and I met with you in order to brief you as to developments to that time on the discussions regarding a model health delivery program for Alaska. We appreciate the time that you gave us to discuss the matter.

A memorandum was developed on September 18, 1979, from me to Governor Hammond. A copy of that summary memorandum is attached in order to share with you the latest developments in the Department's thinking regarding the proposed program.

At a meeting on September 19 in Governor Hammond's office, attended by Deputy Commissioner McGinnis, Jerry Reinwand, Karen Corey, Fran Ulmer and myself, the attached memorandum, having been read by the parties, was discussed.

At the conclusion of the conference, Governor Hammond did indicate to all of us that he had signed his approval to the recommendation made at the end of the memorandum. It will be the Department's plan to proceed with further exploration of the concept and we will plan to keep you informed, as well as others in the Governor's Office. Any comments or recommendations you may have with regard to this proposed program would be welcomed by the Department.

Attachment: Memo, 9/18/79, as indicated

of ALASKA

MEMORANDUM

TO: Helen D. Beirne, Commissioner
Dept. Health & Social Services

DATE: November 5, 1979

FILE NO:

TELEPHONE NO:

FROM: Frederick McGinnis
Deputy Commissioner
Dept. Health & Social Services

SUBJECT: Briefing Memorandum re Conference in Washington, D.C. with Lt. Gov. Terry Miller; Administrative Assistant to the Lt. Gov. Pete Rouse; and William Fullerton of the Firm of Health Policies Alternatives, Inc.

As you may remember, Lt. Gov. Terry Miller mentioned earlier his discussions in Washington, D.C. on a prior visit with Mr. William Fullerton of Health Policies Alternatives, Inc., with regard to Alaska's interest in developing a model health financing plan. You may recall also that Lt. Gov. Miller raised the question informally at a meeting with me and with Pete Rouse in the Governor's Office in Anchorage with regard to whether it might be possible to advance one part of our proposed programming for model programs to improve the catastrophic illness insurance program earlier.

In order to keep you abreast of later developments, at the request of Lt. Gov. Miller I met with him, Mr. Rouse and Mr. William Fullerton in Washington at the place of the Federal Health Policies Conference on Friday afternoon, November 2, at 2 PM. At that meeting, Alaska's plan to do a major study on alternatives in health financing programs was discussed.

No commitments were made to Mr. Fullerton and the following points were made by Lt. Gov. Miller.

1. The Lt. Gov. will discuss with Governor Hammond the possibility of a liberalized catastrophic illness program to assist people of middle to lower incomes who are above the poverty level income and therefore not eligible for relief programs (Medicaid, General Relief Medical).

2. Lt. Gov. Miller felt that the initiative for the short-range program, as well as the long-range program, should rest with the State Department of Health and Social Services.

3. Lt. Gov. Miller will brief Governor Hammond on his interest in improving the catastrophic illness assistance to a newly-defined group of Alaskans. It was understood that Deputy Commissioner McGinnis would brief Commissioner Beirne on these discussions in order that she may be fully aware at each step of the discussions.

4. Lt. Gov. Miller suggested that it might be well if the Governor's Office sponsored a small working party named by the Governor, including the Department of Health and Social Services as lead agency, the Department of Labor, the Department of Commerce (Insurance Division), and the Department of Law for legal counsel, to give guidance to developing some plan for the Governor to present to the Legislature at the forthcoming session.

Mr. McGinnis suggested that if the Fullerton firm should become involved in helping to do any of the research on the short-term or long-range project, it would be necessary for a Request for Proposal to be developed and that equal access to all information concerning Alaska's plan be made to at least three firms who may be interested in providing the professional assistance. It was also indicated that financial resources would have to be found for the additional research in order for either the short-term catastrophic illness program, as well as the longer range, fully innovated program anticipated.

It was indicated that Deputy Commissioner McGinnis would meet again with Mr. Fullerton on Monday afternoon, November 5, which conference did take place, and Mr. Fullerton made available certain materials from his firm as to their experience, which will be made available to you by mail.

Attached is a list of items that I believe the State Health Planning and Development Agency should begin assembling, with at least six copies of all the materials, as soon as possible in order that these materials may be made available to any firm considered as professional consultants to this short-range program, as well as the long-range problem.

