

HB

41

COMMITTEE REPORT
SENATE

4/30/81

FURTHER: Finance

Date: 4/30/81

Mr. President:

The Committee on HEALTH, EDUCATION AND
SOCIAL SERVICES has had CSBHB 41(Fin)(efc failed
health of residents of the state

under consideration and (a majority of the committee) (the committee)
reports it back with the following recommendations:

- ☒ do pass ☐ do not pass
- ☐ do pass with attached amendments(s)
- ☒ replace with CS for CSBHB 41(Fin)(efc failed ☐ same title
- ☐ new title
- and recommends _____
- ☐ AND attaches a "Letter of Intent" ☐ New Fiscal Note
- ☐ reports it back without recommendation
- ☐ referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

CHAIRMAN

page 1, lines 15-18:

(c) ~~The commissioner may contract for the underwriting [of the program] and [may contract for the] administration of the program.~~ A contract entered into under this subsection shall be for a maximum of three years [period] and shall be based on competitive ~~bids~~. *proposals*

conversations with representatives in the insurance industry indicate that there may be some hesitancy to underwrite a "social" group, whose characteristics are unknown, and that the state may need to underwrite the risk for the initial period of the program until risk factors are proven. Similarly, there may be some difficulty finding a company to sign a three year contract.

page 1. lines 19-23:

(d) The program shall provide for copayments and deductibles, and shall provide for an annual deductible payment for each member and a maximum deductible payment for each family unit.

(e) The program shall provide for the payment of reimburseable institutional and professional charges incurred by a member or covered dependent to a maximum level as determined by regulation. After such level is reached, the program shall provide for 100% of reimburseable charges.

the intent of (d), in addition to guaranteeing the use of copayments and deductibles in the plan, was to insure a type of "catastrophic" coverage to the plan with a limit on the out-of-pocket expenses in any given year to an individual and dependents.

page 3, line 4"

(9) "subsidized medical care" means medical care provided at reduced charge or no charge to an individual and their eligible dependents.

intent is to acknowledge that all types of subsidized care available is not necessarily free of charge.

page 1, lines 13-14

(b) The state health insurance program shall provide professional and institutional benefits at a level specified by regulation

page 1, line 28

their covered dependents

page 2, line 2

their covered dependents

page 2, line 22 insert:

"covered dependent" means any person considered a dependent by the Internal Revenue Service.

"deductible" means a clause in an insurance policy stating that the insurer will pay a percentage of claims remaining after a stipulated amount, paid by the insured party, is deducted.

page 2

"insurance" means prepaid health plans or health indemnity plans

page 2 line 5-6

(b) the commissioner may not pay the insurance premium for a resident and their covered dependents etc.

page 2, line 28

delete: "during the time period has" and add: continually maintains...

reconstructed taxpayer by expenditures unreported income mortgage payments for drugs, for which incarcerated from 6, 1977. Tax Court was entitled to 2 de- for his sons. Lin- 73 T.C. 280.

vided over half her certain third-party home nursing care claimed her as de- 152(a) of this title, taxpayer was enti- exemption under tion, since extraor- ses paid under Medi- gulated from elimi- nate insurance bene- ficially excluded from Eureka v. Com- b, followed. Archer 1963.

he claimed depend- ent and daughter- d over half support who had no income; signed joint return- ing refund for tax- ad's reported earn- ing of couple did of return and no ve existed for el- separately. Court- ers were not enti- son, since they- contributed over rt, and (2) taxpay- dependency exemp- aw, since joint re- n and daughter-in- for refund under C.I.T. 109, and Rev. 80, which Court ap- T. R., 1978, 71 T.C.

entitled to depen- er subsec. (e) of r-old son, on rec- was not a student or half his support v. C. I. R., 1977.

entitled to depen- tions for 2 grand- provided total sup- taxable year, when one income of over 1 IRS instruction return, on which child was student, at apply, did not Bunn v. C. I. R.

old-age assistance- ed to petitioner's paid her Medicare e premiums which amount spent by ther's support, on vided over half port and was en- dependent, since pend all her old- s on her own sup- plied in determin- ation under Fed- is one of ac- and o characterization et because based arter v. C. I. R.,

father's payments a 1962 substantiat- e sole support for n they resided in- nee was adduced could infer range it for children by

others during balance of 1962 when chil- dren were living with mother in her par- ents' home, so that exemptions were disallowed, notwithstanding agreement that father could claim exemptions since section 152(a) of this title requires determination to be made in terms of ac- tual expenditures and not contemplated support arrangement. Brown v. C. I. R., 1967, 48 T.C. 42.

Court in marriage dissolution proceed- ing had jurisdiction to award income tax exemption for minor children to father who was required to make child support payments. Roberts v. Roberts, Mo.App. 1977, 553 S.W.2d 305.

Trial court did not abuse its discretion in awarding income tax exemption for minor children to father who was re- quired to make child support payments upon dissolution of marriage. Id.

3a. — Age

On facts showing that taxpayers pro- vided more than half support of niece and aunt for each of years 1957-60 and that taxpayer H attained age 65 before end of 1959, taxpayers were entitled to depen- dency exemptions for niece and aunt in 1957-60 and to additional exemption, not claimed by taxpayers, for H in 1959-60. Harper v. C. I. R., 1970, 51 T.C. 1121.

3b. — Computation

In determining whether, for a given calendar year, an individual has received over half of his support from the taxpay- er and thus is a dependent of taxpayer for federal income tax dependency ex- emption purposes, the amount of support received from the taxpayer must be com- pared to the entire amount of support which the individual has received from all sources. Klatta v. U. S., D.C.Ohio 1971, 333 F.Supp. 781.

Where divorced husband had not lived in residence since divorce and his former wife was lessee of residence and was to pay a fixed rental therefor, former wife had the "right to use and possession" of the property and was entitled to be cred- ited with the lodging support for the mi- nor children determining whether hus- band or wife had provided more than one-half support of children for purpose of dependency exemptions for federal in- come tax purposes, notwithstanding hus- band's claims that divorce decree, which ordered him to convey real estate in question to wife as alimony, violated oral settlement agreement and that quitclaim deed was invalid. Id.

Arrangements paid by H for child support in 1960 and 1967 in addition to current support were not child support for purposes of determining total support for dependency exemption deduction, follow- ing rule which prevents father from claiming exemptions he might not ordi- narily be entitled to by shifting child support payments from one year to an- other. Labay v. C. I. R., 1970, 55 T.C. 6.

5. Burden of proof

Taxpayer claiming dependency deduc- tion for taxpayer-husband's 17-year-old son, who was living with his mother from whom husband had been divorced, had burden of establishing that they con- tributed more than one-half of total sup- port of claimed dependent. Schluter v. C. I. R., C.A.Cal.1971, 444 F.2d 107.

7. Findings

Classification, whereby person with gross income of over \$600 per year does not qualify as dependency exemption for taxpayer, and child under 19 or full-time student qualifies as dependency exemp- tion, though he has income in excess of \$600, is not unreasonable. Bearangela v. C. I. R., C.A.3, 1969, 418 F.2d 223.

Where no one qualified as dependency exemption of unmarried taxpayer, taxpay-

er was not entitled to compute his income tax as head of household. Id.

Evidence supported Tax Court's finding that divorced taxpayer, who claimed de- pendency exemption, did not provide over one-half of his daughter's support during 1963. Phillips v. C. I. R., C.A.Va.1968, 390 F.2d 650.

Tax Court decision that taxpayer was not entitled to claim exemptions for mi- nor children who were in custody of his former wife was not clearly erroneous. Genco v. C. I. R., C.A.8, 1966, 372 F.2d 129.

§ 152. Dependent defined

(a) General definition.—For purposes of this subtitle, the term "de- pendent" means any of the following individuals over half of whose sup- port, for the calendar year in which the taxable year of the taxpayer be- gins, was received from the taxpayer (or is treated under subsection (c) or (e) as received from the taxpayer):

- (1) A son or daughter of the taxpayer, or a descendant of either,
- (2) A stepson or stepdaughter of the taxpayer,
- (3) A brother, sister, stepbrother, or stepsister of the taxpayer,
- (4) The father or mother of the taxpayer, or an ancestor of either,
- (5) A stepfather or stepmother of the taxpayer,
- (6) A son or daughter of a brother or sister of the taxpayer,
- (7) A brother or sister of the father or mother of the taxpayer,
- (8) A non-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer, or
- (9) An individual (other than an individual who at any time during the taxable year was the spouse, determined without regard to section 143, of the taxpayer) who, for the taxable year of the taxpayer, has as his principal place of abode the home of the tax- payer and is a member of the taxpayer's household.

(b) Rules relating to general definition.—For purposes of this sec- tion—

- (1) The terms "brother" and "sister" include a brother or sister by the halfblood.
- (2) In determining whether any of the relationships specified in subsection (a) or paragraph (1) of this subsection exists, a legally adopted child of an individual (and a child who is a member of an individual's household, if placed with such individual by an author- ized placement agency for legal adoption by such individual), or a foster child of an individual (if such child satisfies the requirements of subsection (a) (9) with respect to such individual), shall be treat- ed as a child of such individual by blood.

(3) The term "dependent" does not include any individual who is not a citizen or national of the United States unless such individual is a resident of the United States or of a country contiguous to the United States. The preceding sentence shall not exclude from the definition of "dependent" any child of the taxpayer legally adopted by him, if, for the taxable year of the taxpayer, the child has as his principal place of abode the home of the taxpayer and is a member of the taxpayer's household, and if the taxpayer is a citizen or national of the United States.

[See main volume for text of (4) and (5); (c)]

(d) Special support test in case of students.—For purposes of subsec- tion (a), in the case of any individual who is—

- (1) a son, stepson, daughter, or stepdaughter of the taxpayer (within the meaning of this section), and
- (2) a student (within the meaning of section 151(e)(4)), amounts received as scholarships for study at an educational organiza- tion described in section 170(b)(1)(A)(ii) shall not be taken into ac-

February 25, 1982

Notes:

Assumptions Related to development of certain attached options.

(1) Alaska Executive and legislative branches probably will not entertain substantial, quantum increases in health care expenditures in FY 1983 budget.

(2) It is doubtful that expenditure or legislative branches will consider seriously for enactment extensive, complex insurance programs which would (a) be costly in public financial outlays or (b) intrude in adverse ways into private and private sector coverages; (HB 41 and two insurance options in Battelle Study). If insurance options appear to be seriously considered time to refine cost impacts will be available related to actual proposals.

(3) Known Federal initiatives being considered to reduce federal health expenditures and current uncertainties regarding federal limits on health expenditures change certain options available to Alaska when study began: eg for example withdrawal from Medicaid; unlimited federal financial participation in new additions of non-mandatory options, assumed 14% increase in Alaska Indian Health budget.

(4) For FY 1983 the Legislature may be willing to approve executive branch proposals limited and conservative in approach as related to:

- (a) limited additional funding;
- (b) limited additional services;
- (c) limited additional eligibles;

ALASKA HEALTH CARE AND FINANCING REVISIONS 1982
NO ADDITIONAL FINANCING COSTS/COST SAVINGS

	REVISION	COST IMPLICATIONS	COMMENTS/OBSERVATIONS
I	Adopt under Medicaid current General Relief Medical Services: Prescription Drugs, Physical Therapy, Occupational Therapy, Prosthetic Devices and Adult Dental Care (Emergency) (Page 42; Option 6)	0 to \$600,000 (Page 42) (Savings)	Estimated savings; actual savings dependent on "cross-over" experience Indian Health Service Beneficiaries to Medicaid program. Legislative action needed.
II	Patient Cost Sharing: (a) Optional Medicaid Services, (b) General Relief Medical, (c) with Federal waiver Medicaid mandated services (Page 43; Option 7)	\$680,000 (Page 43) (Savings) (\$400,000 General Relief Medical, \$280,000 Medicaid Mandatory Services)	Reduces levels of utilization of services; based on \$2 per visit; \$1 per prescription; Federal waiver required for Mandated Medicaid Services; State Statute should reflect authority to institute patient cost sharing.
III	Prospective Reimbursement/Hospitals	0 to \$220,000 - \$410,000 per year (Savings)	Based on 1981 inpatient expenditures (Medicaid and General Relief Medical) assumes savings in range of 2.5% to 4.6% based on Coelen/Sullivan Study (Page 49). While Battelle estimates savings of \$220,000 to \$410,000, initial Prospective Reimbursement plan may produce increased costs to the State for no more than three years while costs are being more fairly distributed between payors.
IV	Prospective Reimbursement/Nursing Homes	0 to \$1,850,000 Total or \$925,000 State General Fund (Savings)	Based on 1981 expenditures of \$16,800,000. The 1983 Budget Request is \$22,332,000. While Battelle estimates savings of \$220,000 to \$410,000 initial Prospective Reimbursement plan may produce increased costs to the State for no more than three years while costs are being more fairly distributed between payors.

February 25, 1982

ALASKA HEALTH CARE AND FINANCING REVISIONS: 1982
LIMITED FINANCIAL COSTS/MAXIMUM SERVICES

	REVISION	COST IMPLICATIONS	COMMENTS/OBSERVATIONS
V	Medicare "Buy-in" initiated Alaska participation in Medicare "Part B" for ancillary medical services for Medicaid	\$112,092 Savings	Based on payment by Medicare of \$220,200 less \$108,108 cost to Alaska. (DPA Medicare buy-in computations) 1,298 potential enrollees receiving DPA cash payment and 170 enrollees receiving medical coverage only.

ALASKA HEALTH CARE AND FINANCING REVISIONS: 1982
LIMITED FINANCIAL COSTS/MAXIMUM SERVICES

February 25, 1982

	REVISION	COST IMPLICATION	COMMENTS/OBSERVATIONS
I	A. Provide premium payment of \$12 monthly for estimated 11,000 Medicare beneficiaries who are not Medicaid-eligible but are medically needy B. Provide premium payment coverage to persons over 65 with annual incomes of \$15,000 or less.	A. \$1,584,000 B. \$306,720	A. DHSS needs to develop policy recommendation on how many additional recipients to cover. Approximately 11,000 over 65 Medicare eligible in Alaska (1982) of these 9,000 have Medicare Part B premium (pay premiums out of own pocket). If Alaska picked up all Part B premiums the cost would be \$1,584,000 (11,000 x \$12 x 12 mo) B. Of the 11,000 over 65 persons in Alaska approximately 1/3 have annual incomes of \$15,000 or less; or 3,630 persons. If Alaska paid Medicare Part B premium for those individuals, excluding Medicaid eligibles for whom Part B premiums are otherwise provided: (3,630 persons less 2,300 Medicaid eligibles = 1,330 non Medicaid eligible. Assuming the 750 non-native and 750 native OAA persons should properly be deducted from the 3,630 persons otherwise eligible = 2,130 persons for whom Part B would be purchased (2130 persons x \$12 x 12 mo = \$306,720 required) to cover Part B for over 65 persons with incomes less than \$15,000 not otherwise covered.
II	Increase catastrophic illness coverage	\$1,000,000	Revise regulations related to income and resource criteria and services covered would increase eligibility pool by 100 to 200 families.
III	Admit certain poor children not now covered to Medicaid eligibility: Ribicoff Children.	\$1,500,000 Total cost to state to add both natives and non-natives	This figure is based on a worst-case projection which assumes that IHS would no longer provide services in Alaska. (Assumes 1981 caseload)

February 25, 1982

ALASKA HEALTH CARE AND FINANCING REVISIONS: 1982 (Continued)
LIMITED FINANCIAL COSTS/MAXIMUM SERVICES

	REVISION	COST IMPLICATIONS	COMMENTS/OBSERVATIONS
IV	Seek alternatives to nursing home care wherein Medicaid eligible clients could be cared for through case management services, homemaker services, home health aide services, personal care services, adult day health services, habitation services, respite care services, and other services.	May cost \$200,000 for first full year. Cost in future years conditioned upon development of Prospective Reimbursement system for Nursing Homes.	Waiver required from federal DHHS Secretary for these alternatives; amend state plan following the granting of the waiver. One Field case management person to assess needs and coordinate services.
V	Increase dental care for medicaid eligible adults	\$1,000,000 to \$2,000,000 State General Funds depending upon adding Ribicoff Children (FY 83).	Current options do not cover other than emergency care for adults. Cost figure comes from DPA estimate. Statutory changes would be required.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y. State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 12, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: David Teal, Jon Sherwood, and Leslie Longenbaugh
Research Staff

RE: Fiscal Note for Health Insurance (HB 41)
Research Request Number 82-72

This agency was asked to estimate costs related to HB 41, a bill which would implement a statewide health insurance plan. Your office also requested an analysis of several options which are not currently included in HB 41. We have estimated the costs of a health insurance plan under these options, but, as instructed, have not considered any language changes that may be required to adopt the options.

Estimated Costs of HB 41

Table 1 presents estimates of cost under assumptions described in this memorandum. Although we believe we used the best data available to us, we have some questions about the reliability of data used to produce cost estimates and are therefore somewhat uncomfortable about the range of potential error of the estimates.

Table 1
Estimated Costs of HB 41

<u>Group</u>	<u>Estimated Cost (\$ millions)</u>
Not Covered by Health Insurance	\$14.9
Covered by Private Insurance Plans	7.0
Covered by Employer Insurance Plans	8.1
High Risk	<u>1.0</u>
TOTAL	\$31.0

Source: House Research Agency 3/82

Table 1 shows that the estimated cost of implementing HB 41 is \$31 million, with about half of that cost directed toward those who currently have no health insurance coverage. The estimates in Table 1 do not include 1) administrative costs; 2) adjustments for regional cost differences which were specified in the bill; 3) costs of providing insurance coverage to the Native population; or 4) costs of providing insurance coverage to employees who are currently covered by employer-provided plans and who would find it financially advantageous to switch to the State plan only if "side deals" were made with their employers. A brief discussion of assumptions and of the process used to derive the estimates in Table 1 is included in this memorandum.

The agency was requested to analyze various options related to HB 41. Those options are discussed below. Cost estimates for the options are presented in Table 2.

Table 2
 Estimated Cost of HB 41 Under Various Options
 (in millions of dollars)

Option	Non-Natives		All Residents	
	Subsidy for:		Subsidy for:	
	Premiums and Co-Payment	Premiums Only	Premiums and Co-Payment	Premiums Only
HB 41 (per Table 1)	\$31.0	\$25.4	\$55.8	\$45.7
Private Individual Plans Excluded	24.0	19.7	48.8	40.0
90 Day Restriction on Cost Sharing	20.8	17.1	41.6	34.1

Source: House Research Agency 3/82

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Premium Subsidy Only. In its present form, HB 41 would subsidize both premiums and out-of-pocket expenses for those below certain income levels. If out-of-pocket--or co-payment--expenses were not subsidized, the cost of all options of the plan would fall by about 18 percent.

Private Individual Plans. If the bill were revised in a way that prevented those currently covered by private individual plans from switching to the State plan, program costs would decline by about \$7 million. The Battelle study assumes that no Natives have private individual coverage, so the estimated costs under this option show the same \$7 million decline for both "non-Native" and "all residents" options.

Restricted Eligibility for Cost Sharing. A provision restricting the cost-sharing features of HB 41 to those who had not had health insurance coverage during the 90 days preceeding membership in the State plan could have a significant impact on program costs. If such a provision prevented 50 percent of those covered by employer plans, 75 percent of those covered by private individual plans, and 90 percent of those in the high risk group from switching to the State plan, costs of providing health insurance coverage under the State plan would decline by approximately \$10.2 million for the non-Native group. Expected cost reduction for coverage to all residents would decline by about \$14.2 million.

