STATE HEALTH INSURE.

#3

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1959-1978 (8 years-House of Representatives; 12 years-Senate).

2. Attorney-at-Law.

3. Former Vice-President of the Bank of Hawaii (1963-1979).

4. Presently Deputy Director of the Dep rtment of Regulatory Agencies, State of Hawaii.

5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald Ching

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

by Tom Fink

THE ACME of legislation so far this session which interferes with our democratic way of life has been the introduction of House Bill 977. This bill is entitled "an act relating to the health of residents of the state". HB977 was introduced shortly before another similar bill was passed by the State House, Committee Substitute for House Bill 60.

The biggest trepidation many of us have in regard to the state's huge monetary wealth is that money will be used to interfere with our free and democratic society. It is for that reason that many of us suggested that the state use the surplus to pay off our debt and to build capital improvements which improve our economic viability and our conveniences of living.

We've all heard of national health insurance. The first part of HB 977 is state health insurance. The bill provides an employer must cover all employees with a certain type of insurance policy. An employee can only pay a limited amount for that policy so that the employer must pay the difference. Since the coverage is broad, the employer's cost is very substantial. Under certain circumstances an employer can obtain some reimbursement from the state.

IN THE NEXT section of the bill a state medical insurance corporation is set up in which all of the private carriers selling insurance in the state must become a part. Anyone who cannot buy standard coverage of the quality required may purchase insurance from this corporation. Any losses this corporation suffers must be paid for by the private carriers. The end result of this legislation is that the private carriers of medical insurance will be crowded out of the market and the state will be the sole insurer of health insurance. At that time the cost to the state treasury will be enormous.

CSHB60 is primarily a capital appropriations bill. Twenty pages of the 39-page bill and about $250 million is for the construction of all sorts of facilities throughout the state. Some of them are boondoggles, but by and large the facilities will contribute to the future economic viability of the state.

The other 18 pages of the bill, however, appropriates about $27 million for projects such as the following:

— $54,600 Anchorage current event society.

— $12,000 Anchorage Child Abuse Board for Advertising.

— $305,000 Anchorage operation of treatment alternative to street crime program.

— $87,000 Tyonek Village documentary film.

— $75,000 Alaska Federation for Community Self-Reliance grant.

— $180,000 Alaska Conservation Foundation.

— $35,000 Anchorage grant to task force on smoking and health.

— $453,000 Anchorage — Alaska Public Advocacy Corporation.

— $75,000 Alaska Public Interest Research Group.

— $48,000 Anchorage — Citizen Participation Project.

— $317,500 Anchorage — Alaska Center for Policy Studies.

These expenditures are the type that are only made when the state has money burning a hole in it's pocket. Many of these appropriations are to accomplish goals that are not proper for a government. Many of the appropriations are made to new organizations set up to employ friend of those in government. Many of them will result in substantial intrusions upon our democratic society.

IN ADDITION we have legislation pending to subsidize the cost of fuel and electricity so that there will be one price anywhere in the state regardless of the quantity used or the remoteness of the area from the product. We will have legislation also to establish one price for transportation of anyone or a commodity north of Seattle. Even if you happen to be in favor of this state subsidization, you must realize the result will be the state control of all those services and commodities. The legislature only pays the cost of a program for so long before it takes it over and establishes the manner of it's operation, the number of employees, the pay, and the profit margin.

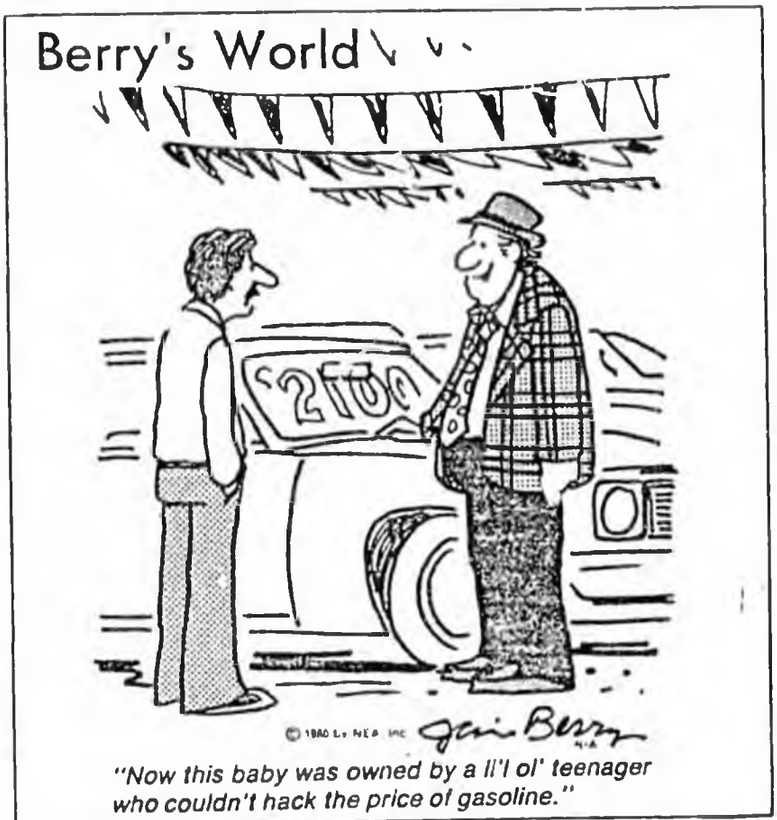
We already, of course, have set up a Renewable Resource Corporation with many millions of dollars and a Fish and Agricultural Bank which recently announced it is opening up six branches in the state. These institutions are totally state owned.

There really are only two answers to stop government expenditures for improper purposes this session. First of all the governor could and should veto by line item such expenditures. However, the probability is the governor will go to the Free Conference Committee and tell them if they add $50 million for his pet projects, he will agree not to veto any part of it.

THE SPEAKER of the House recently in a speech asked the public to quit putting pressure on the legislature to spend more money because they are unable to withstand the pressure. The Speaker knows or should know that this pressure will always exist as long as the government has a surplus. The Speaker is one of the people in the leadership who has to have the fortitude to say "no". It is the problem of which he complains that convinces most of us that we must spend the state's money on debt reduction and capital improvements so that the money isn't there for all these foolish operational programs.

Unless the leadership is going to assume the fortitude to say "no", I suggest the legislature gets about it's business and ends the sessions. Repeal taxes, make money available at reasonable rates for credit within the state, pass the operational budget, and adopt a large capital improvement budget.

The pressure to spend on all sorts of foolish programs will get stronger rather than weaker with every passing day.



"Now this baby was owned by a li'l ol' teenager who couldn't hack the price of gasoline."

generally prevailed.

Yet, always there is the hope of government for all. And so, on April 20, will try again. Five yea three general junta took President Oswaldo Lope was charged with takin bribe from United Brands United Fruit. The junta is tarily relinquishing powe the heady prospect of a open election with a mod curate vote count.

But it is difficult not to Nicaragua, where leftists ists combined to get Anastasio Somoza, now be sliding into Cuban-sty nism. Although the El Sa has ordered the expropr agricultural properties acres the radicals are and shooting continues. ago a cache of bodies ered in a Guatemala ca parent work of right squads.

Why can't Central make democracy work?

First, there is the self, mostly Indian, poli but gyrating between asms and black despair reach out and touch though they were angel dicious cynicism neces ble self-government.

Then, there is the n tral America's agricu coffee fincas may be re client, but sugar and best raised on large t land-owning companie been fair game for but either they or the tem of bickerin, coo necessities. Either wa men wielding machet their own masters.

But in recent ye arisen a more compel social chaos, and that ation of people due t ering of the death rat tries are due to doub tions in the next 18 like the Puerto Rica grate freely to the U the Mexicans who c the fence, these nat cape hatch.

IN 1968, HONDUR with El Salvador t squatters. The Mex thrown back Guatem from the south. With for arable land in t desperate people mo where they form lar increasingly restive

If the population off in this lovely spi two continents pros right, for technology But every advance new tide of babies.

And Marxism, one-time dividend and redistribution, song.

ALASKA LEGISLATIVE COUNCIL

LEGISLATIVE AFFAIRS AGENCY

REPORT OF THE

INTERIM COMMITTEE ON HEALTH CARE,

SOCIAL SERVICES AND

MENTAL HEALTH DELIVERY SYSTEMS

FEBRUARY 1974

The Health-Care Merry-Go-Round

by George Silver

The health insurance plan offered by Senator Long (left) has the best chance of getting through Congress this session.

FOR ALMOST 60 years now, a political event has unfolded each spring, a ritualized controversy over the value and scope of a national health program. While it is usually billed as "national health insurance," the underlying argument has little to do with health, and only a bit more to do with real insurance.

In the past 20 years, because the Democratic party has adopted national health insurance as a plank in its political platform, the spring ritual has become curiously formalized. The President issues a "health message" around February; White House aides and agency (usually HEW) experts prepare a legislative proposal that goes to the appropriate committee (or committees) in March or April. Then hearings are held, the witnesses for and against heard. The media join the fray with articles, learned discourse on local and national TV, and books. The administration announces the imminence of a legislative health program; Congress denounces the proposal and offers its own alternatives. In fact, a particularly novel aspect of this seasonal rite has been the lush proliferation of congressional counter-proposals, making the health insurance field look more like a war of all against all than an intra-party squabble. The rapid and uncontrollable escalation of the costs of medical care has convinced everyone that some sort of bill should be passed; but the profusion of bills has made consensus even harder to reach. Thus, after a great deal of noise about the need for sweeping reform, one bill cancels out another, and, in the end, only a small, tentative step is taken. And the 1978-80 congressional term looks like a textbook case of the usual formula.

While the ritual has remained more or less the same, the substance of the debate has grown ever more complicated. Seventy years ago national health insurance meant little more than being able to pay a doctor for care. Today we have solved the basic problems of acute and epidemic disease, infant mortality, and the like—except for minority groups and the poor—and we are more concerned with a *program* of care, a guarantee of *systematic* care. We have learned that our piecemeal system doesn't work, doesn't help the people it was presumably targeted for—the needy—and works against the others because it inflates and distorts, and deprives everyone when it doesn't work for the targeted population.

With this new element added, nobody can agree on exactly what national health care means. The variety of proposals is staggering and self-defeating. Once the principal obstacles to national health insurance were such antagonists as physicians, entrepreneurs in pharmacy manufacture or equipment, industry and insurance companies; now there is a plethora of protagonists with such conflicting proposals that the result is the same as if they were antagonists too. There are public and private advocates; professional anti-professionals recommending "health" insurance (as against medical-care insurance) with emphasis on preventive services, lifestyle change, and self-help; syndicalists with a platform of worker-management control; populists with a platform of community control.

The academic world has not been idle either, and there are contrasting economic recipes: tax revenue funding as against employer-employee funding; co-insurance and co-payment advocates as against those who argue for no payment at the time of service; and the anti-insurance cohorts who recommend a heavy personal financial commitment by the patient before *any* government support in order to check the heedless and prodigal use of, and demand for, medical services. Political scientists argue the benefits of a regulatory approach or a public utilities model, while management experts (the new mandarins) propose complex, computerized schemes for controls that would limit costs, adjust distribution, and assure quality.

Congress watchers point to the American Medical Association's multimillion-dollar political contributions and Washington "information office" as the chief villain and architect of the anti-national health program campaign. Certainly political contributions play an important role and have a strong impact on legislators and legislation. But it would be a mistake to give this factor too important a role in frustrating the legislative possibilities over the years. That block has been effective in over 10 administrations. Can the AMA be held solely and totally accountable? On the U.S. political scene representative government requires shifting minority allegiances to [illegible]

position by reciprocal trade-offs: Lesser issues buy votes on larger issues. Health insurance just may not represent a big enough issue for most congressmen to stake out a major position on the agenda.

In any case, it's not the AMA that's responsible for the bewildering variety of health bills now facing Congress; it would rather that none be promoted. Personal experience may shed some light on a more deserving culprit. From 1965 to 1968 I served as the deputy assistant secretary for Health. My boss was the first assistant secretary ever appointed to that job. Another first was the assistant secretary for planning and evaluation, brought over from the Department of Defense to introduce managerial skills and planning expertise into the hodgepodge of the HEW bureaucracy. Planning had one deputy also, for health program evaluation. All in all, there were about a dozen health professionals charged with the responsibility for developing programs agreed upon by the secretary of HEW and proposed by the President. There were also one or two assistants in the White House with such interest. At HEW, we occupied a few rooms on one side of the fifth floor of the old HEW building at Fourth and Constitution.

Congress was similarly endowed: The House and Senate each had one health staff member attached to the relevant committee. Wilbur Mills, then chairman of the House Ways and Means Committee, had a knowledgeable staff man, too, but he liked to keep a strong grip on health financing matters himself.

Today, nearly 250 people are preoccupied with the ramifications of health program development and health planning and evaluation in HEW. There is a huge new building down the street on Independence Avenue to house them. There are over 100 professional staff people in six congressional committees to deal with health legislation. Each congressman on a committee that touches health matters has a specialized staff assistant for health.

In the 1960s the dozen of us managed to get more than 40 health bills through the Congress: powerful instruments like Medicare, Medicaid, and a health manpower development act. Today's hosts have had to postpone even housekeeping measures like salary appropriations from one session to the next because they couldn't muster a majority vote on any health issue.

The problems of bureaucratic overkill and legislative free-for-all are not, of course, confined to health care; most social programs suffer from the same confused welter. The same may be said for the general American resistance to radical reform of any kind. Our taste for "creeping incrementalism" has led to a passion for tinkering and crude adjustment; whether in health care, the tax code, or welfare reform, reconstruction and systematic change have been neglected and delayed, so that social change proceeds at a snail's pace.

THE PRESENT congressional season features an apparent showdown in health-care legislation: Both President Carter and his nemesis, Senator Kennedy, have submitted major health-care bills. But the likelihood is that the prize will elude both. The best we can probably look forward to in this session of the Congress is Senator Russell Long's Catastrophic Health Insurance Protection Bill, possibly to be known as the National Health Insurance Act, even though it will not be, in scope or coverage, what the national health insurance struggle is about.

Kennedy's ambitious health care bill provides free medical care to everyone.

The Kennedy bill provides for everyone in the U.S. to have a credit card entitling him or her to medical care in the home, doctor's office, or hospital without added charge; old people would have their prescribed medicines paid for as well. There is no limit on use (except for psychiatric services) and preventive services are paid for. Funds will come from some employee contributions, larger employer contributions, tax funds for the poor, and contributions from the elderly (who will pay a part themselves as they do today under Medicare). The self-employed will pay, if they choose, a special health insurance premium geared to their income. The monies will go to privately controlled insurance funds, which will dole them out and monitor their use; the program will be planned and supervised by a variety of groups at the local, state, and national levels. There is a special fund set aside to develop and allocate resources (and redistribute them where necessary). And there is a ceiling, unfixed as yet, on expenditures. All this is to become operative in 1983.

The Carter plan is not so ambitious. It puts a ceiling on the total any person would have to spend for health care ("catastrophic" health insurance coverage); prescribes free care for pregnant women and infants under one year of age; recommends fee schedules for private health insurance for which the employer will pay at least three-quarters of the premium; and draws up fee schedules for public medical care to which doctors must adhere. Probably the largest jump in governmental responsibility is in federalizing medical care for the poor. Where now the states set income levels for Medicaid, the new law would set a new federal poverty level and immediately raise by more than 50 percent the number eligible. The Carter plan envisions phasing in of its objectives: After phase one has been implemented, there will be a review of the whole and consideration of what additional steps might be taken next.

Senator Kennedy's proposal, despite its grand intentions, is seriously defective. The surrender to the private insurance industry is curious, for Senator Kennedy has been the principal antagonist of the industry and has criticized it for stoking inflation in collaboration with health-care providers. While a ceiling on expenditures is proposed, and physician income may well be curtailed in this way, *non-physician* income is untouched. Since 60 percent of hospital costs are personnel costs and hospital costs are 40 percent of overall medical-care expenditures, there is a large loophole for sharply rising costs to escape the ceiling. What measures will be taken if institutions exceed budget? Will they file for bankruptcy? More serious is the vast increase in personnel proposed, layered on top of an existing regulatory bureaucracy. By now we must have learned that large bureaucracies cannot provide human services with efficiency.

President Carter's plan has highly visible flaws and no appeal to the articulate constituencies (like labor) that seek national health insurance legislation which will benefit *them*, immediately. It is *targeted* for specific groups, a shibboleth of his economic advisors, and offers little universal benefit. The failures of implementation of existing reform legislation bode ill for that part of the effort. It prescribes a reliance on unsupervised private insurance far greater than does Senator Kennedy's proposal. The whole effort is more pious and prayerful than useful. Costs would continue to mount, most of the poorly served would remain so, specialism would increase, and enrichment of the medical profession would continue to be guaranteed. No ceiling on expenditures means no ceiling on costs or income.

Sadly enough, in extending the Medicaid principle and reinforcing it, the Carter plan continues the "two-tier" sys-

tem of medical care that has been the curse of the present system: poor medical care for poor people, better medical care for the better off.

Senator Long's plan, the leading contender for passage in this Congress, if any bill is to pass, is relatively simple and ineffectual in altering the circumstances that contribute to present dissatisfactions. It will most certainly augment inflation. The plan advocates a catastrophic protection clause: After a family spends $2,000, government insurance would pay the remainder of any medical bills that year. It encourages hospital care and offers incentives to doctors and hospitals to raise fees ("get over that barrier" of $2,000 as quickly as possible to make the family eligible). President Carter's endorsement of this proposal as part of his phase one is equally inflationary.

But if history is our guide, Long's plan has the inside track. First of all, it will change nothing, a considerable advantage. Second, national legislation usually waits for state models to provide guidelines as well as to test the water of public acceptance. The states serve as "laboratories" for national experimentation, to use Brandeis's phrase. We have had state experiments in the health field before passage of other national health legislation; and in the past five years we have had state catastrophic health insurance laws (Rhode Island and Hawaii, for example). But we have never had a state compulsory health insurance law, despite some efforts on occasion in California, New York, Massachusetts, Michigan, and Pennsylvania. The generally successful experience with state catastrophic health insurance laws makes the probability of Long's plan becoming law more likely.

Political wisdom might dictate to Senator Kennedy (or Governor Brown, and other potential presidential candidates practicing in the bullpen) a powerful effort to obtain a model state program of compulsory health care. Who controls the politics of Massachusetts anyway?

TODAY'S PROPOSALS for national health insurance offer little cause for optimism that real change will take place in the system. The one thing that none of the plans promise—neither Carter's nor Kennedy's nor Long's—is equity. A concern with equity makes us ask the question: Do we want the poor and minorities to have the same medical care as the rich and the white? Do we want a health-care system that says that we are all entitled to care, as we need it, when we need it? Or one that says, if we can find it, or get it, an insurance company will pay for it?

It may be that, given the alignment of forces, this is the time to suggest a state health insurance program that undertakes radical reform, but in a smaller arena, say child health care, to test the feasibility, cost, and organizational considerations. We should seek equal access and high-quality cost control in this smaller arena by cooperative effort in which the federal government waives rigid regulations for the use of federal funds and the states incorporate these sums into a statewide health service financial budget. Applying such a program to child health care would naturally include an emphasis on preventive services, which are especially cheap for children: The most comprehensive program, instituted in Holland, costs roughly 9¢ per child per day. Since the Dutch standard of living and wage scale aren't too different from ours, it's likely that such a preventive system will cost no more here.

Carter's plan has visible flaws and is more pious and prayerful than useful.

If such a program worked for children, the lessons ultimately could be applied to adults and to the nation as a whole. There is already fairly widespread acceptance of the rough outline of an effective and economical national system. It will be prepaid; that is, people will pay little or nothing at the time of care to overcome costly and cumbersome bookkeeping, financial barriers to prompt use of services, and the quirky variations in charges that make budgeting impossible. Doctors will be part of a group organization, making all kinds of specialized care readily available to patients. The doctors will be salaried, eliminating the competitive aspects of present practice that encourage overuse of technology and referrals.

Primary care will be a team process, with family doctors and nurse practitioners or medical assistants liberally distributed in small clusters throughout the neighborhoods of the communities for easy access by patients. The teams will be part of groups, which in turn will be part of hospital units serving designated populations. Very complicated, delicate, and expensive hospital procedures will be restricted to a few regional hospitals, and effective transport and emergency vehicles will tie this network of care together.

From an organizational standpoint, regional commissions, possibly elected units like regional school boards, will deal with budgets, distributional problems, and manpower. Local committees, also possibly elected, will serve as channels of communication between the patients and the professionals: Grievances can be mediated this way, and local supervision can provide information on the operation of the groups and teams.

The entire program will be highly localized in order to keep huge bureaucracies from developing and becoming the self-serving megastructures that are the bane of modern life. If the regional commissions actually carry out their supervisory functions, this allocation of funds to local communities to plan imaginative and locally satisfactory approaches to medical care will ensure a useful national health program.

It will follow that while the monies for the service will be in the hands of local boards for disbursement, the source of the funds still will have to be federal and state taxes. The actual way in which the tax structure will have to be changed to accommodate a valid national health-care system remains unclear.

It's easy for someone outside the system to spin out an ideal plan, particularly if that someone won't have to take the responsibility for what happens if it should become operative. Nonetheless, the political possibilities are there and the potential examples abound. Ten million Americans belong to prepaid group practice systems. There are school systems with comprehensive preventive programs for children. Nearly 30 percent of the doctors in the United States are on salary now. Many neighborhood hospitals, like neighborhood schools, serve the local population exclusively. What is missing is a national commitment, national standards, assent to equity.

The agonizing over a national health program is only another example of the struggle Americans have had in this century to come to terms with the contradictions of their political heritage: individual responsibility and freedom to succeed and achieve, and to fail and suffer, on the one hand; on the other, government responsibility for the good and welfare of all. Our political tradition is cautious, too, not wanting to take too big a bite at one time. It makes sense to try the new remedy in a few states before you prescribe it for 215 million people. But you must try it, then, or be reconciled never to have a remedy at all!

Dr. Silver is a professor of public health at the Yale School of Medicine. His most recent book is Child Health: America's Future.

Health Boards

Board or Commission	Appointee	Term

BOARD OF NURSING
AS 08.68 - 7 members; 5 year term; removed only for neglect of duty or for unprofessional or dishonorable conduct after a fair and impartial hearing.

Norma J. Frank, R.N. — March 31, 1979
Box 4229
Mt. Edgecumbe, Alaska 99835
747-8244 (home)
966-8342 (work)

Eileen Montano, R.N. (chairman) — March 31, 1981
SR Box 10033
1.5 Mile Chena Ridge Road
Fairbanks, Alaska 99701
353-4227

Betty Irwin Hodo, R.N. — March 31, 1980
3812 Katmai Circle
Anchorage, Alaska 99503
274-3740 (home)
272-5522 Extention 140 (work)

Kandace Henry (public member/secretary) — March 31, 1980
1222 16th Avenue
Fairbanks, Alaska 99701
452-5310 (home)

Carol Ann Verga — March 31, 1982
Box 5138
Ketchikan, Alaska 99901
225-2620 (home)
225-6688 (work)

Erna Rasmussen (public member) — March 31, 1981
Box 2
Nome, Alaska 99762
443-2919 (home)
443-2798 (work)

Marion E. Bayless, R.N. — March 31, 1983
Chief, Area Nursing Services Branch
Alaska Area Native Health Service
Box 7-741
Anchorage, Alaska 99510
265-3121; 265-3122 work
333-5742

Board or Commission	Appointee	Term
STATE MEDICAL BOARD AS 08.64 - 7 members; 4 year term, serves until new member is appointed and qualified.		
	Jeffrey A. Partnow SR 3, Box 31473 Fairbanks, Alaska 99701 456-4724 (home) 452-4769 (work)	November 6, 1980
	Thomas J. Harrison, M.D. 3500 Lateuche, Suite 250 Anchorage, Alaska 99501 333-~~4513~~ (home) 4563 277-4151 (work)	July 8, 1980
	Thomas Stengl, M.D. Box 1059 Auke Bay, Alaska 99821 586-7466 or 586-6601 (work) 789-0805 (home)	January 12, 1980
	Hilbert J. Henrickson, M.D. (chairman) 3612 North Tongass Avenue Ketchikan, Alaska 99901 225-58[illegible] (home) 225-5146 (work)	April 21, 1982
	Winthrop Fish, M.D. 1249 Bannister Anchorage, Alaska 99504 279-8262 (home) 272-5733 (work)	April 21, 1981
	Janette P. Adasiak 1835 Crescent Drive Anchorage, Alaska 99504 279-4970	August 13, 1980
	Hugh Gellert Box 386 E. SRA Anchorage, Alaska 99507 344-3240 (home) 272-4922 (work)	January 19, 1981

Board or Commission	Appointee	Term

BOARD OF PHARMACY
AS 08.80 - 7 members, 5 year term; serves until the new member is appointed and qualified; Legislative co..firmation.

Eldon Ulmer (chairman) P.O. Box 1420 Anchorage, Alaska 99510 344-1260 (home) 277-2567 (work)	March 31, 1982
James L. Murphy 1114 Galena Street Fairbanks, Alaska 99701 456-4667 (home) 452-2328 (work)	March 31, 1981
Lester E. Elkins P.O. Box 409 Petersburg, Alaska 99833 772-3241 (work)	March 31, 1983
Charles R. Rush Box 3728 Anchorage, Alaska 99501 277-2701 (home) 272-6431 (work)	March 31, 1979
James H. McCorcle Box 450 Juneau, Alaska 99802 586-1025 (work) 586-2493 (home)	March 31, 1980
Fred Savok (public member) 8320 East 10th Anchorage, Alaska 99504 337-4965 (home)	March 31, 1981
Robert K. Snider (public member) P.O. Box 1620 Anchorage, Alaska 99510 277-5306 (home) 279-6471 (work)	March 31, 1980

Board or Commission	Appointee	Term

BOARD OF EXAMINERS IN OPTOMETRY
AS 08.72 - 5 members; 3 year term; serves until new member is appointed.

Timothy B. McLaughlin, O.D. (chairman) — June 15, 1979
P.O. Box 498
Sitka, Alaska 99835
747-6645 (work)
747-8449 (home)

John T. Shank, O.D. — June 15, 1980
P.O. Box 827
Kodiak, Alaska 99615
486-3859 (home)
486-5504 or 5592 (work)

Thomas Kinsella (public member) — June 15, 1981
SR Box 31071
Fairbanks, Alaska 99701
456-2617 (home)
452-1155 (work)

Carolyn J. Black — June 15, 1979
Box 24
Haines, Alaska 99827
766-2583 (home)
766-2576 (work)

Dr. Maynard Falconer — June 15, 1981
P.O. Box 919
Anchorage, Alaska 99501

Board or Commission	Appointee	Term

BOARD OF DISPENSING OPTICIANS
AS 08.71 - 7 members; serve at the pleasure of the Governor, 3 year term

George Tresnak — June 14, 1979
6051 East 22nd Avenue
Anchorage, Alaska 99504
333-9931 (home)
272-5715 (work)

Dick L. Kleinkopf (chairman) — June 14, 1981
P.O. Box 1660
Fairbanks, Alaska 99701
456-5316 (home)
452-5208 (work)

Philip A. Lampert — June 14, 1979
P.O. Box 4-2183
Anchorage, Alaska 99509
274-2273 (home)
274-9210 (work)

Edna M. Lyon — June 14, 1981
P.O. Box 92
Anchorage, Alaska 99510
272-6328 (home)
272-5715 (work)

Robert Sherwood (public member) — June 14, 1980
730 I Street
Anchorage, Alaska 99501
279-0422 (work)
276-4960 (home)

Harry J. Lang (public member) — June 14, 1979
1406 West 47th Avenue
Anchorage, Alaska 99503
279-5741 (work)

Larry E. Harper — June 14, 1980
404 K Street
Anchorage, Alaska 99501
349-4394 (home)
272-8632 (work)

Board or Commission	Appointee	Term

STATE PHYSICAL THERAPY BOARD
AS 08.84 - 5 members; 3 year term; shall serve until successors are appointed; appointed by the Governor.