I will be glad upon return to Alaska to comment further if you wish on the matters summarized ever so briefly in this briefing memorandum.

FMcG/mag
Attachment, as indicated above

ITEMS THAT THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY SHOULD ASSEMBLE IN CONNECTION WITH MODEL HEALTH DELIVERY PROJECT

1. General demographic information on the Alaskan population--income, age cohorts, cost of living, rates of inflation, family formation, birth rates, etc.

2. Medicaid Plan--plus all recent statistical data: eligibility, benfits by claim expenditures, administrative costs, etc.

3. Description of existing catastrophic plan, plus all recent statistical information on eligibles, payments and benefits.

4. Statistics on existing health insurance coverage--by plan, numbers of insured (any evidence of overlap?), government employee plan (federal, state and local), benefits covered, major medical or catastrophic provisions).

5. State Health Plan (under health planning law, plus statistical information on kinds, numbers and locations of all classes of health care providers.

6. Alaska Medicaid laws and regulations.

7. General Relief Medical laws and regulations.

8. Catastrophic Illness laws and regulations.

9. Department of Health and Social Services and Indian Health Services Memorandum of Agreement on Medicaid.

10. Any other related information deemed by SHPDA to be important to understand the clear status of health programs in Alaska today.

06-F1LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

REPORT AND RECORD OF CONFERENCE

Center for Health Services Research
School of Public Health and Community Medicine

University of Washington Seattle

Monday, October 29, 1979

Present: Mr. Marc E. Provence, M.P.H. (HMO)
Ms. Shirley McEvoy, Research Assistant
Frederick McGinnis, Deputy Commissioner

The meeting between the above listed individuals began at 10:30 a.m. and concluded during early afternoon.

Mr. McGinnis outlined developments to date on the Alaska Model Health Program and reviewed earlier meetings with groups including the meeting with Dr. Stephen H. Shortell, Director of the Center, Ira Moscovic, Andy Dolan and Laura Beth Lawson last year, when the idea of a revised health plan for Alaska was first being discussed.

Copies of the Department memorandum dated August 2, 1978 to the Alaska State Health Coordinating Council and September 18, 1979 to Governor Jay S. Hammond were discussed as background papers to indicate the present thinking of Department leadership.

A complete discussion transpired with regard to:

Alaska Medicaid Program and costs;
Alaska General Relief Medical Program and costs;
Indian Health Service Delivery System in Alaska/ Medicaid Reimbursement policies;
Alaska Catastrophic Illness Program;
Alaska Military Health Programs;
Private insurance coverages in Alaska;
Other related topics bearing on current status of Alaska health programs.

McGinnis indicated his views of some of the important next steps in developing the anticipated program:

(1) Developing a Planning Task Force;
(2) Providing an Advisory Body;
(3) Creation of small staff and Director;
(4) Development of Data Gathering and Research Projects:

*Survey/Gathering of published data from all sources bearing on related areas of concern;

*Determination of current total costs in current Plan of health services delivery:

Department of Health & Social Services;
Indian Health Services;
Military forces;
Veterans Administration;
Native Health Corporations;
Private insurance premiums & payments on plans;
Labor insurance plans;
Private insurance plans;
Other identifiable costs;
Federal government/other.

*Determination of gaps in data needed;

*Provide for research needed to meet data needs on expenditures of health funds in Alaska;

*Provide for research to determine number of citizens without adequate health services; estimate costs of providing needed services under agreed upon options available;

*Synthesis and interpretation of all data on hand and provided through special research tasks;

*Other research components determined necessary as planning gets underway and new needs develop.

(5) Determination of human/personnel and financial resources available from all sources to finance the project of planning:

*Within Health and Social Services Department/ State of Alaska;

1979 Fiscal Year:

Divisions related to health;
State Health Planning Agency;
Governor's Policy/Planning Budget;
Governor's Contingency Fund.