Permanent Fund Dividends. There was some discussion with your staff on the potential for using Permanent Fund dividends to partially offset the costs associated with HB 41. Unless residents were required to use their dividends to pay a portion of the State's costs, the dividends would reduce the cost to the individual but would not decrease costs to the State.

Due to the uncertainty surrounding the status of Permanent Fund dividends, no accurate assessment of the effect of dividends on HB 41 can be made at this time. Permanent Fund dividends may indirectly reduce costs to the State by increasing the income of individuals and so reducing the level of subsidy for which they qualify. Unless dividends exceed several hundred dollars, this factor should not be significant.

Discussion of Assumptions and Methodology

Premium Amount. The estimates in Table 1 of this memorandum are based on monthly premiums of \$130 per household. Although \$130 may be the average health insurance premium in Alaska, it is possibly higher than the current premium that might be expected to apply to a plan such as that described in HB 41. According to Kurt Fortney, of Blue Cross, the average group premium (including vision and dental care) for Alaska's private sector is \$106 per month. Higher deductions and deletion of provisions for vision and dental care can be expected to result in lower premiums, but we do not have an estimate of premiums that may be required for the plan specified in HB 41. Based on premium increases experienced in the last few years, the \$130 figure appears to be a reasonable estimate of costs of insurance coverage in 1983 under HB 41.

Co-payments. In all cases, \$200 was used as the deductible and \$300 as the average individual's share of medical expenses once the deductible is surpassed.

Subsidies. Subsidies were calculated according to the schedule below.

Table 3
 Subsidies for Health Insurance under HB 41

<u>Family Income as a percent of Median Family Income</u>	<u>Premium Subsidy (percent)</u>	<u>Co-Payment Subsidy (percent)</u>
125	0	0
120	10	0
115	20	0
110	30	0
105	40	0
100	50	0
95	60	9
90	70	18
85	80	27
80	90	36
75	100	45
70	100	55
65	100	64
60	100	73
55	100	82
50	100	91
45	100	100

Source: Louann Cutler, Representative Buchholdt's Office

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Median Income. Based on information provided by the Alaska Department of Labor, the estimated median income for families of three and four persons was calculated as \$28,555 for 1982. The same information was used to calculate a 1982 median income of \$18,625 for one and two person families. Because we were unable to discover distributions of income according to family size, we used only two groups instead of four separate levels of median income.

Distribution of Income. Income tax data for Alaska residents filing for 1979 were used to derive distributions around the median income levels described above. Residents who itemized and filed jointly were used to represent families of three and four. Residents taking the standard deduction were used to represent families of one and two. In both cases, inflation was taken into account by assuming an even distribution of income within each tax bracket and moving the top quarter of filers in each bracket into the next higher bracket. This approximates the impact of 33 percent (7.5 percent per year) inflation from 1979 to 1983.

The distribution would provide subsidies to about 70 percent of one and two person families and about 51 percent of three and four person families. Table 4 provides greater detail on subsidies. Families with income greater than 125 percent of median income for that family size receive no subsidies, families with income between 45 and 125 percent of median income are on the subsidy schedule and are eligible for subsidies of less than 100 percent of costs, and families earning less than 45 percent of median income are fully subsidized.

Table 4
Distribution of Alaskans by Eligibility
for Subsidy Under HB 41

<u>Family Size</u>	<u>Percent with No Subsidy</u>	<u>Percent with Partial Subsidy</u>	<u>Percent with Full Subsidy</u>
1 and 2	30	38	32
3 and 4	49	40	11

Source: House Research Agency 2/82

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Amount of Subsidy. Given the data described above, the amount of State funds to be spent on subsidies under HB 41 can be calculated for various situations. Table 5 presents estimates of the average amount of subsidy which would be paid to those with incomes of less than 125 percent of the median income. The figures are based on the subsidy schedule presented in Table 4 and assume premiums of \$130 and co-payments of \$500.

Table 5
Estimated Subsidy per Household Under HB 41

	<u>Families of 1 and 2</u>	<u>Families of 3 and 4</u>
Premium	\$1,237	\$ 976
Co-payment	271	222
TOTAL	\$1,509	\$1,198

Source: House Research Agency 2/82

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Cost of Plan. Cost calculations were performed for four major groups. The groups and assumptions used in computing costs are described below.

Not Presently Covered

- Assumptions:
- 44,000 individuals (14,667 households) have no health insurance (Battelle estimate)
 - half (7,333) these households are 1- and 2-person families and half are 3- and 4-person families
 - price elasticity of demand is .65 (Battelle Estimate)

- Conclusions:
- 45% of 1- and 2-person families elect coverage
 - 23% of 3- and 4-person families elect coverage
 - subsidy to this group (those not presently covered by health insurance) is \$14.9 million

Private Individual Coverage

- Assumptions:
- 25,000 individuals (8,333 households) have private individual health insurance coverage (Battelle estimate)

- half of these households (4,167) are 1- and 2-person families and half are 3- and 4-person families
- the State subsidizes costs whether these households retain private coverage or switch to the State plan

Conclusion: • subsidy to this group is \$7 million

Covered by Employee Plans

- Assumptions:
- 194,000 individuals (64,667 households) are presently covered by health insurance through their places of employment (Battelle estimate)
 - half (32,333) of these households are 1- and 2-person families and half are 3- and 4-person families
 - 40% would not switch because their employer pays all costs of their present plan (Battelle, Table X-4)
 - 25% of those with partial payment plans would switch to the State plan (Battelle, Table X-5)

- Conclusions:
- subsidy to this group is \$8.1 million
 - if "side deals" between covered persons and their employers resulted in all presently covered employees converting to the State plan, the subsidy to this group would increase to \$32.4 million (note: side deals were not included in the cost calculations shown in Table 1)

High Risk Individuals

As explained in the Battelle study, data on this group are limited. The cost of providing coverage to this group is included in Table 1, but the figures are rough estimates based on work performed by Battelle. The Battelle study uses a premium of 125 percent of the

standard premium for the high risk group. That figure was combined with data from Battelle's Table X-9 and Table 5 of this memorandum to produce an estimate of \$.8 million for premium subsidy and \$.2 million for subsidization of co-payments.

Native Population

We have no data on the distribution of income among Natives. Based on the results of the Battelle study, inclusion of Alaskan Natives would roughly double the cost of the plan. This approximation was used to develop the numbers in Table 2 of this memorandum.

* * *

Although we have attempted to present the above information in a non-technical manner, we realize that mathematical data can be confusing. If you or your staff have any questions about the source of numbers or what calculations were performed, please call and we will try to help. We will be pleased to perform additional work on this project if the provisions of HB 41 change. Please do not hesitate to call if we can be of further service.

POSITION PAPER
COMMITTEE SUBSTITUTE FOR
CS FOR SPONSOR SUBSTITUTE
HOUSE BILL NO. 41 (FINANCE)

DRAFT

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

I. DEPARTMENTAL OVERVIEW OF CS FOR SPONSOR SUBSTITUTE HOUSE BILL NO. 41 (FINANCE)

Committee Substitute for CS for Sponsor Substitute to House Bill No. 41 (Finance) is composed primarily of four parts:

- a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan available to all residents of the State which will pay all or a part of the coverage for low income persons.
- b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that certain Group insurance plans include coverage for alcoholism and drug dependence.
- c. Section 9 directs the Commissioner of Health and Social Services to contract for medical services through insurance companies or health care services organizations for beneficiaries of the Department's medical programs once contracting is determined cost competitive. (Medicaid, General Relief Medical, Catastrophic Illness, Crippled Children's, and Maternal and Child Health Programs).
- d. Sections 10 and 11 expand the Medicaid program by adding new beneficiaries and services respectively.
- e. Section 12 is a definition section.
- f. Section 13 mandates that the Legislative Council shall study and make recommendations to improve coverage of Medicare and Indian Health Service.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Governor has, as prescribed and funded by the 1980 Legislature, requested the Department for a "Comprehensive Health Care and Financing Study" for Alaska. That study is now completed. The study examined the present health care delivery and financing systems in Alaska, identifying existing and potential funding sources, examining improvements to the present systems and a discussion of alternative methods of providing for health care and cost distribution in Alaska.

The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8. We support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other governmental units.

We believe such benefits have the potential to be cost-saving for the State, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9. We support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, except medically needy, not just those that currently exist under state statutes. A clearer picture of the federal plan for Medicaid has not materialized in the last 9 months. In fact, even greater confusion surrounds this issue than before.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. Again, a clearer picture of the federal plan for Medicaid does not exist at the present time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) - ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees:

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employee health benefits package and make such coverage optional to employees of other governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of needed alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organizations around the country (Kennecott Copper, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structure Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphemistic diagnoses for claiming benefits, as many now admittedly do in apparently somewhat massive numbers.

The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

The need for sections 5-8 of this bill was formally identified in several statewide hearings conducted by the Senate Select Committee on Alcohol Abuse in 1977, and initially was introduced to the Senate as SB 545 in March, 1978. Although not acted upon that session, an interim committee of legislators, insurance industry, and state personnel were appointed to further evaluate the issue resulting in the introduction of SB 227 in March, 1979, which passed the Senate that year. Late in the 1980 session the House HESS Committee substantially amended SB 227 to include the ideas contained in Sections 1-4 and 9-11 of the current HB 41, which passed the House in 1981.

Since the provisions contained in sections 5-8 of HB 41 did pass the Senate in 1979 and the House in 1981, consideration might be given to separating these sections from HB 41 for passage this session.

IV. SPECIFIC DEPARTMENTAL CONCERNS IN SECTIONS 9, 10 and 11 (MEDICAL ASSISTANCE)

Section 9 - Line 22 on Page 7 Through Line 14 on Page 9:

AS 47.05.070 - Directs the Commissioner of DHSS to select either the option of purchasing and paying premiums on policies of insurance, or paying the expenses of health care service contracts when judged cost-effective by the Commissioner. The Department supports this concept so long as there is a determination of program wide cost-effectiveness rather than on a service-by-service basis. It should be pointed out that the Department already has the ability to purchase insurance or health care service contracts under existing federal law. This change would simply make it mandatory for the Department to do so.

AS 47.05.100 - We support the general public policy intended by this portion of the bill, however, we would like to offer an amendment as follows:

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

- (1) interest at the rate of one percent per penalty month when payment is delayed more than 45 days after presentation of the clean claim. A "penalty month" starts on the 46th day and consists of 30 day increments thereafter until the claim is paid.

- (2) no change
- (3) the interest for a full month if the overdue claim is not paid by the 15th day of any penalty (calendar) month.

Section 10 - Line 15 on Page 9 Through Line 20 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, except the medically needy. This includes the unborn child group, the unemployed parent group, caretaker relatives and certain individuals under 21.

As stated earlier the Department would recommend phasing selected eligible groups into the programs instead of adding all remaining groups simultaneously.

By staging the categorical groups a number of benefits would result:

- (1) The Department may have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented by September 1982 and the added bill processing burden will be eased.
- (3) The Department would be prepared in advance with regulations and additional staff to handle the new coverage groups.

Section 11 - Lines 21 Through 25 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under the Medicaid program. It is suggested the following services be specifically listed in CSSSHB41 (Finance) rather than the current blanket provision adding all services:

- (1) Physical Therapy
- (2) Occupational Therapy
- (3) Prescribed Drugs
- (4) Prosthetic Devices and Medical Supplies
- (5) Other Practitioner Services
 - a. private psychologist
 - b. nurse practitioners
 - c. physician assistants

- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and federal funds for certain services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program could be claimed.

Creation of a comprehensive health plan as contained in Section 1 would allow the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified. Also, the relationship between the comprehensive health plan under CSSHB 41 (Finance) and the present catastrophic illness program should be clarified. Most payments made under the catastrophic illness program are for major medical types of coverage that may also be covered under the comprehensive health plan.

V. DEPARTMENTAL POSITION

- (1) The department offers no position on the Statewide comprehensive health plan presented in Sections 1-4 of this bill.
- (2) The department supports passage of the alcohol provisions of this bill (Sections 5-8).
- (3) The department supports passage of Section 9 which requires purchase of medical services under the Department's programs through health insurance contracts when judged cost-effective by the Commissioner.
- (4) Adding all new beneficiaries and services (Sections 10 and 11) under Medicaid as proposed in this bill in view of the unclear federal financial picture and the State's own forecasts for smaller revenues due to the worsening oil market should be carefully considered. It appears that some new benefits could be added at little or no additional cost to the State.

POSITION PAPER/Department of Health & Social Services

Recommended by:

Rod Betit
Rod Betit, Director
Division of Public
Assistance

Date:

2/25/82

Robert L. Cole by [Signature]
Robert Cole, Coordinator
Office of Alcoholism and
Drug Abuse

Date:

Approved by:

Helen D. Beirne
Commissioner

Date:

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41
Title An Act relating to the health of residents of the state
Requested by Senate HESS Committee Date 2/25/82

II. FISCAL DETAIL

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

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.	0	(5311.9)	(6108.6)	(7024.9)	(8078.7)	(9290.5)
TOTAL	0	(5311.9)	(6108.6)	(7024.9)	(8078.7)	(9290.5)

FUNDING (Thousands of Dollars)

GENERAL FUND	0	(5311.9)	(6108.6)	(7024.9)	(8078.7)	(9290.5)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

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

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

IV. DATE 2/25/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
Original: Legislative Finance PHONE 465-3347
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41
Title An Act relating to the health of residents of the state.
Requested by Senate HESS Committee Date 2/25/82

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
Program Category Affected Health/Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Medicaid/Eliq. Deter./PA Admin.
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	0	389.3	428.2	471.0	518.1	569.9
200 TRAVEL	0	14.2	15.6	17.2	18.9	20.8
300 CONTRACTUAL	0	147.2	161.9	178.1	195.9	215.5
400 COMMODITIES	0	7.2	7.9	8.7	9.5	10.4
500 EQUIPMENT	0	14.6	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	20576.9	23663.5	27213.0	31295.0	35989.2
TOTAL	0	21149.4	24277.1	27888.0	32037.0	36805.8

FUNDING (Thousands of Dollars)

GENERAL FUND	0	8100.6	9296.4	10679.1	12267.8	14096.6
FEDERAL FUNDS	0	13048.8	14980.7	17208.9	19769.2	22709.2
OTHER (Specify Source)						

POSITIONS

FULL TIME	0	12	12	12	12	12
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 2145 new cases under the Medicaid program. Administration of program benefits would require 11 field positions and 1 central office position, office space, and additional commuter time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 48% federal except for the Indian Health care program which is funded at 100% federal funds.

IV. DATE 2/25/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
Original: Legislative Finance PHONE 465-3347
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

MEDICAID SERVICES

Currently Covered Services

Hospital - Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (ICF)

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

Laboratory and X-Ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

Early Periodic Screening, Diagnosis, and Treatment of Individuals under 21 years of age (EPSDT)

- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community Mental Health Clinics

Family Planning Services

Outpatient Surgical Care Centers

Rural Health Clinics

Nurse Midwife

Services Added by CSSSHB-41(Finance)

Podiatrist services

Chiropractic Services

Private Duty Nursing

Personal Care Services

- * Physical Therapy
- * Occupational Therapy
- * Prescribed Drugs

Dentures and Routine Dental Services

- * Prosthetic Devices and Medical Supplies

Other Diagnostic, Screening Preventative & Rehabilitative Services

Services to Individuals Over 65 Years of Age in ICF Institutions for Mental Diseases

Services to Individuals Over 65 Years of Age in Institutions for Tuberculosis

Other Practitioner Services

- a. private psychologist
- b. nurse practitioner
- c. Physician assistant

Clinic Services - other than Community Mental Health Clinics

Services by Christian Science Practitioner

Services by Christian Science Sanatoria

* Currently accessible through General Relief Medical

BACKGROUND INFORMATION FOR FY 83

FISCAL NOTES ON CSSSHB 41--

GENERAL RELIEF MEDICAL

COMPONENT	FY 83 REQUEST	FISCAL NOTE	TOTAL REMAINING
Hospital	\$ 4,548.0	\$(2,695.5)	\$ 1,852.5
Physician	2,031.5	(1,121.2)	910.3
Other Services	2,757.9	(1,495.2)	1,262.7
Nursing Homes	501.1	0	501.1
Catastrophic Ill.	2,158.4	0	2,158.4
Residential Care	181.4	0	181.4
TOTAL	\$12,178.3	\$(5,311.9)	\$ 6,866.4

BACKGROUND INFORMATION FOR FY 83
FISCAL NOTES ON CSSSHB 41--
MEDICAID

COMPONENT/NEW SERVICE GROUPS	FY 83 REQUEST	NEW CATEGORICALLY NEEDY COVERAGE	TOTAL WITH CATEGORICALLY NEEDY
Hospital	\$12,327.8	\$ 3,007.1	\$15,334.9
Physician	7,858.1	1,631.2	9,489.3
Other Services	1,695.5	447.5	2,143.0
EPSDT	2,751.9	2,672.5	5,414.4
Nursing Homes	21,831.3		21,831.3
SUBTOTAL	\$45,109.4	\$ 7,748.3	\$52,857.7
Indian Health	5,450.0	5,577.7	11,027.7
SUBTOTAL	\$50,559.4	\$13,326.0	\$63,885.4
New Other Services		2,671.4	2,671.4
New Dental Services		2,120.1	2,120.1
New Drug Services		2,459.4	2,459.4
TOTAL	\$50,559.4	\$20,576.9	\$71,136.3

SUMMARY OF FY 83 BUDGET FOR CSSSHB 41

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	\$21,149.4	\$13,048.8	\$ 8,100.6	12
(2) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(5,311.9)	---	(5,311.9)	---
	_____	_____	_____	_____
TOTAL	\$15,837.5	\$13,048.8	\$ 2,788.7	12

CASELOAD ESTIMATES FOR FY 83
FISCAL NOTES ON CSSHB 41

PROGRAM CATEGORY	CURRENT CASELOAD	GRM REDUCTION	CATEGORICALLY NEEDY	TOTAL WITH CATEGORICALLY NEEDY
AFDC	5595		3752	9347
OAA	2272			2272
AB/AD	2185			2185
GRM	4218	(1607)		2611
TOTAL	14,270	(1607)	3752	16,415



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 19, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: David Teal *Teal*
Research Staff

RE: Fiscal Note for Health Insurance (HB 41)
Supplementary Information: Research Request Number 82-72

Research request number 82-72 was transmitted to you on March 12, 1982. It contained estimates of costs related to HB 41, a bill which would implement a statewide health insurance plan. Louann Cutler, of your staff, responded to that memorandum with a request for additional information. Specifically, she asked that 1) a fourth option--a combination of a 90 day restriction on joining the plan and a provision excluding those presently covered by private individual health insurance coverage--be added to the options presented in memorandum 82-72; 2) individuals covered by general relief medical (GRM) and medicaid be omitted from the non-covered population under the "premium subsidy only" options; and 3) regional cost differences be explored.

As discussed with Louann, an expanded version of memorandum number 82-72 may have greater clarity than a memorandum containing only the supplemental information. Accordingly, memorandum 82-72 has been revised and appears as an attachment to this memorandum.

Attachment



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 19, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: David Teal, Jon Sherwood, and Leslie Longenbaugh
Research Staff

RE: Fiscal Note for Health Insurance (HB 41)
Research Request Number 82-72

This revised version of a memorandum transmitted to you on March 12, 1982 incorporates the additional information described in the cover document to this memorandum.