Edward T. Heuston (secretary) Star Route, Box 6014 Eagle River, Alaska 99577 694-9761 (home) 274-3505 (work)	September 1, 1980
Gary W. McCarthy 1940 Patterson Anchorage, Alaska 99504	September 1, 1980
Donna Klokkevold, RPT (chairman) 3710 East 20th Avenue Anchorage, Alaska 99504 277-2219 (home) 272-0586 (work)	September 1, 1981
J. Michael James, M.D. 3710 East 20th Avenue Anchorage, Alaska 99504 277-1312 (work) 279-6094 (home)	September 1, 1980

Board or Commission	Appointee	Term

BOARD OF NURSING HOME ADMINISTRATORS
AS 08.70 - 5 members; 3 year term; serve at the pleasure of the Governor.

Leona Bowles 318 4th Street, Graehl Fairbanks, Alaska 99701 456-4586 (home) 452-1735 (work)	October 1, 1981
Roberley Reh Potter (administrator) Box 1176 Sitka, Alaska 99835 747-8250 (work)	October 1, 1979
Jane Hanna, R.N. (chairman) Route 3, Box 3738 Juneau, Alaska 99801 586-1529 (home)	October 1, 1980
Donna M. Stephens SR Box 50060 Fairbanks, Alaska 99701 479-4543 (home) 452-1921 (work)	October 1, 1980
Dove M. Kull 326 4th Street Mendenhall Apartments #1010 Juneau, Alaska 99801 586-2670 (home)	October 1, 1980

Board or Commission	Appointee	Term
BOARD OF CHIROPRACTIC EXAMINERS AS 08.20 - 5 members; 3 year term; serve at the pleasure of the Governor.		
	Keith Godfrey (chairman) 3800 Lake Otis Parkway Anchorage, Alaska 99504 272-0123 (work) 279-5838 (home)	July 15, 1979
	Adrian Barber (secretary) Klatt Station Box 10033 Anchorage, Alaska 99501 344-1501 (work) 344-7674 (home)	July 15, 1978
	Lee Q. Burger (vice president) 320 Bawden #306 Ketchikan, Alaska 99901 225-6815 (work) 225-2018 (home)	July 15, 1980
	Locke Jacobs (public member) 3540 Wingate Circle Anchorage, Alaska 99504 277-5682 (home) 277-1587 (work)	July 15, 1979
	Linnea Burmeister (public member) P.O. Box 1103 Nome, Alaska 99762 443-2958	July 15, 1981

Board or Commission	Appointee	Term

BOARD OF DENTAL EXAMINERS
AS 08.36 - 7 members; serves 5 year term, until new member is appointed and qualified

Wayne Putman, D.M.D. — February 1, 1983
Route 5, Box 5107
Juneau, Alaska 99803
789-6983 (work)
789-9045 (home)

Arthur Hansen (chairman) — February 1, 1982
3487 Airport Road
Fairbanks, Alaska 99701
479-2100 (work)
479-2101 (home)

Leonard Yuknis, D.D.S. — February 1, 1979
2601 Boniface Parkway
Anchorage, Alaska 99504
333-9591 (work)
344-5784 (home)

John R. Beard (public member) — February 1, 1981
425 G Street
Anchorage, Alaska 99501
277-3213 (work)

Jana M. Varrati, R.D.H. (dental hygienist) — February 1, 1981
7030 Foothill Drive
Anchorage, Alaska 99504
333-9591 or 272-7232 (work)
279-0268 (home)

Claude G. Rick, D.D.S. — February 1, 1981
3606 Rhone Circle
Anchorage, Alaska 99504
279-6235 (work)
272-0812 (home)

John Kobylarz, D.M.D. (secretary) — February 1, 1980
P.O. Box 830
Soldotna, Alaska 99669
262-4690 (work)
262-4942 (home)

Board or Commission	Appointee	Term

BOARD OF VETERINARY EXAMINERS
AS 08.98 - 3 members; 4 year term; serves at the pleasure of the Governor.

Berton A. Gore, D.V.M. (chairman) — July 31, 1980
P.O. Box 666
Palmer, Alaska 99645
745-3219 (work)
745-3345 (home)

Clifford D. Lobaugh, D.V.M. — January 31, 1981
RR#6 Box 3552
Juneau, Alaska 99803
789-9210 (home)
789-7551 (work)

David Howe, D.V.M.
2639 Boniface Parkway
Anchorage, Alaska 99504
337-1561 (work)
333-7207 (home)

Board or Commission	Appointee	Term

BOARD OF PSYCHOLOGISTS AND PSYCHOLOGICAL ASSOCIATE EXAMINERS
AS 08.86 - 5 members; 3 year terms; serves at the pleasure of the Governor.

Dorothy Whitmore, Ed.D. (chairman) — July 1, 1980
207 E. Northe Lights Blvd.
Suite 202
Anchorage, Alaska 99503
344-2078 (home)
276-2230 (work)

James C. Parsons — July 1, 1979
207 E. Northern Lights Blvd.
Suite 202
Anchorage, Alaska 99503
276-2230 (work)
279-3735 (home)

Robert D. Bowers — July 1, 1981
7744 Boundary Avenue
Anchorage, Alaska 99504
337-6256 (home)
279-9544 (work)

Dick L. Madson — July 1, 1980
Suite D, Nerland Building
543 Third Avenue
Fairbanks, Alaska 99701
456-7219 (home)
452-4215 or 452-4254 (work)

Pam Delys Raglien, Ph.D. — July 1, 1981
Kodiak/Aleutian Mental
Health Center
P.O. Box 712
Kodiak, Alaska 99615
486-5742 (work)

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

March 28, 1980

To: Members of the House HESS Committee

From: Representative Thelma Buchholdt, Chair
House HESS Committee

Subject: HB977

Coming up for hearing in Committee on Monday, March 31 and Tuesday and Wednesday, April 1 and 2, will be a major bill to extend health coverage in this state. Enclosed is background material on the legislation. Briefly, it includes:

I. Summary of Proposed Health Legislation

This is a detailed explanation of the provisions of the bill. Section one requires employers to sponsor prepaid group health care plans for their employers. Section two requires insurance carriers to form a joint underwriting association and issue coverage for high risk "uninsurable" clients. It also establishes state standards for "qualified" health policies and requires carriers to offer qualified olicies to their clients. The remaining several sections expand s ate medical assistance programs and address provider payment problems.

II. An Analysis of the Extent of Health Care Coverage and Gaps in Coverage

This is an excerpt from Third Party Health Coverage in Alaska published by Legislative Affairs Agency Research Division in April, 1978. The author estimates that between 20 and 25 percent of the non-Native non-military population state-wide currently lack third party health coverage. An addendum h been included estimating that roughly 200 high risk clients uld enroll for the pooled risk coverage.

III. An Analysis of the Social Impact of the Proposed Health Legislation

This section considers the bill's impact on the public, on employers and employees, and on insurance carriers. It is estimated that the legislation would expand health coverage in the state to cover more than 95 percent of the population. Mandatory employer sponsored covera in which the premiums

are shared by the employer and the employee would raise labor costs to the employer and would lower the take-home pay of the employee. The premium cost of the required coverage is estimated at $30 to $50 per month for a single employee and $75 to $110 per month for an employee with dependents. The impact on insurance carriers would depend on how closely the bill's requirements match current practice and how large the volume of health insurance business the carrier has in Alaska.

IV. The Experience in Other States

This section includes two speeches presented at the "Health Care Financing Options for Colorado" conference, September, 1979. The first speech is by George Yuen, Director of Health, State of Hawaii, and describes the operation of Hawaii's Prepaid Health Care Act mandating employer sponsored coverage. The second speech is by Brian Oberg, Administrative Assistant to the Health and Welfare Committee, Minnesota House of Representatives. It describes the operation of Minnesota's Comprehensive Health Insurance Act which sets minimum standards for health insurance policies and establishes a mandatory assocaition of insurance carriers to underwrite health insurance for people who, because of existing health conditions, are unable to buy standard coverage. Both states have been very pleased with the results of their legislation and have experienced very few problems with it.

V. Legal Issues

A law suit has been brought against the Minnesota law challenging its constitutionality. While it is too early to predict the final outcome, the State of Minnesota is confident that the law will survive this test. This section includes a speech by John Igrassia, Supervisor of the Life and Health Section of the Minnesota Division of Insurance, discussing some of the legal issues in the case.

PROJECT HEALTH

The Multnomah County Medical Society supports the concept and goals of "Project Health" in principal, as they act to care for the medically indigent in our community. The Society encourages individual physicians to give consideration to participation in this project.

POSITION: Board of Trustees 2/27/74 - Executive Committee

PROJECT HEALTH I

The Multnomah County Medical Society recommends that, in the interest of quality patient care, physicians participating in the 'Project Health' pilot program should continue to bill their usual fees for professional services. When 'Project Health' funds are exhausted, the Multnomah County Medical Society urges its members to continue to provide care for these patients.

The Society also asks the 'Project Health' staff to provide an accounting of those patients who received care, showing the number of patients receiving care, the amounts billed, and the amounts paid.

POLICY: Board of Trustees 3/27/74 - Executive Committee

LA11 2313 11.28 JA01 0020 11.28 04/03/80

TO REP. BUCHHOLDT AND HER STAFF

BERNEICE BAR, 4220 B ST., SUITE 201, ANCHORAGE, AK 99503 WAS AT THE TELECONFERENCE ON HB 977 THE OTHER DAY, AND DURING THE COURSE OF THE CONFERENCE ASKED WHAT "REHABILITATIVE SERVICES" ON P. 33, LINE 8, ENTAILED. SHE SPOKE WITH SOMEONE FROM REP. BUCHHOLDT'S STAFF (COULDN'T REMEMBER THE NAME) WHO TOLD HER THAT SHE WOULD RESEARCH IT AND SEND HER INFORMATION. MS. BAR WORKS WITH REHABILITATION SERVICES AND THIS IS OF PARTICULAR INTEREST TO HER.

MS. BAR WAS EXPECTING THIS INFO TO BE TELECOPIED TO HER THROUGH OUR OFFICE.

WILL THE INFO BE FORTHCOMING? COULD I TELL HER WHEN TO EXPECT IT? THANKS. EFFIE (ANCHORAGE LEGISLATIVE INFORMATION OFFICE)

Jan 5

LA11 2390 14.02 JA01 0066 14.02 04/10/80

TO: JAN IN REP. BUCHHOLDT'S OFFICE
HOUSE MESS

FROM BERNEICE BAR, 4220 B. ST., SUITE 201, ANCHORAGE 99503
PHONE 279-9431

I HAVE NOT YET RECEIVED THE INFORMATION WHICH I REQUESTED ABOUT THE REHABILITATION SERVICES MENTIONED ON P. 33 LINE 8, OF HB 977. YOU MENTIONED WHEN I INQUIRED LAST WEEK THAT YOU WOULD BE MAILING IT.

Sent 4-11

YOUR PROMPT ATTENTION TO THIS MATTER WOULD REALLY BE APPRECIATED.
THANKS.

LIMITS ON EMPLOYEE SHARE OF PREMIUM COST

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

ESTIMATED PREMIUM COSTS FOR NUMBER TWO QUALIFIED PLANS[1]

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

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

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

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

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

A 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

Section 18.12.040, on Page 3. This section discusses the commencement of coverage. It will mean a change in the usual probationary periods that have been set up by employers for their employees. The four week phase-in into the health care plan does not jibe with the usual two month, or sometimes three month, probation period for employees joining a company and may create a problem for an employer. We would need, here at Blue Cross, to adjust for our Alaskan employees the standard probationary period of our company. This would create a problem for our company as it would for any other company who has employees both in Alaska and in other states.

Section 18.12.070, Pages 4 and 5. This section of the legislation enables a person who has coverage as a dependent under some other health care plan to waive his coverage through his employer. That will create a complication in administration for employers. Looking at it from the point of view of insurance coverage, it will also create the possibility of selection of coverage, where the person knowing himself/herself to be in poor health will accept coverage under both types of employment and the healthy individual will not. That will result in the utilization being increased and therefore the cost to the employer for premium also will rise.

4B/11
js

Section 21.50.010(d) on Page 13. In this section of the bill an "unqualified policy" is used as terminology. There is no definition in this bill of an unqualified policy. This bill also uses the term "nonqualified plan" and there is confusion between "unqualified policy" and "nonqualified plan."

js
4B/12

Section 21.50.030(1), on Pages 14 and 15. The definition of minimum benefits needs some major corrections. All benefits offered in a state health plan should be determined to be medically necessary. A definition of medically necessary should be included in the definition section of this legislation. The reference throughout this subsection to services by varying health care practitioners never refers to them as licensed health care practitioners which I think should be inserted into the bill. The bill does not require that the service [redacted] be provided by a practitioner [redacted] within the scope of his practice. Tightening up the language will eliminate payment of claims for procedures that were provided by a practitioner whose scope of practice does not include that procedure and would eliminate payment for procedures which are not necessary to the life or health of the patient. In Subsection (D), services of a nursing home are included as a benefit. Nursing homes should be identified either as licensed or Medicare-approved.

Subsection (E) defines services of a home health agency. In the delineation of services by a home health agency I would urge you to list those services which will be covered for a patient served in his home. In other insurance contracts home health services often lists the practitioners whose services will be accepted as well as the paraprofessionals that will be included in this service. This bill, as it is now written, could result in a tremendous increase in home health costs and therefore an increase in premium price over a more restricted benefit.

Subsection (L) of this bill deals with oral surgery. While the root canal and oral surgery definitions are well worded, the wording of the language dealing with periodontal work would be very hard to administer. It would be difficult to explain to a patient that his periodontal services will be paid for if only periodontal work is done, but will not be paid for if, at the same time as having the periodontal surgery, there is some extraction or repair of teeth.

In subsection (N) the provision of payment for transportation must be more succinctly defined. As written,it is very broad and will be very expensive and administration will be difficult.

js
4B/13

Section 21.50.030(2) on Page 15. Subsection 2 deals with the exclusions for services or articles which will not be covered in the insurance. In (b) of that section, the phrase "birth defect" is used. I would suggest that a definition of birth defect be included in the definition section.

I would urge you to add a 5th exclusion to this section for services of custodial care. I would urge you to add a definition of custodial care which might read "Any portion of a service, procedure or supply rendered to manage a patient's illness, disease or injury after he or she has reached a point in recovery where such management, can no longer be expected to improve the condition."

Subsection (3) of this minimum benefit section lists benefits with specialized co-insurance, premium deductibles, and limitations. A definition of "well baby care" is needed. The inclusion of routine physicals and annual physicals should be limited more than the present language. Annual physicals, technically, are not prescribed by a physician. To control overutilization of this benefit, you may want to look at some of the recent changes announced by the American Cancer Society where they are recommending that cancer check-ups for persons between ages 20 and 40 be limited to one every three years. They are talking in terms of mammography for breast cancer detection yearly only for women over 50 and they are reducing the recommended number of chest x-rays as well as the recommended number of Pap smears from one a year to one every three years. This seems to be the trend in the detection of illness area and the language used in this bill should perhaps refer either to limitations of this sort or to dollar limitations in order to control utilization of a procedure that may not be cost effective.

Multiphasic screening should also be limited either by a dollar limitation or by a limitation on the number of procedures per year which will be paid for by the insurance.

All these changes have been suggested to eliminate the probability of excessive use, to eliminate inappropriate utilization, and to control costs to those necessary for the good health of Alaskans.

js
4B/14

Section 21.50.040 on Page 16. This section, which deals with Medicare Supplement Plans, does not seem to recognize that Medicare Supplement is also available to the disabled person under age 65 who is a Medicare recipient. The language of this section needs to take into account the fact that there are persons under 65 who are disabled who do purchase Medicare Supplement policies.

It is our concern that the benefits in this section for the Medicare Supplement Plan are so extensive that the costs will become too high for the average person to purchase a Medicare Supplement policy. The benefits which the State of Alaska would include in a Medicare Supplement Plan (which are not now included in Medicare-approved services) are prescription drugs, prostheses, durable medical equipment, oral surgery, and transportation. Two of the services, those of physical therapists and alcoholism treatment, are now limited by Medicare and an appreciable portion of the costs for services of this sort would then be born by the Supplement Plan. Since there is also a limitation of a $1,000 per person out-of-pocket for these covered services, it is expected that the utilization of these benefits would be extremely heavy and would therefore make the cost of the Medicare Supplement Program extremely high.

At the time that Congress was debating Medicare coverage, prescription drugs, transportation, and custodial care in nursing homes were all subjects which were debated and which were dropped out of Medicare coverage because the Federal Government did not feel that it had sufficient revenues to pay for these coverages. While the addition of these benefits would be of interest to many senior citizens in Alaska, the cost of providing these services may result in pricing the Medicare Supplement contract out of the reach of anyone on a retirement income.

js
4B/15

Section 21.50.080, Subsection 6(c), Page 21. This section specifies a 12-1/2 percent limit for retention costs and agent fees for the writing carrier of the State Plan. I know of no information which would indicate that this is a reasonable percentage. I would suggest that the Division of Insurance determine a reasonable limit and adopt it in regulations after sufficient experience indicates what that limitation should be.

In Section 6(e) the wording should be amended on lines 23 and 25 of Page 21 so that the losses which the members of the association will share will be losses due to administrative as well as claims expenses. I would suggest that on lines 23 and 25 that the words "and administrative" be inserted between the word "claims" and "expenses".

Section 21.50.080(6)(f) concerns the assessment of losses and they are offset either by income tax or premium tax payable in the State of Alaska. This offset will of course result in a loss of state revenue. It is the opinion of those persons at Blue Cross who have studied this legislation that the write-off should be eliminated and instead that rates for the state plan should be adjusted to assure revenue sufficient to refund the assessments paid by members of the association. This would eliminate the loss of revenue to the state and would place all members in an equal status regardless of whether they are accident and health insurers or nonprofit health service plans.

If an offset is included in this legislation then the second sentence of paragraph (f) should be amended in order to assure that the report to the legislature is placed within a workable time frame. It is my understanding that premium tax payments are made on a calendar year basis. They must be reported to the state during February of any year and are payable by March 31 of that year. A report concerning the losses from premium tax which is due before the end of January would not be feasible in my estimation.

js
4B/16

Section 21.50.100, Page 23. This section specifies the method by which the state plan is administered, however, there is no definition of a source of monies from which claims will be paid if those claims are in excess of the premium paid into the plan. There is no money available to continue payment of claims until the assessment against losses is paid as this legislation is now written.

Section 21.50.130, Pages 26 and 27. In this section a "individual coverage qualified plan" is referred to. I can find no definition of what an individual coverage qualified plan is.

Subsection (b) of this section is unclear. Blue Cross assumes that this subsection refers to a widow/widower of a person who has a conversion policy but we are not certain of this interpretation. If this section refers to the right of the widow/widower of a group member, then the language is obtuse and administration of that provision will be difficult.

js
14B/17

Section 21.50.200 on Pages 27 and 28. One of the definitions in this section is the definition of "dependent". You have specified that this includes "A household member who is financially dependent on the primary insured". That addition to the usual "family" dependents which can be identified by a legal action (marriage, divorce or adoption) or by birth will create administrative headaches and excessive additions or deletions on dependent lists. This definition of dependent would be open to abuse. It is conceivable that "dependents" could be changed readily creating administrative problems and claims payment problems and that dependents, in some cases, might be added solely for the ability to provide them with health care coverage through the policy being paid for by the primary insured's employer. That portion of the definition of dependent should be deleted from this bill.

js
4B/18

METHOD USED TO DEVELOP FISCAL NOTE FOR HB 977

House Bill 977 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 HB 977, 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 HB 977.

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

Medicaid money for services that they are already providing to persons eligible for AANHS, 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 HB 977, the amount in that fiscal note was doubled to reflect the fact that HB 977 would 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 HB 977 does not say specifically that the provision would apply only to the Medicaid and GRM 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 GRM 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.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

Foreword

This study was prepared by Sharman Haley of the Legislative Affairs Agency staff at the request of Representative Thelma Buchholdt. The issue of access to health care in Alaska is a matter of general concern to many other policymakers as well, and we are therefore making the report available, with Ms. Buchholdt's permission, in this more convenient format.

Interested readers are invited to share with us any comments they may have on the report or its subject matter.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
April 1978

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SUMMARY

With the costs of health care continuing to rise, third party health coverage is becoming increasingly crucial for the protection of people's health and financial security. A variety of state and federal health programs and private health insurance policies provide piecemeal third party coverage for Alaska's civilian population. It is estimated that 20 to 25 percent of Alaska's non-Native, non-military-dependent civilian population are without third party health coverage of any kind. The comprehensiveness of coverage or level of coverage provided the covered population is not known; in some cases the coverage may be inadequate to protect people from financial hardship or inappropriate levels of medical care. There are a variety of approaches the legislature may consider to improve or extend third party health coverage in Alaska. These options include: state subsidized health insurance, state mandated employer subsidized health insurance, state regulation of health insurance carriers, and expansion of the state's Medicaid program. While plugging these coverage gaps would not cure all the ills of the health care system, it would be a step.

I. INTRODUCTION

With the dramatic increases in health care costs in the last decade or two, routine medical care has become for many an unaffordable luxury. A serious illness or accident for them would be a financial catastrophy. More and more people are relying on health insurance and other kinds of third party health coverage to finance the major part of their unpredictable health expenses. To an ever growing extent people are demanding third party coverage for routine health expenses as well. Third party health coverage has become an integral and crucial part of the health care system.

Because public and private third party payers foot the bill for two-thirds of the nation's personal health care expenditures, their policies profoundly affect the nature and terms of the health care itself. For example, many insurance policies will pay for hospital care, but not nursing care; so patients are hospitalized in many cases where nursing care would be sufficient, and less costly. Similarly, many people will not see a doctor until health conditions become acute, because preventive care is not customarily covered. The policies of third party payers also affect providers in terms of the rates they charge, the quality of care they provide, and the services they can afford to develop.

As third party health financing becomes paramount to ensure financial access to health care, the gaps in third party coverage become more glaring. The following chapters of this report address themselves to

these gaps in third party coverage. Sections II and III describe all the major public programs and private plans which currently provide third party health coverage in Alaska. Section IV analyzes available data on the extent of existing coverage and identifies some of the gaps both in terms of the covered population and services covered. Section V outlines a smorgasbord of legislative remedies to plug some of these gaps. The concluding chapter indicates other areas which may be of concern to the legislature.

II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

As this report is concerned primarily with comprehensive health care, only the public programs which cover a broad range of health services and serve a significant portion of the population are described here. There are a number of programs which cover only specific health services, such as family planning or treatment of occupational injuries, or serve only a narrowly defined segment of the population, such as crippled children, which are not described here.

Alaska Area Native Health Service

The Alaska Area Native Health Service (AANHS) is a regional administrative unit of the Indian Health Service, which is a branch of the U. S. Public Health Service. It serves an estimated 65,000 eligible Alaska Natives, spouses, and dependents.

Primary care is provided in villages by 216 community health aides, each selected by the village council and paid under contract with AANHS. These aides are responsible for giving first aid in emergencies, examining the ill, reporting their symptoms to the physician, carrying out the treatment recommended, instructing the family in giving nursing care, and conducting on-going health education in the villages. Routine primary care is also delivered in the villages by itinerant doctors, nurses, dentists, and other health professionals.

If the injury or illness is serious enough to require inpatient care or more specialized diagnosis and treatment, the patient is referred to the nearest of the seven field hospitals. This secondary level of

care includes routine hospital admissions for common illnesses or injuries, for minor surgical conditions, or for pregnancy. The field hospital staff also provides primary care for their immediate community.

Serious or life-threatening illnesses or injuries are referred to Alaska Native Medical Center in Anchorage for treatment under the immediate direction of a specialist. Major surgery and complex diagnostic procedures are performed at the Medical Center. The Alaska Native Medical Center also provides primary health care for the Anchorage area AANHS eligibles and secondary health care for the Anchorage Service Unit.

In areas where direct health care by AANHS is not available, or for services which AANHS is unable to provide, health care is purchased under contract from private physicians, dentists, optometrists, hospitals, and pharmacies by AANHS on behalf of Native patients. Highly specialized treatments, such as heart surgery or kidney transplants, are referred out-of-state. In areas of the state where private health services exist, contractual care is an important component of the AANHS delivery system.

Despite the comprehensive design, there are gaps in this delivery system. Budgeted funds for contractual services are limited, and frequently become depleted long before the next allocation. If it is not an emergency condition, the patient must wait, or else pay for the treatment himself. If it is an emergency condition, transportation is usually arranged to another delivery point.

U. S. Public Health Service

The Bureau of Medical Services, a division of the U. S. Public Health Service akin to Indian Health Services, provides direct comprehensive health care for the Coast Guard and merchant seamen, and provides occupational health care and safety services for all federal employees. Federal health care responsibility for seamen derives from a 1798 act of Congress providing for the "relief of sick and disabled seamen".

In Alaska this care is delivered by the Alaska Area Native Health Service under contract with the BMS. In addition to an estimated 24,000 Coast Guard personnel and dependents, and bonafide merchant seamen, many fishermen are eligible for Public Health Services. Fishermen and other boaters qualify if they are owners or principal operators of a documented vessel. A documented vessel is a seaworthy power boat registered with the Coast Guard which could be utilized by the Coast Guard in case of a national emergency. There are an estimated 3,750 documented vessels in Alaska, including fishing boats and pleasure boats. There may be more than one principal operator of a boat. Dependents are not covered.

Uniformed Services Health Benefits Program

The military provides comprehensive health care to enlisted personnel through military medical facilities and staff. They also provide comprehensive health care to retirees and military dependents through the Uniformed Services Health Benefits Program (USHBP). USHBP provides health services to military dependents in two ways: through military medical facilities and staff on a space-available basis, and through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) when necessary medical services are not available through

military facilities. CHAMPUS is a supplementary health insurance plan purchased from a private carrier. CHAMPUS will reimburse 75 - 80 percent of allowable charges for necessary medical care. A $50 deductible is also collected on outpatient services. The CHAMPUS carrier in 1975 estimated that 55,000 dependents and retirees were covered in Alaska.

Medicare

Medicare is a federal health insurance program for people 65 and over, and certain disabled people under 65. It is financed by a combination of employee contributions, employer contributions, monthly premiums and federal funds, and is administered by the Social Security Administration.

Part A of Medicare is hospital insurance which is provided at no premium charge to those who have worked long enough under social security, and provided to others over 65 for a monthly premium of $54. Medicare Part A only helps pay for medically necessary covered services up to a specified number of inpatient days or home health visits. The Medicare patient must pay a deductible and a scheduled percentage of the covered costs, as well as the costs of uncovered services and services beyond the limits of Medicare coverage. The Part A hospital insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility when it is medically necessary following a hospital stay, and certain prescribed services from a home health agency following a hospital stay. Medicare does not pay for custodial or long-term care.

Part B of Medicare is medical insurance. Anyone eligible for Part A hospital insurance is eligible for Part B medical insurance at a monthly premium of $7.70. Medicare medical insurance can help pay for doctors' services, outpatient hospital care, outpatient physical therapy

and speech pathology, and many other health services and supplies which are not covered by Part A hospital insurance. The medical insurance enrollee must pay the first $60 worth of covered services each year. After that the medical insurance pays 80 percent of "reasonable charges" for covered services and supplies. "Reasonable charges" are computed each year by Aetna (the Medicare carrier in Alaska) based on billings the previous year. The actual charges by the provider may exceed the "reasonable charges" covered by Medicare, and the patient must pay the difference, as well as paying the uncovered 20 percent of the "reasonable charges". Among the services not covered by Part B medical insurance are: routine physical exams, prescription drugs, eye glasses, hearing aids, dentures, dental care, and chiropractic services.