*Center for Health Services Research
University of Washington

*Institute of Social/Government Research
University of Alaska

*Possible Demonstration Grants/
Department of Health, Education & Welfare

*Alaska Legislative Appropriation
1980 Fiscal (Supplemental Year)
1981 Fiscal Year

*Private Foundation Grant(s) and other private sources

*Other sources

(6) Preparation of budget identifying available manpower and funds for 1980 fiscal year and 1981 fiscal year.

(7) Other tasks to be developed and assigned as necessary as project develops.

(8) Determination of technical assistance needs in economics, statistics, planning, accounting, legal and other assistance and provision for securing needed assistance, including professional services contracts as deemed necessary.

Earlier, Dr. Shortell had indicated to the State of Alaska that possible assistance which might be arranged through the Center for Health Research included:

Informal counsel and assistance;
Guidance reviews;
Contracts for defined components of work;
Assistance in planning evaluation;
Systems design, policy formulation.

Mr. Provence and Ms. McEvoy restated some of the above listed points during the meeting, emphasizing the possibility of specific contracts for specific components of the necessary work. It was indicated that beyond the expertise available in the Center for Health Services Research the Center has access to many sources of expertise within the University of Washington which could be called on for participation.

It was agreed at the conclusion of the meeting that:

* Discussions would be held with Dr. Shortell, Director, on his return to Seattle and a report made of today's discussion.

* A careful review of the two memoranda referred to herein earlier and the concepts contained therein would be discussed in staff.

* Following the above steps they will prepare a letter to the Department with their observations and comments. Included in the comments will be a review and listings of the Center's potential involvement in the project and the bases (financial, personnel and otherwise) of such participation.

Following the outline of the conclusions and summaries listed above, the meeting was adjourned.

Frederick McGinnis
Deputy Commissioner

cc for information:

Commissioner Helen D. Beirne
Deputy Commissioner Allen K. Korhonen
Deputy Commissioner Catherine M. Lloyd
✓State Health Planning & Development Agency
Karen Cory, Governor's Office, Juneau
Fran Ulmer, Governor's Office, Juneau

STATE
of ALASKA

MEMORANDUM

TO: Karen Cory, Special Assistant
Office of the Governor
and
Fran Ulmer, Director
Division of Policy Development
and Planning
Office of the Governor

DATE: November 5, 1979

FILE NO:

TELEPHONE NO: 465-3030

SUBJECT: Model Health Delivery System for Alaska

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

Helen D. Beirne

As you will note from the enclosed material, the Department of Health and Social Services is moving rapidly ahead on a comprehensive study of a model health delivery system for Alaska. The Department's coordinator of this study is Deputy Commissioner Frederick McGinnis. As you are aware, Dr. McGinnis, who is at present located in Anchorage with a logistic responsibility for the Southcentral area, has had significant experience in the field of health and social services. His interest in the present topic dates back to when he served as the Commissioner of the Department of Health and Social Services for a period of four years. It could be stated that he has a greater depth of knowledge in this particular area than any other person in the state.

Deputy Commissioner McGinnis and I have met with Governor Hammond on two occasions and have received his concurrence that we should proceed on this matter as rapidly and thoroughly as possible with frequent informational and directional contacts with the Governor's Office.

In this packet you will find Dr. McGinnis' briefing memorandum regarding his conference in Washington, D.C., with Lieutenant Governor Terry Miller, which is their second meeting since the Governor's concurrence with the project. Also included are reports and records of the conferences he has recently attended to supplement our knowledge of model health delivery systems, to test the interest of those agencies with whom we must coordinate, and to determine from where assistance for such a program may come.

These reports, and those to follow, will express to you the Department's intense and dedicated interest in establishing a health delivery system for Alaska that will address the health and medical needs of all Alaskans in the most cost effective manner possible.

From this date on, and to expedite this study, Deputy Commissioner McGinnis will be copying you simultaneously with the Commissioner's Office as we move to a resolution of one of the state's most pressing problems in conjunction with the Governor's Office.