This agency was asked to estimate costs related to HB 41, a bill which would implement a statewide health insurance plan. Your office also requested an analysis of several options which are not currently included in HB 41. We have estimated the costs of a health insurance plan under these options, but, as instructed, have not considered any language changes that may be required to adopt the options.

Estimated Costs of HB 41

Table 1 presents estimates of cost under assumptions described in this memorandum. Although we believe we used the best data available to us, we have some questions about the reliability of data used to produce cost estimates and are therefore somewhat uncomfortable about the range of potential error of the estimates.

Table 1 shows that the estimated cost of implementing HB 41 is \$31 million, with about half of that cost directed toward those who currently have no health insurance coverage. The estimates in Table 1 do not include 1) administrative costs; 2) adjustments for regional cost differences which were specified in the bill; 3) costs of providing insurance coverage to the Native population; or 4) costs of providing insurance coverage to employees who are currently covered by employer-provided plans and who would find it financially advantageous to switch to the State plan only if "side deals" were made with their employers. A brief discussion of assumptions and of the process used to derive the estimates in Table 1 appears later in this memorandum.

Table 1
Estimated Costs of HB 41

<u>Group</u>	<u>Estimated Cost</u> <u>(\$ millions)</u>
Not Covered by Health Insurance	\$14.9
Covered by Private Insurance Plans	7.0
Covered by Employer Insurance Plans	8.1
High Risk Group	<u>1.0</u>
TOTAL	\$31.0

Source: House Research Agency 3/82

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Regional Cost Adjustments. Although HB 41 allows regional adjustments to be made to median income, section 18.27.030 does not specify a formula for making such adjustments. We would be willing to do additional work on this subject if you wish, but can do little with the limited information currently available. As you may be aware, small villages tend to have both higher living costs and lower levels of median income than urban areas of Alaska. This fact allows a very broad range of subsidy adjustments to be made. Perhaps a verbal discussion of the intent of adjustments would be useful if more work on this topic is desired.

Table 2 gives estimates of the cost of implementing several health insurance options. The cost estimate presented in Table 1 is the basis for the estimates in Table 2, with alternative plans increasing or decreasing costs from the starting point of \$31 million. The effects of various options on the estimated cost of the health insurance plan are discussed below.

Table 2
 Estimated Cost of HB 41 Under Various Options
 (in millions of dollars)

Option	Non-Natives		All Residents	
	Subsidy for:		Subsidy for:	
	Premiums and Co-Payment	Premiums Only	Premiums and Co-Payment	Premiums Only
HB 41 (per Table 1)	\$31.0	\$17.8	\$55.8	\$32.0
Private Individual Plans Excluded	24.0	12.1	48.8	26.4
90-Day Restriction on Cost Sharing	20.8	9.4	41.6	20.4
Private Individual Plans Excluded and 90-Day Restriction on Cost Sharing	19.1	8.0	39.9	19.0

Source: House Research Agency 3/82

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All Residents. Based on results of the Battelle study, coverage of Natives would increase costs of the basic insurance plan by about 80 percent. This factor was used to obtain a cost of \$55.8 million if the present form of HB 41 were available to all residents of Alaska. This \$55.8 million cost was used as a starting point for plans which would extend coverage to all residents. Cost savings under the various alternatives were subtracted from this figure.

We have no data on the distribution of income among the Native population and have no good indication of the number of Natives that would adopt the various health insurance options presented in Table 2. The figures in Table 2 are therefore rough estimates of program costs.

Premium Subsidy Only. In its present form, HB 41 would subsidize both premiums and out-of-pocket expenses for those below certain income levels. If out-of-pocket--or co-payment--expenses were not subsidized and the same number of people were covered by the plan, the cost of all options of the plan would fall by about 18 percent. However,

program costs can be expected to decline due to lower participation rates among those currently eligible for general relief medical (GRM) and medicaid. Because no patient co-payments or deductibles are required under GRM or medicaid, the 5,000 non-Native families eligible for those programs are assumed to forego coverage under the "premium subsidy only" options of the health insurance plan.

Although those eligible for GRM or medicaid constitute only about one-third of non-Native Alaskans without health insurance coverage, they would be the most heavily subsidized group and their exclusion would reduce costs by over \$9 million. The effect of excluding those eligible for GRM or medicaid plus the effect of subsidizing only premiums for the remainder of participants would be to lower costs of the program to about \$17.8 for non-Natives and to about \$32 million for all residents.

Private Individual Plans. If the bill were revised in a way that prevented those currently covered by private individual plans from switching to the State plan, program costs under the "premium and co-payment subsidy" option would decline by about \$7 million. The Battelle study assumes that no Natives have private individual coverage, so the estimated costs under this option show the same \$7 million decline for both "non-Native" and "all residents" options. Under the "premium subsidy only" options, costs would be reduced to about \$12.1 million and \$26.4 million for the non-Natives and all residents, respectively.

Restricted Eligibility for Cost Sharing. A provision restricting the cost-sharing features of HB 41 to those who had not had health insurance coverage during the 90 days preceeding membership in the State plan could have a significant impact on program costs. If such a provision prevented 50 percent of those covered by employer plans, 75 percent of those covered by private individual plans, and 90 percent of those in the high risk group from switching to the State plan, costs of providing health insurance coverage under the State plan would decline by approximately \$10.2 million for the non-Native group. Expected cost reduction for coverage to all residents would decline by about \$14.2 million.

The above percentages were used as examples; we have no way of predicting the actual effect of a 90-day restriction. If the same percentages are applied to the "premium subsidy only" options, estimated costs are reduced to \$9.4 million for non-Natives and to \$20.4 for all residents.

Permanent Fund Dividends. There was some discussion with your staff on the potential for using Permanent Fund dividends to partially offset the costs associated with HB 41. Unless residents were required to use their dividends to pay a portion of the State's costs, the dividends would reduce the cost to the individual but would not decrease costs to the State.

Due to the uncertainty surrounding the status of Permanent Fund dividends, no accurate assessment of the effect of dividends on HB 41 can be made at this time. Permanent Fund dividends may indirectly reduce costs to the State by increasing the income of individuals and so reducing the level of subsidy for which they qualify. Unless dividends exceed several hundred dollars, this factor should not be significant.

Discussion of Assumptions and Methodology

The following discussion applies to estimated cost of a health insurance plan under the current language of HB 41. As noted earlier in this memorandum, costs under various alternatives were derived by computing the effect of changes to the current version.

Premium Amount. The estimates in Table 1 of this memorandum are based on monthly premiums of \$130 per household. Although \$130 may be the average health insurance premium in Alaska, it is possibly higher than the current premium that might be expected to apply to a plan such as that described in HB 41. According to Kurt Fortney, of Blue Cross, the average group premium (including vision and dental care) for Alaska's private sector is \$106 per month. Higher deductions and deletion of provisions for vision and dental care can be expected to result in lower premiums, but we do not have an estimate of premiums that may be required for the plan specified in HB 41. Based on premium increases experienced in the last few years, the \$130 figure appears to be a reasonable estimate of costs of insurance coverage in 1983 under HB 41.

Co-payments. In all cases, \$200 was used as the deductible and \$300 as the average individual's share of medical expenses once the deductible is surpassed.

Subsidies. Subsidies were calculated according to the schedule below.

Table 3
Subsidies for Health Insurance under HB 41

<u>Family Income as a percent of Median Family Income</u>	<u>Premium Subsidy (percent)</u>	<u>Co-Payment Subsidy (percent)</u>
125	0	0
120	10	0
115	20	0
110	30	0
105	40	0
100	50	0
95	60	9
90	70	18
85	80	27
80	90	36
75	100	45
70	100	55
65	100	64
60	100	73
55	100	82
50	100	91
45	100	100

Source: Louann Cutler, Representative Buchholdt's office

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Median Income. Based on information provided by the Alaska Department of Labor, the estimated median income for families of three and four persons was calculated as \$28,555 for 1982. The same information was used to calculate a 1982 median income of \$18,625 for one and two person families. Because we were unable to discover distributions of income according to family size, we used only two groups instead of four separate levels of median income.

Distribution of Income. Income tax data for Alaska residents filing for 1979 were used to derive distributions around the median income levels described above. Residents who itemized and filed jointly were used to represent families of three and four. Residents taking the standard deduction were used to represent families of one and two. In both cases, inflation was taken into account by assuming an even

distribution of income within each tax bracket and moving the top quarter of filers in each bracket into the next higher bracket. This approximates the impact of 33 percent (7.5 percent per year) inflation from 1979 to 1983.

The distribution would provide subsidies to about 70 percent of one and two person families and about 51 percent of three and four person families. Table 4 provides greater detail on estimated subsidies payable under current language of HB 41. Families with income greater than 125 percent of median income for that family size receive no subsidies, families with income between 45 and 125 percent of median income are on the subsidy schedule and are eligible for subsidies of less than 100 percent of costs, and families earning less than 45 percent of median income are fully subsidized.

Table 4
Distribution of Alaskans by Eligibility
for Subsidy Under HB 41

<u>Family Size</u>	<u>Percent with No Subsidy</u>	<u>Percent with Partial Subsidy</u>	<u>Percent with Full Subsidy</u>
1 and 2	30	38	32
3 and 4	49	40	11

Source: House Research Agency 2/82

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Amount of Subsidy. Given the data described above, the amount of State funds to be spent on subsidies under the current version of HB 41 can be calculated. Table 5 presents estimates of the average amount of subsidy which would be paid to those with incomes of less than 125 percent of the median income. The figures are based on the subsidy schedule presented in Table 4 and assume premiums of \$130 and co-payments of \$500.

Table 5
Estimated Subsidy per Household Under HB 41

	<u>Families of 1 and 2</u>	<u>Families of 3 and 4</u>
Premium	\$1,237	\$ 976
Co-payment	271	222
TOTAL	\$1,509	\$1,198

Source: House Research Agency 2/82

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Cost of Plan. Cost calculations were performed for four major groups. The groups and assumptions used in computing costs under the current version of HB 41 are described below.

Not Presently Covered

- Assumptions:
- 44,000 individuals (14,667 households) have no health insurance (Battelle estimate)
 - half (7,333) these households are 1- and 2-person families and half are 3- and 4-person families
 - price elasticity of demand is .65 (Battelle Estimate)

- Conclusions:
- 45% of 1- and 2-person families elect coverage
 - 23% of 3- and 4-person families elect coverage
 - subsidy to this group (those not presently covered by health insurance) is \$14.9 million

Private Individual Coverage

- Assumptions:
- 25,000 individuals (8,333 households) have private individual health insurance coverage (Battelle estimate)

- half of these households (4,167) are 1- and 2-person families and half are 3- and 4-person families
- the State subsidizes costs whether these households retain private coverage or switch to the State plan

Conclusion: • subsidy to this group is \$7 million

Covered by Employee Plans

- Assumptions:
- 194,000 individuals (64,667 households) are presently covered by health insurance through their places of employment (Battelle estimate)
 - half (32,333) of these households are 1- and 2-person families and half are 3- and 4-person families
 - 40% would not switch because their employer pays all costs of their present plan (Battelle, Table X-4)
 - 25% of those with partial payment plans would switch to the State plan (Battelle, Table X-5)

- Conclusions:
- subsidy to this group is \$8.1 million
 - if "side deals" between covered persons and their employers resulted in all presently covered employees converting to the State plan, the subsidy to this group would increase to \$32.4 million (Note: Side deals were not included in the cost calculations shown in Table 1 or Table 2.)

High Risk Individuals

As explained in the Battelle study, data on this group are limited. The cost of providing coverage to this group is included in Table 1, but the figures are rough estimates based on work performed by Battelle. The Battelle study uses a premium of 125 percent of the standard premium for the high risk group. That figure was combined

Representative Buchholdt
March 19, 1982
Page 10

with data from Battelle's Table X-9 and Table 5 of this memorandum to produce an estimate of \$.8 million for premium subsidy and \$.2 million for subsidization of co-payments.

* * *

Although we have attempted to present the above information in a non-technical manner, we realize that mathematical data can be confusing. If you or your staff have any questions about the source of numbers or what calculations were performed, please call and we will try to help. We will be pleased to perform additional work on this project if the provisions of HB 41 change. Please do not hesitate to call if we can be of further service.

Relationship Between Insurance and Health Care Costs

The total U. S. expenditures for health care increased 1,400 percent during the period 1950-1978. This represents an increase in actual dollars of 170.3 billion dollars. The percentage of the Gross National Product consumed by health care went from 4.5% in 1950 to 9.1% in 1978; and it is felt that unchecked, health care will be consuming approximately 13.1% of the GNP by 1990. Several factors has contributed to the increased cost of health care. These factors included:

1. increased medical care prices,
2. population growth, and
3. increased demand for medical care.

The Center for Health Services Research and Development has indicated that increase in medical care prices account for 59.3% of the increase in personal health expenditures in the U.S. for the period 1950-1978. Clearly, then the increase in medical care prices is a major factor. What has contributed to the increase in medical care cost? While it is true that inflation is an important attributable factor, evidence indicates that the cost of health care goods and services generally increased more rapidly than the overall measure of the price of consumer goods. The President's Council on Wage and Price Stabilization reported that in 1978 the rate of inflation of physician's fees had consistently outpaced "the overall inflation except during the 1971-74 period of wage price control."

Physician and Hospital Reimbursement have come under increasing scrutiny as an important factor in the rapid rise in the cost of medical care. Two recent studies of the effect of current physicians reimbursement policies on charges to Medicaid and Medicare were examined in detail. Both studies concluded that the current policy of reimbursing "the customary, prevailing and reasonable charge" tends to be inflationary.

The dominant practice in insurance today is to pay the physician's charges or "the customary, prevailing and reasonable charge," whichever is less. While the maximum charge for any given service is supposed to be secret, it is easy for a physician to discover the charge. All she/he has to do is to charge a high fee and see if it gets paid. If the entire charge is accepted then she/he is at or below the customary level. In addition, charges that are above the customary level, but less than twice the customary level, are used in the pool of charges that determines the charges in subsequent allowances.

In a study of customary allowance for selected procedures covered under Blue Shield in Washington, D.C. during the period 1975-1978, the increase in the customary allowance for physician fees ranged from 29% to 75%.

In fact, one surgical group of two physicians who performed 68.9% of coronary artery by-pass operations in the state was primarily responsible for a 75% increase in the customary allowance for the operations.

Martin Feldstein of Harvard has argued that increases in hospital costs have been induced primarily by increases in insurance coverage and rising incomes. As growing insurance coverage reduces the net price of out-of-pocket cost of hospital/physician care, individuals demand more services, higher quality care, and more amenities. Since increasing insurance coverage allows hospitals to charge higher prices without any reduction in capacity utilization, hospitals use additional revenues to introduce more expensive technology, employ additional staff, etc.

The potential increase in hospital prices induced by insurance coverage is quite high. For example: suppose that in the absence of hospitalization insurance a hospital could charge \$100 per hospital stay and maintain a given level of capacity. A change to insurance coverage which reduces out-of-pocket costs to 20% of hospital charges permits the hospital to charge \$500 per stay without any increase in the out-of-pocket cost to the individuals. By increasing insurance coverage, the hospital can greatly increase the cost of hospital care without increasing the direct financial burden on the patients.

Third-party insurance (including Medicare/Medicaid) which are based on reasonable charge methodology has resulted in an enormous rise in the cost of health care. Before the advent of reasonable and customary charge reimbursement, both the patient, the physician, and the hospital were necessarily concerned with the patient's ability and willingness to pay for various options. With ever more comprehensive health care insurance coverage, patients can not only afford more health care, but have little incentive to seek care in the most economical manner. The cost doesn't concern the hospital or the physician since they can pass them on to the third party payors and the third parties aren't worried about the cost since they can pass them on in higher premiums.

Bibliography

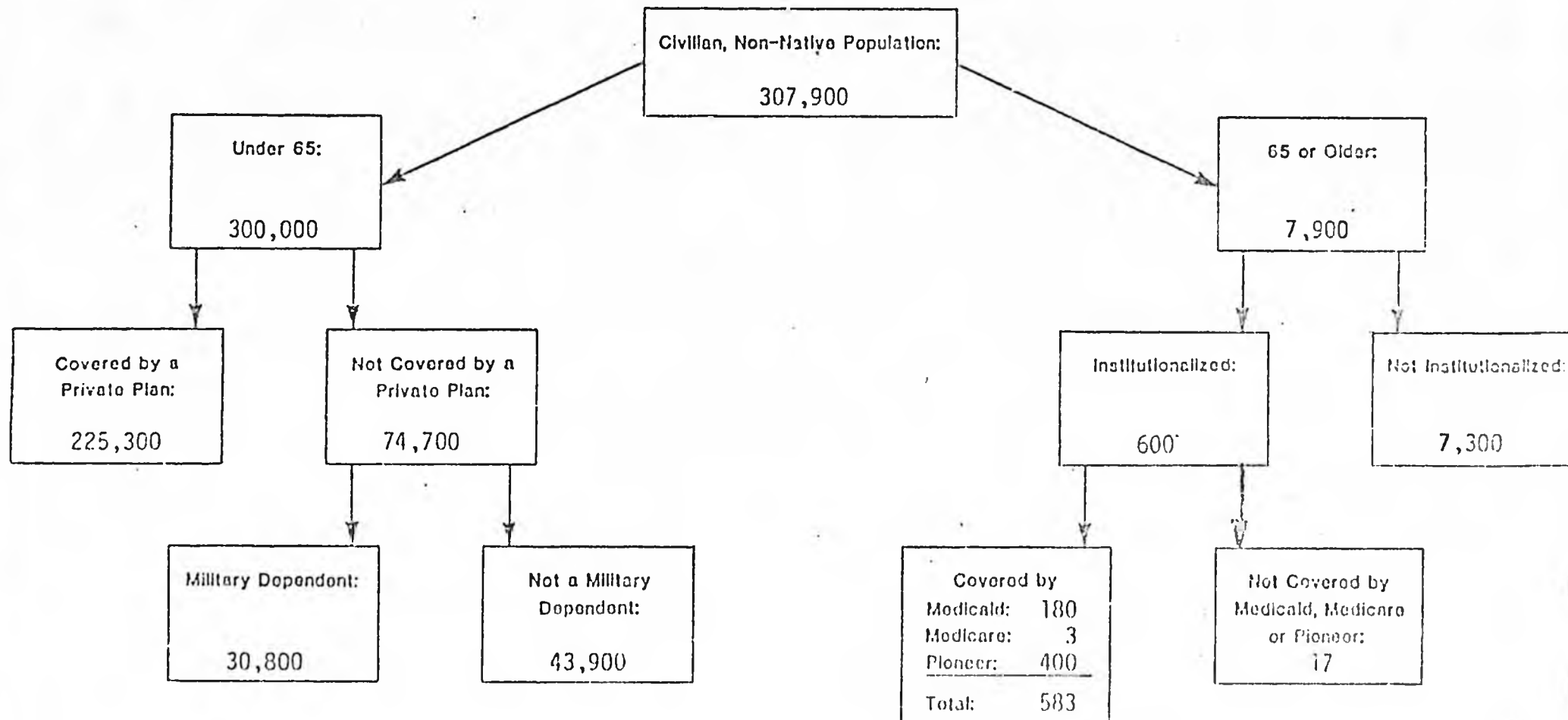
Davis, Karen, "Rising Hospital Costs: Possible Causes and Cures" Bulletin of New York Academy of Medicine, Vol. 48, No. 11
Decon 1972, p. 1354-1371

Delbonco, Thomas et.al., "Paying the Physician's Fee - Blue Shield and the Reasonable Charge" New England Journal of Medicine, Vol. 301, No. 24, p. 1314-1320

Lee, Phillip, "Paying for Primary Care - Time for a Change?" American Journal of Medicine, vol. 68, March 1980, p. 319-321

U. S. Department of Health, Education, and Welfare, Trends Affecting the U. S. Health Care System, p. 195-199

CIVILIAN NON-NATIVE POPULATION: THIRD-PARTY COVERAGE



Source: Battelle Research Center



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

April 8, 1980

MEMORANDUM

TO: Representative Hugh Malone

ATTN: Paul Quesnel

FROM: Christine Johnson *Johnson*
Research Staff

SUBJECT: Research Request No. 81-60
State Health Care Coverage

Some time ago Paul Quesnel of your staff asked us to find out whether or not the State is paying for health care coverage for both husbands and wives when both work for the State. Since the State's health plan fully covers the spouses and dependents of State employees, it seems as though the State would only need to pay for coverage once when both husband and wife are State workers.