Though people over 65 must have accumulated sufficient work under the social security system to automatically be eligible for hospital insurance, the 1966 law "grandfathered in" all the social security ineligibles at that time. It is estimated that now 99 percent of the non-Native population in Alaska over 65 are enrolled in Medicare.

Medicaid

Medicaid is a medical assistance program funded jointly by the state and federal governments. In Alaska it is open to public assistance clients and eligibles, and certain other needy people in nursing homes, or inpatient psychiatric hospitals. Medicaid clients receive care from participating private providers, who then bill the Medicaid program. Alaska's Medicaid program covers all the federally mandated services: inpatient and outpatient hospital services, physicians services, x-ray and lab services, skilled nursing home services, home health

services, family planning services, transportation, and early and periodic screening, diagnosis and treatment (EPSDT) for eligible people under the age of 21. In addition, the state program covers a few optional services: inpatient psychiatric care for those over 65 or under 22, intermediate nursing home care, eye glasses, treatment for speech, hearing and language disorders, and approved outpatient mental health care. The state Medicaid program does not cover the following services for which federal match is available: prescription drugs, dental care or dentures for those over 21, prosthetic devices for those over 21, physical therapy, chiropractor's services, or preventive care for those over 21.

In FY 1976, 22,952 Alaskans, or 5 percent of the civilian population, were enrolled in the categorical public assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, Aid to Families with Dependent Children, and Supplemental Security Income) and eligible for Medicaid.

To be eligible for public assistance, and therefore Medicaid, a person must not only meet income criteria, but categorical criteria of need, such as over 65, blindness, mental or physical disability, under 18 and deprived of the care of one or both parents, or a person related to and caring for eligible dependent children. Many Alaskans, such as low income families with both parents present, meet the income criteria for public assistance but do not meet the categorical criteria, and are therefore not eligible for Medicaid.

Because Natives receive much of their medical care from the U. S. Public Health Service, Native eligibles account for only one-third of Medicaid expenditures even though nearly two-thirds of the Medicaid

eligibles are Native. This may change with the implementation of the Indian Health Care Improvement Act of 1976. This federal law requires that medical care provided to Native Medicaid eligibles by the U. S. Public Health Service be billed to the state Medicaid program, with the state receiving 100 percent reimbursement from the federal government for Medicaid expenditures in behalf of Natives. This new billing procedure has not yet been implemented in Alaska.

General Relief Medical

The state-funded General Relief Medical program covers needy people and services not covered under Medicaid, as funding permits. People who meet the income criteria for Medicaid but do not meet the program criteria and have no prior health resource (such as Indian Health or health insurance) are eligible for all General Relief Medical covered services. Any Medicaid eligible is also eligible for those General Relief Medical services not covered under Medicaid. The GRM program covers the same services as Medicaid (inpatient and outpatient hospital care, physicans services, x-ray and laboratory services, nursing home care, home health care, mental health care, eyeglasses, treatment for speech, hearing, and language disorders, and transportation) plus many more not covered by Medicaid, such as drugs, physical therapy, prosthetic devices, hearing aids, chiropractors, podiatrists, emergency dental care, wheelchairs and other equipment. Nearly all services except hospital and physican care must be pre-authorized by the state program administration, and most services are subject to strict limitations. Medically justified services will be refused when funds are not available. The budget is established by the legislature.

The General Relief Medical program ensures that all Alaskans under the income limits for public assistance have some health care resource. For a single adult paying over $35 rent per month, that income limit is $334 per month; for a couple it is $490. For a family the formula is based on adjusted net income; the first $30 of earned income, one-third of every dollar of earned income after that, and reasonable work-related expenses are deducted from the net income to maintain an incentive for cash assistance recipients to work. Therefore, there is no simple dollar figure for General Relief Medical eligibility for a family. While the estimated 22,950* Alaskans below the federal poverty level might meet the income criteria for General Relief Medical, it should be noted that many of these are Alaska Natives or Medicaid eligibles, and so have a prior health resource. In FY 77, $3.7 million was expended in the GRM program, and $4 million was budgeted for FY 78.

Catastrophic Illness Program

The state Catastrophic Illness Committee administers a program that provides financial aid for persons of all income levels who have suffered a catastrophic illness--an illness that incurs high medical expenses. Total medical bills related to the illness must exceed $1000 in a 12 month period after all sources of third party payment, such as state and federal medical assistance programs, private and military health insurance, and awards in legal actions, have been exhausted. The Committee

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* U. S. Department of Commerce, 1976 Survey of Income and Education Preliminary Results.

meets twice a month to determine the eligibility of applicants and the amount of medical assistance to be awarded, using a formula based on annual income, number of dependents, amount of assets, and the assumption that the applicant's share will be paid to the provider on a payment schedule covering a period of at least three years.

In its second year of operation, the program has granted aid to over 80 persons with the number of applicants steadily increasing as the program becomes better known. The largest portion of applicants are those in lower income brackets who do not qualify for other forms of aid. While applicants would have to be refused aid if funds were depleted, it is anticipated that the $450,000 appropriation for FY 78 will be adequate to meet this year's needs.

III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

Private Health Insurance

Health insurance pays benefits on an indemnity basis. When covered health expenses are incurred, the subscriber submits a claim to the insurance carrier. Benefits are normally paid to the subscriber. Normally, benefits are calculated on the basis of "reasonable charges" for each service or a schedule of maximum fees, rather than actual charges, and the subscriber must pay the difference if actual charges are higher.

Hospital expense coverage is the core of health insurance, because hospital care is the largest single medical expense. Hospital costs have risen faster in the last ten years than any other item in the consumer price index, and they continue to rise. Similarly, surgery has become a highly technological and expensive component of medical care, and the expansion of surgical expense coverage has followed closely the expansion of hospital expense coverage. Regular medical expense coverage is the third component of what is known as "Basic Protection", and covers physicians' services, and other medical services such as x-rays and lab tests. Basic protection policies are designed to cover one or more of these key medical services and the bulk of unpredictable medical expenses. Basic protection policies typically have limits on the number of days, dollars or visits covered, as well as a schedule of maximum benefits for services.

Major medical is the other main category of health insurance, and is designed to protect the subscriber from very large, unpredictable

medical expenses. It covers virtually any kind of health care prescribed by a physician. The maximum benefits under major medical is characteristically high, and the subscriber is typically required to pay a deductible and co-insurance as a disincentive for unnecessary utilization of medical care. Major medical insurance can either be designed to supplement a basic protection policy, or to incorporate basic protection and provide comprehensive coverage.

Blue Cross

Blue Cross is not an insurance company, but a hospital/medical service corporation, along with Fairbanks Physicians' Service and Delta Dental. As well as being non-profit, a hospital/medical service corporation differs from an insurance company in that it contracts with health care providers to deliver services to subscribers. The providers bill the corporation directly for the services provided, according to a fee schedule established in the contract. The subscribers pay a flat monthly premium for the coverage.

Blue Cross is specifically a hospital service corporation and maintains contracts with all the general hospitals in the state (not military or PHS hospitals). Fairbanks Physicians' Service is a medical service corporation and contracts with local physicians for services. Delta Dental is a dental service corporation and contracts with local dentists.

Blue Cross, however, covers more than just hospital expenses. Blue Cross provides major medical coverage, and subscribers are required to pay deductibles and co-payments, just like an insurance policy. Covered

expenditures delivered by providers not under contract with the service corporation are handled like insurance claims, on an indemnity basis. Benefits are based on "reasonable charges" and the subscribers must pay the difference if actual charges exceed "reasonable charges".

Pre-paid hospital/medical service plans are typically less expensive than health insurance through private carriers for several reasons: 1) they are non profit corporations, and any money in excess of their benefit payments and operating expenses usually goes toward equipment purchases for participating providers; 2) through their contracts with providers they are able to exert some cost and quality control pressure on providers, however, the effectiveness of this is mitigated by the extensive use of cost-plus contracts; and 3) though they do advertise, they do not deal through insurance agents and do not pay commissions. The end result is that an estimated 90 percent of subscriber premiums to an established hospital medical service plan are paid out in benefits, while only 50 to 80 percent of subscriber premiums to a private insurance carrier are paid out in benefits.*

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a full range of health care services to enrollees either directly through plan-owned facilities and plan-employed providers, or by contract with private facilities and providers. Enrollees pay a flat monthly rate for compre-

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* Source: Don Koch, Alaska Department of Commerce and Economic Development, Division of Insurance.

hensive health care, with no deductibles or co-payments. HMOs have proven to be the most cost effective form of comprehensive health care services, because they are the only form of health care delivery which has built-in cost controls and an orientation toward preventive health care. HMOs have demonstrated significantly lower hospital utilization rates than any other kind of health care plan. Hospitalization continues to be the largest and fastest growing component of health care expenses nationwide.

The federal government has taken a great deal of interest in HMOs. There is a federal loan program for planning and establishing qualified HMOs, there is a federal law requiring large employers in HMO service areas to offer HMO coverage as an alternative to health insurance benefits, and DHEW is currently organizing a conference of labor and industry leaders to promote the HMO concept.

Alaska has one HMO in the planning stage, the Greater Anchorage Health Plan.

Teamsters

In most union health plans, employer contributions for health benefits are paid into a trust fund, and the trustees of the fund purchase group insurance for eligible union members. The Alaska Teamster-Employer Welfare Trust is unlike other union health trusts in that it is a self-insurer. In other words, the Teamster trustees do not purchase health coverage from a private health insurance carrier; they are their own carrier, and pay health insurance benefits to qualifying Teamsters directly from their own trust fund. In addition to a health insurance plan, the Alaska Teamster-Employer Welfare Trust offers an alternate

HMO-type plan called the Alaska Health Plan. The Alaska Health Plan is not officially an HMO under federal law because it does not offer open enrollment and does not provide the full range of services required of a qualified HMO. However, its operation is similar to an HMO. The Alaska Health Plan contracts with the Alaska Clinic and the Alaska Hospital and Medical Center to provide preventive, curative, and rehabilitative health services to plan members. The relationship between the Teamsters and the Alaska Hospital is more than just contractual, however, as Teamsters financed the hospital and serve on the board. The Teamster Alaska Dental Plan is also on an HMO model, but it differs from the health plan in that the Alaska Dental Clinic is directly owned and the dentists are directly employed by the Teamsters.

There are an estimated 28,000 Teamsters Local 959 members in Alaska, though they are not all eligible for health benefits. Eligibility is determined by the number of hours worked, and with the high post-pipeline unemployment, some Teamsters have exhausted their health benefits.

IV. AN ANALYSIS OF THE EXTENT OF HEALTH CARE COVERAGE AND GAPS IN COVERAGE

The Covered Population

Nationally, 178 million people - more than 8 out of 10 persons in the civilian non-institutional population - had some form of private health insurance in 1975, according to the Health Insurance Institute. The same survey reported 250 thousand people in Alaska, (two thirds of the civilian population) had private coverage.

The major public programs, U.S. Public Health Service, Medicaid and Medicare, provide health coverage to an estimated 20% of Alaska's civilian population. It is not known to what extent public coverage duplicates private coverage state-wide. However, random sample surveys were conducted in 1974-75 in both Anchorage and Kodiak Island Borough with questions regarding health coverage. The Anchorage survey reported that 79.9% of the sample had third party health coverage of some sort, and 20.1% had none. In Kodiak Island Borough 92.6% of the respondents reported third party health coverage, while only 7.4% reported none. This high percentage of health coverage in Kodiak Island is largely due to the high proportions of Indian Health Service eligibles (over 40%) and military personnel and dependents (over 25%). Those 7.4% without coverage constituted over 20% of the non-Native non-military or military dependent population.

The 20.1% of the Anchorage sample without health coverage constituted over 25% of the non-Native non-military or military dependent population in Anchorage.

If we can assume that a similar percentage (20-25%) of the non-Native non-military population state-wide currently are without third party health coverage from any source, 56 to 71 thousand Alaskans totally lack third party health coverage.

The biggest hole in this coverage patchwork is moderate and low income people who are self-employed or marginally employed, or non-union employees of an employer who doesn't provide health benefits. These people are above the income eligibility standards for Medicaid or General Relief Medical, yet their cash income is not adequate to afford either the expense of private health insurance, nor the expense of many medical services on a fee-for-service basis. This group includes farmers, shop owners, small contractors, temporary and part-time employees, casual laborers, subsistence providers and the unemployed. It also includes a large number of non-union workers, particularly those working for small employers, such as child care workers, waitresses, clerks, clerical workers, delivery truck drivers, gas station attendants and construction workers in home building. And of course the dependents of these bread-winners normally lack coverage as well.

In Alaska there are many seasonally employed people as well who have health coverage only part of the year while they are employed, such as loggers and cannery workers. Most construction workers (outside of home building) are unionized and have "hour banks" for health benefits such that if they work enough hours over the summers their accrued health benefits will last through to the next season. However, when there is not enough work to go around, many people are not able to accumulate enough health coverage to last the winter.

Services Covered

Health plans vary widely in the services covered and the levels of coverage provided. The foregoing analysis distinguished between people who have any sort of third party health coverage, and those who have no coverage at all. We have not yet considered whether those with some coverage have coverage that is adequate to protect them from financial hardship. Some policies, for instance, are specialized and cover only hospital expenses, or only surgical expenses. Many policies do not cover particular services such as prescription drugs, office visits, or nursing care outside of a hospital.

In the Anchorage survey, while 20% of the respondents lacked hospital coverage, 24% of the respondents lacked surgical coverage, 46% lacked coverage for visits to the doctor's office, 60% lacked dental coverage, and 70% lacked mental health coverage.

Many policies have limits on coverage that are exhausted by severe illnesses, or require co-payments which can add up to substantial sums. Many policies limit their payments to "reasonable charges" as defined by the insurance company, regardless of the actual charges, and the consumer must pay the difference.

It is not difficult for a consumer even with some health insurance to incur heavy financial losses due to health care expenditures. The following statistics suggest that insurance companies in fact are not paying the bulk of health care expenses.

While the private health insurance industry claims to serve over 80% of the nation's civilian non-institutionalized population, in 1976 they paid only 26% of personal health care expenditures nationally.

Government programs paid another 40%, and consumers paid 32% directly. The remaining 1% of personal health care expenditures was paid by philanthropic organizations.[1]

1 "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

There are several measures which have been conceived to fill some of the gaps in health care coverage. Maine, Connecticut, Rhode Island, Minnesota, and Alaska have all enacted some form of state assistance for catastrophic illnesses. Connecticut and Minnesota have also made some cautious steps toward more comprehensive coverage with legislation that regulates health insurance carriers, mandating minimum benefit standards, controlling premium rates, and mandating pooled coverage for high risk subscribers. Hawaii has taken the boldest step toward expanding health coverage by mandating that all employers subsidize health coverage for their employees. These states are pioneers. Their state health insurance programs are new, and are being watched with interest by other states.

No state has instituted a universal or a state subsidized comprehensive health insurance program. While universal coverage is the goal for proponents of government sponsored health coverage, no one has been able to develop an acceptable scheme of financing universal coverage, either at the state or national level. If universal coverage is not yet a viable option for states, we are left with a patchwork approach to health coverage, covering only the holes we can reach. The following is an inventory of some of the "patches" available to state legislatures, in order of decreasing cost to the state.

Universal Coverage

Uniform and universal coverage for all residents is the fairest and most expensive approach to state sponsored health insurance. If group coverage comparable to the plan for state employees was purchased by the state for all state residents without federal health coverage, it would cost about 87 million dollars. Such broad coverage is certainly unnecessary because it duplicates and discourages coverage from other sources. It could also cause a substantial migration of people seeking free health coverage into Alaska. No state has tried such a plan.

Coverage for the Uncovered

State sponsored health insurance for all residents without coverage from other sources would avoid the problem of duplicating coverage, but it would still discourage private coverage and cause in-migration. Groups and individuals would drop their private coverage because they know the state would pick them up. In the long run, the program would approach universal coverage. Using estimates of the currently uncovered population, the cost for such state purchased coverage could be anywhere from $27 million to $40 million dollars in 1977. No state has tried such a plan.

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proach state subsidies could be targeted for those who need them most. The main target groups to be considered would be the unemployed, part time, employed, and the low income self-employed--people without access to group coverage, or the financial resources to pay for private insurance. This plan avoids some of the problems of the broader coverage as discussed above, because it is not likely that significant numbers of people would leave their jobs to get state subsidized health insurance, nor is it likely the unemployed people from out-of-state could afford to move to Alaska just to get coverage. This approach would dovetail well with mandatory employer coverage as discussed later.

The cost to the state of subsidizing health care premiums for these groups would be substantial, but it could be contained in at least two dimensions: the eligible population could be limited by definition, and the state's rate of subsidy could be set at any desired level. To discourage in-migration, the state subsidy could vary according to length of residency, with first year residents getting little or no subsidy, and long term residents getting a more substantial subsidy. Or the state subsidies could vary according to the income of the subscriber with a higher subsidy for low income people and a lower subsidy for higher income people.

A sliding scale of premium subsidization would provide a continuum of access to health care insurance up and down the income scale, avoiding the injustices of an arbitrary threshold. However, it would also require an extensive investigation into each subscriber's income to determine which rate they are eligible for, much like the eligibility determination for welfare. Eligibility would constitute the larges. administrative task under this plan.

The total premium costs for group coverage for the unemployed, self-employed and the non-labor force population without coverage from public sources would be an estimated $25 million. If the state opted for less than 100% subsidization, some members of the target groups would not enroll. The resulting savings to the state would not be as large as one might expect, however, because with any voluntary plan in which subscribers bear some costs, the premiums would be higher than with a universal plan. This is due to the fact that subscribers would be self selecting toward higher use of medical care. In other words, people who do not expect to use much medical care would be less likely to purchase the insurance, while people who expect high medical expenses would be very likely to purchase the insurance. Also, many low income people who have immediate needs and expenses are less likely to purchase insurance, because the benefits of medical insurance are deferred and uncertain. Low enrollment on the whole would save the state money, but it would also contradict the purpose of state subsidized health insurance, namely to make health care available to more people. No state has ever instituted a direct health insurance subsidy program.

Income Tax Credit

A state income tax credit for health insurance would be an indirect way for the state to subsidize health insurance, and avoids many of the administrative problems associated with direct subsidy programs. The Alaska tax forms would provide a line for the taxpayer to enter the appropriate credit against their Alaska state taxes. The credit would be equally available to all state residents filing income tax returns,

including employers. Yet at the same time, if it were a fixed dollar amount, it would be a relatively greater benefit to low income people than to higher income people. If a fixed dollar tax credit were offered, the state would probably want to require evidence that the health insurance purchased meets minimum state standards. This would ensure that state dollars would subsidize only health coverage of acceptable quality, and no one could collect the credit for just token coverage costing less than the credited amount.

If the credit were computed as a percentage of the premium cost, with an upper limit provided, no minimum benefit level would need to be established, because the state would be contributing only a token amount to token coverage, and a more substantial amount to more substantial coverage.

This alternative would not reach low income people who do not file tax returns, nor those who cannot afford even a percentage of the premiums for health insurance. It would be extremely difficult to estimate how many people would respond to such an incentive program. A higher credit could predictably get more response. The current state employee health plan has an annual premium well over $800. If an $800 tax credit were offered currently covered taxpayers, the initial costs would be an estimated $68 million, and would rise as more people responded to the incentive. If a $250 credit were offered, the initial cost to the state would be around $21 million.

Medicaid Medically Needy Program

"Medically needy" is an optional Medicaid program with federal matching dollars. Currently Medicaid provides medical care to anyone eligible for public assistance grants under categorical programs: Aid to families with Dependent Children, Old Age Assistance, Aid to the Blind, and Aid to the Disabled. These public assistance programs have program criteria (blindness, age, disability, dependent children) as well as income criteria for eligibility. There are many Alaskans who meet these categorical criteria, but have incomes a few dollars above the income threshold for public assistance eligibility. These Alaskans are able to meet their daily living expenses out of their own incomes, but medical expenses put a severe strain on their budgets, and often deplete their resources to the point that they must again resort to public assistance grants and Medicaid.

Under the medically needy option, people who meet program criteria but have incomes within a limited range above the income threshold for public assistance grants, are also eligible for Medicaid. Twenty nine states, two territories, and the District of Columbia currently participate in the medically needy option. Medically needy includes a "spend down" provision. This means that people categorically eligible but financially ineligible can become eligible for medical assistance if their income above the medically needy threshold is spent on medical bills. The difference between the person's income and the medically needy threshold is essentially an income-related deductible which must be met to be eligible for Medicaid. The medically needy program and the spend down provision soften the line between people eligible for both

public assistance grants and Medicaid, and those ineligible for either due to a few dollars more income. It also serves as an emergency medical resource for low income people with categorical eligibility who cannot afford adequate health insurance.

Originally, the Alaska Medicaid program was limited to the federally mandated target groups and benefits. The primary reason for this was that 65% of Medicaid eligibles have another medical resource--the Alaska Native Health Service--which is 100% federally funded. Medicaid is funded jointly by the state and federal governments. The state has kept its 100% state funded General Relief-Medical program which can pay for medically necessary services not provided by Medicaid, or ANHS, subject to state administrative controls.

Since the Indian Healthcare Improvement Act of 1976, the federal government must reimburse the State for Medicaid expenditures on behalf of Natives. This act has not yet been implemented in Alaska, but when it is implemented, it will significantly reduce the fiscal liability of the State for Medicaid. A program expansion such as Medically needy would then become much more feasible. Some of the medical assistance now provided under the state's General Relief-Medical program could be paid for jointly by the state and federal governments under the Medicaid medically needy program. HEW Region X estimated that, based on Washington State experience, a medically needy program would expand the current Medicaid budget by 10-13%.

Unlike other Medicaid eligibles, for "spend downers" (those who must spend their excess income on medical bills to become eligible for Medicaid under the medically needy option) there is a dual liability for

medical bills - the person is responsible for medical bills until the deductible is met, then Medicaid takes over. This dual liability causes administrative problems. It is difficult to determine exactly when the deductible has been met and when eligibility commenced, which bills the patient is liable for, and which Medicaid is liable for. The only states that have developed an efficient system of administering the spend down program are out of compliance with federal regulations.

Mandatory Employer Coverage

Of the various approaches open to the Legislature for extending health care coverage, the program with the least impact on the state budget for the greatest increase in coverage would be mandating employer sponsored coverage available to all employees. Such legislation would stipulate minimum benefit standards for employee group plans and would set minimum rates for employer contributions to the premium costs. To make such a program more palatable the legislation could also provide that the state subsidize premiums when necessary in small, marginal businesses.

Hawaii for example requires that employers pay at least 50% of the premium. Employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, are entitled to state subsidies in the amount that the excess over 1.5% of the payroll exceeds 5% of the employers income from the business. Though several employers applied for state subsidies under the Hawaii legislation, none were found to be eligible according to these criteria.

Mandating employer coverage however has potential side effects. Mandatory group health plans would be similar to raising the minimum wage - it would be more expensive for employers to employ people, so fewer people would be hired. Though the resulting unemployment would probably not be significant among skilled and experienced workers, teenage workers would certainly be hit hardest. On the positive side, mandating employer coverage would be most beneficial to women and minorities who often work in the non-union low paid jobs without fringe benefits such as health insurance.

High Risk Reinsurance Pools

Many people are unable to purchase full health insurance coverage because existing health conditions (a weak heart, chronic illness, etc.) make them a bad insurance risk. To fill this gap in health insurance availability, two states, Minnesota and Connecticut, have established mandatory carrier reinsurance pools. All health insurance carriers in each state are mandated to offer a health insurance package to high risk subscribers at a reasonable premium. Such coverage is reinsured by the carriers association, in which membership is mandatory, so that the risk is pooled among all carriers in the state.

Because premiums are limited to affordable levels, the high risk coverage does not necessarily pay for itself. Any deficit must either be absorbed by the insurance carriers, or by the state. Connecticut and Minnesota both have established such reinsurance pools with virtually no administrative or premium expenses for the state.

Minimum Benefits Standards

Legislation establishing minimum standards for health benefits is a form of consumer protection. It is designed to insure that purchasers of state approved plans have the recommended range of coverage to protect them from financial hardship due to large medical expenses. The legislation can either mandate that all plans sold in the state meet minimum standards, or that all carriers offer a state qualified plan. Another variation is mandating that all employment related group health plans meet minimum benefit standards.

Such standard setting legislation would be an extension of existing state regulatory powers. The impact of such regulation on the state's major carriers would probably be minimal, but some small carriers may decide to drop their health insurance business rather than comply with such regulations. The more stringent regulation, setting minimum benefit standards for all health insurance plans, may also make it more difficult for low income people to afford health insurance, because low priced, low benefit insurance would be prohibited.

The Ninth Legislature considered minimum benefit legislation in their second session. House Bill 792 would have required that health insurance policies written in the state cover less costly alternatives to hospitalization, such as nursing care and home health care.

VI. CONCLUSION

The possible legislative approaches outlined in this report are only partial. They are not solutions to the problems of the health care system in this country. The health care system has many other major problems not addressed in this report, such as: cost control, quality control, appropriate levels of care, unnecessary treatment, and access to providers. The remedies discussed in this report don't even resolve the issue that they address: that of financial access to health care. It is not likely that all these problems of the health care system can be resolved on a state by state level.

However, states can take significant steps in each of these areas, and in doing so contribute to the body of knowledge and experience on which a national solution may be built. The intent of this report is to provide the legislature with the information they need to consider whether or not state intervention to improve third party coverage in Alaska is desirable, and what, if any, the next step will be.

There are three general philosophies of state intervention in service delivery. One assumes that the private sector is capable of meeting the demand for services, and that the state need only subsidize the purchase of services to ensure the satisfactory delivery of services to the desired target group. The second assumes that additional state intervention is necessary, in the form of regulation to ensure quality or accountability, or centralized planning to ensure coordination of service delivery, or technical or financial assistance to aid the private provider, to ensure that the private sector will deliver services

to the desired target group to the satisfaction of the state. The third philosophy assumes that it is to the state's and the public's advantage, for whatever reason, to deliver the desired services directly.

The first four remedies discussed in this report, three levels of state sponsored coverage and the income tax credit, would subsidize consumers to purchase health coverage from private providers. They reflect the first philosophy, that the private sector is capable of satisfactorally meeting the expanded demand. The last four approaches, Medicaid medically needy, mandatory employer coverage, high risk pools, and benefits regulation, embody the second philosophy, that intervention on a policy level is required. The Catastrophic Illness Program, already enacted by the state, reflects the third philosophy of direct state service delivery. The state is directly providing a form of catastrophic health insurance to all state residents.

Any of these alternatives that significantly expand health care coverage would increase the demand for health care, and as a result, health care costs would tend to rise. It would therefore be prudent to accompany any legislation substantially expanding coverage with legislation instituting cost controls on the health care industry. Though cost control legislation is not within the scope of the analysis presented here, it also deserves consideration.

The alternatives discussed in this report are not exclusive or exhaustive. Many of the ideas can be re-combined with each other or with other ideas not explored in this report. State intervention in third party coverage is a subject for pioneering.

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.

PROFILE OF ALASKA CARRIERS 1978

Of the more than

300 carriers licensed to write accident and health insurance in Alaska, only

204 carriers reported any group or individual accident and health policy premium volume;

21 carriers reported over $500,000 in accident and health individaul and group premiums;

36 carriers reported $50,000 to $499,000 in accident and health individual and group premiums;

68 carriers reported 5000 to 49,000 in accident and health individual and group premiums; and

79 carriers reported less than $5,000 in accident and health individual and group premiums.

Hospital medical services corporations reported the following premium volumes:

Blue Cross of Washington and Alaska	$31,260,000
Deltal Dental Plan of Alaska	741,000
Physicians Services of Fairbanks	214,000
National Hospital Association	32,000

data from the 1979 Insurance Report by the Department of Commerce and Economic Development

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
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STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

April 14, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska

Dear Representative Buchholdt:

It's been one full week since I have returned to my desk after my visit to Juneau and the "Lower 48". Our Legislature is in the midst of winding up for a possible adjournment this Friday. Therefore, I have been running from one conference committee meeting to another, especially since my Director is in Denver, Colorado, on official business.