HDB/mag
Enclosures, as indicated above
cc: Governor Hammond
Lieutenant Governor Miller

TO: Honorable Jay S. Hammond
Governor
State of Alaska

DATE: September 18, 1979

FILE NO:

TELEPHONE NO:

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

SUBJECT: Model Health Delivery Program for Alaska

From time to time discussions have taken place within the Department and with others with regard to a "Model Health Delivery System" for the State of Alaska. For a number of years, delays have been encountered in active planning for an improved delivery system for Alaska because of the prospect of the National Health Insurance program being enacted by the Federal Congress. While numerous discussion continues to go forward with regard to a National Health Insurance program, it now appears that the enactment of and the implementation of such a plan are receding farther and farther into the future.

The question continues to be raised as to whether Alaska should consider the possibility of a Model Health Delivery System geared to the needs of our state. If such a system could be developed and become operative sometime before any National Health Insurance program is in place, it could serve as a prototype for the nation.

There are several reasons why Alaska should consider developing, as rapidly as good planning will permit, a Model Health Delivery Plan for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery plans in place already, it would seem that Alaska could adjust its present program and add thereto in order to create a truly comprehensive and effective health delivery system. It will take bold, creative and extensive work to develop such a system for Alaska.

There are numerous parties at interest in such a proposed plan. In addition to the State of Alaska (executive and legislative branches), the Federal Department of Health, Education and Welfare and its several divisions have strong interests. The private physicians and hospitals of the state, which together become the strongest foundation stones of health delivery systems, would have substantial interests.

The Indian Health Service and the Alaska Native Health Corporations have strong interests, as would the insurance industry serving Alaska. Additional exploration will reveal other important interests to be considered, including the planning arm of our Department, the Office of Planning & Research of the Governor's Office, local, regional health planning agencies and the State Health Coordinating Council. As plans develop, all such segments with interest in such a program will need to be involved in the

planning, goal and objective setting, and implementation phases of any new program.

Apart from social and health policies concerned and apart from the different funding mechanisms and health providers, there is a national, as well as Alaskan, growing concern over the spiraling medical care costs. According to the U. S. Department of Labor, Bureau of Labor Statistics, the medical care costs in Anchorage, Alaska, in 1977 were 60% over the U. S. urban average costs. Los Angeles, California medical care costs were only 25% above the U. S. urban average costs.

A variety of studies has indicated that hospital charges and doctors' fees have been rising at higher rates throughout the nation than the Consumer Price Index has been accelerating.

Any new system planned should address (1) improved social policy, (2) improved health policy, (3) strong interest in prevention, (4) a more equitable access to health services, and (5) cost containment and cost effectiveness.

All of the above considerations, and others, have initiated certain discussions with regard to the prospects of the State of Alaska designing a new system and plan for the delivery of health services.

A careful analysis of a part of public spending for health in Alaska on the federal and state levels easily identifies approximately 183 million dollars being spent in FY 1980 for health programs (excluding capital expenditures) through our Department and the Indian Health Service alone. Other expenditures related to military personnel would be on top of that. In addition, special federal grants to the Native health corporations and other organizations in Alaska probably would bring the total into the 200 million annual range during FY 1980. Those figures exclude also the health care coverage of State, federal and local government employees covered under health insurance programs. Such costs represent an outlay of public funds on behalf of those employees of government at all levels in Alaska. Excluded also are industry, business and private insurance programs. In 1977, at least $84,822,000 in health care and accident insurance premiums were paid.

A considerable amount of research will need to be done before Alaska can develop a definitive statement as to the total actual expenditures for health services in the State. Such research should be undertaken and facts developed as completely and as accurately as possible as to the status of spending at the present time. Any proposal for a revised program of health delivery in the state should be based upon sound statistical and fiscal data and should be able to demonstrate an improvement over the present

system. Any proposal would need to be acceptable to private providers.

The following contacts have been made and conferences on the concepts presented herein have been held as follows:

I. Washington, D.C.

Dr. George Lythcott of the Health Services Administration. Dr. Emory joined the discussions.

Mr. Isadore Seeman of the Office of Health, Policy, Research & Statistics of the U. S. Public Health Service

Mr. Ronald Carlson of the Health Care Finance Administration.