As we have indicated to Mr. Quesnel, when both husband and wife work for the State, the state is paying for medical coverage for each. The current monthly cost of this coverage is \$123.71 per person. This may increase next year to approximately \$150.00.

Apparently, this topic has been discussed extensively. According to the State Division of Retirement and Benefits, the State is providing coverage for each spouse at the insistence of the collective bargaining units, as under this policy the couple's medical coverage is improved. The regular health care plan which each employee receives at no cost, covers only 90% of the hospital and doctor costs incurred by the employee and his or her dependents. Furthermore, the coverage does not extend to certain services such as routine physicals. Employees who would like more comprehensive coverage must purchase supplemental coverage. Individuals who are covered both as employees and as the dependents of employees have the equivalent of two health care insurance plans, and receive 100% coverage without paying for supplemental benefits. In addition, their maximum coverage increases from \$250,000 to \$500,000.

CJ

NORTH SLOPE BOROUGH

Anchorage Liaison Office
3201 "C" Street, Suite #602
Anchorage, Alaska 99503
Telephone: (907) 276-4374
Telex Number: 26522

March 25, 1981

Charles Parr, Chairman
Health and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear sir:

The North Slope Borough Health and Social Service Agency would like to lend its support to the passage of H.B. 41, an act relating to health care for state residents. In so doing, however, the following points need to be made:

I.A. The act as now written excludes consideration for Alaska Natives, both rural and urban, unless they are employed;

B. A detailed study is needed of the impact this exclusiary clause will have;

C. There are misconceptions regarding the type and depth of coverage, as well as access to that coverage by Alaska Natives;

D. There are misconceptions regarding the access to that same level of care through Indian Health Service in rural areas by non-natives, non-IHS beneficiaries. Currently, non-beneficiaries enjoy access to and through IHS to identical levels of care at the Service Unit Hospitals, and at a cost that would not meet or exceed deductibles of an insurance policy. The only exceptions may be hospitalization by referral, or specialist care not locally available.

E. Access, particularly for those in the villages is predicated on having the money to pay for air fares to and from the Service Unit. This aspect has been one of the largest stumbling blocks to adequate preventive and early treatment of illness for village residents.

II. The expansion of Medical/Medicare is a vital need for all

Alaskans, and its expansion into a fully functional program would be a great step forward for the population who are often at greatest risk, and whose health is key to taking advantage of increased opportunities in other life spheres. Also, the contracting of this program to a private carrier has advantages in administration that are superior.

III. Inclusion of alcoholism and drug addiction services in the benefits package is another positive step in providing better access to care that is needed. Specific coverage for mental health, including services of psychologists, psychiatrists, and hospital facilities should be included under the same aegis.

IV. There are many small scale employers in the state. Full costs of such coverage could be a significant deterrent to financial success of these businesses. Consideration should be given to applying a sliding fee for cost of coverage based upon factors including the following:

- net receipts on an annual basis
- number of employees
- location of business
- length of operation

Such consideration would benefit not only the myriad small businesses, but their many employees.

It is recognized that coverage such as that would increase costs associated with expansion of services, but the services are badly needed throughout our state and are, in our judgement, a justified expenditure which will have immediate and lasting benefit for all Alaskans.

We reiterate the need for and value of a study regarding Alaska Native inclusion within the provisions of this act.

Sincerely yours,

Elise Patkotak

Elise Patkotak, Director
Health and Social Service Agency
North Slope Borough

Relationship Between Insurance and Health Care Costs

The total U. S. expenditures for health care increased 1,400 percent during the period 1950-1978. This represents an increase in actual dollars of 170.3 billion dollars. The percentage of the Gross National Product consumed by health care went from 4.5% in 1950 to 9.1% in 1978; and it is felt that unchecked, health care will be consuming approximately 13.1% of the GNP by 1990. Several factors has contributed to the increased cost of health care. These factors included:

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The Center for Health Services Research and Development has indicated that increase in medical care prices account for 59.3% of the increase in personal health expenditures in the U.S. for the period 1950-1978. Clearly, then the increase in medical care prices is a major factor. What has contributed to the increase in medical care cost? While it is true that inflation is an important attributable factor, evidence indicates that the cost of health care goods and services generally increased more rapidly than the overall measure of the price of consumer goods. The President's Council on Wage and Price Stabilization reported that in 1978 the rate of inflation of physician's fees had consistently outpaced "the overall inflation except during the 1971-74 period of wage price control."

Physician and Hospital Reimbursement have come under increasing scrutiny as an important factor in the rapid rise in the cost of medical care. Two recent studies of the effect of current physicians reimbursement policies on charges to Medicaid and Medicare were examined in detail. Both studies concluded that the current policy of reimbursing "the customary, prevailing and reasonable charge" tends to be inflationary.

The dominant practice in insurance today is to pay the physician's charges or "the customary, prevailing and reasonable charge," whichever is less. While the maximum charge for any given service is supposed to be secret, it is easy for a physician to discover the charge. All she/he has to do is to charge a high fee and see if it gets paid. If the entire charge is accepted then she/he is at or below the customary level. In addition, charges that are above the customary level, but less than twice the customary level, are used in the pool of charges that determines the charges in subsequent allowances.

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Martin Feldstein of Harvard has argued that increases in hospital costs have been induced primarily by increases in insurance coverage and rising incomes. As growing insurance coverage reduces the net price of out-of-pocket cost of hospital/physician care, individuals demand more services, higher quality care, and more amenities. Since increasing insurance coverage allows hospitals to charge higher prices without any reduction in capacity utilization, hospitals use additional revenues to introduce more expensive technology, employ additional staff, etc.

The potential increase in hospital prices induced by insurance coverage is quite high. For example: suppose that in the absence of hospitalization insurance a hospital could charge \$100 per hospital stay and maintain a given level of capacity. A change to insurance coverage which reduces out-of-pocket costs to 20% of hospital charges permits the hospital to charge \$500 per stay without any increase in the out-of-pocket cost to the individuals. By increasing insurance coverage, the hospital can greatly increase the cost of hospital care without increasing the direct financial burden on the patients.

Third-party insurance (including Medicare/Medicaid) which are based on reasonable charge methodology has resulted in an enormous rise in the cost of health care. Before the advent of reasonable and customary charge reimbursement, both the patient, the physician, and the hospital were necessarily concerned with the patient's ability and willingness to pay for various options. With ever more comprehensive health care insurance coverage, patients can not only afford more health care, but have little incentive to seek care in the most economical manner. The cost doesn't concern the hospital or the physician since they can pass them on to the third party payors and the third parties aren't worried about the cost since they can pass them on in higher premiums.

Bibliography

Davis, Karen, "Rising Hospital Costs: Possible Causes and Cures"
Bulletin of New York Academy of Medicine, Vol. 48, No. 11
Decon 1972, p. 1354-1371

Delbonco, Thomas et.al., "Paying the Physician's Fee - Blue Shield and the Reasonable Charge" New England Journal of Medicine, Vol. 301,
No. 24, p. 1314-1320

Lee, Phillip, "Paying for Primary Care - Time for a Change?"
American Journal of Medicine, vol. 68, March 1980, p. 319-321

U. S. Department of Health, Education, and Welfare, Trends Affecting the U. S. Health Care System, p. 195-199

THE FOLLOWING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

INDICATORSHOUSE BILL 41BATTELLESTATE SUBSIDIZED EMPLOYMENT
BASED PROGRAMBATTELLESTATE SPONSORED HEALTH
INSURANCE PLAN

Key Factors

A health insurance program for Alaska residents and dependents whose total adjusted gross income is at or below 75% of the base income.

Under this option, the state would subsidize certain employers who offered a group health insurance plan to their workers. The key features of this program are:

- * An eligibility criteria designed to target the program at employers least likely to offer group plans, i.e. small employers with low income, part-time and temporary workers; and to minimize the number of employers which already offer group health from qualifying for the subsidy. This could be done by including an employer payroll limit of 5 or 10 times the average wage and salary income in Alaska.
- * The amount of subsidy would vary across employers and be determined based on the employer's total premium costs and total payroll. No employer would receive a subsidy of 100% of 100% of the premium cost under this scheme. The amount of subsidy would equal the difference between employers total premium cost and 5% or 10% of his total payroll, subject to a maximum.
- * Participation by employers who satisfy the eligibility criteria would be voluntary - they could collect a state subsidy by offering a group health plan to all their workers provided the employer pays at least 50% of the unsubsidized share of the premium.

*Open for enrollment to all residents of Alaska.

*A graduated premium subsidy for low income participants based on annual family income.

*A state subsidy for the high risk population based on charging high risk population premium rates below the true cost of their health insurance coverage.

*Premium rates for participants who do not qualify for subsidy based on their expected levels of utilization.

Number of New Family
Coverages

Not Stated

2,050 to 4,600

4,600

Number of Total Coverages

Not Stated

6,300 to 11,100

22,600 to 30,800

<u>INDICATORS</u>	<u>HOUSE BILL 41</u>	<u>BATTELLE</u> <u>STATE SUBSIDIZED EMPLOYMENT</u> <u>BASED PROGRAM</u>	<u>BATTELLE</u> <u>STATE SPONSORED HEALTH</u> <u>INSURANCE PLAN</u>
Total Premium Costs to State	\$31 Million (Non-Native Only)	\$3,530,000 to \$12,890,000	\$45,900,000 to \$51,580,000
Premium Cost Per Household	\$130 Per Month \$1198 to \$1509 Per Year	\$130 Per Month \$1560 Per Year	\$1600 to \$2100 Per Year
Basic Program Structure	Commissioner of the Department of Administration shall: * establish a health insurance program for residents * establish minimum program benefits * May contract for administration of program by competitive bid and for a three year period. * The program shall provide for co-payments, deductibles that have annual limits.	* Legislature shall establish by law and regulation * Employers participating would choose benefits package up to a minimum based on market premium cost of a standard group health benefit plan (state defined).	*Program to be administered by private insurance carrier via contract awarded by competitive bid *Typical major medical plan of somewhat higher than usual deductibles and co-insurance rates.

THE PRECEDING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

FISCAL NOTE

I. REQUEST
 Bill/Resolution No. Sponsor Substitute House Bill 41 (partial)
 Title State Comprehensive Health Plan
 Requested by House HESS Date _____

II. FISCAL DETAIL
 Agency Affected Department of Administration, Division of Retirement & Benefits
 Program Category Affected Public Health
 BRU, Program, or Subprogram(s) Affected Retirement & Benefits
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)
EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		144.8	591.1	650.2	715.2	786.7
200 TRAVEL		3.0	3.0	3.3	3.6	4.0
300 CONTRACTUAL		862.6	353.3	388.6	427.5	470.3
400 COMMODITIES		1.0	3.2	3.5	3.9	4.3
500 EQUIPMENT		12.0	5.0	2.0	2.0	2.0
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	1,023.4	955.6	1,047.6	1,152.2	1,267.3

FUNDING (Thousands of Dollars)

	1,023.4	955.6	1,047.6	1,152.2	1,267.3
GENERAL FUND					
FEDERAL FUNDS					
OTHER (Specify Fund Source)					

POSITIONS

	12	16	16	16	16
FULL TIME					
PART TIME					
TEMPORARY					

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

Assumption:

- 30 thousand accounts first year with 75,000 covered individuals.
- Field offices in Anchorage, Fairbanks, Nome and Juneau.
- Staff costs increase by 10% after FY 83.
- Does not include benefit costs under the cost sharing program or the costs under Sections 5-8.

This fiscal note addresses only the estimated costs of administering the state comprehensive health plan and state health insurance cost sharing program and producing the report called for in Sec. 2 of the bill.

IV. DATE February 26, 1981 PREPARED BY Ken Humphreys, Deputy Director
 AGENCY Division of Retirement & Benefits
 PHONE 465-4462

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) Buchholdt
 Office of the Governor (Keith Specking)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SSHB41

Title An ACT relating to the Health of Residents of the State

Requested by HOUSE HESS Committee Date 2/26/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Deter/Pub. Assistance Admin.

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		147.4				
200 TRAVEL		5.4				
300 CONTRACTUAL		55.7				
400 COMMODITIES		2.7				
500 EQUIPMENT		5.6				
600 LAND & STRUCTURES		0				
700 GRANTS, CLAIMS, ETC.		8812.9				
TOTAL		9029.7				

FUNDING (Thousands of Dollars)

GENERAL FUND		3320.4				
FEDERAL FUNDS		5709.3				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		5				
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 920 new cases under the Medicaid program. Administration of program benefits would require 4 field staff positions and 1 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care Program which is funded at 100% federal funds.

IV. DATE 2/26/81

PREPARED BY David M. Davidson

AGENCY Division of Public Assistance

PHONE 465-3347

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) M&B Approval

David M. Davidson Date 2/26/81

POSITION PAPER

WORK DRAFT OF SENATE COMMITTEE SUBSTITUTE FOR
COMMITTEE SUBSTITUTE FOR SPONSOR SUBSTITUTE FOR
HOUSE BILL NO. 41 (HESS)I. BACKGROUND

The work draft for Senate HESS committee substitute for House Bill No. 41 would create a state-sponsored health insurance program. Previous versions of HB 41 have included proposals to make changes in the Medicaid and General Relief Medical (GRM) programs, create an employer-based health insurance subsidy program, and create a high-risk health insurance program. While the HB 41 work draft would establish the health insurance program in the Department of Administration, the subject matter of the bill does involve the Department of Health and Social Services. During the last eighteen months, the Battelle Institute has been studying health care financing in Alaska under a contract with the Department of Health and Social Services, and the results of that study are now available.

Several factors emerge from that study which bear mentioning as they relate to legislation proposing to establish a state-sponsored health insurance program:

1. There are approximately 30,000 Alaskans who have no public or private health insurance or health care coverage and:
 - a. almost all are civilian non-Natives under age 65;
 - b. approximately 12,000 are dependent children;
 - c. of the approximately 18,000 adults in this group, 14,500 are employed at least part of the year;
 - d. approximately 6000 of the 18,000 adults are childless single individuals or couples.
2. The Medicaid program could be expanded to provide coverage to many of the individuals who would be eligible for the state-sponsored health insurance program and thereby result in federal funds being used rather than state funds.
3. The scope of benefits under a state-sponsored health insurance program, the extent of state subsidy, the extent of crossover from existing employee plans, and the amount of the deductible will have a major impact on the cost of the program.

II. EFFECT OF THE HB 41 WORK DRAFT

Battelle Institute has estimated that the cost of implementing a state-sponsored health insurance program of the type proposed by the HB 41 work draft would cost the State of Alaska between \$23 and \$52

million for benefits and between \$1.5 and \$3.6 million for program administration. In addition, program administration will involve between 60 and 90 employees.

Given the present fiscal problems experienced by the State of Alaska due to the decline in the world price of oil, the development of a state-sponsored health insurance program could take place only if new state revenues were found or if funds were diverted from presently funded programs or projects. While this does not appear likely to happen this year, it is still important to discuss some concerns that the Department has about the HB 41 work draft.

1. The HB 41 work draft does not specify what categories of service would be covered under the state-sponsored health insurance plan, leaving this responsibility to the Commissioner of the Department of Administration. The nature, cost, and desirability of the program will vary greatly depending on the services covered.

2. No mention is made of coverage for preventive health care. Under Medicaid, the Early and Periodic Screening, Diagnosis and Treatment program provides preventive health screening and treatment services for all Medicaid-eligible children, including routine dental care. Without preventive coverage, the state-sponsored program will merely be providing illness insurance.

3. Since the HB 41 work draft lacks detail on what the program would entail, there is no information as to what the period of eligibility will be for state subsidy of premiums and deductibles. Under Medicaid and GRM, individuals must report as frequently as monthly or lose eligibility. If longer periods of time are used for the state subsidy, will there be adjustments for seasonal variations in income. Also, no mention is made of how personal assets will be considered in determining eligibility. Under the Catastrophic Illness program, a percentage of personal assets above a maximum level are considered available to meet the applicant's medical needs.

4. Expansion of the Medicaid program could provide the same type of health insurance coverage as would be created under the state-sponsored health insurance program for those individuals who will likely receive full state subsidies. The primary difference is that by expanding the Medicaid program, the State of Alaska would be able to take advantage of federal funds to make up 48% of the benefit and administrative costs.

5. Nothing in the HB 41 work draft indicates the basis upon which payment will be made to health care providers. Some of the alternatives are: usual and customary charges; usual, customary, and reasonable schedule of maximum allowances; percentage of charges; lower of costs or charges; flat rate; interim rates with retrospective cost settlement; per capita payments. Whatever the payment method used, several studies have shown that fee-for-service health insurance programs are not the most cost-effective method of providing health care coverage. A state-sponsored health insurance program may be more efficiently administered through the development of health maintenance organizations or other prepaid health plans that operate on a per capita basis rather than a fee-for-service basis.

6. A major factor in the delivery of health care in Alaska is access to health care providers. The availability of health insurance is of little value if an individual does not have access to services. Under the Medicaid program, necessary, medically-related transportation is a program benefit. Consideration should be given to assuring that necessary medically-related transportation is included in a state-sponsored health insurance program.

7. The HB 41 work draft would preclude state subsidy for individuals who already receive government subsidized health insurance or health care services. However, such an exclusion should apply only when the individual's other subsidized program provides equal or better coverage than available under the state-sponsored health insurance program.

8. Federally-operated health care facilities providing services at no cost to beneficiaries are not eligible to receive payment for them under almost all health insurance programs. Whether or not this will be the case under a state-sponsored health insurance program depends partly on the willingness of federally-operated facilities to provide health care to non-beneficiaries, and the cost-effectiveness of providing transportation to private health care providers more distant from their homes than federally-operated facilities.

III. POSITION OF THE DEPARTMENT

Given a more promising financial picture for the State of Alaska, we believe that a state-sponsored health insurance program that has taken into consideration the factors raised in part II could be a worthwhile expenditure of state revenues and contribute to the overall productive of the people of the state of Alaska. However, in the present fiscal reality, we believe that the creation of a state-sponsored health insurance program would require a major redirection of state spending priorities which the Department believes cannot be undertaken at this late date in the 1982 legislative session. As an alternative, the Department would like to suggest that the contents of CSSB 817 be considered as a Senate HESS committee substitute for HB 41. CSSB 817 would transfer funds between the GRM and Medicaid programs to take advantage of federal Medicaid funds that are available without increasing the state budget. Under CSSB 817, the Department would provide health care coverage, including preventive health care services, to over 4000 children not presently eligible for Medicaid, and provide prenatal care to almost 400 pregnant women not currently eligible for Medicaid. Passage of CSSB 817 would not cost the state any money, but would provide health care services to a portion of the population targeted for coverage under the state-sponsored health insurance program in the HB 41 work draft.