I want to thank you and all of your associates for making my visit to Juneau very enjoyable and interesting. I have already discussed with Mrs. Ching plans to travel up the inland sea on a cruise, if not this summer, possibly next. I do not know whether the cruise will go as far north as Juneau, but I would like to show your capital to her.

I hope my visit was of some help to you and your proposed legislation I commend you for your efforts in trying to make Alaska a better community for Americans to live in. My best wishes to you and your associates in the successful conclusion of your efforts in regards to the Prepaid Health Care Insurance. Please call on me if I can be of any further assistance to you.

My best regards to all of your staff and associates.

Aloha,

Donald Ching

STATE OF MINNESOTA

Commissioner of Banks
(612) 296-2715
Commissioner of Insurance
(612) 296-2488

Commissioner of Securities
(612) 296-6848
Executive Secretary
(612) 296-2283

DEPARTMENT OF COMMERCE
500 Metro Square Building
St. Paul, Minnesota 55101

April 9, 1980

The Honorable Thelma Buchholdt
State Representative
Committee on Health, Education and Social Services
State of Alaska
State Capitol
Juneau, Alaska 99801

Dear Representative Buchholdt:

Thank you for the hospitality you and your staff extended to me during my recent visit to your beautiful state. It was a wonderful experience for me, one that I shall never forget.

I'm enclosing a copy of the statement I presented to the Pennsylvania House Insurance Committee last year. The presentation summarizes our experience and my thoughts on mandatory insurance coverage for treatment of drug and alcohol abuse.

I shall be happy to respond to any questions or to send you additional information on our insurance statutes or on the Minnesota Comprehensive Health Association.

Sincerely,

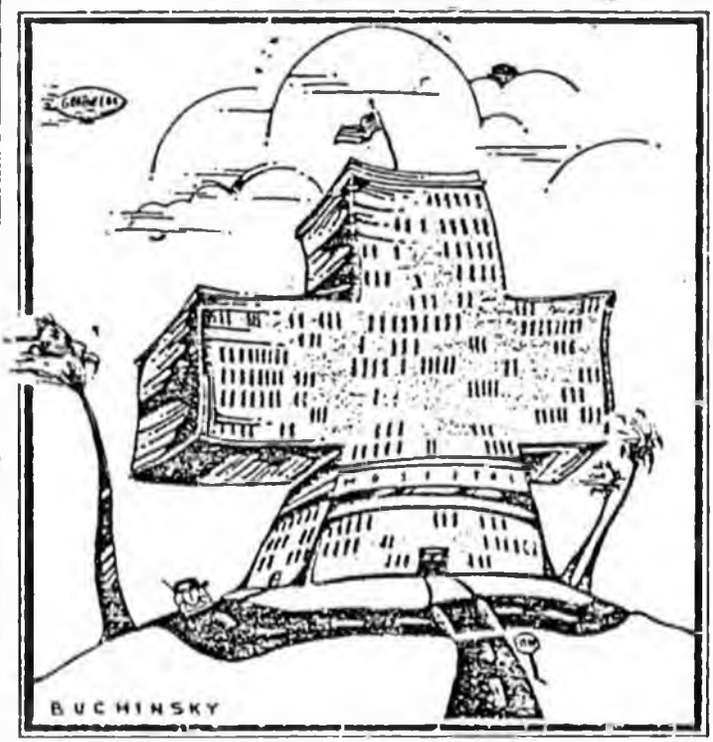
John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division

mw
enclosure
0509

Mother's Healer

YOUR HEALTH AT TOO HIGH A PREMIUM

by Hugh Drummond, M.D.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Needless to say, there were other changes.

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

MEMO

TO: REP. TERRY GARDINER
FROM: JAMES LOVE
RE: HEALTH CARE
DATE: FEB. 20, 1980

A number of legislators have expressed an interest in health care legislation, but there is currently no program slated for consideration this year. What started out as a priority for 1980 has been pushed back a year, in the minds of several legislators.

While a year's delay is comforting for many reasons, there are equally compelling reasons for action this year. First, the legislature can accomplish a number of important objectives this year which will significantly expand health care services to many low-income and unemployed Abaskans, without attempting to design a comprehensive state insurance plan. The preliminary research on these proposals is in hand now. Specific proposals could be ready for introduction within two weeks, and floor action could be scheduled within four to six weeks.

This is an election year, and political consequences are important. But although some may see health care as a risky proposition, it has always recieved good marks from the public in opinion surveys. A state with a large supplus could do worse than spend some of it on the health of it's citizens.

Senate passage of any good legislation is always problematical, but we may have a few drawing cards. For example, the House and Senate are deadlocked on the State Medical Board, over the provision which requires doctors to treat Medicaid patients. The impact of this is twofold. The doctors are put in the position of arguing that health care for the poor is a government, rather than a private sector, responsibility. The doctors are also going to put pressure on the Senate for continuation of the Medical Board. The House can trade the Medicaid provision for movement on other health care bills.

Moreover, Hackney is pushing a health bill - something called "medic-alert" - which will provide for in-home care for the elderly. (this according to news reports). It may provide a vehicle for tacking on the House health package, which will include the elderly care, plus expanded care for many other Alaskans. This would get us to a vote on the Senate floor, in an election year, where Colletta, Bradley, Hackney, Sumner and others are running for re-election.

Several people are ready for action this year. Thelma is anxious to work on health care bills, willing to introduce a package through her committee, and willing to lend significant staff time to the effort. McKinnon is personally interested, and he chairs the Finance Subcommittee on health. Parker is interested and I imagine a number of other key House members would weigh in. Thelma and Joe, with some help from Parker, could provide the lead. In some ways both have held back, waiting for you to make your move.

AkPIRG will make health care a major priority this year if the pieces can be pulled together. We have one person already working full-time on the problems faced by Medicaid patients, and she could spend time lining up support for a health package.

The key consideration, in my thinking, concerns our ability to get solid back-up research for a legislative package - on a tight time table. Thelma will ask Jan to work on this, and Parker will ask Jim Erickson, but neither individual has prior experiance in the health care field. Duncan Read, who already has requests from Parker and others, has assigned Kreinheder to look at several of the proposals that should go this year, such as the Hawaii mandatory employer coverage. However, while Duncan's staff is certainly competent, they are also sorely overextended, and will not be able to provide the day by day, blow by blow, back-up needed to prepare a bill for passage within the short time frame needed for action this year.

According to Duncan, this could be remedied somewhat if he recieved requests from several legislators to work on health care problems. With enough interest, he could approach his governing council and ask that one staff be assigned full time to the health care area. Of course this would require that the other research topics be assigned a lower priority, and this by itself may not be desired.

The one person who knows more about this area than anyone else is Sharman. Her two memorandums to Thelma in 1977 and 1978 are still the basic research on the issue. She is working as a waitress for the federal cafeteria. She is interested in consulting on health care legislation. I imagine that she would need about two months work to justify quitting her present job. She would be available within five working days.

John Crandall tells me that the House will take up a supplemental this week or next which could provide funding for additional committee staff or consultants. Thelma, I am told, would prefer to have a contract with the Alaska Center for Policy Studies, or AkPIRG, than to expand her committee staff. This woild also solve the timing problem a bit, because either the Center, or AkPIRG could start work immediately on assurances from you or thelma that funding would be forthcomming.

The Alaska Center for Policy Studies, as I may have told you, is a non-profit corporation which undertakes public policy studies. It currently has two contracts with the legislature, including contracts with Rogers' Susitna Alternatives Committee and McKinnon's Leasing Policy Committee. The board of the Center includes Joe Josephson, Chairman, Vic Fischer, Vice-Chairman, and Hugh Fleischer, Sec/Treas. Other board members include Matt Berman, Pat Dobey, and Peter Gruenstein.

Assuming that we can agree to proceed, we could begin work on the following proposals:

1. Mandatory Employer Coverage. Hawaii now requires every employer to provide health insurance. This would expand coverage to many non-union workers, particularly those in low-paying service industries, who now lack coverage. Large employers, or those who have been organized by unions, should not be a source of opposition to this bill. Hawaii provides a special program for small employers which subsidizes the cost of insurance if it exceeds certain criteria.

2. Minimum Benefit Standards. The State would be given the authority to regulate the level of service covered by health insurance policies. Several states already do this, and in addition, the National Association of Insurance Commissioners (NAIC) has developed model state health insurance legislation for setting minimum health benefit standards.

3. Medicaid Medically Needy Program. This is an optional medicaid program which extends medicaid assistance to needy people who are a bit over current income guidlines. Twenty-nine states, two territories, and the District of Columbia participate in this program. Alaska does not.

4. Amend Medicaid Statutes. Provide Oregon option to use medicaid funds to purchase health insurance; provide for funding of interest payment penalties when the state is delinquent on its bills; and add additional services to the medicaid program, such as dental care.

5. Reinsurance Pools. Several states have developed mandatory reinsurance pools to ensure health care coverage availablity to high risk persons at reasonable rates. There will be little cost to the state to implement this.

6. Expand State Direct Service Programs. Additional funding could be made available to health clinics throughout Alaska to provide care to Alaskans on a sliding fee basis, according to income. The federal government already subsidizes physicians in areas like Juneau and Palmer, where the availability of services is a problem. This would also be a big help to communities that have doctors, if there was a problem of access, such as a refusal by doctors to accept medicaid coupons.

While these programs do not close all gaps, or address all health care issues, such as cost containment, they will extend services to many Alaskans, at a reasonable cost. Nothing is particularly novel, and experiance from other states is available. It can be pulled together as a House health package within the time frame detailed below.

Feb. 22 decision to proceed

29 detailed drafting request to LA legal

March 7 bills ready for introduction

17 hearings begin in HESS

31 legislation ready for floor action

With a combination of focus, coordination, and concentration, we can put together an excellent package this session. It would affect people's lives directly and immediately.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3600

MEMORANDUM

May 27, 1977

SUBJECT: State Health Insurance (W.O. #4206)

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley SH
Research Analyst

Carter's National Health Insurance Proposal

The Carter Administration has not developed a comprehensive health insurance proposal. An advisory committee was recently established to evaluate the alternative approaches to national health insurance, and they are currently taking testimony in several cities across the country.

During the campaign, Carter promised national health insurance with the following provisions:

1. universal and mandatory coverage, implemented in stages based on priorities of need and financial feasibility;
2. comprehensive and uniform benefits with emphasis on preventive medicine;
3. financing by payroll taxes and general tax revenues;
4. cost and quality controls, uniform standards and set rates;
5. maximum personal interrelationship between patient and physician consumer choice of provider, and basic concern for the dignity of the person, unrelated to wealth or income;
6. incentives for improved delivery of services, for increased productivity, for redistribution of health personnel, and

resources for the development of alternative delivery systems;

7. consumer representation in development and administration.

Carter estimated the cost of implementing this program at $10 billion of new federal expenditures. It is not clear what his reasoning was to arrive at such a low figure, since he has not proposed a plan that can be costed out. One comprehensive mandatory plan that has been cost estimated is the Health Security Act, and the estimate of new federal expenditures for that pla is $80 billion.

There were 23 different national health insurance proposals before Congress last year, but none are moving now.

State Approaches

Two national organizations have developed model state health insurance legislation. The Conference of Insurance Legislators proposes a comprehensive health care program with universal voluntary coverage, regulated by the state, but administered by private carriers and financed by consumers. The National Association of Insurance Commissioners proposes a catastrophic health care program financed by the state. We have requested copies of these two models.

There are five states that have passed and implemented state health insurance. In Rhode Island, Maine, and Minnesota, the state provides financial assistance for catastrophic health expenses. In Hawaii, Connecticut and Minnesota, again, the state regulates private comprehensive health coverage to insure quality and availability and to control costs. No state directly subsidizes comprehensive health insurance for its residents, because it appears to be prohibitively expensive.

Hawaii: Every employer in Hawaii is required to offer a qualified health care plan to his/her employees and to pay at least half the premium. Qualified plans must meet state minimum standards. Small employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, when that excess is greater than 5% of the employer's income from the business are entitled to a state subsidy for the remainder of the premium. This statute took effect in 1975, and though several employers applied for state assistance, none were found to be eligible.

Connecticut: The Connecticut comprehensive health care plans statute insures the universal availability of comprehensive health care insurance contracts meeting state minimum standards, at standardized premiums. The Health Reinsurance Association is created with mandatory membership of all carriers in the state to pool risk for the mandated coverage. The premium rates vary by sex and age, and for group contracts by geographical area, as well. Sample quarterly premium rates are in Table I.

Table I - Sample Quarterly Premium Rates for Connecticut Comprehensive Health Care Plans

Individual/ /Group*	30-year old Female	60-year old Male
Deductible		
$200	$114.57/ /$103.11	$243.15/ /$218.82
$500	$ 85.92/ /$ 77.34	$182.37/ /$164.13
$750	$ 74.46/ /$ 67.02	$158.04/ /$142.23

* Rate for Hartford, New Haven and Fairfield region.

Minnesota: The Minnesota statute requires all health insurance carriers to offer health coverage which meets minimum state standards, and requires employee health benefits to meet minimum standards. It also established a state comprehensive health plan available to any resident who is rejected, restricted, or limited in their health coverage from the private sector. This state plan is offered by all carriers and reinsured by an association of carriers, in which membership is mandatory, to pool the profits and losses of high risk coverage.

This comprehensive health insurance statute in Minnesota took effect in January of this year. There are now 12 law suits pending challenging the law. Interstate employers complain that when Minnesota law requires a high standard of health benefits for employees, the employer must offer the same high benefits to its employees in other states. Thus, the law has impact beyond the borders of the state and may be unconstitutional.

Minnesota also has a Catastrophic Health Expense Protection Act under which the state pays 90 percent of a resident's health care expenses after the resident's out-of-pocket expenses exceed (a) 40 percent of his/her household income under $15,000, 50 percent of his/her household income between $15,000 and $25,000, plus 60 percent of his/her household income in excess of $25,000; or (b) $2,500; whichever is greater. This statute does not take effect until July 1 this year, so its fiscal impact is not known. On the basis of very crude estimates, it was budgeted for $18 million over the two year budget period, plus $50,000 for administration.

Rhode Island: Rhode Island's catastrophic health insurance statute has been in effect for three years. For the 85 percent of Rhode Island's residents who have private health coverage which meets minimum standards,

the state will pay costs of health care beyond the limits or coverage of the private insurance and above $500 or 10 percent of the resident's income. For the other 15 percent who do not have private insurance, the state will pay costs over $5,000 or 50 percent of the resident's income. The program is not well known yet. Of the 300 to 400 applications to the state for payment of health bills received each year, only half are found to be eligible. The annual state expenditure for the coverage is running $1,500,000 per year.

A health resources development fund is established not only to pay catastrophic costs but to make grants, loans, or contracts for the improvement of health facilities, services or education.

The statute also authorizes state regulation regarding consumer protection, quality of health coverage, universal availability, and rates.

Maine: The Maine catastrophic illness statute provides that the state will pay all remaining eligible health care expenses when the resident's out-of-pocket expenses reach 20 percent of the resident's net income, plus $1,000. For residents whose net worth exceeds $20,000 and such net worth includes cashable assets, 10 percent of such cashable assets are added to the out-of-pocket expenses threshold.

Considerations for Alaska

Although Alaska has a Catastrophic Illness Committee, it has not been given clear guidelines nor adequate funding.

The state approaches which have been tested elsewhere which you may want to consider for Alaska include:

1. state minimum standards for comprehensive health plans offered by private carriers;
2. mandatory availability of such plans to all state residents regardless of age or physical condition;
3. mandatory membership of all health insurance carriers in a reinsurance association to pool risk;
4. regulation of premium rates and provider reimbursements;
5. comprehensive health benefits mandated for all employees, with at least 50 percent of the premiums paid by employers;

All of the above provisions combined would still leave some people without comprehensive coverage. Self-employed, part-time or non-working people with adequate incomes would have a choice whether or not to purchase coverage, and some would choose not to. Self-employed, part-time, unemployed and non-working people with low incomes, however, could not afford to purchase private health insurance. People in this category might include farmers, homesteaders, miners, independent truckers, fishermen, small family business people, widows, retired people not eligible for Medicare, lots of low paid part-time workers (mostly women) and, of course, all their dependents. In addition, there are large numbers of seasonally employed people in Alaska who would only have coverage part of the year, such as loggers, cannery workers, and tourist industry employees. Public Health Services, Medicaid, and Medicare provide coverage for large sectors of low income Alaskans, plus General Relief-Medical and other state programs provide piecemeal health services for eligibles, but we are still far from comprehensive coverage for all.

The only way for the state to insure universal coverage is to subsidize it to the tune of millions of dollars.

Before we can proceed to draft a state comprehensive health insurance plan for Alaska, some policy decisions must be made:

1. Coverage - is enrollment voluntary or mandatory, and for whom is the coverage targeted?
2. Benefits - which expenses will be covered?
3. Financing - what portion will the state or employers pay? How much in premiums, deductibles, or co-payments must the consumer pay?
4. Cost and Quality Control - how will rates or standards of care be set?
5. Administration - what is the role of private carriers? What is the role of the state?

There will be a seminar on state health insurance plans on Friday, July 29, in Washington, D. C., sponsored by the Georgetown University Health Policy Center. There will be four forums: (1) political planning for enactment of state health insurance; (2) administrative aspects; (3) benefit coverage and eligibility; and (4) the cost of state health insurance, and looking ahead to national health insurance. Reservations or inquiries should be directed to: Jordan Braveman, Director of Policy Analysis, Georgetown University Health Policy Center, 3520 Prospect Street, N.W., Washington, D. C. 20057. He can also be reached by phone at (202) 625-3092.

We will be happy to meet with you at your earliest convenience to discuss these questions.

SH:jm

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March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1959-1978 (8 years-House of Representatives; 12 years-Senate).

2. Attorney-at-Law.

3. Former Vice-President of the Bank of Hawaii (1963-1979).

4. Presently Deputy Director of the Department of Regulatory Agencies, State of Hawaii.

5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald Ching

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

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 mre 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 qualifie 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 reasons 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.

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM

March 18, 1980

TO: Representative Bill Parker
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst JK

RE: State Health Care Programs
Research Request No. 61

You have asked that we: (1) provide any available studies on Medicaid, state health insurance, and th State's health care program in general; and (2) determine whether the State could provide medical care for low-income groups in medically underserved areas of the state. The enclosed materials represent all the relevant materials we were able to locate, with the exception of past copies of the State Health Plan and the Medicaid Annual Status Report. These reports were not included because of their bulk and uncertain value to you; should you wish to review these documents, please let us know.

Our major findings with regard to direct State delivery of medical services are the following:

1. There appear to be no legal reasons why the State could not hire doctors to treat low-income groups or any other class of people; however, four major practical difficulties with such an approach were raised during the course of our research. The first problem is that everyone we contacted believed the medical community would oppose the competition which direct State participation in the delivery of medical services would represent. Secon., the State would need to purchase malpractice insurance for doctors in its employment, thus incurring substantial costs. Third, if the legislature approved funding for such a program, and later discontinued it, or if State physicians' services were to be provided on a temporary basis, the problem of "medical abandonment" could result in lawsuits against the State unless adequate arrangements were made for the further treatment of patients handled under the program. Fourth, it appears that medical services provided by State physicians would not be eligible for federal Medicaid funds

except on a temporary or special situation basis; therefore, the State would have to bear the full cost of the program unless State-provided services were demonstrated to qualify for a waiver from the usual federal Medicaid requirements.

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over $22 million per year in federal Medicaid funds.

3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paper-work requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.

4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

Delta Dental for Medicaid cases usually occurs within two weeks, as compared to up to several months for other Medicaid claims handled by the State, is the main reason for the almost universal acceptance of Medicaid cases by Alaska dentists.

In an administrative review of the Alaska Medicaid program completed in 1979, HEW officials recommended that the Division of Public Assistance contract with a fiscal intermediary for Medicaid processing. The Division is planning to solicit within the next six months requests for proposals for the processing of all Medicaid claims by a fiscal intermediary, although H&SS may still elect to process claims in-house. Robert Ogden, Chief of Medical Assistance for the Division, stated that a fiscal intermediary handling all Medicaid claims could probably process claims as rapidly as Delta Dental currently does for dental claims, thus improving the prospects for physicians accepting Medicaid patients. However, the choice between the use of a fiscal intermediary and processing the Medicaid claims in-house will depend on administrative decisions made within the department.

Each of the four points summarized above will now be discussed in more detail.

State Medical Care

According to the sources we contacted, the basic answer to your second question is yes, the State could hire doctors to treat low-income groups. Eligibility could be determined in a number of ways and would not need to parallel the federal Medicaid system. Placement of the State-employed doctors throughout the state could be based on whatever criteria were deemed appropriate by the State.

The State already provides direct delivery of medical services to a limited degree. Nurses employed by the Division of Public Health administer the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children throughout the state. The program is small in comparison to other medical services, but it does provide a precedent on the State level for direct delivery of services.

Political resistance by the medical community was cited by several persons with whom we spoke as the greatest obstacle to the direct employment of doctors by the State. Our contacts believed that many doctors would view such an action as State competition with the private sector,

and as "socialization" of the medical profession. The apparent acceptance by the medical community of the EPSDT program suggests that opposition to the State physician approach would not be as strong if the approach were used only in a few selected areas or were clearly temporary in nature. For example, if the State adopted a procedure similar to that which was employed by the federal Department of Health, Education, and Welfare (HEW) to identify and designate the low-income population of Anchorage as a Critical Health Manpower Shortage Area (see Attachment A), doctors might be more willing to accept the State delivery approach than if it were part of a comprehensive, state-wide system.

Under the HEW system, which is authorized by section 332 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

This ratio qualified the low-income population of Anchorage as a degree-of-shortage group 4, which makes the area eligible to: (1) apply for placement of National Health Service Corps (NHSC) physicians; (2) be an eligible service area for purposes of repayment of health professions student loans and for the NHSC scholarship program; and (3) apply for grant funds under various sections of the Public Health Act.

A similar approach to improving medical care for medically underserved areas or population groups could be utilized by the State. Designation under the program might qualify an area for the placement of State-hired physicians, for grants to improve health care delivery, or perhaps for a special streamlined medicaid process which would encourage doctors to accept Medicaid patients. The latter option might be effective in a case like Anchorage's, in which the number of practicing physicians in an area is sufficient to meet the medical needs of the population, but the physicians will not accept Medicaid patients because of dissatisfaction with the reimbursement system.

Attachment B, which is a letter to Representative Martin from Commissioner Beirne, suggests other questions which should be considered if the State elects to provide medical care directly and/or withdraw from the Medicaid program. As Duncan Read indicated in his earlier memo, Dr. Frederick McGinnis, Deputy Commissioner of H&SS, has proposed a major study of health care financing options which would address questions relating to

State provision of health care, such as who would be eligible for the program, and what services should be provided. Dr. McGinnis has apparently expanded the scope of the proposed study and is attempting to obtain about $170,000 for the project. If the study is conducted, the results would be submitted to the 1981 legislature.

If the State physician health delivery system is to be pursued, the problems of malpractice insurance and medical abandonment must be considered. Neither of these problems would prevent the State from hiring doctors, but their cost and legal implications may have some bearing on the issue. The State currently carries a small amount of malpractice insurance for doctors employed in administrative capacities, apparently in the event that they are called upon in an emergency situation. To fully insure doctors employed by the State who regularly provided medical services would require a substantial expenditure. The magnitude of the insurance cost would depend on the number of doctors employed the service provided, and the scope of the program, but the cost could be significant.

Medical abandonment appears to be a relatively easy problem to avoid, but it could present legal problems if it is not considered in the design of any State-provided medical care program. Under state and federal law, physicians are responsible for arranging for continued medical care for their patients if, for any reason, they discontinue their treatment. A doctor not fulfilling this responsibility may be sued by a patient. The two ways in which the issue of medical abandonment could arise are: (1) if the legislature suddenly discontinued funding for the program, and (2) if the program were discontinued in an area because it was determined that the private physicians in the area could now adequately serve the population. In both instances, the problem of medical abandonment could be avoided by ensuring that adequate arrangements were made for the continuing treatment of patients after the State ceased providing service directly.

A final point to be considered regarding direct State delivery of medical care is the Medicaid funding question. I contacted officials with the Northwest regional office of the HEW Medicaid Bureau in Seattle to determine if federal Medicaid funding could be provided for medical services delivered by State-employed physicians. A firm answer could not be secured within the time frame of this project, but it appears that a waiver from certain federal regulations pertaining to reimbursement procedures and other matters would be required for federal funding to be given for State-provided services. The necessary conditions for such a waiver are also unclear at this time, but HEW officials indicated that the designation of an area or population group having a severe shortage of medical care might meet the waiver requirements.

You have indicated an interest in the possibility of the State withdrawing entirely from the Medicaid program, and the question of Medicaid support for State-provided services may therefore not be a major concern. However, the State currently receives over $22 million each year in federal Medicaid funds. It may, therefore, be desirable to retain these funds if a State medical care program could meet, or be exempted from, the necessary federal regulations without compromising the program. Please let us know if you would like a more concrete response to the Medicaid funding question. A written request to HEW would be required and their response could take two weeks or more, but we would be glad to pursue this issue if you would like.

Medicaid Issues

Although we were not asked to specifically address the Medicaid program in this memorandum, we obtained information on Medicaid during our research which may be of value to you in considering health care options. The greatest problem with the current Medicaid program in Alaska is that the claims processing system is inefficient, requires excessive paperwork, and results in long delays in provider reimbursement. It is the paperwork and the payment delays which have been the primary cause of Alaska physicians refusing to accept Medicaid patients. Attachments C and D provide a physician's perspective on the problems of the Medicaid system. In many cities, most notably Anchorage, the number of physicians seems to be adequate, but a Medicaid patient cannot see a doctor because the majority of physicians refuse to take Medicaid cases. It therefore appears that a more efficient and rapid claims processing system could do much to alleviate the difficulty of obtaining medical care for low-income Alaskans.

The current program of Medicaid dental services lends strong support to this premise. Medicaid claims for dental care do not go through the State system used for other medical services, but instead are handled by the Delta Dental Plan of Alaska, which acts as a fiscal intermediary between the providers and the State. The pertinent statistics regarding Medicaid participation by dentists were cited in the findings section, but the importance of Delta Dental in this discussion is that the vast majority of the state's dentists accept Medicaid patients. The two-week Medicaid reimbursement time which Delta Dental provides for dentists is the primary reason for the high degree of cooperation by Alaska dentists with the Medicaid program.

The obvious question, then, is if Delta Dental is so efficient, why doesn't the State use Delta or another fiscal intermediary to process all its Medicaid claims. There are a number of reasons why fiscal intermediaries do not represent an easy solution to the Medicaid and low-income health care problems.

The first is that Delta Dental does not appear eager, and may not have the capability to take on the processing of medical claims. Attachment D is a letter from the Pediatricians' Association to Representative Martin suggesting that the State contract with Delta Dental for payment of Medicaid claims for pediatric services. However, I spoke with Denise Knapp, Executive Director of Delta Dental, and she indicated that Delta has not agreed to process pediatric claims and is still only discussing the idea. Robert Ogden, Chief of Medical Assistance for H&SS, stated that while he has been very pleased with Delta's performance, he is not sure if Delta could handle the large volume of Medicaid claims for medical services, and knows of no other in-state firms who could.