II. Seattle, Washington - Region X

Dr. David Johnson
Mr. Michael Street
Mr. David Hanson
Mr. Jim VanHoomison
Deputy Commissioner Frederick McGinnis (DHSS)
Ms. Sharon Osborn (DHSS)

III. Juneau, Alaska

Department of Commerce, Division of Risk Management:
  John George
  Richard Reiner
Office of Planning and Research
  Virginia Stonkus
  Chris Pohl
Governor's Office
  Mike Harper
DHSS
  Commissioner Helen D. Beirne
  Deputy Commissioner Frederick McGinnis
  Special Assistant Janice Gates

IV. University of Washington - Seattle

Dr. Stephen M. Shortell, Director, Center for Health Services Research
Ira Moscovic, Rural Health Care and Manpower
Andy Dolan, Health Law, Regulation, Manpower
Laura Beth Lawson, Coordinator, Technical Assistance, Region X

V. State of Hawaii - Honolulu

Department of Labor
Department of Public Assistance
Department of Health

The purpose of this memorandum is to bring you up to date with the Department's present thinking and the explorations which have been going forward recently.

While your representatives at several meetings indicated that the concept should be explored further, the Department requests your formal approval to proceed further in development of the plan. Our plan would be to keep you advised at each phase and to seek your concurrence in any major commitments which would be needed as the study phase develops.

It is anticipated that the following steps will be taken in the near future by the Department, provided your approval to proceed is given at this time:

1. A survey of present planning and research funds available within the State of Alaska to assist in this planning effort. Included in the survey of financial resources will be the Office of Health Planning and Development of our Department, the budgets of the health divisions of our Department (Mental Health, Public Health, Alcoholism & Drug Abuse). Explorations may go forward with regard to resources which may be available from private foundations and the federal government.

2. A clarification of assistance that may be available through the University of Washington's Center for Health Services Research, Department of Health Services, under their contract with the federal government to assist states in Region X with health planning. In addition, explorations should be made with the University of Alaska's Institute of Social, Government and Economic Research as to any assistance they may be able to give the project.

3. If financial resources can be made available, the setting of criteria for and the naming of a project director for the plan. The project director and/or staff probably should be located within the Department's Office of Health Planning and Development, but given the specific task of working on this specific project.

4. Based on budget considerations and availability of funds, a small but competent staff should be identified

either to do the research or to contract for the research necessary to develop the data needed to carry forward the plan envisioned.

5. Preliminary conversations and/or discussions should be held with other parties at interest within Alaska, including:

   - Indian Health Service
   - Alaska Hospital Association
   - Alaska Medical Association
   - Alaska Legislature
   - Insurance industry
   - Governor's Planning Office
   - Consumer representatives

6. In due course, a broad-based advisory panel should be named to advise the project director and staff. Consideration will be given to whether or not the State Health Coordinating Council might serve as the advisory group to the project with possible provision for additional technical expertise if needed.

7. A proposed schedule of activities with time frames and objectives should be developed in order to plan realistically for the project.

Additional information will be provided to you if requests on any of the topics presented in this briefing memorandum.

RECOMMENDATION:

It is recommended that your approval be given to explore further the concept of a revised, improved and comprehensive health delivery system for Alaska with the goals of better services and cost efficiencies.

_____Approved

_____Not approved at this time

_____
Jay S. Hammond, Governor

Fiscal
Information

SUMMARY SHEET

House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)
(In Thousands of Dollars)

For Full Fiscal Year 1981

		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 for Full Fiscal Year	$31,174.3	$15,717.0	$15,457.3	33

House CS for CS for Sponsor Substitute for Senate Bill No. 227 (Finance)
For 6 Months Implementation
FY 81

January 1, 1981 - June 30, 1981

		Total	Federal	State	New Positions for 6 Months Only
1.	Addition of Medicaid Services and New Eligibles	$12,097.3	$7,858.5	$4,238.8	17
2.	Drecrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligibility Groups	(2,235.9)	-0-	(2,235.9)	-0-
3.	State Only Medically Needy	5,584.7	-0-	5,584.7	16
4.	Interest Payment	282.2	-0-	282.2	-0-
	TOTAL for 6 Months	$15,728.3	$7,858.5	$7,869.8	33

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

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

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

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 (Hess Committee Name)

Prepared by: David B. Davidson Date: May 2, 1980

Division of Public Assistance

Department of Health & Social Services

Approved by: Date:

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

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

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

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.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (Last Legislature Named)

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

Approved by: Pers. & Plgt: Date:

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

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

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

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 Prepared by: David H. Davidson Date: May 2, 1980

cc: Budget and Management Division/Office: Public Assistance Phone: 465-3347

Phone Sponsor (Last Legislation Named) Department of Health & Social Services

33 (rev 12/79) Approval (OMB, Exec. Budget): Date:

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

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

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

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 prevision 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.