Approved by:


Helen D. Beirne, Commissioner

Dated:

4-7-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SCS CSSH 41 (work draft)

Title An Act establishing a state health insurance program

Requested by Senate HESS Committee Date 3/30/82

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected None

BRU, Program, Or Subprogram(s) Affected None

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

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

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

The HB 41 work draft proposes to create a state-sponsored health insurance program in the Department of Administration and would therefore have no effect on the Department of Health and Social Services.

IV. DATE 4/7/82

PREPARED BY David M. Davidson

AGENCY Division of Public Assistance

Original: Legislative Finance

PHONE 465-3347

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

Jcc

*CHARLIE PARK - FIVE
Health & Social
P.L. 94-437*

A - PFB *FY1* *#1/81*
PDS
cufo

Tanana Chiefs Conference, Inc.
201 First Avenue
Fairbanks, Alaska 99701

March 25, 1981

Senator John Sackett
Pouch V
Juneau, Alaska 99801

Dear Senator Sackett,

This is to request your assistance in resolving a current problem with Medicaid reimbursement to ANHS for outpatient services at three health centers in the State. At stake in the Interior Service unit is approximately \$280,000 for FY81 alone.

According to the Division of Public Assistance, payment cannot be made on billings from these health centers because State statutes disallow their eligibility, in conflict with the intent of P.L.94-437.

It is our understanding that language to resolve the problem is included in SB41; given the likely delays in action on this bill, a more expeditious solution would be to modify Statute 47.07.030 (Welfare, Social Services, Institutions) Definitions section, to repeal the clause in Section 4 defining clinic services.

If this amendment could be processed in this session, these revenues to ANHS could be released resulting in greatly improved patient care in our region.

Please advise us concerning the necessary actions in this matter. We are prepared to provide additional information necessary to allow this action to be taken.

Sincerely,
TANANA CHIEFS CONFERENCE, INC.

Paul Sherry
Paul Sherry
Director, Health Authority

cc: Dave Mather, Regional Health Development
William C. Williams, President
Dr. Ron Gould Patient Care Services
Tanana Chiefs Regional Health Board

GH IVEY
(JERRY)

DIRECTOR

ALASKA AREA
NATIVE HEALTH
SERVICE

*750,000 + would be able to give back
health corps or provide more health
services.*

265-3153

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

June 2, 1981

Document# 154-81

The Honorable Don Clocksin
Chairman
House HESS Committee
Alaska State Legislature
State of Alaska
Pouch V
Juneau, AK 99811

Dear Mr. Clocksin:

Your staff requested language to allow the three major Alaska Area Native Health Service satellite clinics in Ketchikan, Juneau, and Fairbanks to bill for Medicaid eligible services and the State to receive 100% federal reimbursement. We would recommend the amendment of AS 47.07.080(4) as follows to accomplish this:

(4) "clinic services" means services provided by [WHICH ARE RESTRICTED TO] state approved outpatient community mental health services which receive grants under AS 47.30.520 - 47.30.620, [AND] state-operated community mental health clinics, and physician clinics.

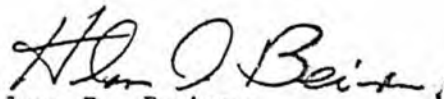
This action would require the addition of \$750,000 to \$1,000,000 in the first fiscal year of operation, with that amount of federal receipts being added to the state's Medicaid budget.

We must caution that adding any new services to Medicaid at this time must be done with the consideration that Congress is currently reviewing proposals to place a "cap" on federal Medicaid reimbursement. If a "cap" were to be placed by Congress on Medicaid federal reimbursement, the addition of AANHS clinics to the Alaska Medicaid program at this time may be done without assurance that 100% federal receipts will be realized.

We also have concerns regarding increasing possible state responsibility for services traditionally provided by federal agencies, such as AANHS. Such a move has the possibility of setting an undesirable precedent which may confuse the lines in the future of who is responsible for these medical care costs in the state for eligible Alaska Natives. This will especially be true when additional federal health care dollars for Medicaid services have a possibility of being significantly limited.

We appreciate your interest in this matter.

Sincerely,

A handwritten signature in dark ink, appearing to read "Helen D. Beirne". The signature is fluid and cursive, with the first name "Helen" and last name "Beirne" clearly distinguishable.

Helen D. Beirne
Commissioner

POSITION PAPER
COMMITTEE SUBSTITUTE FOR
CS FOR SPONSOR SUBSTITUTE
HOUSE BILL NO. 41 (FINANCE)

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

I. DEPARTMENTAL OVERVIEW OF CS FOR SPONSOR SUBSTITUTE HOUSE BILL NO. 41 (FINANCE)

Committee Substitute for CS for Sponsor Substitute to House Bill No. 41 (Finance) is composed primarily of four parts:

- a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan available to all residents of the State will pay all or a part of the coverage for low income persons.
- b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that certain Group insurance plans include coverage for alcoholism and drug dependence.
- c. Section 9 directs the Commissioner of Health and Social Services to contract for medical services through insurance companies or health care services organizations for beneficiaries of the Department's medical programs once contracting is determined cost competitive. (Medicaid, General Relief Medical, Catastrophic Illness, Crippled Children's, and Maternal and Child Health Programs).
- d. Sections 10 and 11 expand the Medicaid program by adding new beneficiaries and services respectively.
- e. Section 12 is a definition section
- f. Section 13 mandates that the Legislative Council shall study and make recommendations to improve coverage of Medicare and Indian Health Service.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Care and Financing Study" for the development of a comprehensive health care and cost distribution plan for Alaska. That study is now at mid-point. The study is examining the present health care delivery and financing systems in Alaska, identifying existing and potential funding

sources, examining improvements to the present systems and a discussion of alternative methods of providing for health care and cost distribution in Alaska, and designing legislative and administrative proposals for the implementation of potential new systems or methods.

At present the Governor's study is to be completed by December 15, 1981. This presents tight timing for the Department of Administration to consider the information in the Governor's study and report by the 30th day of the 1982 legislative session.

Since the Reagan Administration and Congress are reviewing alternative approaches to funding and administration of the Medicaid program, it is not advisable for Alaska to immediately to adopt all eligible groups, except for medically needy, and all 16 outstanding optional services at this time. Absent a clearer picture of the financial and administrative ramifications involved, the potential long term consequence could be funding of this program expansion with all state general funds.

As early as January, 1982, the Department and the Alaska Legislature will have a clearer picture of the effects of the various proposals in Congress concerning Medicaid and will have the benefit of the information included in the "Comprehensive Health Care Study".

For the above reasons, therefore, the Department of Health and Social Services cannot support CSSSHB-41 at this time.

The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8, we support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other governmental units.

We believe such benefits have the potential to be cost-saving for the state, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9. We support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, except medically needy, not just those that have been added piecemeal to the state statutes. We would prefer that such major changes be delayed until we have a clearer picture of the federal budget impacts and the benefit of the results of the comprehensive health study. If the legislature wishes to pursue this, we would recommend phasing additional eligible groups into the program rather than adding all remaining groups at a single time.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. We would prefer that such major changes be delayed until we have a clearer picture of the federal budget impacts and the benefit of the results of the comprehensive health study. Again, we would recommend phasing additional services into the program rather than adding all 16 outstanding optional services at a single time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) - ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees:

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employees health benefits package and make such coverage optional to employees of other governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of needed alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organi-

zations around the country (Kennecott Copper, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structured Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphemistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers.

The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

IV. SPECIFIC DEPARTMENTAL CONCERNS IN SECTIONS 9, 10 and 11
(MEDICAL ASSISTANCE)

Section 9 - Line 22 on Page 7 Through Line 14 on Page 9:

AS 47.05.070 - Directs the Commissioner of DHSS to select either the option of purchasing and paying premiums on policies of insurance, or paying the expenses of health care service contracts when judged cost-effective by the Commissioner. The Department supports this concept so long as this determination of cost-effectiveness is accomplished looking at the entire program rather than on a service-by-service basis. It should be pointed out that the Department already has the ability to purchase insurance or health care service contracts under existing federal law. This change would simply make it mandatory for the Department to do so.

AS 47.05.100 - We support the general public policy intended by this portion of the bill, however, we would like to offer an amendment as follows:

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

- (1) interest at the rate of one percent per penalty month when payment is delayed more than 45 days after pre-

sentation of the clean claim. A "penalty month" starts on the 46th day and consists of 30 day increments thereafter until the claim is paid.

- (2) no change
- (3) the interest for a full month if the overdue claim is not paid by the 15th day of any penalty (calendar) month.

Section 10 - Line 15 on Page 9 Through Line 20 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, except the medically needy. This includes the unborn child group, the unemployed parent group, caretaker relatives and certain individuals under 21.

As stated earlier the Department would recommend phasing additional eligible groups into the programs instead of adding all remaining groups simultaneously. We would suggest that categorical groups be added in the following timeframes:

- (1) July 1982: Unborn Child Group
Caretaker Relatives
Individuals Under 21
- (2) July 1983: Unemployed Father Group

By staging the categorical groups in this manner a number of benefits would result:

- (1) The Department will have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented and the added bill processing burden will be eased.
- (3) The Department would be prepared in advance with regulations and staff to handle the new coverage groups representing approximately 2,000 additional families.

Section 11 - Lines 21 Through 25 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under

the Medicaid program. We would prefer that such major changes be delayed until we have a clearer picture of the federal budget impacts and the benefit of the results of the comprehensive health study. If the legislature wishes to pursue this, we would recommend phasing additional services into the program rather than adding all 16 outstanding optional services at this time. It is suggested the following services be specifically listed in CSSSHB41 (Finance) rather than the current blanket provision adding all services:

- (1) Physical Therapy
- (2) Occupational Therapy
- (3) Prescribed Drugs
- (4) Prosthetic Devices and Medical Supplies
- (5) Other Practitioner Services
 - a. private psychologist
 - b. nurse practitioners
 - c. physician assistants
- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and would permit DHSS to claim federal funds for other services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program.

Creation of a comprehensive health plan as contained in Section 1 would permit the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified. One method of doing this would be to limit GRM coverage to one episode during any 12 month period. Finally, the relationship between the comprehensive health plan under CSSSHB 41 (Finance) and the present catastrophic illness program should be clarified. Most payments made under the catastrophic illness program are for major medical types of coverage that may also be covered under the comprehensive health plan.

Recommended by:

Rod Betit
Rod Betit, Director
Division of Public
Assistance

Date:

May 5, 1981

RLC by George Mundoff
Robert Cole, Coordinator
Office of Alcoholism and
Drug Abuse

Date:

May 5, 1981

Approved by:

Helen D. Beirne
Helen D. Beirne
Commissioner

Date:

5-11-81

MEDICAID SERVICES

Currently Covered Services

Hospital - Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (SNF)

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

Laboratory and X-Ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

Early Periodic Screening, Diagnosis, and Treatment of Individuals under 21 years of age (EPSDT)

- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community Mental Health Clinics

Family Planning Services

Outpatient Surgical Care Centers

Rural Health Clinics

Services Added by CSSSHB-41(Finance)

Podiatrist services

Chiropractic Services

Private Duty Nursing

Personal Care Services

- * Physical Therapy
- * Occupational Therapy
- * Prescribed Drugs

Dentures and Routine Dental Services

- * Prosthetic Devices and Medical Supplies

Other Diagnostic, Screening Preventative & Rehabilitative Services

Services to Individuals Over 65 Years of Age in Institutions for Mental Diseases

Services to Individuals Over 65 Years of Age in Institutions for Tuberculosis

Other Practitioner Services

- a. private psychologist
- b. nurse practitioner
- c. Physician assistant

Clinic Services - other than Community Mental Health Clinics

Services by Christian Science News

Services by Christian Science Sanatoria

* Currently accessible through General Relief Medical

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR CSSSHB41 (FINANCE)

MEDICAID

Component/New Service Groups	FY 82 Request	New Categorically	Total with Categori- cally Needy
Hospital	11,826.7	2,614.9	14,441.6
Physician	6,415.2	1,418.4	7,833.6
Other Services	1,759.6	389.1	2,148.7
EPSDT	3,455.5	2,315.2	5,770.7
Nursing Homes	21,521.0		21,521.0
Subtotal	44,978.0	6,737.6	51,715.6
Indian Health	7,239.1	4,850.2	12,089.3
Subtotal	52,217.1	11,587.8	63,804.9
New Other Serv.		2,323.0	2,323.0
New Dental Serv.		1,843.6	1,843.6
New Drug Serv.		2,138.6	2,138.6
Total	52,217.1	17,893.0	70,110.1

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR CSSSHB41 (FINANCE)

GENERAL RELIEF MEDICAL

<u>Component</u>	<u>FY 82 Request</u>	<u>Fiscal Note</u>	<u>Total Remaining</u>
Hospital	7,102.7	(2,343.9)	4,758.8
Physician	2,954.6	(975.0)	1,979.6
Other Services	2,600.4	(1,300.2)	1,300.2
Nursing Homes	305.9		305.9
Catastrophic	980.2		980.2
Residential	189.7		189.7
Total	14,133.5	(4,619.1)	9,514.4

CASELOAD ESTIMATES FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR CSSH41 (FINANCE)

Program Category	Current Caseload	GRM Reduction	Categorically Needy	Total with Cate- gorically Needy
AFDC	6665		3752	10,417
OAA	2421			2,421
AB/AD	2398			2,398
GRM	4664	(1607)		2,857
Total	15,948	(1607)	3752	18,093

SUMMARY OF BUDGET FOR CSJ...341 (FINANCE)

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	18,413.4	11,631.8	6781.6	12
(2) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(4,619.1)	-	(4619.1)	-
	_____	_____	_____	_____
TOTAL	13,794.3	11,631.8	2162.5	12

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41 (Finance)

Title An ACT Relating to the Health of Residents of the State

Requested by Senate HESS Committee Date May 5, 1981

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health

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

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)
TOTAL		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)

FUNDING (Thousands of Dollars)

GENERAL FUND	(4,619.1)	(5311.9)	(6108.6)	(8024.9)	(8078.7)
FEDERAL FUNDS					
OTHER (Specify Fund Source)					

POSITIONS

FULL TIME					
PART TIME					
TEMPORARY					

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

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

IV. DATE May 5, 1981

PREPARED BY David M. Davidson

AGENCY Public Assistance

PHONE 465--3347

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) M&B Approval 11/9/10/00/00/01 Date May 5, 1981

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41 (Finance)

Title An ACT Relating to the Health and Residents of the State

Requested by Senate HESS

Date May 5, 1981

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Deter./Public Assist. Admin.

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		353.9	389.3	428.2	471.0	518.1
200 TRAVEL		12.9	14.2	15.6	17.2	18.9
300 CONTRACTUAL		133.8	147.2	161.9	178.1	195.9
400 COMMODITIES		6.5	7.2	7.9	8.7	9.5
500 EQUIPMENT		13.3	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES		-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.		17893.0	20576.9	23663.5	27213.0	31295.0
TOTAL		18413.4	21135.4	24277.1	27888.0	32037.0

FUNDING (Thousands of Dollars)

GENERAL FUND		6781.6	7782.0	8938.8	10268.4	11796.0
FEDERAL FUNDS		11631.8	13353.4	15338.3	17619.6	20241.0
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		12	12	12	12	12
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 2145 new cases under the Medicaid program. Administration of program benefits would require 11 field staff positions and 1 central office position, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care Program which is funded at 100% federal funds.

IV. DATE May 5, 1981

PREPARED BY David M. Davidson

AGENCY Division of Public Assistance

PHONE 465-3347

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) M&B Approval

Date May 5, 1981

HB 41 file



Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

April 30, 1981

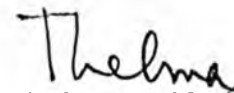
Honorable Charlie Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Charlie:

As you know, HB 41 has now passed the House and has been referred to your Committee for its consideration. As you also know, I would very much appreciate your scheduling HB 41 for a hearing before your Committee when it fits your schedule.

Thanks alot.

Sincerely,


Thelma Buchholdt
State Representative
District 9 (Spenard)

Alaska State Legislature



Senate

SENATOR MIKE COLLETTA

May 11, 1981

MEMORANDUM

TO: Senator Charles Parr
Chairman, HESS

FROM: Senator Mike Colletta

Mike Colletta

SUBJ: Recommended Committee Change - CSHB 41

It has been brought to my attention that Sec. 11 of this bill, relating to the definition of services covered, does not provide for chiropractic treatment coverage.

I would appreciate the Committee's consideration of including chiropractic care in this bill, as well as a review of other normal, necessary, and desirable services which may have been excluded in Title XIX of the federal Social Security Act, which serves as the definitional base for services covered under this measure.

Thank you.

POSITION PAPER
SPONSOR SUBSTITUTE
HOUSE BILL NO. 41
"An Act relating to the health of residents of the state; and providing for an effective date."
I. DEPARTMENTAL OVERVIEW OF SPONSOR SUBSTITUTE HOUSE BILL NO. 41
Sponsor Substitute House Bill No. 41 is composed primarily of four parts:
a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan to provide health insurance benefits for all Alaskans who are otherwise not covered under a private or public health plan and includes a cost-share program wherein the State may share in paying for insurance of low income persons.
b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that CERTAIN Group insurance plans include coverage for alcoholism and drug dependence.
c. Section 9 allows the Commissioner of Health and Social Services to contract for medical services through insurance companies and other health organizations for the payment and/or delivery of medical services to Department beneficiaries.
d. Sections 10 and 11 expand the Medicaid program by adding new services and beneficiaries.
II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS
The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Department is supportive of the provision or development of this method of health care financing. However, the Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Financing Study" for the purpose of informing all Alaskans of various alternatives to coordinating existing health resources, identifying and filling gaps where health resources currently do not exist and methods of financing services in a comprehensive and coordinated way.
With this study in mind the Department is concerned that the report required in Section 2 of SSNB-41 have the benefit of the comprehensive data and recommendations that will be included in the Governor's study. At present the Governor's study is to be completed by December 15, 1981. This timing does not provide the opportunity to the Department of Administration to consider the information in the Governor's study and report by the 10th day of the 1982 legislative session. Therefore, the Department recommends that line 13, page 3 be amended to read as follows:
"The Commissioner of Administration shall report by the (10th) 90th day of the Second Session of the Twelfth State Legislature on:"

POSITION PAPER

SPONSOR SUBSTITUTE

HOUSE BILL NO. 41

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

I. DEPARTMENTAL OVERVIEW OF SPONSOR SUBSTITUTE HOUSE BILL NO. 41

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- c. Section 9 allows the Commissioner of Health and Social Services to contract for medical services through insurance companies and other health organizations for the payment and/or delivery of medical services to Department beneficiaries.
- d. Sections 10 and 11 expand the Medicaid program by adding new services and beneficiaries.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Department is supportive of the provision or development of this method of health care financing. However, the Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Financing Study" for the purpose of informing all Alaskans of various alternatives to coordinating existing health resources, identifying and filling gaps where health resources currently do not exist and methods of financing services in a comprehensive and coordinated way.

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POSITION PAPER/Department of Health and Social Services

The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8, we support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other government units.