A second possible problem with the expanded use of fiscal intermediaries is cost. Each claim processed by Delta Dental costs the State an average of more than $14, while the medical claims processed under the current system cost only about $1.45 each. However, Mr. Ogden was quick to point out that the current system does not meet federal requirements, and meeting these requirements is likely to increase the cost of processing claims whether a fiscal intermediary is used or not. In addition, Delta's cost is much higher than would be that of a fiscal intermediary handling all medical claims, because the fixed costs of the Delta claims processing system are spread over a relatively small number of claims (8,000 per year). A fiscal intermediary handling all Medicaid claims for medical services would process about 144,000 claims per year; cost per claim would therefore be much lower, perhaps in the $2.50 range, according to Mr. Ogden.

HEW has mandated that the Division of Public Assistance implement a new claims processing system by September, 1980. In an administrative review completed a year ago, HEW officials recommended that the Division contract with a fiscal intermediary for the processing of all Medicaid claims. (See Attachment E, Chapter 7, for more detail on this recommendation.) However, it is still uncertain whether this recommendation will be followed. The Division plans to solicit requests for proposals (RFP) for claims processing within the next six months. At least six to eight firms are expected to bid on the contract, but it appears that the decision to use a fiscal intermediary or to process Medicaid claims in-house will be more dependent on administrative decisions within H&SS than on the results of the RFP process.

We hope the information we have provided is useful to you. This memorandum is a brief treatment of a complex subject, so please let us know if you would like additional research, or if we may be of further assistance in any other way.

JK/dp

cc: Representative Terry Martin

Attachments:

A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.

B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.

C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.

D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.

E. HEW administrative review of the Alaska Medicaid program.

F. H&SS task force recommendations on the Medicaid program.

G. Information supplied by Delta Dental on their program.

H. Alaska and National Health Insurance--report by Dr. McGinnis of H&SS.

I. Third Party Health Coverage in Alaska--1978 report by the former Legislative Affairs Research Division.

J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.

K. H&SS 1977 Medicaid Annual Status Report.

L. January. 1980 State Health Plan.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

IV. AN ANALYSIS OF THE EXTENT OF HEALTH CARE COVERAGE AND GAPS IN COVERAGE

The Covered Population

Nationally, 178 million people - more than 8 out of 10 persons in the civilian non-institutional population - had some form of private health insurance in 1975, according to the Health Insurance Institute. The same survey reported 250 thousand people in Alaska, (two thirds of the civilian population) had private coverage.

The major public programs, U.S. Public Health Service, Medicaid and Medicare, provide health coverage to an estimated 20% of Alaska's civilian population. It is not known to what extent public coverage duplicates private coverage state-wide. However, random sample surveys were conducted in 1974-75 in both Anchorage and Kodiak Island Borough with questions regarding health coverage. The Anchorage survey reported that 79.9% of the sample had third party health coverage of some sort, and 20.1% had none. In Kodiak Island Borough 92.6% of the respondents reported third party health coverage, while only 7.4% reported none. This high percentage of health coverage in Kodiak Island is largely due to the high proportions of Indian Health Service eligibles (over 40%) and military personnel and dependents (over 25%). Those 7.4% without coverage constituted over 20% of the non-Native non-military or military dependent population.

The 20.1% of the Anchorage sample without health coverage constituted over 25% of the non-Native non-military or military dependent population in Anchorage.

If we can assume that a similar percentage (20-25%) of the non-Native non-military population state-wide currently are without third party health coverage from any source, 56 to 71 thousand Alaskans totally lack third party health coverage.

The biggest hole in this coverage patchwork is moderate and low income people who are self-employed or marginally employed, or non-union employees of an employer who doesn't provide health benefits. These people are above the income eligibility standards for Medicaid or General Relief Medical, yet their cash income is not adequate to afford either the expense of private health insurance, nor the expense of many medical services on a fee-for-service basis. This group includes farmers, shop owners, small contractors, temporary and part-time employees, casual laborers, subsistence providers and the unemployed. It also includes a large number of non-union workers, particularly those working for small employers, such as child care workers, waitresses, clerks, clerical workers, delivery truck drivers, gas station attendants and construction workers in home building. And of course the dependents of these bread-winners normally lack coverage as well.

In Alaska there are many seasonally employed people as well who have health coverage only part of the year while they are employed, such as loggers and cannery workers. Most construction workers (outside of home building) are unionized and have "hour banks" for health benefits such that if they work enough hours over the summers their accrued health benefits will last through to the next season. However, when there is not enough work to go around, many people are not able to accumulate enough health coverage to last the winter.

Services Covered

Health plans vary widely in the services covered and the levels of coverage provided. The foregoing analysis distinguished between people who have any sort of third party health coverage, and those who have no coverage at all. We have not yet considered whether those with some coverage have coverage that is adequate to protect them from financial hardship. Some policies, for instance, are specialized and cover only hospital expenses, or only surgical expenses. Many policies do not cover particular services such as prescription drugs, office visits, or nursing care outside of a hospital.

In the Anchorage survey, while 20% of the respondents lacked hospital coverage, 24% of the respondents lacked surgical coverage, 46% lacked coverage for visits to the doctor's office, 60% lacked dental coverage, and 70% lacked mental health coverage.

Many policies have limits on coverage that are exhausted by severe illnesses, or require co-payments which can add up to substantial sums. Many policies limit their payments to "reasonable charges" as defined by the insurance company, regardless of the actual charges, and the consumer must pay the difference.

It is not difficult for a consumer even with some health insurance to incur heavy financial losses due to health care expenditures. The following statistics suggest that insurance companies in fact are not paying the bulk of health care expenses.

While the private health insurance industry claims to serve over 80% of the nation's civilian non-institutionalized population, in 1976 they paid only 26% of personal health care expenditures nationally.

Government programs paid another 40%, and consumers paid 32% directly. The remaining 1% of personal health care expenditures was paid by philanthropic organizations.[1]

1 "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 2, 1980

HEALTH INSURANCE BILL TO BE HEARD ON TELECONFERENCE NETWORK

The House Health, Education and Social Services Committee, chaired by Rep. Thelma Buchholdt, will hold three teleconferenced hearings on HB 977, " An Act relating to the health of residents of the state".

The first hearing will be teleconferenced to all sites on Tuesday, April 8th at 1:30 p.m., Juneau time, and will include testimony from all interested persons.

The second hearing, also on the 8th, will be held at 7:00 p.m., Juneau time. The committee will be taking testimony from insurance carriers and will include all teleconferencing sites.

The third hearing will be teleconferenced to all sites on Thursday, April 10th at 7:00 p.m..

Persons interested in testifying or observing at these hearings should contact the local Legislative Information Office in the following communities: Anchorage, Bethel, Fairbanks, Dillingham, Kotzebue, Nome, Kodiak, Soldotna, Ketchikan and Sitka. Further information may be obtained from the Committee Chair (465-3797) or the Teleconference Coordinator (465-4980)

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

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

MEMO

To: Those interested in health care coverage
Re: Health care
Date: March 1980
From: Susan Johnson

Below is an outline of the legislation we discussed at the meeting held February 29, 1980 at the Federal Building, for you to review. The legislation is presently being drafted by Thelma Buchholdt's (hESS) Committee. The components are as follows:

1/ Mandatory Reinsurance: Several states have developed mandatory reinsurance pools to ensure health care coverage availability to high risk persons at reasonable rates. Many people are unable to purchase full health insurance coverage because existing health conditions make them a bad insurance risk. This component of the bill would mandate all health insurance carriers in each state to offer a health insurance package to high risk subscribers at a reasonable premium. Such coverage is reinsured by the carriers association, in which membership is mandatory, so the risk is pooled among all carriers in the state.

2/ Minimum Benefits Standards: The state would be given the authority to regulate the level of service covered by health insurance policies. Several states have already implemented this and the National Association of Insurance Commissioners (NAIC) had developed model state health insurance legislation for setting minimum health benefit standards. This would address, for example, persons who are excluded from coverage because of pre-existing conditions.

3/ Amend Medicaid Statutes: This would provide the Oregon option to use Medicaid funds to purchase health insurance; provide for the funding of interest payment penalties when the state is delinquent on its bills, and to add additional services to the Medicaid program, such as prescription drugs, dental care, etc.

4/ Medicaid Medically Needy: 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 persons 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.

5/ Mandatory Employer Coverage: Hawaii requires every employer to provide health insurance. This would expand coverage to many non-union workers, especially those in low-paying service industries, who now lack coverage. Hawaii offers this to employees who work a minimum of 20 hours. Small employers may apply for state subsidation, if the cost of insurance exceeds certain criteria.

Finally, AkPIRG supports appropriations for expended direct services by the state and local government and non-profit providers. For example, two GYN's will be added to the Neighborhood Health Center in Anchorage. Any suggestions are welcomed concerning other areas that could use additional funding.

I will contact you again when the bill has a number. Feel free to call should you have any questions.

Again, thank you for attending the meeting.

Sincerely,

To: Billy Berrier, Director
Legal Services Division
Legislative Affiars Agency

From: Representative Thelma Buchholdt
Health, Education and Social Services Committee Chair

Subject: Request for bill drafting

Please have one of your staff prepare for introduction one bill which will include the following elements:

Medicaid Amendments. This bill would add the Medically Needy program and several optional services to the state's participation in the federal Medicaid program. The bill would also allow the use of medicaid funds for the purchase of private health insurance as provided in Oregon law (ORS 414.115). The following Medicaid options would be included: prescription drugs, adult dental care, dentures, adult prosthetic devices, physical therapy and related services, chiropractors' services, podiatrists' services and private duty nursing.

Mandatory Employer-sponsored Health Insurance. This bill would require employers in the state to subsidize group health insurance plans for their employees. The bill would be modeled after the Hawaii Prepaid Health Care Act.

Health Insurance Regulation. This bill would give the state authority to regulate the level of service covered by health insurance policies sold in the state. The bill would also mandate coverage of high-risk clients and pooling of risk among all carriers. The bill would be modeled after relevant portions of the Comprehensive Health Insurance Act in 1980 Suggested State Legislation, Vol. 39, by The Council of State Governments.

TABLE 2

Average Ranking of Selected Medicaid Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

To: Billy Berrier, Director
Legal Services Division
Legislative Affiars Agency

From: Representative Thelma Buchholdt
Health, Education and Social Services Committee Chair

Subject: Request for bill drafting

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Health Insurance Regulation. This bill would give the state authority to regulate the level of service covered by health insurance policies sold in the state. The bill would also mandate coverage of high-risk clients and pooling of risk among all carriers. The bill would be modeled after relevant portions of the Comprehensive Health Insurance Act in 1980 Suggested State Legislation, Vol. 39, by The Council of State Governments.

My assistant Jan Sorice will be in charge of this project and any further direction to the drafters will be provided by her. She may be reached at 465-3797.

This bill is to be introduced by the House Health, Education and Social Services Committee by request of Representative Thelma Buchholdt.

By federal statute, the maximum limit for income eligibility under Medicaid medically needy is 133 1/3% of the state AFDC standard for an equivalent family size (except that for a single person, the two-person family income standard is used). The following chart indicates what the Medicaid medically needy income limit would be for certain family sizes and types (where two income limits are listed, the difference is based on whether or not the adult-only household has rent, mortgage or other payments greater than $35 per month).

Household	AFDC	GRM	APA	MN (133 1/3%)
1 Person	$150	$235/ $300	$335/ $414	$466.55
2 Adults		$335/ $400	$502/ $608	$466.55
1 Adult, 1 Child	$350	$300		$466.55
1 Adult, 3 Children	$450	$400		$600

TABLE 2

Average Ranking of Selected Medicaid
Options by Type of Public Assistance Client

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4th	Physical Therapy and Related Services	Dentures
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6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
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[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

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.

Alaska Native Health Board

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10/26/79
pbm

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COPPER RIVER NATIVE ASSOCIATION

KODIAK AREA NATIVE ASSOCIATION
MAUNELUK ASSOCIATION
THE NORTH PACIFIC RIM
NORTH SLOPE BOROUGH HEALTH CORP.

NORTON SOUND HEALTH CORPORATION
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION

OREGON

...th or tuberculosis not otherwise expressly ... posed or granted by law.
...556 §10]

...090 [1953 c.204 §6; renumbered 414.860 and ... 566.370]

414.095 Exemptions applicable to ... ments. Neither medical assistance nor ... ments payable to vendors out of public ... assistance funds are transferable or assigna... at law or in equity and none of the money ... ed or payable under the provisions of ORS ...435 and this chapter is subject to execu... levy, attachment, garnishment or other ... process.
...556 §11; 1967 c.502 §14]

414.105 Recovery of certain medical ... stances; certain transfers of property ...idable. (1) The Adult and Family Services ...sion may recover from any person the ... ...nts of medical assistance incorrectly paid ... behalf of such person.

(2) Medical assistance pursuant to ORS ...435 and this chapter paid on behalf of an ...idual who was 65 years of age or older ... he received such assistance may be ... ...ered from his estate, or if there be no ... the estate of the surviving spouse, if ..., shall be charged for such aid paid to ... or both; provided, however, that claim ... such medical assistance correctly paid to ... may be established against the estate, but ... shall be no adjustment or recovery ... until after the death of the surviving ..., if any, and only at a time when he has ... surviving child who is under 21 years of ... or is blind or permanently and totally ...bled. Transfers of real or personal prop... by recipients of such aid without ade... consideration are voidable and may be ... aside under subsection (2) of ORS 411.620.

(3) Except where there is a surviving ..., or a surviving child who is under 21 ... of age or is blind or permanently and ...ly disabled, the amount of any medical ... paid under this chapter is a claim ... the estate in any guardianship or ...servatorship proceedings and may be paid ...uant to ORS 126.353.
...556 §12; 1967 c.502 §15; 1969 c.507 §2; 1971 c.334 ... c.334 §1; part renumbered 416.280; 1975 c.386 ...

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts. In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the Adult and Family Services Division shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and 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 needy or the medically needy, or both. The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the division must guarantee:

(1) To provide medical and remedial care and services of the type, to the extent and according to standards prescribed under ORS 414.065;

(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 ORS 414.065, 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 all laws, rules and regulations applicable thereto; and

(4) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the division as may be required by the division for its records, reports and audits.
[1967 c.502 §9; 1975 c.401 §1]

414.125 Rates on insurance or service contracts; requirements for insurer or contractor. (1) Any payment of available medical assistance funds for policies of insurance or service contracts shall be according to such uniform area-wide rates as the Adult and Family Services Division shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstra-

tion project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state.
[1967 c.502 §10; 1975 c.509 §6]

414.135 Contracts with direct providers of care and services. The Adult and Family Services Division 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 in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the division as may be required by the division.
[1967 c.502 §11]

414.145 Implementation of ORS 414.115 to 414.135. The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented [illegible] Department that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the Adult and Family Services Division to the providers of medical assistance.
[1967 c.502 §11a; 1975 c.401 §3]

MEDICAL ADVISORY COMMITTEE

414.205 Medical advisory committee. (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions, providers of medical and remedial care and services and the general public. In making his appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory committee shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account.
[1967 c.502 §18]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

414.215 Duties of committee. The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division.
[1967 c.502 §19]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

414.225 Division to consult with and assist committee. (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.065.

(2) The division shall provide secretarial services to the medical advisory committee.
[1967 c.502 §20]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

[illegible]

414.300 [1957 c.692 §5; repealed by 1963 c.631 §2]

MISCELLANEOUS

414.305 Payment of cost of medical care for institutionalized persons. (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health Division from the Adult and Family

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

March 1980 NEWSLETTER Vol. 6, No. 2

New Date for Annual Meeting

The annual meeting will be held on *April 1, 1980* at the Pioneer Schoolhouse at 3rd and Eagle. The time of the meeting is set for 7:00 p.m. The primary business of the meeting will be the election of new members to the Board of Directors. Ballots and numbered envelopes are included in this newsletter; each number coincides with a member's name. Please return your ballot in the designated envelope so we can ensure that each member votes only once. Ballots will be counted the night of the meeting. If you can't attend the meeting to voice your concerns about the direction taken by AkPIRG during the past year, *mail your ballot* anyway. The election of an informed and dynamic Board of Directors is crucial to the well-being of AkPIRG.

Mike Ireton: Volunteer of the Year

Mike Ireton has been selected as Outstanding Volunteer for the year 1979 and will be honored at the University Affiliates Volunteer of the Year Award Presentation on March 21. Mike has put in an incredible number of hours working for AkPIRG and the entire staff and Board of Directors thank him warmly.

Thanks also to *all* AkPIRG volunteers for the generous donation of their time and energies. Volunteers are always needed and appreciated; if anyone is interested in participating as a volunteer, please call 278-3661.

The Alaska Public Interest Research Group newsletter is available to any AkPIRG member. The subscription price is included in the membership dues: $10 for individuals, $25 for institutions or businesses, and $5 for persons on limited incomes. The Alaska Public Interest Research Group is a non-profit citizens group, tax exempt under 501(c)(3) of the Internal Revenue Code.

AkPIRG offices are located at 513 West Seventh Avenue, Anchorage, Alaska. The mailing address is P.O. Box 1093, Anchorage, AK 99510. The phone number is 278-3661.

Comments on the newsletter, or any other aspect of AkPIRG activities are appreciated.

Editor: Laurie H. Otto.

Typography by Visible Inc., Anchorage, AK.

Oil Rig Discrimination

A legislative investigation of charges of discrimination against women in oil rig hiring practices was initiated March 5 by Speaker of the House Terry Gardiner. The need for an investigation was brought to light by OIL WATCH, a recently formed citizens-group which monitors all aspects of oil development in Alaska. The investigation will be conducted by the Commerce Committee, which is chaired by Fred Brown, D-Fairbanks.

In mid-November, Jim Bounds, member of Hotel, Restaurant, and Construction Camp Employees Union Local 878, came to OIL WATCH and told them that he had evidence that Amoco Production Company and Union Oil were responsible for discrimination against women. Bounds said that women in the culinary workers' union who had faithfully paid their union dues were waiting in the hiring halls, but not being dispatched for jobs for which they were qualified. Many of these women were on the union's "A" list, the top list of those waiting for jobs, while men lower on the lists or even outside the union were being dispatched instead, sometimes secretly.

The union is under contract to Universal Services Incorporated International (USI) to supply the labor promised by USI in its own contract with Amoco and Union Oil to do culinary work on their platforms in Cook Inlet. When Bounds asked officials in his union why no women were being dispatched, he was told that the contractor, USI, had warned the union not to send women out on dispatch on penalty of losing the USI contract. USI would apparently go with non-union labor if it had to, just to avoid sending women out to the platforms. The union officials explained that they had been told by USI people that a similar threat was in turn coming down on USI from Amoco and Union Oil. Apparently, the oil companies had told USI not to send women out to their platforms, or else USI would lose *its* contract with the companies. So, to hold onto its contract with Amoco and Union Oil, USI had decided to comply with these companies' requests not to send women out to the platforms in filling culinary jobs.

Mr. Bounds' evidence was primarily a series of taped telephone conversations between himself and officers of Amoco, Union Oil, and the field supervisor of their catering subcontractor, USI. An excerpt from the transcript of one of the tapes is presented below. The excerpt is from a conversation between Jim Bounds and Bob Gurnand, who is a field supervisor in the Kenai area for USI.

Jim Bounds: Here's what it boils down to: in other words, the oil companies come to the catering companies and say, "We don't want no women out there on them jobs," right?

Bob Gurnand: That's—well, more or less.

Jim Bounds: Then the catering companies go to the union and the catering companies tell the unions that, "We absolutely don't want no women out there on them jobs, and if you want

(continued on page 4)

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 ws 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 an excessive amount of paperwork before reimbursements are 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

Oil Rig *(cont. from page 1)*

the contract, you don't send no women out there," right?

Bob Gurnand: Well, that's just what the Union Oil Company man told me. He said if I send a woman out there, he's going to send her right back to us, and we lose the contract. And the union up there knows too, goddamnit.

After reviewing Jim Bounds' tapes, members of OIL WATCH interviewed and took sworn affidavits from other members of Local 878. One individual, Ruth Callan, gave particularly compelling testimony. Ms. Callan has lived in Alaska for thirty-three years and has been an officer of the Hotel, Restaurant and Construction Camp Employees Union, Local 878, since 1955. She served as a member of Local 878's Elective Board for ten years, including one term as President. For the past twenty years she has been a delegate to the Central Labor Council. She currently serves as Vice-President of the State Labor Council.

Ms. Callan has served as both head business agent and Secretary-Treasurer of Local 878. She stated in a sworn affidavit:

> While I was Secretary-Treasurer of Local #878, Bob Ryan, the head of USI in Alaska, told me that USI would lose its contract with the oil companies if women were sent out to the rigs. He said that one reason for this was the lack of "facilities" for women, meaning the lack of separate bunking and bathroom facilities.

It is interesting to note that both Bob Gurnand and Ruth Callan, in her affidavit, mentioned the dispatch of Dorothy Jackson, and the oil company's subsequent refusal to accept a woman dispatch on its rig. Ruth Callan stated:

> In May of 1979, USI called the Local for a bull cook which they needed by 5:00 p.m. I was told that if a woman answered the call that I should tell her that she would have to bunk and sleep with the men and use their same latrine facilities. This was intended to discourage a woman from accepting the dispatch. They didn't figure on Dorothy Jackson though. She said she didn't care, she was broke. I notified USI. Bob Ryan told me not to dispatch her because she was a woman. I replied that I was not going to refuse her a dispatch because she was a female. Bob Ryan told me that he would have to find some way to keep her off the rig. When Dorothy Jackson got to USI she was told that the dispatch was cancelled because the USI employee who had been scheduled to take R&R had changed his mind. Bob Ryan called me and said that I had cost some other union member his job because I had dispatched a woman. He told me that if the union dispatched women, the oil companies would end their USI contract and hire some non-union outfit that hired only men.

Bob Gurnand's version goes as follows:

> **Gurnand:** Well, I'll tell you here a while back I got into a situation with Union Oil Company, and I called Anchorage for a bull cook. So they put it on the open call in the union hall, and a woman took it. So they called me back and told me that a woman had taken the dispatch and I said "...Don't send her down there," I said, "...because they won't let her out there." So this was explained to the gal that took the dispatch, that there wasn't separate facilities and all this stuff for her, you know, and she was going to—she insisted on taking the dispatch and coming. So the Anchorage office called me back and they wanted me to call out there and explain the situation to the Union Oil Company people. I called out there, and you know what they told me?
>
> **Bounds:** No
>
> **Gurnand:** He said, "You send a woman out there, you lose the catering contract, and we'll go to a non-union contractor."

Union Oil Company dismissed Bounds' evidence by saying the whole thing was ridiculous. Union did confirm, however, that only one of the fourteen platforms in Cook Inlet had any women on it working in culinary positions. They asserted that women didn't want jobs on the platforms, since the conditions were "...awfully rough on a gal, and most gals prefer to work elsewhere."

Amoco has not responded to Bounds' charges; however, they also confirmed that only one of fourteen platforms has a woman currently working on it in a culinary position. Amoco asserted that to build separate facilities for women would be to discrimate against men.

The Alaska State Commission on Human Rights was asked to investigate this matter. The Director of the Commission, Neil Thomas, declined to initiate an investigation. Although Mr. Thomas acknowledes that this matter comes under the jurisdiction of the Commission, he has advised OIL WATCH that the Commission's present level of funding and its current caseload prevent him from investigating a matter which, under more favorable conditions, he would undertake.

The National Labor Relations Board was also asked to investigate, but the Board has the authorization to investigate only union matters—not oil companies or their sub-contractors.

The legislative investigation is expected to bring forward witnesses and victims of discrimination who have until now been unsure of where to go. OIL WATCH is continuing its independent investigation and will be aiding the committee in its legislative inquest.

Alaska Legislative Information

The following teleconferences have been scheduled to allow constituents the chance to discuss the issues with their legislators. For more information contact your local Legislative Affairs office. The phone number in Anchorage is 278-3668.

March 10: Anderson, Hohman at 7:00 p.m., Dillingham, 842-5319.

March 11: Interior Delegation at 7:00 p.m., Fairbanks 452-4448.

March 12: District 12 at 7:00 p.m., 1024 6th St. Anchorage.

March 13: District 10 at 7:00 p.m., 1024 6th St. Anchorage.

March 17: Hohman at 2:30 p.m., Bethel, 543-3541.

March 18: Interior Delegation at 7:00 p.m., Fairbanks, 452-4448.

March 19: Carney at 6:00 p.m., Mat-Su Office, 376-3704. Mulcahey, Zharoff at 7:00 p.m., Kodiak, 486-4881.

March 20: District 9 at 7:00 p.m., 1024 6th St. Anchorage.

March 24: District 13 at 7:00 p.m., Kenai, 264-9364.

March 25: Interior Delegation at 7:00 p.m., Fairbanks, 452-4448. District 8 at 8:00 p.m., Mt. View Library.

March 26: District 7 at 5:00 p.m., 1024 6th St. Anchorage. Munson at 7:30 p.m., 1024 6th St., Anchorage.

March 27: District 8 at 7:00 p.m., Eagle River Library.

Individual memberships play an important role in maintaining the vitality of AkPIRG. Membership renewals allow AkPIRG to continue its effective and responsive representation of the interests of Alaska's citizens. During this coming month AkPIRG will attempt to contact those persons whose memberships have lapsed. Please renew! For all members who have moved, please let us know your current address, so we can keep you informed of AkPIRG's ongoing activities.

Thursday March 20, 1980

TO: Reps. Buchholdt, McKinnon, and Parker

FROM: Sharman Haley
Alaska Public Interest Research Group

The proposed health legislation which is being prepared for introduction next week is scheduled for hearing in the House Health, Education and Social Services Committee the first week of April. A major portion of this bill is based on the Minnesota Comprehensive Health Insurance Act of 1976. In this act Minnesota pioneered the creation of a mandatory insurance carriers association to underwrite coverage for high risk "uninsurable" clients, as well as state regulation of minimum standards for health insurance policies. You may wish to bring someone from the State of Minnesota to testify on the proposed Alaska legislation from the perspective of the experience in Minnesota.

In the course of my research on the proposed legislation I have spoken at length with John Igrassia, Supervisor of the Life and Health Section of the Division of Insurance in Minnesota, and would recommend him as a good source of expert testimony on this subject. He has worked in his present capacity since the inception of the Minnesota legislation and is quite familiar with all its provisions, its administrative implementation, it's political fortune, and the legal challenges to it. Mr. Igrassia is proud of Minnesota's innovation in the area of health insurance and has testified in at least two other states who are considering similar legislation. He indicated that he would probably be able to come to Alaska in the time frame we are contemplating.

Travel and per diem expenses to bring Mr. Igrassia to Juneau would amount to less than $800. If you would like to extend an invitation to him to come, he may be reached at (612) 296-6929 in St Paul, Minnesota. I do not have a mailing address for him.

3/31/80
4/2/80

Intelligencer

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3/23/80

—P-I PHOTO BY CARY TOLMAN

turned Domingo from college and career bound to house bound.

Doctors vs. Medicaid

Thousands Caught In Crossfire

By Carol Perkins

Significant numbers of doctors, extremely unhappy with the state Medicaid program, are refusing to treat welfare patients, doctors told The Post-Intelligencer.

Some experts fear that a monumental health-care crisis is imminent because thousands of welfare patients are caught in a crossfire between doctors and the state Department of Social and Health Services over what are reasonable fees and necessary services.

Medicaid is the $350,000 joint federal and state health care program for the poor. Administered by the state, it serves 260,000 persons.

One such patient is Lenore Erdmann, who has a jaw and gum disease that is so excruciating that she goes for days without eating — sipping only a mixture of vinegar and honey to numb the pain.

A $4,000 operation could relieve the 55 - year - old Holly Park woman's agony. But her only income is a $253 monthly public assistance check.

But for nine years, the state has refused to pay for her requested oral surgery. And doctors are not lining up to perform the operation for free.

At the heart of the Medicaid issue is economics and professional dignity, doctors say. Under a new fee schedule, many are receiving less for treating welfare patients than they did last year.

The boycott of patients is scattered — but is growing in momentum. Many community health clinics report they are beginning to feel the crunch as more Medicaid patients are turned down by private physicians.