[illegible] Legislative Finance Prepared by: David E. Davidson Date: May 2, 1980

[illegible] Budget and Management Division: Public Assistance Ph: [illegible]

Primary [illegible] (Last Legislative Contact) Department of Health & Social Services

[illegible] (Rev. 1) Approved by: [illegible] Date:

[illegible] (Rev. [illegible])

METHOD USED TO DEVELOP FISCAL NOTE FOR HCS for CS for SSSB 227(Fin.)

SB 227* proposes to add new coverage and new eligible categories to the Medicaid and General Relief Medical (GRM) programs administered by the Department of Health & Social Services through the Division of Public Assistance. The bill would add services and eligible beneficiaries not presently covered by a medical assistance program administered by the Department. In order to attempt to gauge the effect of SB227, it was necessary to do some projections based on the present Alaska Medicaid and GRM programs and the Medicaid programs in other similar states. In developing a fiscal note for SB 320, the Department acquired financial reports from five western states having medically needy programs. The financial reports covered the federal fiscal years 1977 and 1978 for Hawaii, Montana, North Dakota, Utah, and Washington. This information also was used to develop the fiscal note for SB 227.

The fiscal note is divided into four pages to allow for separate considerations of adding new services and eligible groups to Medicaid on the GRM program by the effect that addition to Medicaid, the creation of a medically needy program, and the payment of interest on past due medical claims.

The first page of the fiscal note covers the addition of new eligible groups and service categories under the Medicaid program. The basic Medicaid request for FY 81 minus the 100% federally-funded Indian Health Care Improvement Act coverage ($40,720,600) was used as a base. To that was added 17.1% additional funds for those new service categories that are not presently covered under the Alaska Medicaid program. This brings the total to $47,683,800. The 17.1% figure is derived from the average percentage in the five other states for those categories of service that are not covered under the Alaska Medicaid program that would be added by this bill. This subtotal was then multiplied by 1.5, the factor by which I believe the overall cost of the Medicaid program would increase ($71,525,700). Alaska has a lower percent of the total population participating in the Medicaid program than in other states, particularly in the groups of individuals under 21 and intact families.

To double check these perceptions, and to arrive at a more precise budget projection, the fiscal note was developed by budget components. It was projected that the Medicaid components would be affected in the following ways: hospital increase by 1.33, physicians increase by 1.33, other services increase by 1.33, EPSDT increase by 2.0, nursing homes remain constant, and Indian health increase by 2.0. The effect on the GRM budget, reflected by page two of the fiscal note, would be as follows: hospital reduced by .33, physicians reduced by .33, other services reduced by .50, and nursing homes and catastrophic illness remaining constant. These changes by specific component produced the total used for the fiscal note of $71,487,900 for Medicaid in FY 81.

The high amount of federal funds shown in the fiscal note is the result of a large increase predicted in the Indian health component which is 100% federal funding. This increase would not be a function of people receiving new services but the result of a funding change--the Alaska Area Native Health Service (AANHS) would be able to receive more federal

* In all cases, Senate Bill 227 means House CS for CS for SSSB227 (Finance)

Medicaid money for services that they are already providing to persons eligible for AAHHS, but who are not Medicaid eligible now simply because Alaska's Medicaid program does not provide coverage for intact families.

The third page of the fiscal note covers the effect of adding a medically needy program in Alaska. It is based on the projections done in developing the fiscal note for the Senate HESS Committee for SB 320. For purposes of SB 227, the amount in that fiscal note was doubled to reflect the fact that SB227would require medically needy coverage for not only adult cases but also for families and individuals under age 21, and would establish a higher cut-off point for eligibility.