We believe such benefits have the potential to be cost-saving for the state, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9 we support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, not just those that have been added piecemeal to the state statutes. We would rather see additional eligible groups phased into the program than all remaining groups being added at a single time. Each group should be evaluated on its own merits, rather than in mass to determine whether it is necessary to include them and what the cost of each might be.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. Again, we would rather phase into additional services than add all services at a single time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) - ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employees health benefits package and make such coverage optional to employees of governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of need alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organizations around the country (Kennebec Insurance, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structural Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphmistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers. The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

IV. SPECIFIC DEPARTMENTAL DISCUSSION OF SECTIONS 9, 10 AND 11 (MEDICAL ASSISTANCE)

Section 9 - Line 25 on Page 6 Through Line 27 on Page 8:

AS 47.05.070 - Provides the Commissioner of DHSS the option of purchasing and paying premiums on policies of insurance or paying the expenses of health maintenance organizations service contracts or medical or hospital service contracts. As indicated we support this concept and would only suggest that "health maintenance organizations" be defined.

AS 47.05.080 - Recommend deletion of this section entirely. Current federal laws and regulations adequately cover the methods of contracting for health, medical and remedial services, and supplies. Also Alaska's current statutes and regulations concerning uniform purchasing (AS 37.050.220 - 330) provide contracting authority and obligate contractors to make payments promptly as provided in contract. If this portion is left in the bill, the term "remedial care" should be defined.

AS 47.05.100 - We support the intent of this portion of the bill, however, we would like to offer an amendment as follows:

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

- (1) interest at the rate of two percent per penalty month when payment is delayed more than 60 days after presentation of the clean claim. A "penalty month" starts on the 61st day and consists of 30 day increments thereafter until the claim is paid.
- (2) Providers should receive a full month's interest entitlement if the bill is paid after the 15th day of any penalty month.

This change accomplishes the intent of the bill, however, provides less administrative problems and costs for providers and the state in accounting for interest owed and received.

AS 47.04.120 - Add definition of "health maintenance organization", "non-exclusive contract", "medical or hospital service contracts", and "remedial care".

Section 10 - Line 28 on Page 8 through Line 2 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, primarily the unborn child group, the unemployed father, caretaker relatives, individuals under 21 and the medically needy group.

As stated earlier the Department would rather see additional eligible groups phased into the programs instead of all remaining groups being added at a single time. We would suggest the categorical groups be added in the following timeframes:

- (1) July 1982: Unborn Child Group
Caretaker Relatives
Individuals Under 21
- (2) July 1983: Unemployed Father Group

By phasing in the categorical groups in this manner a number of benefits would result:

- (1) The Department will have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented and the added administrative burden will be eased.
- (3) The Department would be prepared in advance with regulations and staff to handle the added recipient volume.

The Department recommends that the medically needy group not be added under Medicaid but instead be included under the state comprehensive health plan portion of SSHB-41.

Medicaid eligibility is broken down into two types: categorically needy and medically needy. Categorically needy includes those individuals whose eligibility is based on their income being below an amount based on cash assistance payments (under the AFDC, APA, and SSI programs). Medically needy goes beyond categorically needy to provide coverage to those individuals who meet the categorical eligibility requirements of the cash assistance programs (age, disability or deprivation of parental support), but who are not eligible for cash payments because their income is too high. Under medically needy they would be permitted to spend a portion of their income on their medical needs and thus become eligible for Medicaid to pay the remaining cost of the covered services. To a certain extent, medically needy coverage under Medicaid would duplicate coverage under the comprehensive health plan and the cost-sharing program, but would permit the State to receive federal funds to provide part of those services. However, at the income levels permitted under the Medicaid medically needy program, individuals who would receive health coverage at no expense under this bill would be required to pay part of their income for health care under a medically needy program.

Section 11 - Lines 3 Through 7 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under the Medicaid program. The Department recommends that each service be evaluated on its own merits, adding only those services that are important to maintaining the general health of Medicaid recipients. It is suggested the following services be specified listed in SSHB-41 rather than the current blanket provisions:

- (1) Physical Therapy
- (2) Occupational Therapy
- (3) Prescribed Drugs
- (4) Prosthetic Devices and Medical Supplies
- (5) Other Practitioner Services
 - a. private psychologist
 - b. nurse practitioners
 - c. physician assistants
- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and would permit DHSS to claim federal funds for other services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program. It should be emphasized that while a broad category of service under Medicaid permits DHSS to make payment for services, DHSS is required to establish the conditions under which payment will be made. For each category of service, DHSS creates controls to assure that only medically appropriate treatment receives reimbursement.

The creation of a comprehensive health plan with a cost-sharing program as contained in section 1 would permit the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified to assure that GRM is not a disincentive to participation in the comprehensive health plan. One method of doing this would be to limit GRM coverage to one episode during any 12 month period.

The relationship between the comprehensive health plan with the cost-sharing program and the present catastrophic illness program should be clarified. The cost-sharing program requires that beneficiaries of the comprehensive health plan incur some portion of the expenses of the program based on their ability to pay. If the deductible requirements under the catastrophic illness program are nearly as low as or lower than those under the cost-sharing program, there will be little incentive for anyone to participate in the comprehensive health plan, in part defeating the intent of the bill. Since most payments made under the catastrophic illness program are for major medical types of coverage that may be covered under the comprehensive health plan, there is potential for overlap.

SUMMARY OF BUDGET FOR SSHB41

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	18,413.4	11,631.8	6781.6	12
(2) ADDITION OF MEDICAID MEDICALLY NEEDY GROUPS	9,029.7	5,709.3	3320.4	5
(3) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(4,619.1)	-	(4619.1)	-
(4) INTEREST PAYMENTS	<u>667.2</u>	<u> </u>	<u>667.2</u>	<u>-</u>
TOTAL	23,491.1	17,341.1	6150.1	17
TOTAL WITHOUT MEDICALLY NEEDY	14,461.5	11,631.8	2829.7	12
TOTAL WITHOUT INTEREST PAYMENTS	13,794.3	11,631.8	2162.5	

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
333 DENALI STREET
ANCHORAGE 99501

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Deputy Commissioner
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ADVISORY COMMITTEE FOR ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY

Page Three

Darryl Trigg
Alaska Native Health Board
P.O. Box 966
Nome, Alaska 99762

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811

PHONE:

465-3030(MA)
Budget Response #19

May 6, 1981

The Honorable Thelma Bucholdt
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Bucholdt:

The Budget Breakdown proposal for the Phase II of the Alaska Comprehensive Health Care and Financing Study is as follows:

200	Travel	\$ 27,000
300	Contractual	123,000
	TOTAL	<u>\$150,000</u>

The 200 line item for travel includes:

1. The travel necessary for the project director.
2. Travel and per diem for up to 17 persons directly and/or indirectly related to the statewide Advisory Committee. (No travel or per diem costs have been involved for representatives of the Governor's Office, the Lt. Governor's Office, the Insurance Industry, or Region X representative. Included however are provisions for travel and per diem for members representing the Alaska State Medical Association and the Alaska State Hospital Association which may or may not continue to cover travel and per diem expenses as has been the case in the past.)
3. Travel and per diem for one member of the Committee, the Director of the State Health Planning and Development Agency, assuming that the agency's budget will not be sufficient to cover the expenses.
4. Expenses for two possible necessary trips to Washington, D.C. by two Battelle representatives with regard to negotiations for waivers relating to the Medicaid program, if developments make this necessary.
5. The assumption that airline fares may go up beyond the 15% currently being discussed in the next few months and providing an inflation factor of 30% for airline travel during the conclusion of the study phase and a few months into the 1982 calendar year for the implementation period.
6. A figure of approximately \$1,000 to allow for any possible increase in per diem payments or other unexpected travel claims for the project.

7. Travel and per diem provisions assuming that one meeting of the Committee may be held in Fairbanks and one in Juneau.
8. Provision for travel and per diem relating to necessary Advisory Committee and project staff relating to Public Hearings called for in the contract for the project.

The 300 line items in contractual include contract funds which may be required for research and data gathering not included in the contract with the Battelle Institute as provided for in Phase I of the study.

Sec. 2.4 PHASE I - - INITIAL PLANNING DOCUMENT. Subsection 1 e requires the contractor as a part of the work under Phase I to provide....

" A description of the types of data not available at present but needed to decide which alternative health care provision and financing approaches would be desirable and feasible for the State of Alaska to pursue, and the cost of obtaining those data. "

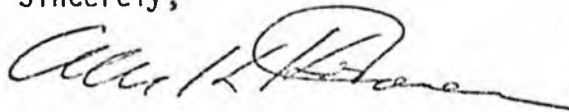
The contractor has submitted topics related to collection of primary data not included in the original scope which the study needs to address but has not yet addressed. Examples of this include:

1. Collection and refining of certain data related to the private sector insurance coverage. Additional knowledge of existing coverage levels for different types of benefits is necessary for final options to be considered. Profile information generated to date relies upon data from principal insurers and certain national level data. Information needed could be derived through scientific sample surveys of coverage offered by employers in the state. Within that data additional advantages develop.
2. Any new program doubtless will address private coverage and/or state funded coverage of alcoholism coverage. Exploration and data gathering are needed with regard to such questions as return on current investment in alcoholism care, etc..
3. Research as to the impact of the growing size of Alaska's elderly population following the Bureau of the Census projection of 125-210% increase in the next 20 years. Implications for state policy making and funding in the presence of a possible ceiling on Medicaid funds should be addressed. Certain other relevant data with regard to the elderly population is needed.
4. Physician distribution in rural areas with regard to access to services as relates to physical availability as well as the non-physician provider relating to recent trends and expectations for the future.

5. Present status of native non-profit health corporation assumption of responsibility for health care from federal government and from state government; current or potential capacity for assumption of more local control; and financial implications present and future.
6. Impact of federal fund reductions on state options.
7. Limited additional sets of data and exploration are needed such as disease patterns in the rural population and their impact on health care needs; hospital costs and utilization and alternatives for cost containment; implications of any new program structure on the demand on health care resources; cost to the state; and incentives for changes in private sector behavior under any new health care plan and financing development.

Up to \$110,000 is allocated for planning purposes for potential expenditures to complete the research and data gathering. The additional \$13,000 is allocated to other contract expense activities such as extra copies of the Battelle reports for distribution within the state, potential added expenses incurred with the public hearing process, telephone, telegraph and mailing charges, and additional copying expenses associated with the project.

Sincerely,



Helen D. Beirne
Commissioner

cc: Senate Finance Committee
House Finance Committee
Health, Education & Social Services Committee

THE UNCOVERED POPULATION

43,917 Alaskans currently have no health care coverage. Of these 43,917, about 40% are children, 25% are parents, 35% are single individuals. 60% are employed. Of the 60% employed, 29.7% are in business services; 24.7% are in wholesale or retail trade; 18.8% are in construction; 15.3% are in manufacturing, transportation, and utilities; 7.1% are in personal services; 2.7% are in agriculture, forestry and fishing (this figure does not take into account all the fishermen that will be without coverage in October, when PHS no longer plans to provide coverage to seamen with documented vessels); and 1.1% are in mining. About 5% of the 43,917 are categorized as "high risk". (There are about 4,000 high risk individuals in the state; some have private insurance but all would probably be interested in joining the plan created by this legislation because rates may be less expensive for high risk individuals than rates currently available in the market.)

Source: Survey of Income and Education (US Bureau of the Census):
John Wills, Battelle Research Center

19,000
16,000
3,000

(LC: 3/30/81)

How the Health Plan and the cost sharing program would work

The State Comprehensive Health Plan envisioned in section 1 (hereafter referred to as "the Health Plan") would be most attractive to those who have no coverage now, or those who have coverage that provides fewer benefits than the Health Plan would provide. The first group is comprised largely of those with high risk health conditions that make them ineligible for most individual health insurance policies; non-union or seasonal workers such as fishermen, cannery workers, construction workers, and legislative employees; and self-employed individuals. The latter group consists largely of those with individual health insurance plans.

The State Health Insurance Cost Sharing Program in section 1 (hereafter referred to as "the cost sharing program") would be attractive to many Alaskan individuals and families whose income is less than 125% of the median adjusted gross income figure for each family size. As long as a resident is enrolled in the Health Plan or a plan with comparable or better benefits for which no cost sharing is available from an employer or another source, the resident would be eligible for cost sharing under the program. The cost sharing program would also be an incentive to carriers who currently offer nonsubsidized policies with less than comparable benefits to upgrade their policies so that they will be competitive with the Health Plan.

The Department of Administration will report back to the legislature at the beginning of next session on various aspects of the Health Plan and the cost sharing program. After the legislature approves the Department's plans, the Department will engage in extensive advertising of the Health Plan and the cost sharing program, and coverage and cost sharing will commence on July 1, 1982. The advertising is necessary to ensure that as many people as possible know of the Health Plan and the cost sharing program so that they can enroll immediately in July if they wish to.

It is important to recognize the distinction between the Health Plan and the cost sharing program. Although cost sharing under the program is available to all enrolled in the Health Plan who meet the income and other requirements of the program, cost sharing is also available to residents enrolled in individual private plans that are certified as equivalent to the Health Plan. Cost sharing is not available to those enrolled in another form of subsidized health care plan, such as an employer or union sponsored plan, or a federal health program. Thus, the Health Plan offers coverage to anyone and especially to those who are currently without it, and the cost sharing program helps the Health Plan's participants and others defray the costs of health care financing.

The cost sharing program is based on incomes of family units; it helps single individuals and families with incomes less than 125% of median income figures. The subsidy schedule distinguishes between premium cost sharing and out-of-pocket cost sharing. Cost sharing for premium payments is available to all those with income less than 125% of the median income

because a family will automatically incur this cost in order to have insurance without ever getting sick. However, cost sharing for out-of-pocket expenses-----which represent the state's share of the consumer's costs when actually seeking health care-----is only available for those who could not afford to meet such expenses without the state's help. The philosophy behind the cost sharing distinction is that the consumer should be encouraged to seek health care only when necessary, and that the best incentive to achieve this policy objective is to insure that the consumer who can afford it, pays for the bulk of his health care expenses.

Eligibility and determination of the level of cost sharing will be performed by the Department in accordance with statute. An individual wishing to join the Health Plan would present proof of eligibility and proof of his level of cost sharing authorized under the cost sharing program to the insurance carrier, who would enroll the resident in the Health Plan. Every participant then, regardless of their income and subsidy levels, would sign up for the Health Plan in the same manner. They would also present their insurance card or other proof of insurance to a provider of care just as any other insured person would do. Claims payment would also be similar to other health insurance policies. Depending on the provider's usual arrangement, the individual would either pay his share of the bill directly to the provider or be billed for his share by the carrier. This would also be the arrangement for those enrolled in the cost sharing program and not in the Health Plan, when provider visits are necessary.

Provider reimbursement under the Health Plan would be the responsibility of the carrier. The carrier would make reimbursement payments directly to a provider and there would be no need for the state to serve as an intermediary in the performance of this function although some monitoring of the carrier's claims payment procedures would be necessary. The state would establish a running account from which the carrier could make claims payments. Claims data and other fiscal information would be compiled by the carrier and be available for the Department's use. The Department would have to keep records on participant's eligibility and subsidy status and perform certain other administrative functions. However, the private carrier will perform the bulk of administrative tasks in the form of claims payment.

Sponsors' Suggested Amendments to SS HB 41

page 1:

line 20--- "amount of copayments and deductibles for each enrolled resident and the resident's covered dependents for"

page 2:

line 7---"plan or covered under a [state or] federal health program and"

page 7:

line 1---"hospital or dental service contracts that provide one or more of the medical"

line 12---"Sec. 47.05.080. CONTRACTS WITH [DIRECT PROVIDERS OF CARE AND SERVICE.] FISCAL INTERMEDIARIES."

page 9:

line 2---"participation, not including residents eligible under the medically needy option, are eligible for medical assistance."

line 7---" [Services] Security Act."

line 8---new section 12 to read as follows: " * Sec. 12. AS 42.07.080 is amended by adding a new subsection (5) to read as follows:
(5) "medically needy" means a person who meets the categorical requirements of eligibility for medical assistance, but whose income exceeds the income standard for categorical assistance and is less than the medically needy income standard." Renumber remaining sections appropriately.

line 10---"* Sec. 14. Sections 5-8 [and 10-12] of this Act take effect January 1,"

line 13---"* Sec. 16. Sections 2, and 3, and 10-12 of this Act take effect immediately in"

CSSSHB 41 (HESS): How it would effect Medicaid in Alaska

To get federal funding for Medicaid services, a state must offer certain mandatory services to certain mandatory groups of eligibles. In addition, it can choose to offer other optional services to other optional groups of eligibles.

Alaska currently offers all mandatory services to all mandatory groups of eligibles. In addition, it offers some optional services to some optional groups of eligibles. CSSSHB 41 (HESS) would require the state to offer all services, mandatory and optional, to all groups of eligibles, mandatory and optional, for which federal funding is available on March 1, 1981, except for those considered "medically needy". The bill does not require the state to pick up the medically needy option because these individuals would be covered under the Plan established in section 1 of the bill; anyone with an income less than 150% of the poverty guideline would receive 100% state subsidy for the cost of the Plan.

This summary describes which services and eligibles are currently provided for in Alaska and which would be added if CSSSHB 41 (HESS) is enacted.

The question of how much will be cut from the federal budget allocation to Alaska for Medicaid is not an easy one to answer. We will not know for sure until Congress acts, since several different ideas are currently being considered. Staff has more information on the different proposals if members are interested.

(LC, using H&SS Medicaid coverage information: 4/2/81)

MEDICAID ELIGIBLES*

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent of AFDC child or other specified relative

Child between 18 and 21 who is a dependent of an AFDC household

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

All children in foster homes or private child-caring institutions

Eligibles added by SS HB 41

Child deprived of support of parent due to unemployment

Spouse of disabled parent

Spouse of unemployed parent

Pregnant woman and unborn child

All other financially eligible children

Caretaker relative of child over 18 but under 21 and not a dependent in an AFDC household

Individuals who would be eligible for AFDC except for child care costs

* In addition to these categorical criteria, a person must also be financially needy

MEDICAID SERVICES

Currently Covered Services

Hospital---inpatient and outpatient
Skilled nursing facility (SNF)
Intermediate Care Facility (ICF)
ICF for mentally retarded persons
and persons with related conditions (ICF/MR)
Laboratory and x-ray services
Physician services
Visual care services, dispensing and
ophthalmic materials
Medical transportation
Speech, hearing, and language services
Psychiatric facility services
Home health care services
Early periodic screening, diagnosis,
and treatment of individuals under 21 (EPSDT)
a. dental services
b. prosthetic devices and medical supplies
c. physical therapy
Community mental health clinics
Family planning services
Patient surgical care centers
Rural health clinics

Services Added by SS HB 41

Podiatrist services
Chiropractic services
Private duty nursing
Personal care services
*Physical therapy
*Occupational therapy
*Prescribed drugs
Adult dentures and routine dental services
*Adult emergency dental services
*Prosthetic devices and medical supplies
Other diagnostic, screening, preventive & rehab. service
Services to those over 65 in mental institutions
Services to those over 65 in tuberculosis institutions
Other practitioner services
a. private psychologist
b. nurse practitioner
c. physician assistant
Clinic services---other than comm. mental health clinic
Services by Christian Science nurses
Services by Christian Science sanatoria

* Currently available through General Relief Medical

**Health, Education and
Social Services Committee**

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta



Official Business

Alaska State Legislature
Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4908

MEMORANDUM

TO: Charlie Parr
FROM: Rocky Plotnick Weller *Rocky*
DATE: April 30, 1981
RE: The Alaska Comprehensive Health Care Financing Study

You have asked for the current status of the Alaska Comprehensive Health Care Financing Study. I have outlined the study's purpose and schedule below:

- I. The study's purpose is to explore health care financing in Alaska, explore alternative means of expanding health care coverage, and improve physical and financial access to health care services.
- II. Phase I of the study was completed by Battelle on March 30, 1981. It describes the present methods of public and private health care delivery, access, coverage and financing in Alaska. Also, it presents alternative approaches to reshape health care coverage and financing, and to a lesser extent, delivery and access.
- III. The Advisory Committee will meet May 7, 1981 to consider the alternative approaches addressed in Phase I and decide which approaches Battelle should develop.
- IV. Phase II will provide a complete plan for implementing and financing each of the alternative approaches selected. The deadline for the

draft is September, 1981. .