Some doctors are treating Medic-

Page A-12, Column 2

Coeds?

U.S. Looking At

Rights Restored To Kim

By Henry Scott Stokes
The New York Times

SEOUL, South Korea — The government's recent action in restoring civil rights to Kim Dae-jung transformed politics here at a stroke.

The action foreshadows a busy summer and autumn as Kim re-engages himself in a bid for the presidency, taking up where he left off in 1971. That year he took 45 percent of the poll in a contest with President Park Chung-hee.

Inevitably, people ask how the decision to let Kim re- enter the political arena was made when the army, the effective controller of South Korea under martial law, was known to detest the aspiring democrat, accusing him of supposed Marxist associations 30 years ago.

The decision was reached, according to reliable informants, through a long process of consultation led by Lt. Gen. Chon Doo-hwan, head of the Army Security Command, an army unit in Seoul, who along with a group of younger officers around him effectively controls the country.

On Dec. 12 these young officers displaced an older group led by the martial law commander, Chung Seung-hwa, in a midnight raid directed by Chon, who seized his commander and several other top generals and forced nearly 40 senior officers to step down. Chung was stripped of his four stars and has been convicted on charges of aiding Park's assassin, Kim Jae-kyu, former director of the Korean Central Intelligence Agency.

The supremacy of the 49-year-old Chon is therefore clear, and yet there are limits to his authority.

For instance, the economy, which was in dire trouble for a time after Chon's midnight action is run primarily by Deputy Prime Minister Lee Hahn-been. Lee visited the United States in February in an attempt to rebuild overseas bankers' trust in South Korea and its extraordinary economy, which since the early 1960's has been the most rapidly growing of its size in the world.

Above Lee, who is head of the central unit in the bureaucracy, the Economic Planning Board, is Prime Minister Shin Hyon-hwak,

Thousands of Patients Caught in Crossfire

From Page A-1

aid patients for emergencies only, while others are taking no new patients. Other doctors continue to treat Medicaid patients, but don't do the paperwork in hopes of putting economic pressure on the state, which receives matching funds from the federal government for the program.

"Everyone is a loser," says Dr. W. Maurice Lawson, Washington State Medical Association president. Because the state refuses to pay customary fees, the losses have to be absorbed by physicians, private pay patients and insurance companies.

The state medical association's judicial committee ruled that the boycott is not unethical unless doctors refuse to serve an entire class of patients.

However, many doctors feel they have a right to restrict the amount of charity work they do, and consider their Medicaid losses as charity.

Doctors are dissatisfied with Medicaid for many reasons:

- They contend fee schedules are grossly below customary fees, ranging from only 35 to 70 percent of their normal charges.
- Doctors maintain that Medicaid limits on types of service, prevent them from giving welfare patients adequate care. They note that preventive measures aren't usually covered.
- Doctors are angered by bureaucratic red tape. Washington Anesthesiologists' Association says that 14 percent of their patients are on Medicaid, but account for 40 percent of their office paperwork. Medical office managers report that it sometimes takes from two months to two years to be reimbursed for Medicaid claims.
- Doctors resent what they call "harrassment" by the state. They are angered because DSHS demands prior authorization for many medical procedures, and because the state audits their medical records, which they maintain violates their patients' rights to privacy.

Dr. Ted Haley, who is a Tacoma representative, says that a widespread Medicaid boycott by doctors next spring is a distinct possibility.

"We'll talk to DSHS, the legislature, the governor, but if we don't get relief, a boycott of the system — not the patient — may be the only alternative."

However, Sen. William "Big Daddy Day," senate social and health srvices chairman, who also is a Spokane chiropractor, asserts that doctors shold bite the bullet. "Hell, they've beenrecipients of state aid when they were in medical school, they can pay it back now by taking more charity cases."

This kind of response is what makes many doctors squeamish about stomping their feet too loudly in Olympia.

"Politically, doctors are the least able to defend themselves, " says Dr. Peter West, a Seattle family practioner. "They aren't seen as a group that is suffering a lot.

"The public is going to be quick to say, 'Those unfeeling bastards don't care about the poor.'"

"But doctors can't tell their secretaries and suppliers to accept 70 percent of usual wages and costs, but that is exactly what the state is doing to us," West says.

Entire clinics are refusing to accept Medicaid patients, except in emergency situations.

"It costs more for us to do the Medicaid paperwork than we get back from the state," says Roberto Robles, Swedish Hospital anesthesiologist.

All 17 of the anesthesiologists at Swedish Hospital are boycotting Medicaid, except in emergency cases, Robles says.

Bruce Ferguson, DSHS Medicaid director, acknowledges there are inequities in parts of the fee schedule and that the doctors have good reason to be upset. "We're working on the problem, but we've only got so much money, and as it is it looks like we're going to be overspent by $20 to $30 million dollars this bieninium."

He maintains that the extensive paperwork and audits "are necessary because we are spending public money."

Both physicians and patients are scrutinized for fraud violations. Last year ony only seven health care specialists were convicted of violations.

Jim Benz, regional federal Medicaid director, says Washington state does "a good job" policing the program, and says that "to my knowledge there are none of the Medicaid mills or kickbacks that are rampant in some areas of the country."

Dr. Fred Quarnstrom, who says he was one of the largest Medicaid dental providers in the state in 1978, no longer takes new welfare patients.

The Beacon Hill dentist says that he could no longer afford to keep up with the losses he was encountering. People think doctors get rich on Medicaid — I guess if you hired dozens of assistants and did hundreds of dentures a day you could make a living at it."

Dr. Larry Iversen, a Bremerton orthopedic surgeon, says, "If a doctor has a large welfare practice, he is scrutitinized and hassled by the state. If he doesn't take any Medicaid patients, he's accused of not being a humanitarian."

Elise Chayet of Evergreen Legal Services, reports a considerable increase in Medicaid clients who can't find doctors or are appealing state's refusal to put them on Medicaid or pay for certain medical expenses.

Community health care clinics are seeing an increase in Medicaid patients unable to get help from private doctors, and the increase is putting a strain on clinic budgets.

Caroline MacColl, King County Visiting Nurse Service director, says the agency stopped accepting new Medicaid patients for a two - month period in 1978. Even though the state finally raised the service's reimbursemnts, the agency will still lose $30,000 a year because of the "Medicaid gap," she says. Social workers are upset because patients are caught in the middle of the battle.

"It's an inhumane system," says Maria Crocker of Country Doctor clinic. "It's terrible when a sick person has to go through the yellow pages looking for a doctor and getting turned down time after time."

State Sen. James McDermott, a Seattle psychiatrist, says, "There is no final solution. All that can be done is to set a health care system in motion and keep adjusting it until it is humane and equitable."

DSHS chief Ferguson agrees, emphasizing that the issue is "cosmic in proportion."

But while health care experts hashes out the issue, patients like Lenore Erdmann continue to suffer

Erdmann, who has applied to Medicaid four times in the past nine years for oral surgery, says, "I don't understand why I have to wait so long when I'm in so much pain. I just keep praying, they'll take me this time."

Shacks Bare Endurance Of Yugoslav Guerrillas

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 18, 1980

Donald D.H. Ching
Deputy Director
Department of Regulatory Agencies
P.O. Box 541
Honolulu, Hawaii 96809

Dear Mr. Ching:

The Alaska House of Representatives is currently considering legislation similar to Hawaii's "Prepaid Health Care Act." As you are an acknowledged expert on this legislation, your testimony would provide needed insight into the benefits of mandatory employment related health coverage.

I would therefore like to invite you to Alaska on March 31 and April 1 to testify on this bill. The legislation is presently being drafted, we will forward you a copy of the bill as soon as it is available. Please contact Jan Sorice of my office at 907-465-3777 if you need further information.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
District 9 (Spenard);
Chair, House HESS Com[illegible]

Third-Party Health Coverage:

A third-party payer includes any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g. Blue Cross and Shield, commercial insurance companies, Medicare and Medicaid). The individual generally pays a premium for such coverage in all private and some public programs. The organization then pays bills on his behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

It is difficult to identify the extent of third party coverage for Alaskans; to identify those that may not be protected by any program or those that may not have coverage adequate to fulfill their needs. Perhaps the most appropriate method of identifying those Alaskans without coverage or without adequate coverage are: 1) through a survey of individuals regarding health coverage, and/or 2) from a search of hospital and other health care billings that were paid "out of pocket" by the individual.

A random survey prepared in 1974/75 by Comprehensive Health Planning of Anchorage reported that 79.9% of the sample had third party coverage of some sort, and 20.1% had no such coverage. The same survey conducted through the Regional Medical Program among residents of the Kodiak Island Borough resulted in 92.6% of the respondents reporting that they had third party coverage, while 7.4% had none. These figures change significantly when applied to the non-Native, non-military population alone. In this perspective, over 25% of the Anchorage sample and over 20% of the Kodiak Island non-Native, non-military sample responded as having no health coverage. If these percentages (20%-25%) can be applied statewide, it would result in an estimate of 56,000 to 71,000 Alaskans lacking any third party health coverage.

A detailed search of hospital bills and other major medical bills that were paid "out of pocket" by the individual may result in significant information regarding not only those without coverage but also those finding that their coverage was not adequate to fulfill their needs. A general indication of the number of discharges from hospitals that result in payment by the individual can be obtained by information collected in the annual hospital survey. The percent of hospital bills paid by the individual varied considerably from one hospital to another. The Alaska Hospital and South Peninsula Hospital reported the highest percentages; 26% of the discharges making "out of pocket" payments. Further screening of this type of information is necessary.

DISCHARGES BY PRIMARY SOURCE OF PAYMENT

CY 1978

(Percent of all Discharges)

HOSPITAL	Workmen's Compensation	Medicare	Medicaid	CHAMPUS	IHS	Blue Cross	Other Commercial Insurance Co.	Prepaid Group Health Plan	Medical Foundation	Private Pay	No Charge	Other
SOUTHEAST												
Ketchikan General	4	10	6	2	21	13	32	-	-	8	-	6
Petersburg General	- not available -											
Wrangell General	-	13	4	-	-	-	-	-	-	-	-	83**
PHS-ANH Mt. Edgecumbe	- not available											
Sitka Community	7	9	3	-	-	43	22	-	-	9	-	5
Bartlett Memorial**	2	9	3	10	17	27	22	-	-	10	-	-
SOUTHCENTRAL												
Cordova Community	- not available -											
Valdez Community	- not available -											
Seward General	-	49	26	-	24	-	-	-	-	-	-	-
Faith	2	9	5	1	25	12	24	0	0	22	-	-
Central Peninsula	-	4	5	-	-	19	-	-	-	17	-	55***
South Peninsula	3	13	8	-	18	12	19	-	-	26	<1	-
Valley	1	10	13	-	-	13	55	-	-	25	-	4
Alaska Hospital and Medical Center	4	2	8	<1	-	11	25	24	-	26	-	-
Providence***	6	8	7	2	<1	15	39	-	-	7	2	13
PHS-ANH Alaska Native Medical Center	- not available -											
USAF Hospital, Elmendorf	- not available -											
Kodiak Island**	54	6	7	-	20	4	-	-	8	<1	-	1
Naval Regional Medical Center, Bremerton-Adak	- not available -											
PHS-ANH Kanakanak	-	-	-	-	100	-	-	-	-	-	-	-
PHS-ANH Bethel**	- not available -											
Norton Sound Regional **	2	6	11	1	65	11	4	0	0	1	0	0
NORTHERN												
PHS-ANH Kotzebue	- not available -											
PHS-ANH Barrow**	- not available -											
Fairbanks Memorial	1	3	10	1	10	14	29	-	-	25	1	-
PHS-ANH Tanana**	- not available -											
Bassett Army	- not available-											

**Includes all sources of payment except Medicare and Medicaid.

***Includes Workmen's Comp., CHAMPUS, Other Commercial Ins., Prepaid Group Health Plan, Medical Foundation and Other.

*Workmen's Compensation and Other.

**Reporting period is as follows: Bartlett Memorial: FY 1978; Kodiak Island: May 15 - Dec. 31, 1978; PHS-ANH Bethel, Barrow, and Tanana: FY 1977.

***Providence Hospital includes both outpatient and inpatient data.

Source: Office of Information Systems, Alaska Dept. of Health & Social Services, 1979 Annual Hospital Questionnaire.
AANHS, IHS, U.S. DHEW, Leading Health Problems of the Alaska Natives, FY 1977.

If the estimates of Alaskans protected by each type of third party coverage or non-fee services are added together, the total comes to 458,305 or more than the current estimate of the resident population (411,211 in 1977). This highlights the fact that there is considerable double coverage within the state such as individuals and their dependents covered by Blue Cross who are also eligible for the CHAMPUS program, Alaska Natives eligible for services by Alaska Area Native Health Services who are also covered by private health insurance, and families with more than one member subscribing to coverage that protects all dependents.

This is certainly NOT to say that all Alaskans are protected by some type of health coverage. Unfortunately, information regarding the number of persons covered by each program will not produce an estimate of who is without coverage. To accomplish this it would be necessary to identify all those with more than one type of coverage (both subscribers/enrollees and dependents).

ESTIMATED ALASKAN POPULATION
PROTECTED BY SPECIFIC HEALTH COVERAGE PROGRAMS

Private Health Insurance & Blue Cross	263,000
Teamster Employee Welfare Trust/Alaska Health Plan	25,200
Alaska Area Indian Health Services	
Alaska Natives	65,857
CHAMPUS & USHBP	
Active Military	24,984
Military Dependents & Retirees	55,000
Medicare Enrollees	9,818
Medicaid Participants (Not all eligibles)	11,815
General Relief Medical Program Participants	2,631
Catastrophic Relief Health Insurance Program	*
Veterans Administration	**

*Catastrophic Health Insurance Program is available to all Alaskans meeting criteria identified later in this chapter.

**The V.A. pays for health care that is related to prior military service.

Private Health Insurance: The major source of third party coverage is through private health insurance and the Blue Cross Plan. Although Blue Cross is considered a hospital/medical service corporation rather than a health insurance company, it is included in these discussions and in the data from the National Health Insurance Institute.

There is considerable variation in the services covered by different types of health insurance policies. Types of coverage include hospital expense, surgical expense, regular medical expense and major medical expense.

The National Health Insurance Institute estimates that 263,000 Alaskans under 65 years of age were covered by some type of health insurance as of December 31, 1976. The number by type of coverage is indicated below.

Figure V-32

PRIVATE HEALTH INSURANCE AND BLUE CROSS

NUMBER OF PERSONS IN ALASKA UNDER AGE 65 PROTECTED BY HOSPITAL SURGICAL, REGULAR MEDICAL AND MAJOR MEDICAL EXPENSE COVERAGE

December 31, 1976

Hospital Expense	263,000
Surgical Expense	246,000
Regular Medical Expense	248,000
Major Medical Expense	146,000

Note: The data refer to the net total of people protected, i.e. duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated. The estimated distribution by states reflects coverage by residence rather than employment. "Major Medical Expense" data refer to people covered by insurance companies only.

Sources: Health Insurance Association of America, Blue Cross Association, National Association of Blue Shield Plans, and the U.S. Department of Health, Education and Welfare.

The total dollar figure in premiums written for Alaskans was over $84 million during 1977. The amount of premiums written compared to losses incurred are summarized below. The total dollar figures of direct premiums written during 1977 by the twenty leading vendors in Alaska are identified in the following Figure V-34. These figures are accessed through the individual insurance companies' annual reports and aggregated by the Division of Insurance.

Figure V-33

TOTAL ACCIDENT & HEALTH INSURANCE
FINANCIAL DATA FOR ALASKA

1977

	Premiums Written	Losses Incurred
TOTAL	$84,822,000*	$63,158,343
Blue Cross	32,483,000*	29,380,307
Other Group	45,377,811	36,661,724
Credit	1,641,059	651,917
All Other	3,650,859	1,464,395
(Additional Figures)	1,669,000*	

*Some figures were rounded to the nearest thousand due to the information available.

Source: Alaska State Division of Insurance; from Annual Reports by each insurance company (Home Headquarters).

Figure V-34

HEALTH INSURANCE PREMIUMS WRITTEN IN ALASKA
Figures From Individual Company Annual Statements - 1977

TOP 20 VENDORS	PREMIUMS WRITTEN (In Thousands of Dollars)
Blue Cross of Washington & Alaska	$32,483.
Aetna Life Insurance Co.	10,082.
Bankers Life Co.	6,462.
Travelers Insurance Co., Life Dept.	4,782.
United Benefit Life Insurance Co.	4,226.
Continental Assurance Co.	2,638.
Metropolitan Life Insurance Co.	2,242.
Connecticut General Life Insurance Co.	1,903.
Equitable Life Assurance Co.	1,859.
New York Life Insurance Co.	1,488.
Pacific Mutual Life Insurance Co.	1,258.
Prudential Insurance Co. of America	1,038.
Western Life Insurance Co.	941.
Penn Mutual Life Insurance Co.	807.
Occidental Life Insurance Co. of Calif.	785.
First Farwest Life Insurance Co.	725.
Combined Insurance Co. of Americal	658.
Mutual of Omaha Insurance Co.	653.
Mutual Life Insurance Co. of New York	564.
Security Benefit Life Insurance Co.	438.
TOTAL PREMIUMS WRITTEN BY 301 COMPANIES:	$84,822.

Medicare: Medicare is a health insurance program administered by the federal government for the aged (Title 18 of the Social Security Act of 1965). Medicare coverage was extended in 1974 to also include disabled persons and persons with chronic kidney disease. Part A, Medicare coverage provides insurance for hospital care, post-hospital extended care and home health benefits. Part B, available on a voluntary basis with the payment of monthly premiums, provides medical insurance that covers not only care by physicians but also hospital outpatient services, physical therapy, diagnostic x-rays, ambulance services, etc.

By 1972, more than 95% of the U.S. population aged 65 and older was covered by Part A of Medicare. However, because of Medicare's deductibles and co-insurance provisions, and because of gaps in Medicare coverage, more than half of the Americans over 65 are buying private insurance to supplement Medicare. Medicare paid less than 35% of the total health bill to those over 65 during 1975.

Medicare expenditures for Alaska totaled over $7 million in 1976. Total Medicare expenditures rose by 54.9% between 1974 and 1976 for Alaska compared to 46.5% nationally. The Hospital Insurance Component (Part A) rose by 54.7% in Alaska and 45.1% nationally. The Supplementary Medical Insurance component (Part B) rose by a full 55.3% for Alaska compared to 50.1% nationally. During 1976, 9,818 Alaskans were enrolled in the Medicare program; including 8,653 persons age 65 and over, 1,165 disability beneficiaries, and 31 individuals with chronic kidney disease.

Figure V-35

MEDICARE ENROLLMENT (JULY 1) AND REIMBURSEMENT FOR HOSPITAL AND MEDICAL INSURANCE

ALASKA & U.S. CY 1976

	Hospital and/or medical insurance			Hospital insurance			Supplementary medical insurance		
	Number of persons enrolled	Amount reimbursed	Monthly average	Number of persons enrolled	Amount reimbursed	Monthly average	Number of persons enrolled	Amount reimbursed	Monthly average
All persons enrolled									
Alaska	9818	$7,161,870	$ 60.79	9750	$4,915,506	$ 42.01	8185	$2,246,364	$ 22.87
U.S.			$ 58.10			$ 42.79			$ 16.38
Persons age 65+									
Alaska	8653	$5,668,674	$ 54.59	8585	$4,101,190	$ 39.81	7174	$1,567,484	$ 18.21
U.S.			$ 56.80			$ 42.42			$ 15.41
Disability Beneficiaries									
Alaska	1165	$1,493,196	$ 106.81	1165	$ 814,316	$ 58.25	1011	$ 678,880	$ 55.96
U.S.			$ 70.82			$ 46.39			$ 26.44
Chronic Peral Disease									
Alaska	31	$ 651,374	$1,751.01	31	$ 189,239	$508.71	30	$ 462,135	$1,283.71
U.S.			$1,108.33			$305.26			$ 830.96

Medicaid and General Relief Medical: Persons eligible for the cash assistance payments (public assistance) under the categorical assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, and Aid to Families with Dependent Children) are eligible for Medicaid coverage of health care costs. Additional eligibility criteria for Medicaid exists for persons in nursing facilities and children in foster care or juvenile care situations. Medicaid is a state administered medical assistance program funded by both federal and state sources.

General Relief Medical coverage is available for persons having no prior medical care resources and who meet financial eligibility requirements for the assistance programs listed above but do not meet other qualifications for Medicaid coverage (under 65, both parents in the home are physically able to work, not blind or disabled under federal definition). General Relief Medical (GRM) provides coverage for some medical services and supplies not covered under Medicaid such as prescription drugs, prosthetic devices and medical equipment. GRM is administered by the state and totally state funded.

During fiscal year 1977, 11,815 persons received Medicaid services in Alaska and 2,631 received services under the General Relief Medical program. The total funds expended and the services covered are identified in Figures V-36, V-37 and V-38.

Medicaid expenditures have grown tremendously as a result of population growth, inflation, increased availability of services, rising cost of services and increased utilization of federal revenues for medical programs. The following figures show that Medicaid expenditures have grown by over 300% between 1973 and 1977.

Figure V-36

FISCAL YEAR	MEDICAID EXPENDITURES	GR MED EXPENDITURES	ADMINISTRATION AND SUPPORT
1973	$ 4,447,219	$ 3,675,277	$ 481,890
1974	7,876,759	2,607,112	631,129
1975	9,309,702	2,358,080	722,778
1976	14,328,201	2,881,213	1,085,086
1977	18,608,568	3,743,128	1,253,002
1978 1/	25,915,719	6,213,100	1,346,800
1979 2/	38,611,695	6,769,100	1,423,950

1/ Projected expenditures
2/ Total of budget request including supplemental requests--includes $6,422,300 for Indian Health Care Improvement Act billings by ANHS; this is 100% federal funds.

SOURCE: Medicaid Annual Status Report FY 77, State of Alaska, Dept Health and Social Services, Division f Public Assistance.

Figure V-37

DISTRIBUTION OF MEDICAID PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977

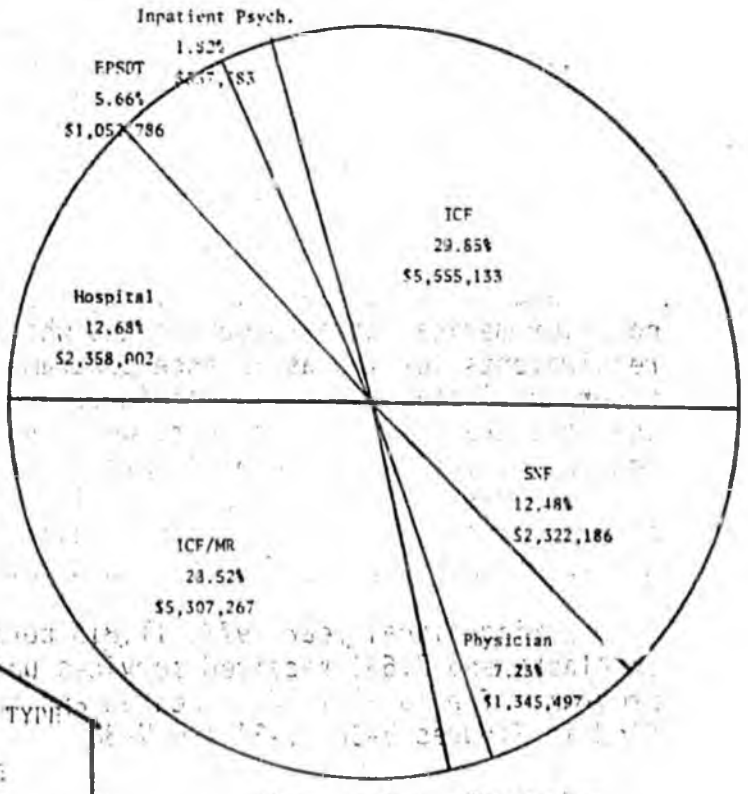
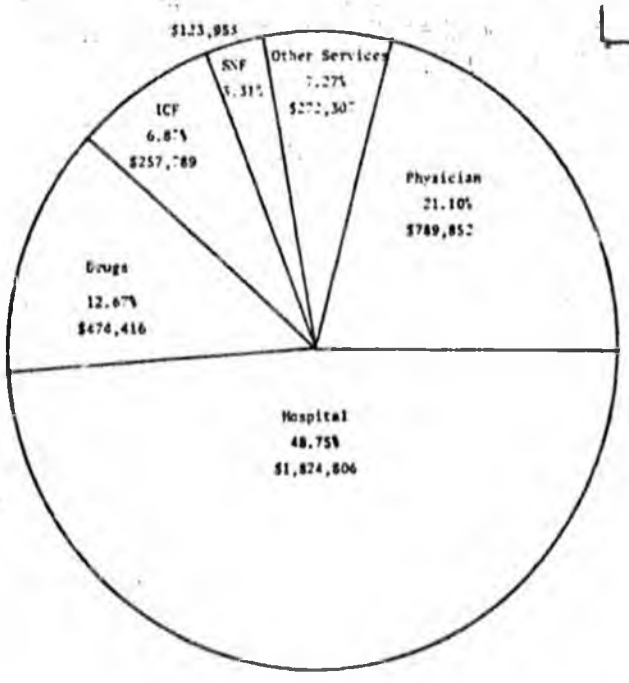


Figure V-38

DISTRIBUTION OF GR MED PAYMENTS BY TYPE OF SERVICE BY DATE OF SERVICE

FISCAL YEAR 1977



SOURCE: Medicaid Annual Status Report FY 77, State of Alaska, Dept Health and Social Services, Division of Public Assistance.

Catastrophic Illness Coverage: The State of Alaska initiated the Catastrophic Illness Program in July 1976 to assist individuals that have suffered an illness that results in high medical expenses. The program applies to medical bills related to catastrophic illnesses of more than $1,000 in a period not to exceed 12 months after all sources of third party payment has been exhausted. An applicant must be a resident of the state of Alaska at the time of the application and must have been a resident at the time of the catastrophic illness.

The Catastrophic Illness Committee, which administers the Program, determines the eligibility of applications and the amount of medical assistance to be awarded. The committee applies a formula for determining the amount of payment based upon family income and assets, and the amount of medical expenses incurred. The total budget for the Catastrophic Illness Program for FY 1979 is $514,000. The number of applications for catastrophic illness coverage which can be approved is therefore restricted by the appropriate budget. The program granted financial aid to over 80 persons during FY 78 and the number of applicants is increasing steadily.

Violent Crime Compensation: "Alaska Statute 18.67, establishing a Violent Crimes Compensation Board, was adopted by the State Legislature in 1972. Its purpose was to alleviate the financial hardships caused by crime related medical expenses or loss of income sustained by innocent victims of violent crimes in Alaska. Additionally, it provides for the payment of pecuniary loss to dependents of deceased victims to mitigate the loss of a loved one." The maximum award allowable per victim per incident is $25,000; except in the case of the death of a victim who has numerous eligible dependents, for which the maximum allowable is $40,000. The growth in the awareness of Violent Crimes Compensation has resulted in an increase in the number of applications received. The following chart documents the applications received and awards granted since 1973.

Figure V-39

APPLICATIONS AND AWARDS

	FY73	FY74	FY75	FY76	FY77	FY78
Applications Received	15	50	71	68	93	100
Applications Heard	-0-	37	51	82	81	99
Total Amount Awards Granted	-0-	36,025.60	125,266.20	272,948.29	120,968.07	285,672.63*
Pending Claims At End Of FY	13	38	41	8	28	33

*The Legislature approved a supplemental appropriation of $75,000.00 for awards for FY78. $94,379.30 of the F /78 award money was spent on prior year claims.

Administrative costs for Violent Crimes Compensation for FY 78 were as follows:

Staff salaries (2 persons) and benefits	$57,315.37
Travel includes board member travel and per diem	5,195.44
Attorney fees, office expenses, equipment, etc	11,372.97
Total Costs	$73,883.78

spouse and such children whose coverage under the policy terminates at the same time, or (ii.) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in paragraphs (10) and (11) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in paragraphs (10) and (11).