The fourth page provides an analysis of the costs of providing interest payments on past due clean claims submitted to the Department. While SB 227does not say specifically that the provision would apply only to the Medicaid and GRH programs, that assumption has been made for purposes of the fiscal note. The amount projected is approximately one-half percent of the total Medicaid and GRH budgets, minus the Indian health component since that is merely a transfer of federal funds and not an actual payment for services rendered. The figure is based on the assumption that the Department will be able to continue to make improvements in its claims processing system, eventually obviating the need for any interest payments to be made. Of course, if the claims processing system would revert back to its previous condition, the amount of this fiscal note would be considerably greater.

The summary sheet totals the costs for the Department for SB 227. Since the fiscal notes were prepared based on the House Hers version of the bill, the budgets reflect costs for a full fiscal year implementation. The current House Finance version begins implementation at a later date on January 1, 1981. Therefore, we have reduced the costs by 50% to reflect only 6 months implementation for that fiscal year.

DIVISION OF PUBLIC ASSISTANCE

BRU	FY79 ACTUAL TOTAL AS OF 11/27/79	FY80 FCC AUTHORIZATION		FY80 SUPPLEMENTAL CURRENT REQUEST	FY80 PROJECTED TOTAL NEED		FY81 REQUEST	
GEN. POP:								
DISCRETIONARY			(GF)			(GF)		(GF)
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)	5381.1	(2690.6)
Other Services	889.9	735.1	(276.6)	435.8	1170.9	(494.5)	1563.1	(671.1)
EPSDT	1600.8	1711.5	(855.7)	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	33182.8	(5372.9)	47960.2	(10840.9)
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	

ELEVENTH LEGISLATURE

FISCAL NOTE

Till 4-5 mp

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 P. Arnoldt

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

AGENCY Division of Retirement & Benefits

PHONE [illegible]

Original Legislative Finance

cc: Budget and Management

[illegible] Senator [illegible] & Senate [illegible]

[illegible]

[illegible]

5/29/80
Bradley

Original sponsors: Colletta, Stimson
and Hohman

IN THE SENATE BY THE FINANCE COMMITTEE

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

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the health of residents of 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. COMPREHENSIVE HEALTH CARE PLANS.

Sec. 21.50.010. RESIDUAL MARKET HEALTH INSURANCE POOL. (a) The carrier which writes the largest premium volume of health insurance in the state as determined by the director shall, as a condition of transacting health insurance, establish and operate a residual market health insurance pool. Individual, group, and Medicare supplemental comprehensive health care plans as described in AS 21.50.020 shall be available through the residual market health insurance pool to every eligible individual or employer resident in the state. Applicants shall have a choice of the low option, the middle option, or the high option deductible established under AS 21.50.020.

(b) The administering carrier shall submit to the director for approval a plan of operation for the residual market health insurance pool which assures the fair, reasonable, and equitable operation of the pool. The plan shall establish procedures for administration, accounting, record keeping, and reporting for the pool, amendment of the plan, and advertising of the coverage provided. If the carrier fails to submit a plan within six months after the effective date of regulations implementing this Act, the director may adopt a plan to carry out the provisions of this section.

20A

(c) Rates for comprehensive health coverage issued through the residual market health insurance pool may not be excessive, inadequate, or unfairly discriminatory. The rate for a given classification or group in the pool may not be more than 125 percent of the rate for a classification or group of at least 25 persons with similar characteristics at standard risk, for equivalent coverage not written through the pool. All policy forms and rates shall be filed with the director and may be disapproved within 30 days from the filing.

(d) Following the close of a fiscal year, the administering carrier shall determine the net premiums, administrative expenses, and incurred losses for the year from the operation of the residual market health insurance pool. Net gains, if any, shall be held at interest to offset future pool losses or allocated to reduce future pool premiums. Net losses may be credited against the carrier's income tax payable under AS 43.20 or its premium tax payable under this title. If the administering 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. 21.50.020. COMPREHENSIVE HEALTH CARE PLANS. (a) Each of the three types of comprehensive health care plans (individual, group, and Medicare supplemental) shall provide minimum standard major medical benefits required by regulation:

(b) A comprehensive health care plan shall provide for a choice of 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 $100 maximum, the $500 maximum and the $1,000 maximum established under this subsection shall be adjusted yearly by the director by regulation 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.