- V. The final document should be completed and submitted to the Department of Health & Social Services, the Governor and the Legislature by December 11, 1981.

AMENDMENT TO CS SS HB 41 (HESS)

Offered by Rep. Buchholdt

Page 2, lines 8-18: Delete sec. 18.27.020(b). Change section numbers and references to sections accordingly.

Page 4, line 28: Add a new section 5, and renumber remaining sections accordingly.

* Sec. 5. JOINT INTERIM COMMITTEE ESTABLISHED. (a) There is established a Joint Interim Committee on Indian Health Service and Medicare of the Twelfth Legislature, composed as follows:

(1) one member of the finance committee of the senate appointed by the chairmen of the finance committee of the senate;

(2) one member of the finance committee of the house appointed by the chairman of the finance committee of the house;

(3) the director of the Division of Retirement and Benefits, Department of Administration, or his representative;

(4) the coordinator of the Division of Adult and Aging Services, Department of Health and Social Services, or his representative;

(5) the area director of Indian Health Service in Alaska, or his representative;

(6) one representative of the Alaska insurance industry;

(7) the executive director of one of the native health corporations, or his representative;

(8) the president of the Alaska Federation of Natives, or his representative; and

(9) the director of the Older Persons Action Group, or his representative.

(b) The committee established under (a) of this section shall by the 30th day of the Second Session of the Twelfth State Legislature

(1) determine and report to the legislature how the Indian Health Service delivery system can be improved;

(2) determine and report to the legislature what role the state should play to complement federal funding of the Indian Health Service;

(3) determine and report to the legislature what role the state should play to complement services available to Alaska's senior citizens under Medicare; and

(4) obtain the assistance of a private attorney skilled in health care financing law, for the purposes of (1) - (3) of this section.

Fiscal note for amendment offered by Rep. Buchholdt

Personal Services (Direct staff support: one a.a., one sec.)	\$ 25,000

Travel (Transportation, per diem for public hearings and other committee business)	\$ 50,000

Contractual (Professional staff: lawyer, health care consultant, computer time-- \$75,000; office space, telephone and equipment rental, supplies-- \$10,000)	\$ 85,000

TOTAL	\$ 160,000

(LC: 4/1/81)



Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

March 6, 1981

TO: Rep. Jack Fuller, Chair
Members of the Bush Caucus

FROM: Rep. Thelma Buchholdt

SUBJECT: SS HB 41 and Indian Health Service

Bill Summary

SS HB 41 does the following: (1) provides for a health plan that any resident can join; (2) provides for cost sharing from the state for those enrolled in the plan (or a comparable plan that has the same or better benefits) who do not presently have a subsidized health care financing plan or policy; (3) provides for alcohol and drug dependency treatment coverage for state employees; (4) attempts to resolve problems associated with Medicaid reimbursement; and (5) expands Medicaid coverage to the maximum extent allowed under federal law. The bill will ensure that all residents have some level of health care. The health plan and cost sharing program will be most attractive to those who do not have care now, i.e. seasonal workers such as fishermen, construction workers, cannery workers, legislative employees and the like; high risk uninsurables; and those who are presently covered by an expensive individual private plan. The bill also improves health care coverage for the Alaskan poor by expanding Medicaid and by allowing free coverage under the health plan for all residents with income less than 150% of the poverty guideline who meet the criteria of the cost sharing program. Further, it provides alcoholism and drug dependency coverage to a stable group of the insured, so that the costs of such coverage can be determined, with the intent of providing such coverage for all Alaskans eventually. Finally, it attempts to clear up the problems caused by the Medicaid bureaucracy so that doctors and hospitals will not refuse to provide care to Medicaid recipients. The bill does not attempt to solve all the problems related to health care financing in Alaska. Rather, it provides some solutions that are workable and carefully constructed, to insure that everyone has at least some level of coverage provided to them, in legislation that both the legislature and the Governor can accept.

Indian Health Service (IHS)

One issue that the bill does not address is the level and quality of services provided by IHS. The reason this issue is left out is not

because I do not feel that it needs to be addressed, but rather because I feel that it is a very complex, serious problem that needs a great deal of study before any action can be taken. Briefly stated, there are two major areas of concern with IHS: (1) not all services are available everywhere in the state, and (2) quality of care is not as good as it should be in many IHS facilities. Regarding the first issue, though this is certainly true, it is also true that every facility, according to Jerry Ivey and James Ambrust, provides major medical, out patient and emergency dental services. As regards the second issue, according to the personal experiences that I have heard about on many occasions, it is also true. However, SS HB 41 is not the vehicle to attack these problems. It has been suggested that some form of secondary or primary coverage for IHS recipients be included in the bill. I think the first suggestion is misleading and the second suggestion is not well thought out and does not take into account the serious ramifications involved.

Secondary Coverage

The secondary coverage "solution" is political double talk. As mentioned earlier, every IHS facility provides major medical, out patient and emergency dental services. The health plan called for in my bill will cover such services. However, I do not know what other services it will cover. It will certainly not be the "cadillac" health insurance that state employees currently enjoy because the health and employment profile of the residents that are likely to enroll would preclude totally comprehensive care because of the enormous cost of such a program for such people. It will not be a truly comprehensive health plan and there will be many types of health care services that it will not cover. Moreover, the three types of services (which are the crucial services that must be offered to ordinarily healthy individuals) that will definitely be provided are the same as those provided by IHS; and an IHS recipient would have to utilize IHS facilities and doctors for those services because IHS would be their primary source of health care and the health plan would only be their secondary source of health care. Thus, secondary coverage is, for IHS recipients, in reality, a myth. It will not benefit the average IHS recipient with a medical problem because he will still be bound to an IHS facility, an IHS doctor, and other IHS services for the health care that really counts, and the health care that is most likely to be needed. Secondary coverage is likely not to provide more benefits to IHS recipients than are currently available even when one recognizes the variability of services provided in different parts of the state, and will definitely not address the issue of quality of care of IHS services.

Primary Coverage

The primary coverage issue is one that we simply do not know enough about at this point in time. If we allow IHS recipients to choose between the plan and IHS, we are inviting--in fact, encouraging the federal government to renege upon its responsibility to provide health care to Native Alaskans. (One could also argue that secondary coverage is this type of encouragement as well.) Is this what we want? Do we want to "take over IHS"? Are we prepared to take over a federal program of this magnitude? I don't think that this solution gets at the real

issues that plague IHS or provides a viable solution to the problem.

It won't be long before the people figure out the myth of secondary coverage or the large and very expensive state bureaucracy that will be needed to run a state-controlled IHS. We need to look at the problems of IHS much more carefully, talk with those who are familiar with health care coverage in the bush, and then decide what the state's role should be in the provision of IHS services. It could be that there's a need to create an interim committee that would look into this issue and report back to the next session on solutions to the problem. In sum, SS HB 41 is not the proper mechanism to clean up IHS. We don't have enough information to know what the proper solution is, but we can obtain that information. We should think before acting, instead of reacting.

FY 82 FISCAL SUMMARY FOR SSHB 41 (with amendments)

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>	<u>Effective Date</u>
<u>Department of Health and Social Services</u>					
(1) Addition of Medicaid Services and New Optional Categorical Groups	18,413.4	11,631.8	6781.6	12	July 1, 1981
(2) Decrease in GRM due to Transfer of Services and Eligibles to Medicaid	(4,619.1)	-	(4619.1)	-	July 1, 1981
(3) Decrease of GRM due to Transfer of Eligibles to Comprehensive Plan	0	-	0	0	July 1, 1982
(4) Interest Payments	667.2	-	667.2	-	
<u>Department of Commerce and Economic Development</u>					
(5) Certification of Insurance Policies as Comparable to Health Plan	38.1	-	38.1	1	July 1, 1982
<u>Department of Administration</u>					
(6) Alcoholism Benefits <i>half year</i>	180.0	-	180.0	-	Jan 1, 1982
(7) Administrative Costs for Studying and Implementing the Comprehensive Plan	1,023.4	-	1023.4	12	immediate
(8) Benefit Costs under Cost Sharing Program	0	-	0	-	July 1, 1982
TOTAL	15,703.0	11,631.8	4071.2	25	

(2/27/81 SH)

→ high est. of enrollees

MEMORANDUM

State of Alaska

TO: Robert G. Ogden
Chief of Medical Assistance
Division of Public Assistance

DATE: 20 January 1981

FILE NO:

TELEPHONE NO:

FROM: David M. Davidson *3347*
Medical Assistance Program Officer
Division of Public Assistance

SUBJECT: Briefing Memo on
HB 41--Comprehensive
Health Plan and
Medicaid Amendments

House Bill 41 is composed of three major parts. A state comprehensive health plan would be created providing for state premium supplement, group insurance plans would be required to include coverage for alcoholism and drug dependence, and changes would be made to the Medicaid and General Relief Medical (GRM) programs by adding new services and beneficiaries. This briefing memo discusses the bill (except for the alcohol and drug provisions), what would be the effect of the proposed changes to existing programs, and proposes some alternatives to the bill that might be considered.

Before discussing sections of the bill, some consideration should be given to recommending that the bill be split into two separate bills. The portions dealing with a comprehensive health plan and alcoholism and drug dependency coverage would add new programs for the general population; the Medicaid and GRM amendments would add benefits to existing welfare programs. It would appear that there may be a conflict in purpose between these two interests that would warrant dividing HB 41 into two separate bills.

Section 1. Beginning with line 4 on page 2, the section discusses the cost sharing and income standards using 80% state payment as the base level of participation. It is not clear whether the reference to \$1000 per month adjusted gross income refers to an individual or a family. Federal figures indicate that the median income for a family of four in Alaska is slightly higher than \$31,000 per year. Thus, if the \$1000 per month adjusted gross income is for a family, it would result in lower middle income families being excluded from participation in the program.

There is a question regarding the relationship between the comprehensive health plan and the catastrophic illness program. The comprehensive health plan in this bill requires some cost sharing. If the scope of catastrophic illness program is expanded by the Governor, and the cost-sharing requirements greatly reduced or eliminated, what incentive is there for anyone to participate in a comprehensive health program where they will have to pay some or all of the cost of their care, versus a catastrophic illness program with little or no cost sharing.

A. Mandatory categorically needy groups. Without discussing all the variety of minor limitations and requirements, the following is a list of the mandatory categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals with income and resources low enough to be eligible for cash assistance under the AFDC program; that is, households with dependent children under the age of 18 deprived of parental support because of the absence or incapacity of one or more parents.
2. Individuals with income and resources low enough to be eligible for a cash assistance payment under the federal SSI program; individuals must be aged (age 65 or older), blind, or disabled.
3. Individuals under age 21 not eligible for AFDC simply because they are age 18 or older; these are individuals still dependent on their families for financial support.

B. Optional categorically needy groups. Without discussing minor limitations and requirements, the following is a list of the optional categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals eligible for cash assistance but not receiving cash payments for whatever reason.
2. Individuals eligible for cash assistance except that they are in an institution and no cash payment is being made.
3. Individuals under age 21 with income and resources low enough to be eligible for AFDC but do not qualify as dependent children; limited to individuals in the protective custody of DHSS, individuals in inpatient psychiatric facilities, and individuals in intermediate care facilities for the mentally retarded (ICF/MR).
4. Individuals who are aged, blind, or disabled, whose income exceeds the SSI limits, but are receiving an optional state supplement payment under the Adult Public Assistance (APA) program.
5. Individuals in institutions who meet the income, resource, and categorical requirements for the AFDC, SSI, or APA programs, but are in institutions (hospitals or long term care facilities); eligibility is limited to those individuals whose income does not exceed three times (300% of) the income standard for a single individual under the SSI program.

2. Individuals who meet the medically needy income and resource criteria and meet all other eligibility criteria for the aged, blind, or disabled for the following groups: A.2. and B.4.

The addition of these groups would increase Medicaid participation, but would also decrease the number of GRM cases. Presently state funds are used to provide GRM coverage for services provided to some individuals who could be covered under an expanded Medicaid program, thus causing Alaska to lose the 50% federal funds that are available for those services. Medically needy coverage would provide 50% federal funding for services provided to individuals who are either not receiving the services presently or are receiving the services but are having difficulty paying for them. These individuals could be covered under the comprehensive health plan (as could all individuals presently eligible for Medicaid) but Alaska would not receive federal funding for coverage under the comprehensive health plan if the premium costs exceed the cost of providing services if Alaska continued to pay the claims directly.

There are some distinct disadvantages to individuals who might be included under the optional medically needy coverage if it was added to Medicaid, and if the comprehensive health plan becomes law. Under medically needy, an individual having income above the eligibility limit may still be eligible for Medicaid coverage for a portion of their medical expenses. However, the individual would be required to pay for all medical expenses incurred until the amount of their expenses equaled the difference between their income and the medically needy income standard. Medicaid would then pay for the remaining costs. As an example, if an individual had income of \$750 per month and the medically needy income standard was \$500 per month, the individual would have to incur \$250 in medical expenses before they would be eligible for Medicaid coverage for any remaining expenses. Therefore, the comprehensive health plan, with an expanded sliding scale would be a more equitable method of providing coverage for individuals in moderately low income brackets under a revised version of the bill.

Section 8. This section would require DHSS to provide Medicaid coverage for all categories of service permitted under federal law rather than be limited to those services listed in the present statute. This change would add some new areas of coverage not presently paid for by DHSS. It would also allow DHSS to claim 50% federal funds for certain services that are presently provided for Medicaid beneficiaries in Alaska using 100% state funds. Listed below are those broad categories of service that are funded by Medicaid, those that are funded for Medicaid beneficiaries using state funds which would be converted to Medicaid coverage under this bill, and those services that would be new areas of coverage under Medicaid.

B. State-funded services for Medicaid beneficiaries. The following are categories of service that are presently covered using 100% state funds for Medicaid beneficiaries in Alaska and would become Medicaid reimbursed services eligible for 50% federal funds under this bill:

1. dental care--limited to emergency treatment for relief of pain and acute infection (for individuals 21 and over),
2. family planning services,
3. pharmaceuticals and over-the-counter drugs,
4. physical and occupational therapy,
5. prosthetic devices and medical supplies.

C. New Medicaid coverage. The following categories of service are not covered by the present Medicaid program in Alaska but would be added by this bill:

1. clinic services--not limited to community mental health clinics, but covering native health service clinics (100% federal funding), well-child clinics, and other types of health care clinics,
2. dental services--not limited to relief of pain and acute infection, but providing routine dental care including dentures, bridges, examinations, and cleaning,
3. private duty nursing--nursing care in the home for individuals who would otherwise have to remain in a hospital,
4. other diagnostic, screening, preventive, and rehabilitative services--immunizations, adult preventive health programs, adult day care, and other services not covered elsewhere,
5. podiatrists' services,
6. chiropractors' services,
7. personal care services--similar to homemaker services,
8. other practitioners--including private psychologists, nurse practitioners, nurse midwives, and physicians' assistants,
9. other miscellaneous coverages--services for individuals age 65 and over in tuberculosis institutions, services by Christian Science nurses, and Christian Science sanatoria.

MEMORANDUM

State of Alaska

TO: Robert G. Ogden
Chief of Medical Assistance
Division of Public Assistance

DATE: 20 January 1981

FILE NO:

TELEPHONE NO:

FROM: David M. Davidson *DM* 3347
Medical Assistance Program Officer
Division of Public Assistance

SUBJECT: Briefing Memo on
HB 41--Comprehensive
Health Plan and
Medicaid Amendments

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Before discussing sections of the bill, some consideration should be given to recommending that the bill be split into two separate bills. The portions dealing with a comprehensive health plan and alcoholism and drug dependency coverage would add new programs for the general population; the Medicaid and GRM amendments would add benefits to existing welfare programs. It would appear that there may be a conflict in purpose between these two interests that would warrant dividing HB 41 into two separate bills.

Section 1. Beginning with line 4 on page 2, the section discusses the cost sharing and income standards using 80% state payment as the base level of participation. It is not clear whether the reference to \$1000 per month adjusted gross income refers to an individual or a family. Federal figures indicate that the median income for a family of four in Alaska is slightly higher than \$31,000 per year. Thus, if the \$1000 per month adjusted gross income is for a family, it would result in lower middle income families being excluded from participation in the program.

There is a question regarding the relationship between the comprehensive health plan and the catastrophic illness program. The comprehensive health plan in this bill requires some cost sharing. If the scope of catastrophic illness program is expanded by the Governor, and the cost-sharing requirements greatly reduced or eliminated, what incentive is there for anyone to participate in a comprehensive health program where they will have to pay some or all of the cost of their care, versus a catastrophic illness program with little or no cost sharing.

Some consideration might be given to eliminating Section 9 of the bill, which proposes to create a medically needy program under the state-funded GRM program. Rather than creating a new welfare program, why not change the income criteria under Section 1 so that individuals with income below \$1000 per month (or some other more precisely determined amount) would be able to participate in the comprehensive health plan with the State paying a greater portion of the premium costs up to 100%. This would avoid adding more work to already busy welfare offices. In fact, consideration should be given to eliminating much of the GRM program by transferring the bulk of the GRM caseload to the comprehensive health plan.

There are four types of cases that receive coverage under GRM: a) family units where both parents are in the home and able to work, b) low-income single individuals or childless couples, c) individuals not eligible for Medicaid who suffer some major accident or injury, and d) disabled or elderly individuals needing expensive long term care with income or resources that exceed the standard of the Medicaid program. Other sections of the bill, discussed below, could deal with health insurance coverage for people in category a). The Governor's proposed expansion of the catastrophic illness program, and the proposed amendments to this bill, would take care of categories c) and d). The remaining persons fall into category b) and could be included in a revised version of Section 1 that would include a state share extending up to 100% based on income.

The revision mentioned above regarding to individuals in category c) could be added to the bill in the form of intent that the comprehensive health plan have some limit of liability at a fairly low amount, with medical expenses over that amount being the responsibility of the catastrophic illness program. By setting the liability limit at a low level under the comprehensive health plan, premium amounts are reduced, keeping down the cost of participation and placing all catastrophic coverage in a single program.

Section 7. As written, this section would require DISS to provide Medicaid eligibility to all optional groups, not just those that have been added piecemeal to the statute. Medicaid eligibility is broken down into two types: categorically needy and medically needy. Alaska presently has only categorically needy coverage for some but not all groups. Categorically needy includes those individuals whose eligibility is based on their income being below a limit based on cash payments made under the AFDC, APA, and SSI programs.