(18) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside [state] must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

Section 3. [*Severability.*] [Insert severability clause.]

Section 4. [*Repeal.*] [Insert repealer clause.]

Section 5. [*Effective Date.*] [Insert effective date.]

Comprehensive Health Insurance Act

This draft statute requires that employers in the state must include qualified catastrophic health insurance protection and minimum types of benefits for routine care in any policy provided to their employees pursuant to the individual's employment. This includes policies which are paid for partly or fully by the employee as well as those which are completely employer-paid. If only nonqualified plans are offered to employees, the employer may not deduct for tax purposes the cost of the insurance to him. In order to qualify, a plan must meet specified benefit levels and have no more than a maximum allowable deductible. This draft act also includes as Sections 18 and 19 a state catastrophic medical insurance plan under which the state will pay the medical expenses of those persons who incur uninsured medical expenses exceeding specified portions of their income.

This medical insurance plan is implemented by requiring in the statute that all insurers writing health insurance in the state must offer a qualified plan to their customers. A compulsory association of all insurers in the state is also to be formed under the act for the purpose of offering a qualified plan of insurance to those individuals whom the insurers have individually refused to insure. For those individuals who may be leaving employment at which they were enrolled in a qualified plan, the act provides mandatory conversion privileges enabling the individual to continue his insurance.

As the above indicates, this draft act is broad in scope and is directed toward multiple purposes. Among the related but separate purposes of the legislation are ensuring minimum standards for group health plans, creating an association of insurers as a resort for those individuals who could not otherwise obtain effective coverage, and providing catastrophic medical expense protection for all through employers and private insurers where possible and through the state welfare system where necessary.

This draft legislation is based on a 1976 Minnesota statute.

Suggested Legislation

(Title, enacting clause, etc.)

Section 1. [*Short Title.*] This act may be cited as the [state] Comprehensive Health Insurance Act.

Section 2. [*Definitions.*] As used in this act:

(1) "Employer" means any person, partnership, association, trust, estate, or corporation, which employs 10 or more individuals who are residents of this state.

(2) "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in [appropriate state statute].

(3) "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 6 of this act or the actuarial equivalent of those benefits.

(4) "Qualified Medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 7 of this act or the actuarial equivalent of those benefits.

(5) "Commissioner" means the [commissioner of insurance].

(6) "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled.

(7) "Employee" means any [state] resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than [30] days by his present employer, nor one who is employed less than an average of [30] hours per week by his present employer.

(8) "Plan of health coverage" means any 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.

(9) "Insurer" means those companies operating pursuant to [appropriate state statute] and offering or selling policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

(10) "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. "Policy" does not include 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, or (v) credit accident and health insurance issued pursuant to [appropriate state statute].

(11) "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care.

(12) "Eligible person" means an individual who is a resident of [state] and meets the enrollment requirements of Section 14 of this act. For purposes of Sections 18, 19, and 20 only, "eligible person" means any person who while a resident of [state] has been found by the [commissioner of public welfare] to have incurred an obligation to pay qualified expenses for himself and any dependents in any [12] consecutive months exceeding (i) [40] percent of his household income up to $[15,000], plus [50] percent of his household income between $[15,000 and $25,000], plus [60] percent of his household income in excess of $[25,000], or (ii) $[2,500], whichever is greater.

(13) "Comprehensive health association" or "association" means the association created by Section 10 of this act.

(14) "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.

(15) "Medicare supplement plan" means any 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.

(16) "State plan premium" means the premium determined pursuant to Section 8 of this act.

(17) "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

(18) "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with [appropriate state statute].

(19) "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

(20) "Self-insurer" 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. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public who provide health care services directly to his employees at no charge to them.

(21) "Self-insurance" means a plan of health coverage offered by a self-insurer.

(22) "Qualified expense" means any charge incurred subsequent to [insert date] for a health service which is included in the list of covered services described in Section 6(a), and for which no third party is liable.

(23) "Household income" means the gross income of an eligible person and all his dependents for the calendar year preceding the year in which an application is filed pursuant to Section 18.

(24) "Gross income" means income as defined in [appropriate state tax statute].

(25) "Third party" means any person other than the eligible person or his dependents.

Section 3. [*Duties of Employer.*]

(a) Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of Section 6 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. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self-insurance, health maintenance contracts, group policies, or individual policies or any combination thereof.

(b) In the event that an employer fails to make available at least a number two qualified plan health benefits to his employees employed in this state, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to [appropriate state tax statute]. In the case of an employer who meets the requirements of [state statute defining tax exempt organizations], if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization.

Section 4. [*Duties of Insurers.*]

(a) For each type of qualified plan described in Section 6, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner 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 this 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 this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this 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 Section 6, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner 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 this 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 within a calendar year for services covered in Section 6(a), benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $[250,000].

(e) No policy of accident and health insurance may be issued or renewed in this state [180] days after [insert date] by an insurer or a fraternal which has not complied with the requirements of this section.

(f) An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with paragraphs (5) and (6) of Section 10(g).

(g) Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Section 5. [*Certification of Qualified Plans.*] Upon 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 Sections 1 to 17, the commissioner shall make a determination within [90] days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Section 6. [*Minimum Benefits of Qualified Plan.*]

(a) A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by [appropriate state statute] and the other laws of this state and whether or not the policy is issued in this state and 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 does not exceed $[150] per person. 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:

(i) Hospital services.

(ii) 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.

(iii) Drugs requiring a physician's prescription.

(iv) Services of a nursing home for not more than [120] days in a year if the services commence within [14] days following confinement of at least

[three] days in a hospital for the same condition.

(v) Service of a home health agency up to a maximum of [180] visits per year.

(vi) Use of radium or other radioactive materials.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prostheses.

(x) Rental or purchase, as appropriate, of durable medical equipment.

(xi) Diagnostic X-rays and laboratory tests.

(xii) 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.

(xiii) Services of a physical therapist.

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

(i) Any charge for any care for any injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another policy of accident and health insurance or Medicare.

(ii) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(iii) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury.

(iv) Any 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.

(v) That part of any 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.

(vi) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or article.

(3) Effective [insert date], the minimum benefits for a qualified plan shall include, in addition to those benefits specified in subsection (a)(1), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(i) Well baby care.

(ii) Physicians' services for routine checkups and annual physicals when prescribed by a physician.

(iii) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for these services.

(b) A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of this 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.

(c) A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of this 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.

(d) A health maintenance organization which provides the services required by [appropriate state statute] shall be deemed to be providing a number three qualified plan.

Section 7. [*Qualified Medicare Supplement Plan.*] Any 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 deductible and copayment required under Medicare and [80] percent of the charges for covered services described in Section 6(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].

Section 8. [*State Plan Premium.*]

(a) For the first year of operation of the comprehensive health insurance plan, the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(1) The premium for the number one qualified plan shall be 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 shall be 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 shall be 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) For the second and subsequent years, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Section 9. [*Duties of Commissioner.*] The commissioner may:

(1) Formulate general policies to advance the purposes of Sections 1 to 17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rulemaking provisions of [state administrative procedure act] to carry out the provisions of Sections 1 to 17.

(2) Supervise the creation of a comprehensive health association within the limits described in Section 10.

(3) 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.

(4) Appoint advisory committees.

(5) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association.

(6) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmnental assistance programs.

(7) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of Sections 1 to 17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections.

(8) Contract with insurers and others for administrative services.

Section 10. [*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 commissioner. To select the initial board of directors, and to initially organize the association, the commissioner 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 upon 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 commissioner. If the board of directors is not selected within [60] days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall 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) All members shall maintain their membership in the association as a condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

(d) All meetings of the association, its board, and any committees of the association shall comply with the provisions of [state open meetings act].

(e) All members shall enter into a contract with the association according to terms specified in Section 11. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain 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 shall be exempt from the provisions of [state antitrust statute].

(g) The association may:

(1) Exercise the powers granted to insurers under the laws of this 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 paragraphs (5) and (6) of this subsection.

(4) Establish administrative and accounting procedures for the operation of the association.

(5) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by Sections 4 and 16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (i) individual qualified plans, excluding group conversions; (ii) group conversions; (iii) group qualified plans with fewer than [50] employees or members; and (iv) 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 shall not be less than [110] percent of the total anticipated expenses incurred by the association for the reinsurance.

(6) Provide for the administration by the association of policies which are reinsured pursuant to paragraph 5 of this subsection. Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. 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.

(a) Upon certification as an eligible person in the manner provided by Section 14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

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

(c) Not less than [87½] percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than [12½] percent shall be used for the payment of agent referral fees as authorized in Section 15(c) and for payment of the writing carrier's direct and indirect expenses, as specified in Section 13(g).

(d) Any 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 comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with Section 10(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 commissioner. 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 reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within [30] days of notification by the association shall be grounds for termination of the member's membership. Net gains, if any, 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.

Section 12. [*Minimum Benefits of Comprehensive Health Insurance Plan.*] The association through its comprehensive health insurance 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. They 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.

Section 13. [*Administration of Plan.*]

(a) Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

(b) Upon the commissioner's approval of the policy forms and contracts submitted pursuant to Section 10, 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 upon 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 commissioner. The commissioner shall approve or deny a request to terminate within [90] days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. [Six] months prior to 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 follow the provisions of subsection (b) in selecting a writing carrier for the subsequent three-year period.

(d) The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate, setting forth a 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 prior to the effective date of the state plan.

(f) All claims shall be paid by the writing carrier pursuant to the provisions of Sections 1 to 17 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

shall include, but need not be limited to, a pro rata reimbursement for that 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 shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

(f) The writing carrier shall at all times when carrying out its duties under Sections 1 to 17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of [appropriate state tort liability statute].

(i) Premiums received by the writing carrier for the comprehensive health insurance plan are specifically exempted from the provisions of Section 15 .

Section 14. [*Enrollment by Eligible Person.*]

(a) The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(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, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least [two] association members within [six] months of the date of the certificate.

(4) A designation of the coverage desired.

(b) Within [30] days of receipt of the certificate described in Section 14(a), the writing carrier shall either reject the application for failing to comply with the requirements in Section 14(a) or forward the eligible person a notice of acceptance and billing information. Insurance shall be 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 Sections 1 to 17. An eligible person may not purchase more than one policy from the state plan.

(c) No person who obtains coverage pursuant to this section shall be covered for any 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.

Section 15. [*Solicitation of Eligible Persons.*]

(a) The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of Sections 1 to 17 and shall administer these sections in a manner which facilitates 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 shall 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 applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Section 16. [*Conversion Privileges.*] Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this 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. The person leaving the group may exercise his right to conversion within [30] days of leaving the group. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived.

Section 17. [*Dual Option.*]

(a) An employer who employs in this state, on the average during a calendar quarter, [100] employees or more, other than employees engaged in seasonal employment, and who offers a health benefits plan to employees, whether purchased from an insurer or a health maintenance organization, or provided on a self-insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual 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 dual 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 this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the board of health.

(c) No insurer shall 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. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

(d) The [board of health], in consultation with the commissioner, shall adopt rules to implement the provisions of this section.

Section 18. [*Application for Assistance.*]

(a) Any person who believes that they are or will become an eligible person may submit an application for state assistance to the [commissioner of public welfare]. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the [12]-month period for computing expenses began.

(b) If the [commissioner of public welfare] determines that an applicant is an eligible person, he shall pay [90] percent of all qualified expenses of the eligible person and his dependents in excess of: (1) [40] percent of his household income under $[15,000], plus [50] percent of his household income between $[15,000] and $[25,000], plus [60] percent of his household income in excess of $[25,000]; or (2) $[2,500], whichever is greater for the [12]-month period in which the applicant becomes an eligible person. If the [commissioner of public welfare] determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the [commissioner of public welfare] determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determinations as to whether or not a charge is excessive. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determination as to whether or not a service was medically necessary. If the [commissioner of public welfare], in accordance with this section, refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Section 19. [*Duties of Commissioner.*]

(a) The [commissioner of public welfare] shall:

(1) Promulgate reasonable rules to implement Sections 18 to 20.

(2) Establish application forms and procedures for the use of persons seeking to be declared eligible persons.

(3) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

(b) The [commissioner of public welfare] may:

(1) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by this act, with other programs which provide or pay for the delivery of health services.

(2) Enter into contracts with third parties to perform some or all of the duties imposed on the [commissioner of public welfare] by Sections 18 and 19.

Section 20. [*Appeals.*] The final decision of the [commissioner of public welfare] in denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to [state administrative procedure act].

Section 21. [*Severability.*] [Insert severability clause.]

Section 22. [*Repeal.*] [Insert repealer clause.]

Section 23. [*Effective Date.*] [Insert effective date.]

STATE OF ALASKA

Legislative Affairs Agency

OPTING

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A Study of Medicaid Client Need

February 1977

O P T I N G

A Study of Medicaid Client Need

PREPARED BY

LEGISLATIVE AFFAIRS AGENCY
DIVISION OF RESEARCH

FEBRUARY, 1977

Foreword

In the fall of 1972, Alaska entered the national Medicaid program, providing certain of its citizens thereby a limited spectrum of medical care services.

Since this modest beginning, the legislature has increased Medicaid coverage by the addition of a few services above those which the state is required to cover in order to participate in the federal program. These optional services allowed the state to earn addition "matching" federal funds, some of which were a direct one-for-one offset to medical care expenditures that the state itself had been previously paying for in their entirety. Other program additions resulted in increased state expenditures, but provided a more complete medical coverage package.

In order to maximize the benefits from the additional expenditures, optional service additions must undergo careful scrutiny to insure that the options chosen return the greatest level of benefits in terms of meeting the health needs of the approximately seven percent of Alaska's population served by the Medicaid program. During 1976, a number of legislators indicated their desire to have better information upon which to base their decisions concerning the addition (or deletion) of various possible optional services. In order to meet this need, Miss Deborah Behr of the Research Division staff began, in June of 1976, an extensive effort directed at reviewing public assistance eligibility supervisors' perceptions of client requirements, analyzing written denials of additional client service requests, and obtaining information from various states regarding their experience with selected options. The present study is the result of this effort.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
February, 1977

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Medicaid is a program funded jointly by the federal and state governments which aids certain needy Alaskans in providing payments for them to receive medical services. It helps assure that medical services are available to those needy eligible persons when they are ill or injured. It also assists in guaranteeing that the highest quality care of the kind required by the patient's condition is available, by mandating certain medical reviews of patient care and treatment. Medicaid also attempts to make services available by utilizing the present system of private practitioners, facilities, and institutions to provide the care required at the lowest possible cost to the taxpayer.

STATE PLAN FOR MEDICAID

The Medicaid program in Alaska is administered by a single state agency, the Department of Health and Social Services, which is required to submit a state plan to the Secretary of the federal Department of Health, Education, and Welfare for his review and approval.

The state plan is essentially a contract between the state department and the federal Department of Health, Education, and Welfare specifying conditions to be met in order to qualify for federal financial participation. Some topics included in it are:

1. eligibility determination
2. recipient eligibility
3. eligibility verification
4. medical services
5. health care
6. quality control
7. fair hearings
8. methods of administration
9. utilization review
10. fraud

Many of these items are required be included in the plan (mandatory), but others the state may decide whether or not to include (optional). The optional portions allow the state to shape a medical assistance program to the needs and financial resources of its citizens.

DIFFERENCES BETWEEN MEDICAID AND MEDICARE

Medicaid is often confused with the Medicare program in the state. Medicaid is a medical assistance program for certain needy low-income people. In Alaska, Medicaid is administered by the Division of Public Assistance, an agency of the Alaska Department of Health and Social Services. It is authorized under Title XIX of the federal Social Security Act and AS 47.07.010-.080 of the Alaska statutes. States can design their own programs within set federal guidelines to meet the needs and resources of its citizens. Medicaid programs can and do vary from state to state.

In comparison, Medicare is a medical insurance program for those people, rich or poor, covered by Social Security. It is administered by the Social Security Administration of the federal government. The program is the same in all fifty states. Almost everyone over 65 and some younger persons who have been receiving Social Security disability payments for at least two years qualify for the program.

BRIEF HISTORY OF MEDICAID PROGRAM IN ALASKA

On July 6, 1972, Alaska became the 49th state to provide the Medicaid program for its residents. The state had, since the mid-60's, provided for such services under the General Relief - Medical program. Costs had risen from $1.8 million to $8.7 million in FY 72. This dramatic increase was due to many factors, the major ones being:

1. The number of eligibles had increased, but the rate of expenditure was increasing at even a faster pace.

2. The scope of the program had been liberalized and expanded with a related increase in utilization of services.

3. Medical care costs were rising at a rate disproportionate to that of other costs of living.

In light of this situation, the administration and the legislature came to basic conclusions that the General Relief - Medical program, which was supported 100% with state monies, had need of administrative controls to review services and, hopefully, reduce health care expenditures. There was a general consensus that either the General Relief - Medical program had to be upgraded or research should be done to investigate the possibility of the implementation of the Medicaid program. In April, 1972, the Department of Health and Social Services contracted with Touche Ross and Company, a public accounting firm, to develop a cost benefit study of the Medicaid program. Budgets were developed and testimony was made to the legislature that session. On June 17, 1972, the enabling bill for the Medicaid program passed the legislature and was later signed into law with an effective date of July 6, 1972. (The history of the program can be traced on Table 1: Medicaid History Timeline.)

TABLE 1

State of Alaska
Medicaid History Timeline

Date	Occurrence
April 10, 19 2	Touche Ross & Company begin Medicaid System Design
April 18-June 9, 1972	Departmental Presentation to Legislature
May 10, 1972	Department of Health and Social Services' Steering Committee Established
June 17, 1972	Enabling Bill Passes Legislature
July 6, 1972	Medicaid Becomes Law
September 1, 1972	Medicaid Implemented
September 28, 1972	State Plan Submitted to Federal Department of Health, Education and Welfare
April 4, 1973	Effective date of Intermediate Nursing Home Care Option
May 16, 1974	Effective date of Inpatient Psychiatric Hospital Option for Eligible Persons 65 or Over and Under 22
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (Primarily needy children under 21 in foster care under supervision by Department of Health and Social Services)
July 13, 1974	Effective date of 60 day limit on filing Medicaid claims
April 15, 1975	New Division of Public Assistance Formed
September 2, 1975	Effective date of Intermediate Nursing Home Care for Mentally Retarded Under 21 who Meet AFDC Need Standards Option
March 12, 1976	Effective date of Eye Glasses and Optometrist Service Options
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles
July 1, 1976	Effective Date of Limited Clinic Services Option (Primarily Community Mental Health Centers and State Operated Mental Centers)
July 1, 1976	Effective date of Treatment of Speech, Hearing, and Language Disorders Option

The Department of Health and Social Services worked during the interim period to provide the necessary procedures and organization to make Medicaid an administrative reality in Alaska. A new Division of Medical Assistance in the Department of Health and Social Services was formed to administer the new program, as well as the remnants of the General Relief - Medical program. On September 1, 1972, the Medicaid program was actually implemented. (The Division continued to administer the program until April, 1975, when the new Division of Public Assistance was formed. This new division combined the eligibility determination, income maintenance, and medical assistance functions into one organizational grouping in the state.) Later that month, the official state plan was submitted to the federal Department of Health, Education and Welfare for its approval.

With the approval of the state plan, Alaska realized the benefits due to implementation of the Medicaid program:

1. Federal matching funds for medical expenditures became 50%, thereby allowing the continuation of the level of medical services without further increase in state general fund expenditure.

2. Federal match for categorical assistance programs under the Social Security Act increased from 30% to 50%.

3. Administrative controls, seen as necessary, were implemented to fulfill Medicaid requirements in order to receive federal financial participation.

When the legislature approved the Medicaid program, it included a restriction in statute mandating that all new services or eligibility group additions must receive its approval. At time of passage, the enabling legislation included those services and eligibility groups mandated by the federal government in order to receive federal financial participation. Since that time, the legislature has added few additional services or eligible groups.

The legislature added the first additional service option in 1973. At that time, intermediate nursing home care was selected. This option permitted the coverage of a lower and less expensive level of nursing home care. This addition allowed many Medicaid recipients in skilled nursing, who did not require that level of treatment, to be properly placed in intermediate nursing care thus "saving" state general fund dollars.

In 1974, the inpatient psychiatric hospital services option was added for eligible persons 65 years of age or over and 21 or under. This allowed the state to claim federal reimbursement for some persons at Alaska Psychiatric Institute, who were eligible for Medicaid coverage and were at that time receiving their care 100% from state monies. Also, other small groups of new eligibles were added at that time. Primarily they consisted of certain needy foster care children under 21 supervised by the Department of Health and Social Services. Prior to

that time these children had, in most cases, received coverage for their health care through the General Relief-Medical program. Also, legislation was passed requiring that medical assistance claims be submitted promptly, no later than six months after date of service or third party payment was received. This permitted more administrative control of expenditures and allowed for greater accuracy in budget projections.

The option to include a new group of needy eligibles under 21 who were in intermediate nursing homes for the mentally retarded became effective in 1975. This permitted a group of children at Harborview Memorial Hospital, Alaska Psychiatric Institute, and Hope Park to receive Medicaid coverage and, hence, additional federal dollars could be earned for their care.

In 1976 the legislature chose to add four new items to the program. A new group of needy persons became eligible for Medicaid coverage for their nursing home care due to an addition of an option. Also, that session, prescription eyeglasses and optometrist's services were added to the program. The legislature also approved the addition of limited clinic services which allowed state operated mental health centers and state approved community outpatient mental health centers receiving grants under A.S. 47.30.520 - 47.30.620 to be covered. This permitted federal funds to be earned in these state general fund supported projects. Also, at that time, the coverage of treatment of speech, hearing, and language disorders was added to the Medicaid program.

The legislature has shown interest in examining and evaluating the available Medicaid options, as seen by the recent history of the program in the state. Many of these options, especially in the case of coverage of nursing home care for certain needy eligible persons, actually "saved" state money. By adding them to the Medicaid program, federal funds could be realized for some of those services, which were being paid at that time 100% from state general funds. Also, by increasing the scope of the service package, a more consistent medical treatment program could be offered to these needy persons. For example, prior to the 1976 addition, eyeglasses were not generally available to all Medicaid eligibles who needed them. Only Medicaid eligible children who had been seen in early screening programs and referred for eyeglasses could be reasonably assured of coverage under the program for their lenses. Needy adults, such as those in nursing homes, had no such guarantee.

Alaska was one of the last states to join the Medicaid program and has been cautious in increasing the scope of the program in the state. In comparison with many other states in the program, Alaska's program is limited, with few service and eligibility group options beyond those basic services and groups required to maintain compliance with the program. This paper will later examine the current scope of the program and the options available under it that the legislature may be called upon to evaluate in 1977 and thereafter.

PART II. CURRENT STATUS OF MEDICAID PROGRAM IN ALASKA

ELIGIBILITY OF CLIENTS

The Alaska Medicaid program provides coverage for certain needy persons receiving or eligible to receive public assistance under:

Federal Supplemental Security Income (SSI),

Alaska Old Age Assistance (OAA),

Alaska Aid to the Blind (AB),

Alaska Aid to the Disabled for Persons who Meet Federal Criteria for Disability (AD), or

Aid to Families with Dependent Children (AFDC),

and certain others (mostly children)

Alaska does not cover the medically needy under its Medicaid program.

In general to be eligible for Medicaid in Alaska, an individual must:

(1) Be physically present in Alaska at time of application and citizen of U.S. or lawfully admitted alien;

(2) Not be in a public institution such as a jail (a person may however be in chronic disease facility such as a nursing home);

(3) Not have more than $1,500 in non-exempt personal property; this excludes a home (there is no lien requirement), personal belongings, in certain cases, a necessary automobile and some types of income producing property;.

(4) Not have transferred property to qualify for assistance;

(5) Meet program requirements such as blind, disabled, aged over 65, or dependent child

The Division of Public Assistance examines the financial and living situation to determine if a person is eligible. As a basic rule, if a family of four meets general program requirements, has monthly net income of no more than $400 earned (excluding reasonable work related expenses) and unearned income, the family would qualify for assistance under Aid to Families With Dependent Children program. There is no geographical differential on the total amounts allowed. The amounts vary for the adult programs (OAA, AB, AD) but generally, if household expenses (excluding fuel) are over $35 a month and the net income is no more than $334 a month of earned (excluding reasonable work-related expenses) and unearned income, a single person family would qualify if other program requirements are met. The $334 figure can vary annually

in accordance with cost of living adjustments required in AS 47.25.640; 47.25.430; 47.25.810. Eligibility for categorical assistance programs automatically makes one eligible for Medicaid.

SERVICES COVERED UNDER MEDICAID

The State of Alaska covers basically two types of services: mandatory, which the states are required to provide, and optional, which the state may provide and receive federal reimbursement. Alaska provides all mandatory services, but optional services are limited.

Mandatory Services

Alaska must provide the following services: 1) inpatient hospital services; 2) outpatient hospital services; 3) physician's services; 4) x-ray and laboratory services; 5) skilled nursing home services; 6) home health services; 7) early and periodic screening, diagnosis, and treatment of children under 21; and 8) family planning services. Alaska also is required to cover transportation necessary to receive medical service, if unavailable from any other source, but it is not listed as a federal requirement.

Optional Services

In addition to the mandatory services, Alaska provides and receives federal reimbursement for the following services:

(1) Inpatient psychiatric hospital services for individuals age 65 or older or under age 22
(2) Intermediate care facility services
(3) Skilled nursing for those persons under 21 years of age
(4) Emergency hospital services
(5) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
(6) Services for individuals with speech, hearing, and language disorders
(7) Services through state approved out-patient community mental health clinics which receive grants under AS 47.30.520-47.30.620 and state-operated mental health clinics
(8) Optometrist's services and limited dental and prosthetic devices as required under EPSDT regulations

Other services that the state could choose to provide for certain of its needy individuals, but which has not yet opted for, include:

(1) Prescribed drugs
(2) Dental Services (for persons over 21 not covered under the early screening program)
(3) Dentures
(4) Prosthetic devices (for persons over 21 not covered under the early screening program)

(5) Private duty nursing
(6) Physical therapy and related services
(7) Chiropractor's services and other practitioners
(8) Podiatrist's services
(9) Care for patients aged 65 or older in Institutions for Tuberculosis
(10) Other diagnostic services, screening, preventive services, rehabilitative services

Parts III through V of this report deal later with these optional services in more depth, examining the need and aspects to consider in the evaluation of these alternatives to the program.

FINANCIAL PARTICIPATION BY FEDERAL GOVERNMENT

The federal government financially participates in the Medicaid program by means of matching state dollars for allowable administrative and medical expenditures. Services to eligible clients receive 50% reimbursement, except for family planning supplies and services which are matched at 90% level. Administrative costs are generally matched at 50%. Professional medical review staff are reimbursed at 75% level. (Certain other administrative services receive special match rates, such as 100% for certification and survey of nursing homes. These special rates are itemized in federal law and regulation.)

At the present time there is no "ceiling" or set limit for Alaska on the amount of federal funds available for reimbursement. There has, in recent years, been much discussion on the federal level to restrict such reimbursement, as was indicated in President Ford's budget address in January, 1976. At that time, he mentioned the possibility of placing the Medicaid program in a block grant package with other federally assisted health care programs. By this method, a dollar limit would have been set on the available federal funds for those purposes. Generally, though, the prospects for major funding modifications in the Medicaid program appear slim, although tighter management and administrative mechanisms to control fraud and quality of services seems to be a continued interest.

NEW DEVELOPMENTS IN MEDICAID

In the fall of 1976 the federal government placed additional responsibilities on the Medicaid program, through the passage of Public Law 94-437. That bill, known as the Indian Health Care Improvement Act, mandated closer coordination of Medicaid and Indian health services and required that all services for Medicaid eligible Alaska Natives in Indian health facilities be billed to Medicaid. The federal government would then reimburse the state's Medicaid program at 100% for such services. Additional administrative functions would receive normal federal reimbursement rates. The services eligible for reimbursement under Public Law 94-437 are only those included in the approved Medicaid state plan and provided to Medicaid eligible Alaskan Natives.