(c) 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. The $1,000 and $2,000 maximums shall be adjusted yearly by the director to correspond with the change in the medical care component of the consumer price index.

(d) A comprehensive health care plan may limit lifetime benefits to a maximum of not less than $1,000,000 per insured person.

(e) The director shall adopt regulations establishing subrogation rights and coordination of benefits.

Sec. 21.50.030. ELIGIBILITY. (a) An individual comprehensive health care plan is open to enrollment by a resident of the state who is under 65 and can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up, or a preexisting conditions limitation by a carrier within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered standard risk.

(b) A group comprehensive health care plan is available to a resident employer of three or more employees whom the employer seeks to enroll in a group plan, who can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up, or a preexisting conditions limitation by a carrier within six months before the application for a group comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a group considered standard risk or a group of 25 members.

(c) A Medicare supplemental comprehensive health care plan is open to enrollment by a resident of the state who is enrolled in Medicare Parts A and B and who can provide evidence, with respect to major medi-

cal coverage, of rejection, requirement of restrictive riders a rate up, or a preexisting conditions limitation by ~~a~~ two carriers within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered a standard risk.

(d) An individual may not purchase or renew coverage under a comprehensive health care plan established under this chapter after ceasing to be a resident of the state.

Sec. 21.50.040. ADDITIONAL CRITERIA FOR ELIGIBILITY. The director may adopt by regulation supplemental or alternative eligibility criteria which reflect the inability of an applicant to obtain coverage substantially similar to that which may be obtained by an applicant who is considered a standard risk or by a group with 25 members.

Sec. 21.50.050. POWERS OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.040 and may adopt regulations under AS 21.06.090 to carry out the provisions of AS 21.50.010 - 21.50.040;

(2) 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;

(3) examine and investigate the operation of the residual market health insurance pool and shall have reasonable access to the books, records, files, papers, and documents of the administering carrier that relate to the operaton of the pool;

(4) examine directors, officers, agents, brokers, or employees of the administering carrier for the purpose of determining if coverage is being adequately and fairly provided through the pool;

(5) 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;

(6) undertake directly or through studies or demonstration programs to develop awareness of the benefits of AS 21.50.010 - 21.50.-040 so that residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.100. DEFINITIONS. In this chapter,

(1) "administering carrier" means the carrier with the largest premium volume of health insurance in the state which is obligated under AS 21.50.010 to establish and operate a residual market health insurance pool;

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

(3) "comprehensive health care plan" means health insurance which provides the benefits required under AS 21.50.020;

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

(5) "family" means the primary insured and the covered dependents of the primary insured;

(6) "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;

(7) "Medicare supplement plan" means a health insurance plan which provides benefits which complement or supplement the benefits provided by Medicare;

(8) "Medicare supplemental comprehensive health care plan" means a plan which, in conjunction with Medicare Parts A and B coverage, provides the benefits required under AS 21.50.020;

(9) "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.

* Sec. 2. AS 21.27.410(a) is amended by adding a new paragraph to read:

(10) if an agent, solicitor, or broker transacting health insurance in the state fails to refer an applicant for health insurance whom the agent, solicitor, or broker has reason to believe may be eligible for a comprehensive health plan through the residual market health insurance pool to the administering carrier.

* Sec. 3. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.50.

* Sec. 4. The director of the division of insurance, Department of Commerce and Economic Development, shall adopt regulations implementing sec. 1 of this Act by January 1, 1981.

* Sec. 5. 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. 6. 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 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 percent 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 provisions apply.

(c) In (a) of 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. 7. 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

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(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. 8. The provisions of secs. 5 - 7 of this Act apply to group policies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and which are 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 provides the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 9. 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 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 state 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 - 47.05.090 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

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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. 10. 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. 11. 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. 12. 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. 13. AS 47.07.020(d) is repealed.

* Sec. 14. Sections 2 - 8 and 10 - 13 of this Act take effect January 1, 1981.

* Sec. 15. Sections 1, 9, 14, and 15 of this Act take effect July 1, 1980.