Total ramifications of the bill are yet unknown. Federal officials report though that Alaska is far ahead of other affected states in implementing the new law. For example, seven of Alaska's nine Indian Health Service hospitals currently meet statutory requirements for participation in Medicaid without further action. State officials note though that unless there is a major shift in procedures for handling people covered under Indian Health Improvement Act, field office work will increase greatly (e.g., issuing medical coupons, arranging necessary transportation, answering client and provider questions). These state officials voiced concern that estimates of the number of new Alaska Native clients attracted to apply for Medicaid coverage are unknown. The attachment of a dollar figure to the cost of medical services for these persons would be just a rough estimation.

PART III. GENERAL INFORMATION REGARDING OPTIONAL SERVICES

CONTROLS THAT STATES MAY IMPOSE ON MEDICAID OPTIONAL SERVICES

Since the addition of optional services is at the discretion of the state, the federal government allows great flexibility for states to determine the scope of the option that they wish to provide for their Medicaid clients. Generally, federal law and regulation define the basic objectives and requirements of the options, all of which must be met in order to obtain federal financial participation. Some of the requirements address equal offering of services to all eligibles, the qualifications of persons providing the services, and degree of supervision required for paraprofessionals. Within those broad parameters states can shape optional services to fit their unique needs and resources.

Alaska can limit optional services by (1) qualifying coverage, (2) requiring prior authorization, (3) limiting usage frequency, (4) requiring clients to share in cost of services, or (5) limiting the amount of provider reimbursement:

(1) *Qualifying Coverage*

Medicaid law and regulation permit the limiting of coverage of optional services. For example, dentures can be selected as a separate service without having to cover other prosthetic devices such as hearing aids, crutches, etc, or without having to cover other dental services. The Medicaid program does require that the option limitations be applied equally to all eligible clients. (There are certain exceptions to this policy. Some options are defined in federal law to include only specific age groups such as persons under 21 or over 65.) The state, for example, cannot as a general rule limit eligibility for optional service to only those persons receiving aid under a particular program such as Old Age Assistance. If a state chooses an optional service, it must be covered for all groups (except as noted in federal law or regulation) or federal reimbursement will be jeopardized.

(2) *Requiring Prior Authorization*

States can control inappropriate overutilization of optional services by requiring the client to receive approval from the Medicaid agency prior to obtaining certain medical care. Preauthorization is usually based on medical need for services and appropriateness of the care requested to the condition being treated. The Division of Public Assistance has, since the beginning of Medicaid, required preauthorization of all nursing home placements. This mechanism serves to reduce unnecessary placements, place clients at appropriate levels of care, and suggest alternative, and usually cheaper, methods of treatment.

(3) *Limiting Usage Frequency*

Optional services can also be limited by restricting client use. This is generally done by limiting the number of treatments or services paid by Medicaid in a specific time period. For example, Maryland limits adults to one eye examination and one pair of eyeglasses every two years. Arkansas limits Medicaid clients to three prescriptions per month. These restrictions must be applied though uniformly to all clients receiving assistance. Limitations of the amount of services should take into account unusual emergency situations. States cannot impose barriers to needed minimum levels of health care, or risk federal sanction.

(4) *Requiring Clients to Share in Cost of Services*

Some states require Medicaid clients to participate in sharing the costs of certain optional services. Federal regulation sets certain maximum allowable limits on the amount of payment that clients can be required to cover. Those regulations also specify the mechanisms that states can use to allow clients to share in the cost of certain services. Fees are generally limited to small amounts such as $.50 per prescription drug and $2.00 per pair of eyeglasses. Originally, this procedure was instituted to control overutilization of services and not to generate funds. California, along with some other states which elected this option, has found that the cost of administration of this mechanism generally did not offset the revenues gained. The charges did not significantly affect client use of services, and the states found that the collecting and controlling of such small fees were bothersome to both client and provider.

(5) *Limiting the Amount of Provider Reimbursement*

Costs of optional services can also be reduced by limiting the amount of provider reimbursement. Often this comes in the form of reducing reimbursement by a set percentage or by "freezing" payment levels at the current standards. (Medicaid pays "reasonable" rates to its providers. The costs allowable under its definitions often differ greatly from those accepted by Blue Cross and other insurance companies. Fees paid under Medicaid are often lower than fees paid by the general public for the same services.) The state of Michigan, for example, recently implemented an 11% reduction in normal fees paid to practitioners, dentists, laboratories, and other providers. Often such changes receive strong provider reaction and sometimes jeopardize the continued participation of those providers in the program. Federal officials also note the potential use of low bid health providers. For example, the state could solicit bids for a contract to supply Medicaid clients with specific services, such as eyeglasses. The state could select the most advantageous bid and award the contract without jeopardizing federal reimbursement.

OTHER ISSUES TO CONSIDER IN EVALUATING MEDICAID OPTIONAL SERVICES

Although this study focuses primarily on client need, there are other factors that must be considered in evaluating the merits of any given Medicaid option. Three of these major considerations are: availability of funds, costs versus benefits of options, and ease of administration.

The availability of funds plays a major role in the scope of services that a state believes it can provide for its citizens. The high cost of medical care demands an in-depth analysis of cost before any new service is added. Although this study does not discuss this financial issue, it is a major part of any decision to modify the program. Legislators who have a well defined proposal for additional option(s) may request the Research Division of the Legislative Affairs Agency to prepare an analysis of its costs, both direct and administrative.

The costs versus benefits of an option can be an important consideration in deciding whether or not the state should participate in it. For example, certain Medicaid options sometimes "save" state money, if that service is currently paid entirely from state funds or if it allows a client to receive less specialized and less expensive type of service that are more appropriate to this medical condition or problem. In 1976, the Alaska State Legislature added coverage of new limited group of needy eligibles who currently reside in nursing homes. The care for those persons at that time was paid for 100% from state general funds through the General Relief-Medical program. By adding that option, the state was able to claim 50% federal reimbursement for their care. Also, in 1973, the state added the intermediate nursing home care option. By covering this lower and less expensive level of nursing home care, many Medicaid recipients in skilled nursing, who did not require that level of treatment, could be placed in intermediate nursing care. The cost per day for each patient was reduced considerably.

The ease of administration is important also in evaluating the merits of certain options. The drug option, for example, requires that strict payment procedures regarding maximum allowable charges be in place. These are spelled out in some detail in the federal regulations, and the state must meet those requirements or risk loss of federal participation. Federal officials note that many of these cost containment mechanisms would normally be in place in any efficiently administered pharmaceuticals program, regardless of source of funding for it. The transfer of a program from state-only funding to federal assistance should cause minimal additional administrative expenses if adequate cost containment measures are in place in the existing program.

IV. MEDICAID CLIENT NEEDS

QUESTIONNAIRE OF PUBLIC ASSISTANCE SUPERVISORS

In Fall, 1976, a questionnaire was prepared to poll public assistance supervisors (eligibility work supervisors) on their estimation of client need for certain services based on their actual experience in the field. The questionnaire, prior to mailing, was reviewed by both the Division of Public Assistance and Department of Health and Social Services Commissioner's Office. The questionnaires were mailed to nineteen supervisors, many of whom had worked with public assistance clients for a significant period of time. (That sample of supervisors was chosen under the guidance of the Division of Public Assistance's Chief of Field Operations.) Approximately one month after mailing, a follow-up questionnaire was sent.

Fourteen, or 75%, of the supervisors polled responded to the questionnaire. All areas of the State were represented, including Anchorage, Fairbanks, Fort Yukon, Juneau, Kenai, Ketchikan, Nome, and Sitka. Each supervisor was asked specific questions concerning his or her evaluations of client need for Medicaid options not yet selected by the State.

QUESTION #1: In your experience, what optional services currently not covered under Medicaid do you feel your Medicaid eligible clients need most?

Table 2 shows the rank order obtained from the supervisor's responses to question #1. Interestingly, the top four items for each category (Adult Public Assistance and Aid to Families with Dependent Children program recipients) were the same. The ranking for dentures option differed slightly, being seen more necessary for older persons receiving Adult Public Assistance than the younger Aid to Families with Dependent Children recipients.

Since the Medicaid program requires that services included in the State Plan be offered equally to all eligible persons (except for certain specialized programs such as early childhood screening) the similar ranking of need options for both Adult Public Assistance and Aid to Families with Dependent Children Program is particularly meaningful. If it were called upon to evaluate new options, the legislature could be reasonably sure that any of the top four options (prescribed drugs, adult dental services, dentures, and physical therapy and related services) would be "needed" by both categories of clients.

QUESTION #2: On the average, how many Medicaid clients a month ask you if they can receive certain services?

Table 3 shows the responses by the supervisors concerning the requests of Medicaid eligibles for additional services. The responses to question #2 did not match the pattern formed from the supervisor's responses

TABLE 2

Average Ranking of Selected Medicaid
Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

to question #1. For example, the Medicaid prescribed drug option which was ranked as needed first for both program categories, received less than 50% of the requests made for adult dental services, which was ranked as needed second by the supervisors. This could be anticipated for Medicaid clients who do not have prior health resources equal or better in coverage to General Relief-Medical automatically receive their drugs through GRM. One Juneau public assistance supervisor noted that for these persons, eligibility for prescription drugs under GRM is automatically determined at the time that Medicaid eligibility is confirmed. Therefore, few Medicaid clients would ask for prescription drugs, since coverage is established at the time they enter the Medicaid program.

Aid to Families with Dependent Children recipients requested fewer services than did the Adult Public Assistance recipients. This was expected, for the recipients of AFDC tend to be young and thus often have less need for diverse health services. Also, many AFDC recipients are eligible for a wider range of treatment service through the Early Periodic, Diagnosis and Treatment Program (EPSDT), a child check-up program. For example, dental care is available to public assistance recipients under 21 as a referral through EPSDT, but currently persons over 21 who are mostly on Adult Public Assistance programs cannot routinely receive preventative dental care under any of the state medical assistance programs.

Many of the Medicaid options available under the federal program do not match with Alaska's availability of services. In rural Alaska, it would be difficult to obtain chiropractor's or podiatrist's services close to home. Also, the option of care for patients 65 or over in tuberculosis institutions is not really relevant to Alaska, since there are no tuberculosis sanatoriums in the State. Care for such conditions would have to be provided in nursing homes, hospitals, and physicians' offices, all of which are currently covered under Medicaid.

The low number of requests in all categories may be due to lack of client awareness that these additional services sometimes can be covered under the state funded medical assistance program, General Relief-Medical. Because of limited funds under that program, the Division of Public Assistance has not actively conducted an outreach program to inform clients of eligibility requirements and services covered. Also, many clients may be reluctant to ask for services, which they feel they stand a likelihood of being rejected. Dentures are a good example of this. Because of funding limitations, dentures can only be covered in extreme hardship situations. Clients often are informed of this policy from their dentists, public health nurses, or social workers, before a formal request is made to the Division of Public Assistance.

SURVEY OF "DENIALS" OF SERVICE RECORDS

The needs of clients were also analyzed through a survey of all denials of requests for additional services for Medicaid clients. Medicaid clients sometimes require services that are not included in the Medicaid

TABLE 3

Total Average Number of Medicaid-Eligibles Requesting Optional Services Monthly by Program Category

Option	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children	Total
Adult Dental Services	81.5	88.0	169.5
Dentures	60.5	21.0	81.5
Prescribed Drugs	38.0	39.0	77.0
Physical Therapy and Related Services	20.5	23.0	43.5
Hearing Aids [1]	27.0	16.0	43.0
Prosthetic Devices	25.5	12.0	37.5
Chiropractor's Services	15.5	15.0	30.5
Private Duty Nursing	13.5	5.5	19.0
Podiatrist's Services	4.0	1 5	5.5
Care for Patients 65 or Over in Tuberculosis Institutions	1.0	0.0	1.0
Total	287.0	221.0	508.0

[1] *Hearing aids, at the time of the survey, were not included in the coverage program offered to all Medicaid clients. An interpretation by federal officials of the treatment of speech, hearing, and language disorders options allowed hearing aids to be covered as part of a treament plan. This policy change was implemented in November.*

TABLE 4

Denials of Optional Services for Medicaid-Eligibles
(September 1, 1972 to July 31, 1976) [1]

1.	Dental Services	140 [2]
2.	Therapy	63
3.	Dentures	44 [2]
4.	Prosthetic Devices	37
5.	Prescription Drugs	28
6.	Hearing Aids	15 [3]
7.	Chiropractor's Services	3
8.	Podiatrist's Services	2
9.	Private Duty Nursing	1
10.	Tuberculosis Institution for 65 or Over	0

[1] *The figure includes only denials of requests submitted in writing to the Division of Public Assistance, Central Office. That Division also handles numbers of informal telephone requests, which are not included in these figures.*

[2] *The figure excludes Delta Dental Corporation denials. Delta Dental Corporation currently reviews and evaluates all public assistance clients requests for care. These records were not readily available in Juneau for the study period. In FY76, Delta Dental denied 454 Medicaid adults for dental services and 20 Medicaid adults for dentures.*

[3] *Hearing aids were added to the Medicaid program as of November, 1976. An interpretation by federal officials of the treatment of speech, hearing, and language disorders option added last session allowed hearing aids to be covered as part of the treatment plan.*

program. If the client has no other prior health care resource equal or better in coverage to that of General Relief-Medical (GRM) Program, that client may be able to receive those services through GRM. Since GRM is funded entirely by state general funds, monies are strictly controlled and extremely limited. In order to insure the equitable use of the funds, many services require pre-authorization by the Central Office of the Division of Public Assistance before they can be provided and paid for by the General Relief-Medical Program.

Requests for service can come in two forms: letters and phone calls. The Division of Public Assistance maintains files of only written requests for service. During the month of July, 1976, a tabulation of those records was performed. Table 4 shows the number of denials of optional services which were requested by Medicaid clients during the period September 1, 1972 to July 31, 1976.

Note that the top four options that eligibility work supervisors felt their clients needed appeared within the top five items requested for those clients. Thus, the public assistance supervisors confirm the client perceived need for dental services, therapy, dentures, and prescription drugs. The survey also revealed a client perceived need for prosthetic devices (such as artificial limbs, crutches, canes, etc.).

These tabulations of requests for service represent only written requests. Because of the "emergency" nature of some services and the ease of telephoning for approval, many denials of services are not represented in the written files. Also, many clients will not request a service which they know is unavailable or which they stand a likelihood of being denied. Clearly, then, these figures substantially under-represent client need.

RESULTS OF STUDY

1. Basically State of Alaska eligibility work supervisors feel that their Medicaid-eligible clients most need:

1. Prescription Drugs
2. Adult Dental Services
3. Dentures*
4. Physical Therapy and Related Services*

* *The rank order of these services varies by program which client is receiving aid. The adult public assistance clients are seen to need dentures much more frequently than do clients of Aid to Families with Dependent Children.*

2. The top four services that eligibility work supervisors feel that their Medicaid-eligible clients ask for most frequently are:

1. Adult Dental Services
2. Dentures
3. Prescription Drugs
4. Physical Therapy and Related Services

3. Records of "denials" of requests for services to be provided from the General Relief-Medical Program to Medicaid recipients indicate that the following services are requested and denied most frequently:

1. Dental Services
2. Therapy
3. Dentures
4. Prosthetic Devices

4. The records for the number of client requests generally underestimate client need because only written records are available and because many public assistance clients will not request a service which they know is unavailable or which they stand a likelihood of being denied.

PART V. ANALYSIS OF OTHER STATES' EXPERIENCE WITH SELECTED OPTIONS

OVERVIEW OF STATES PARTICIPATING IN SELECTED OPTIONS

The survey of denials of requests for services and tabulation of the responses to the questionnaire sent to the public assistance supervisors point to four service options which clients are perceived as needing most. These are: prescription drugs, adult dental services, dentures, and physical therapy and related services.

These optional services have been elected by many other states. For example--

- 96% of all states and United States protectorates have Prescription Drug Option *
- 64% of all states and United States protectorates have Dental Services Option *
- 60% of all states and United States protectorates have Physical Therapy and Related Services Option *

**Only states participating in Medicaid program are included in total figures. Data are as of June 1, 1976 and were obtained from United States Department of Health, Education and Welfare. (Data are unavailable on the number of states offering denture service to their eligibles.)*

Many states added these services in the mid-1960's when Medicaid first began. However, it was found that some states eliminated or restricted some of these options during the period January 1, 1975 to July 1, 1976. With the skyrocketing cost of medical care and the increasing demand upon state dollars, we decided to review the options that were selected as needed by public assistance supervisors and contact those states that had recently modified them.

QUESTIONNAIRE OF STATES MODIFYING SERVICES

In early December, the Research Division of the Legislative Affairs Agency prepared a questionnaire to ask the views of state Medicaid program administrators regarding the options they had recently restricted. Fourteen states that had recently modified optional services included in this survey were contacted. Eleven states (or 79%) responded to the questionnaire. Since existing federal reports do not pinpoint the number of states modifying their denture coverage, that option was not included in the discussion.

State Experience With Prescription Drug Option

Of the 51 states providing prescription drugs, 11 states (or 22%) reduced their coverage during the period of January 1, 1975 - July 1, 1976. Seven of those states responded to the questionnaire. The majority of those states reduced coverage of drugs in order to reduce expenditure of state dollars. They noted that it created a hardship, but most clients felt coverage of only certain drugs was better than no coverage at all of them. Basically, controls were maintained by limiting the number of monthly prescriptions any one client could obtain and by limiting the types of drugs covered.

It is interesting to note that one state, Oklahoma, added the drug option during this period. In responding to the questionnaire, the director of the Oklahoma program stated that the option was added at the direction of their legislature. Certain administrative restrictions were imposed when the option was added. Prescriptions were limited to three per client per month and the different categories of drugs were also restricted. The director noted that public reaction to the addition of services has been generally favorable.

State Experience With Dental Services Option

13% of the states which chose the dental services option eliminated it during the period January 1, 1975 to July 1, 1976. (Recently two states, Massachusetts and New Jersey, have reinstated coverage of this option). Five of the seven states eliminating this option responded to the survey.

Generally, these five states found that the adult dental services option was needed by clients and was easy to administer. Restrictions on the option were basically due to lack of state funds. In one instance, New Hampshire, the legislature set a priority list of services that were to be provided. Since adult dental services received a low priority and funds were limited, the option was dropped. The dropping of the option generated considerable negative client reaction, as evidenced primarily by an increased number of client administrative appeals on this issue.

State Experience With Physical Therapy and Related Services Option

Michigan was the only one of 32 states which included physical therapy and related services in their programs and chose to modify that option during the period January 1, 1975 to July 1, 1976. The Michigan Medicaid program responded to the questionnaire and noted its experience with the option. The respondent found that the option was needed by clients; however, the cut, an elimination of physical therapy in long term care institutions, was made in response to lack of sufficient funding. To date, this change in the program has not been rescinded.

RESULTS

1. At least 60% of all states participating in the Medicaid program also cover some form of prescription drugs, dental services, and physical therapy and related services options for their clients. These services were among the top four requested by Alaska public assistance clients and seen as needed most for them according to a survey of Alaska public assistance supervisors. (Nationwide data on the numbers of states covering dentures in their programs are not available.)

2. Two of the top four services seen as needed for public assistance clients, prescription drugs and dental services, were also the top two services restricted or eliminated by other states during the period January 1, 1975 - July 1, 1976. (See Part IV for survey results.)

3. Most states modified the options to reduce expenditure of state funds. They did not drop or restrict them because of lack of client need or complexities in administration.

4. Restrictions of service options were generally done in four ways: limiting coverage of service, limiting client access, reducing provider fee payments, and charging clients small fees.

5. Reduction of fees generally brought strong reaction by the provider sector.

6. The states believe that limiting coverage to certain number of services allowable per month and restricting coverage of type of service allowable under the option was generally more acceptable than totally eliminating it.

7. In most cases, states modifying these options chose to restrict prescription drug coverage but they chose to eliminate dental services (except as was required under the early screening program).

8. In some cases states reinstated changes in options a short time after they were made. This was generally due to the strong reaction received from the groups affected.

PART VI. CONCLUSIONS TO THE STUDY

From the responses to the questionnaire sent to public assistance supervisors concerning client need, the survey of denial records of requests for additional services, and the responses from other states regarding their experience with the program, the following conclusions can be drawn:

1. Of Medicaid optional services available that Alaska does not currently provide under its program, public assistance clients appear to need most(in descending order of need):

   (1) Prescription Drugs
   (2) Dental Services
   (3) Dentures*
   (4) Physical Therapy and Related Services*

   * *The rank order of these services varies by program under which client is receiving aid. The adult public assistance clients are seen to need dentures as a higher priority than do clients of Aid to Families with Dependent Children.*

2. Three of the optional services listed in Item #1 are included by over 60% of the states participating in Medicaid. Prescription drugs, for example, are included in 95% of all state programs. (Data on coverage of dentures are generally unavailable on nationwide basis.)

3. Two of the options that clients "need" most--prescription drugs and dental services--topped the list of options that states reduced or eliminated during the period January 1, 1975 - July 1, 1976. These modifications were done as cost containment measures and not as a response to lack of client need or to complexities of administering the options.

4. Alaska could be reasonably assured that services listed in Item #1 would be needed and used by clients. The choice to include them appears to be a decision based primarily on the state's availability of state funds. The state could choose to cover an option, but restrict that option in many ways to meet funding limitations.

GLOSSARY OF TERMS

AB - See Aid to the Blind.

AD - See Aid to Disabled.

ADC - See Aid to Families with Dependent Children.

AFDC - See Aid to Families with Dependent Children.

APA - See Adult Public Assistance.

APD - See Aid to Disabled. Stands for Aid to Permanently Disabled.

Adult Public Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to aged, blind, and disabled persons who meet certain income and resource requirements, and who are predominately eligible for Supplemental Security Income (SSI) payments. State administrative costs as well as actual cost payments are 100% state only costs.

Aid to the Blind - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible blind persons who meet certain income and resource requirements, and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Disabled - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education and Welfare. Designed to provide a state legislated level of cash assistance to those eligible disabled persons who meet certain income and resource requirements and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Families with Dependent Children - A federal program administered by the state through an approved state plan filed with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to dependent children who have been deprived of one or both parents, and who meet certain income and resource requirements. Both administration costs and the actual cash payments provided to recipients are shared equally (50%) by the state and federal government.

Categorical Assistance - Aid, in form of income maintenance, to certain needy persons who receive assistance under Old Age Assistance, Aid to the Blind, Aid to the Disabled, Supplemental Security Income, and Aid to Families of Dependent Children programs.

Compliance - In a federal program, the act of performing certain set program functions in accordance with those requirements outlined in the state plan, federal law, and regulation. Generally, meeting all federal program requirements is necessary to receive federal financial participation in the program.

DHSS - See Department of Health and Social Services.

Department of Health and Social Services - A department of the executive branch designated to be single state agency to administer the Medicaid program for the state of Alaska.

EPSDT - See Early and Periodic Screening, Diagnosis and Treatment.

Early and Periodic Screening, Diagnosis and Treatment - A mandatory service under Medicaid which provides for special check-ups at set intervals for certain needy children, in order to find and treat health problems before they become serious. Coverage includes only those Medicaid eligibles under 21 years of age.

Eligible - A person qualified to receive assistance funded under particular program. Eligibility criteria can vary, so that eligibility must be established on program by program basis.

FFP - See Federal Financial Participation.

Federal Financial Participation - The means by which the federal government asssists in supporting certain specific program. The federal government generally provides aid by two methods: 1) matching dollars by set percentage or 2) formula money grants.

GRM - See General Relief-Medical.

General Relief-Medical - A state emergency medical program designed to respond to immediate medical needs of Alaskan families in time of extreme financial crisis. All assistance rendered under this program is in the form of vendor payments to medical providers. State administrative costs as well as actual cash payments to vendors are 100% state-only costs.

Intermediate Nursing Care - An optional service available to be provided under Medicaid program. Denotes a less intensive and less expensive level of around-the-clock nursing care, in comparison to skilled nursing.

Mandatory Coverage - A portion of the Medicaid program that is required to be covered by each and every state in the program, in order for the state to be entitled to federal financial participation. Mandatory coverage items concern persons eligible to receive services and the services provided to those persons. States can still administratively "control" mandatory services and not jeopardize federal financial participation by controlling the amount of service available to client, amount of financial participation (deductible required to be paid by client) in order for the client to receive such services, and other mechanisms.

Medicaid - A federal assistance program established by Title XIX of the Social Security Act and administered by the state through an approved state plan filed with U.S. Department of Health, Education, and Welfare. Designed to provide medical coverage for recipients of Aid to Families With Dependent Children; Supplemental Security Income, elderly and blind recipients of Adult Public Assistance and those disabled persons who meet federal definitions of disability; and certain other groups. State administrative costs are shared equally (50%) by the state and federal governments, except for professional medical support personnel who are funded at 75% federal reimbursement. Actual medical vendor payments are shared equally (50%) by the state and federal government, except for family planning which is funded at 90% federal reimbursement.

Medically Needy - An optional group of eligibles for whom federal reimbursement for necessary medical care may be covered under the Medicaid program. Generally includes individuals who have insufficient income and resources to meet the costs of necessary medical or remedial care and services. Presently Alaska does not include the medically needy under its Medicaid program.

Medicare - An insurance program administered solely by the federal government to provide payments for necessary medical care for those people, rich or poor, who receive Social Security payments.

OAA - See Old Age Assistance.

Old Age Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible persons 65 and over who meet certain income and resource requirements and who are predominately eligible for Supplemental Security Income payments. It is considered an "Adult Public Assistance" program.

Option - A portion of the Medicaid program that is discretionary on the part of the state. Options generally deal with persons eligible for coverage or medical services available for those eligible persons. Options are set out in federal law and regulations and are generally eligible for federal financial participation. Since the choice of options is up to each state, options can generally be designed to fit the state's unique needs and available resources, but each option chosen must meet certain broad federal program requirements.

Public Assistance - A division of Department of Health and Social Services, responsible for administration of the Medicaid, General Relief-Medical, and Income Maintenance programs. This division determines the eligibility of state's residents for such services by carefully reviewing the person's income, resources, and other factors according to state and federal standards.

Quality Control - An office of the Department of Health and Social Services which is assigned the responsibility to verify that

randomly selected cases are eligible to receive services in month that service was rendered. The verification consists of check of files, client contact, and collateral sources.

Recipient - A person receiving income maintenance or assistance services funded under a particular program.

SSA - See Social Security Administration.

SSI - See Supplemental Security Income.

Skilled Nursing Care - A mandatory service required to be provided under the Medicaid program. Denotes highly professional round-the-clock nursing care and monitoring. Generally more expensive and more specialized care than intermediate care.

Social Security Administration - An agency of the federal Department of Health, Education and Welfare assigned the responsibility to administer Social Security, Medicare, and Supplemental Security Income programs.

State Plan - A contract between the single state agency to administer the Medicaid program and the federal Department of Health, Education and Welfare, specifying conditions to be met in order to be eligible for federal financial participation.

Supplemental Security Income - An assistance program funded and administered by federal government which provides payments to certain needy persons who are aged, blind, or disabled and meet program and financial requirements. Payments are uniform nationwide and are based on need.

Title XIX - A portion of the federal Social Security Act which outlines the Medicaid program.

Title XVIII - A portion of federal Social Security Act which outlines the Medicare program.

Utilization Review - Random records check of sample institutional Medicaid billing to insure that services rendered match with those billed to the program. Verifies that institutional records are complete, accurate, and up-to-date. Examines for overuse or misuse of treatment and professional resources and the patient's duration of stay relating to those resources.

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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 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 estimated 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 because of the requirement that employers cover at least half of 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.

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