A. Mandatory categorically needy groups. Without discussing all the variety of minor limitations and requirements, the following is a list of the mandatory categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals with income and resources low enough to be eligible for cash assistance under the AFDC program; that is, households with dependent children under the age of 18 deprived of parental support because of the absence or incapacity of one or more parents.
2. Individuals with income and resources low enough to be eligible for cash assistance payment under the federal SSI program; individuals must be aged (age 65 or older), blind, or disabled.
3. Individuals under age 21 not eligible for AFDC simply because they are age 18 or older; these are individuals still dependent on their families for financial support.

B. Optional categorically needy groups. Without discussing minor limitations and requirements, the following is a list of the optional categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals eligible for cash assistance but not receiving cash payments for whatever reason.
2. Individuals eligible for cash assistance except that they are in an institution and no cash payment is being made.
3. Individuals under age 21 with income and resources low enough to be eligible for AFDC but do not qualify as dependent children; limited to individuals in the protective custody of DHSS, individuals in inpatient psychiatric facilities, and individuals in intermediate care facilities for the mentally retarded (ICF/MR).
4. Individuals who are aged, blind, or disabled, whose income exceeds the SSI limits, but are receiving an optional state supplement payment under the Adult Public Assistance (APA) program.
5. Individuals in institutions who meet the income, resource, and categorical requirements for the AFDC, SSI, or APA programs, but are in institutions (hospitals or long term care facilities); eligibility is limited to those individuals whose income does not exceed three times (300% of) the income standard for a single individual under the SSI program.

C. New optional categorically needy groups. The following are optional categorically needy groups not covered under the present Alaska Medicaid program that would be added by this bill:

1. Individuals under age 21 with income and resources low enough to be eligible for AFDC but do not qualify as dependent children, and are not in the custody of DHSS, not in an inpatient psychiatric facility, and not in an ICF/MR.
2. Expectant mothers with income and resources low enough be eligible for AFDC but do not qualify because they do not have any dependent children yet.
3. Individuals in households with income and resources low enough to be eligible for AFDC but do not qualify because the Alaska AFDC program does not provide cash assistance to families where both parents are in the household and able to work; this group overlaps to a certain extent with that in C.1. because it is possible under C.1. to cover children in these households without covering the parents medical needs.
4. Caretaker relatives with income and resources low enough to be eligible for AFDC if the children for whom they are caring were their own children; caretaker relatives (aunts, uncles, grandparents, sisters, and brothers) are not parents and therefore do not meet the categorical requirements for AFDC coverage even though they receive AFDC payments on behalf of the children.
5. Individuals with income and resources low enough to be eligible for AFDC except that they receive free work-related child care and therefore lack an allowable expense that would permit them to remain eligible for Medicaid.

D. New optional medically needy groups. In addition to the categorically needy optional groups, the optional medically needy groups listed below would be covered under this bill. Medically needy income and resource limits may be set by the state, but the income limit may not exceed 133% of the AFDC income standard for a comparable family. Under medically needy, individuals are permitted to deduct actual and accrued medical expenses to reduce their countable income to the 133% limit. At that point, Medicaid would provide coverage for all eligible services at Medicaid reimbursement rates. The following are the optional medically needy groups that would be added to the Medicaid program:

1. Individuals who meet the medically needy income and resource criteria and who meet all other eligibility criteria for families and children from the following groups: A.1., A.3., and C.1. to C.4.

2. Individuals who meet the medically needy income and resource criteria and meet all other eligibility criteria for the aged, blind, or disabled for the following groups: A.2. and B.4.

The addition of these groups would increase Medicaid participation, but would also decrease the number of GRM cases. Presently state funds are used to provide GRM coverage for services provided to some individuals who could be covered under an expanded Medicaid program, thus causing Alaska to lose the 50% federal funds that are available for those services. Medically needy coverage would provide 50% federal funding for services provided to individuals who are either not receiving the services presently or are receiving the services but are having difficulty paying for them. These individuals could be covered under the comprehensive health plan (as could all individuals presently eligible for Medicaid) but Alaska would not receive federal funding for coverage under the comprehensive health plan if the premium costs exceed the cost of providing services if Alaska continued to pay the claims directly.

There are some distinct disadvantages to individuals who might be included under the optional medically needy coverage if it was added to Medicaid, and if the comprehensive health plan becomes law. Under medically needy, an individual having income above the eligibility limit may still be eligible for Medicaid coverage for a portion of their medical expenses. However, the individual would be required to pay for all medical expenses incurred until the amount of their expenses equaled the difference between their income and the medically needy income standard. Medicaid would then pay for the remaining costs. As an example, if an individual had income of \$750 per month and the medically needy income standard was \$500 per month, the individual would have to incur \$250 in medical expenses before they would be eligible for Medicaid coverage for any remaining expenses. Therefore, the comprehensive health plan, with an expanded sliding scale would be a more equitable method of providing coverage for individuals in moderately low income brackets under a revised version of the bill.

Section 8. This section would require DHSS to provide Medicaid coverage for all categories of service permitted under federal law rather than be limited to those services listed in the present statute. This change would add some new areas of coverage not presently paid for by DHSS. It would also allow DHSS to claim 50% federal funds for certain services that are presently provided for Medicaid beneficiaries in Alaska using 100% state funds. Listed below are those broad categories of service that are funded by Medicaid, those that are funded for Medicaid beneficiaries using state funds which would be converted to Medicaid coverage under this bill, and those services that would be new areas of coverage under Medicaid.

A. Existing Medicaid coverage. The following are categories of service that are presently covered using 50% federal funds for Medicaid beneficiaries in Alaska:

1. hospital--inpatient and outpatient,
2. skilled nursing facility (SNF),
3. intermediate care facility (ICF),
4. intermediate care facility for the mentally retarded and persons with related conditions (ICF/MR),
5. laboratory and X-ray services,
6. physician services,
7. visual care services, dispensing, and ophthalmic materials,
8. medical transportation,
9. speech, hearing, and language services,
10. psychiatric facility services,
11. home health care services,
12. early periodic screening, diagnosis, and treatment of individuals under 21 (EPSDT), which includes the following services limited to persons eligible under this category:
 - a. dental services,
 - b. prosthetic devices and medical supplies,
 - c. physical therapy,
13. clinic services--limited to community mental health clinics and state-operated mental health clinics,
14. family planning services,
15. outpatient surgical care centers,
16. rural health clinics.

B. State-funded services for Medicaid beneficiaries. The following are categories of service that are presently covered using 100% state funds for Medicaid beneficiaries in Alaska and would become Medicaid reimbursed services eligible for 50% federal funding under this bill:

1. dental care--limited to emergency treatment for relief of pain and acute infection (for individuals 21 and over),
2. family planning services,
3. pharmaceuticals and over-the-counter drugs,
4. physical and occupational therapy,
5. prosthetic devices and medical supplies.

C. New Medicaid coverage. The following categories of service are not covered by the present Medicaid program in Alaska but would be added by this bill:

1. clinic services--not limited to community mental health clinics, but covering native health service clinics (100% federal funding), well-child clinics, and other types of health care clinics,
2. dental services--not limited to relief of pain and acute infection, but providing routine dental care including dentures, bridges, examinations, and cleaning,
3. private duty nursing--nursing care in the home for individuals who would otherwise have to remain in a hospital,
4. other diagnostic, screening, preventive, and rehabilitative services--immunizations, adult preventive health programs, adult day care, and other services not covered elsewhere,
5. podiatrists' services,
6. chiropractors' services,
7. personal care services--similar to homemaker services,
8. other practitioners--including private psychologists, nurse practitioners, nurse midwives, and physicians' assistants,
9. other miscellaneous coverages--services for individuals age 65 and over in tuberculosis institutions, services by Christian Science nurses, and Christian Science sanatoria.

It should be emphasized that while a broad category of service permits DPA to make payments to certain types of health care providers, DPA has the responsibility to establish the conditions under which payment will be made. Physical and occupational therapy are categories of service that are covered presently, but the scope of services are limited, the number of visits are limited without special justification, and the services must be requested by a physician. Similar controls would be imposed by DPA on any new categories of service so that payment would be made only for medically-appropriate treatment. Several new categories of service would be infrequently used while others, such as private psychologists, nurse practitioners, chiropractors, and podiatrists, are often requested. While unlimited coverage of the services of these providers would certainly be inappropriate, they do fit within the overall scope of health care that should be provided. There is little question that the adult dental services presently provided are totally inadequate.

Section 9. As discussed under Section 1., this section could be deleted and the coverage incorporated in the comprehensive health plan. In its place would be legislation to delete the GRM program. Some GRM funds would be transferred to Medicaid to partially fund the new services to be added by Section 8., some GRM funds would be retained for the catastrophic illness program, and the remaining GRM funds would be transferred to the comprehensive health plan.

Summary. Under a revised version of HB 41, the following would occur:

1. Medicaid would be expanded to include the optional categorically needy groups not already covered; it would be expanded to permit the remaining optional service categories to be covered with the conditions of participation and limits of coverage to be defined by DPA in regulations; medically needy would not be added.
2. The GRM program would be eliminated.
3. The catastrophic illness program would be expanded to provide greater coverage, including payment for services that have largely been excluded in the past, such as long term care; coverage would be available as a supplement to the comprehensive health plan; the deductible amount and income criteria would be changed to conform to coverage under the comprehensive health plan.
4. A comprehensive health plan would be created. Eligibility would be open to all individuals of the state meeting the income and resource criteria established for the program. Individuals having full-service health care coverage (such as Alaska Native Health Service or the military)

would receive coverage for those services not covered under the full-service program. Individuals with other health insurance coverage would be entitled to participate, but the comprehensive health plan would be a last-pay program. As an example of how state participation would be determined, individuals having income below a certain level, say 150% of the poverty guidelines, would be entitled to 100% state funding of the premium costs and 100% funding of all coinsurance and deductible amounts. Individuals with income above 150% of the poverty guidelines but below 200% of the poverty guidelines would be entitled to 100% funding of the premium costs but would be responsible for all coinsurance and deductible costs. Individuals with income over 200% of the poverty guidelines would be entitled to state payment of the premium costs on a decreasing scale with state participation becoming zero at 115% of the median income amount.

J. Sargnall



Battelle

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4000 N.E. 41st Street
P.O. Box C-5395
Seattle, Washington 98105
Telephone: (206) 525-3130
CABLE: HARCSEA

January 20, 1981

RECEIVED
JAN 23 1981

LT. GOV'S OFFICE

Dr. Frederick McGinnis
Deputy Commissioner
Department of Health
and Social Services
Mackay Bldg., Room 214
338 Denali Street
Anchorage, AK 99501

RE: First Monthly Progress Report on
Alaska Health Care Financing Project
Contract No. 064563
(Project No. P24187)

Dear Dr. McGinnis:

The first month of work on this project has been devoted to establishing contact with the Advisory Committee and defining the outlines of the first two reports, and to data collection and background discussions with a number of individuals knowledgeable about health care in Alaska.

We are proceeding to prepare the first two reports for this project according to the outline we presented at the Advisory Committee meeting on January 5. We have met with Andrew Dolan, the legal consultant for this project, and have begun to outline the nature of his contribution to the report on State Options for Action.

Data collection from the public sector has been proceeding on schedule. We have contacted a number of public sector officials in our data collection thus far, including representatives of the State Division of Insurance, Center for Health Statistics, Department of Public Assistance, Office of Management and Budget, and Department of Labor; the Federal Health Care Financing Administration (Medicare), Department of Defense, Indian Health Service, and Bureau of the Census; and the South Central Health Systems Agency. All have been cooperative, and collection of data from the public sector appears to pose no difficulties.

We have also begun data collection activities in the private sector: commercial insurers, Blue Cross/Blue Shield, and the Teamsters. As expected, this activity is more difficult and time consuming than data collection in the public sector. We are slightly behind our schedule for collecting these data, but this has not

impeded progress and we do not believe it will affect our ability to deliver the first two reports as scheduled.

I have put Mr. Fagnoli in touch with Charles Kuhnen of the Health Insurance Association of America, and they are in the process of identifying a representative of the commercial insurance sector for the Advisory Committee. It is important to identify such an individual promptly, since we believe that this will enhance the cooperation of the commercial insurance sector with our efforts.

Work during the next month will be devoted to further data collection and to drafting the first two reports. As we discussed at the January meeting, we will return to Anchorage on February 23 to give a progress report to the Advisory Committee and have a working session on the development of options for state action. We are planning on a one-day meeting, and hope that we can devote the bulk of it to a working session on the state's options.

This early Advisory Committee input on options is important since the range of issues to be dealt with is broad and time is tight. As examples of areas in which the state might intervene to improve the health care system, we could consider the following:

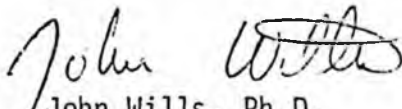
- 1) The state could act to broaden coverage. This might be through regulation which mandated that employers offer health plans to workers, through promotion of voluntary efforts via taxes and subsidies to employers or consumers, through regulation to "assign" high risk individuals to private insurance pools, or through direct state provision of a health insurance plan.
- 2) The state could act to promote minimum benefit packages in private insurance. This again could be through regulation or market incentives. In addition to minimum benefit packages, the state might use the same mechanisms to encourage other features in health insurance plans (such as cost sharing features or eligibility criteria).
- 3) The state could act to promote efficient behavior by providers. Examples of this would be the elimination of cost reimbursement in public programs in favor of other reimbursement methods or discouraging "usual, customary, and reasonable" pricing provisions in health insurance contracts. The attractiveness of these options depends upon how strongly the committee feels that cost containment is a key objective. The state might also attempt to influence where providers choose to practice by various subsidy schemes.

- 4) The state could act to promote healthy and efficient behavior by consumers. Examples of this would be to mandate or promote provisions in insurance contracts which encouraged preventive care, to reward consumers who can demonstrate healthy behavior with lower insurance premiums or subsidies, or to promote insurance features which reward the individual financially for staying healthy.

We hope to discuss these and other options at the February meeting. Indeed, it might be valuable to circulate this letter to the Advisory Committee in order to give an "advance preview" of that meeting.

The project is currently proceeding on schedule.

Sincerely,


John Wills, Ph.D.
Research Scientist

JW:kd

cc: Suresh Malhotra
Andrew Dolan
Jack Fagnoli
William Sanford

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES OFFICE OF THE COMMISSIONER

April 27, 1981

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

The Honorable Charles H. Parr
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

As the 1980 legislature envisioned, by an appropriation to the Department of Health and Social Services for a health care study project, the department proceeded immediately to implement the "Alaska Comprehensive Health Care and Financing Study." The Battelle Human Affairs Research Institute was the successful bidder and has proceeded on schedule to conduct the study.

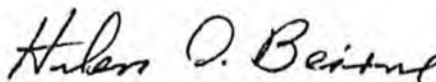
In December 1980, we furnished you with a then-current "Status Report" on developments to that date. By way of keeping you informed as to continuing progress on the study we are pleased to furnish you herewith: Interim Report No. 1: "A Survey of Health Care Resources and Financing in Alaska"; and Interim Report No. 2: "Options for State Action."

The Advisory Committee for the study (list enclosed) continues to meet regularly to confer with the Battelle scientists and departmental representatives. The Committee will meet next on May 7, 1981 to complete work on recommendations for two or three alternative approaches or options for Battelle to develop with all necessary details for consideration by the Department, the Governor, and the Legislature as to potential future state policies and programs in health care and financing.

The work of Battelle, the Department, and the Advisory Committee will continue throughout 1981. Certain additional data, not now available, will need to be secured and evaluated. The final study report is due in December of 1981.

The continued support and interest by the legislators are appreciated very much. Please let us know if we can furnish you any other information regarding this project between now and December when the final report will be completed. It is anticipated that recommendations for legislative considerations and actions will be available not later than the first month of 1982.

Sincerely,



Helen D. Beirne
Commissioner

BRIEFING PACKET

State of Alaska
Comprehensive Health Care Financing Study

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	11. Minutes: Jan. 5 Advisory Committee Meeting

(1)

State of Alaska
Comprehensive Health Care Financing Study

OVERVIEW

The Comprehensive Health Care Financing Study emerged in 1980 as part of this administration's emphasis on human resources in its long term investment strategy. The rationale was that, if an acceptable approach could be found, the state's currently favorable financial position might be used to establish a structure for providing increased health benefits to Alaskans well into the indefinite future. Accordingly, this study was initiated to explore, from a variety of viewpoints, a full range of broad and innovative approaches to the entire question of health care financing in Alaska. Now under way, the study also seeks to explore alternative means of expanding personal health care coverage, and improving both physical and financial access to health care services.

The first phase of the study will conclude on March 30, 1981, at which time policy makers will have their first look at the menu of possible health care financing approaches available. During the study's second phase, which will conclude on December 11, 1981, two or three overall approaches will be selected for detailed study, public review, and the work-up of alternative implementation plans.

Naturally, an undertaking on this scale cannot be accomplished overnight or without the participation of the public and numerous interested parties. The project's organization, therefore, has been designed to maximize the input available from all sectors. A thirteen-member advisory committee has been appointed for the project, representing the public and directly affected parties, and an outreach effort has been initiated to interface with other interested groups, individuals and the Legislature.

STATE OF ALASKA

WAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501STATUS REPORT: DECEMBER 18, 1980

ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY PROJECT

BACKGROUND

For about three years, discussions developed within the Department of Health and Social Services, the Office of the Governor, State Health Coordinating Council and other parties at interest in Alaska. In addition, several conferences were held with U.S. Department of Health, Education and Welfare in Seattle (Region X) and Washington, D.C. Discussions centered on health care and financing.

Several issues were faced in those consultations:

1. For a number of years, delays were encountered in active planning for an improved delivery and financing system for Alaska because of the prospect of the National Health Insurance program being enacted by the Federal Congress. While numerous discussion continues to go forward with regard to a National Health Insurance program, it continues to appear that the enactment of and the implementation of such a plan are receding farther and farther into the future.
2. The question developed as to whether Alaska should consider the possibility of a Model Health Delivery and Cost Distribution Plan geared to the needs of our state. If such a system could be developed and become operative sometime before any National Health Insurance program is in place, it could possibly serve as a prototype for the nation.
3. There were several reasons why Alaska should consider developing, as rapidly as good planning would permit, a Model Health and Cost Distribution Plan for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery and financing plans in place already, it would seem that Alaska could adjust its present program and add thereto if necessary in order to create a truly comprehensive and effective health delivery system. It will take bold, creative and extensive work to develop such a system for Alaska.

4. There are numerous parties at interest in such a proposed plan. In addition to the State of Alaska (executive and legislative branches), the Federal Department of Health, Education and Welfare and its several divisions have strong interests. The private physicians and hospitals of the state, which together become the strongest foundation stones of health delivery systems, would have substantial interests.

The Indian Health Service, the Alaska Native Health Corporations and the insurance industry serving Alaska have strong interests. Other important interests to be considered exist: the planning arm of our department, S.H.P.D.A., the Office of Planning and Research of the Governor's Office, local, regional health planning agencies and the State Health Coordinating Council. As plans develop, all such segments with interest in such a program will be involved in the planning, goal and objective setting, and implementation phases of any new program.

5. Apart from social and health policies concerned and apart from the different funding mechanisms and health providers, there is a national, as well as Alaskan, growing concern over the spiraling medical care costs.

A variety of studies has indicated that hospital charges and doctors' fees have been rising at higher rates throughout the nation than the Consumer Price Index has been accelerating.

6. Any new system planned should address (1) improved social policy, (2) improved health policy, (3) strong interest in prevention, (4) a more equitable access to health services, and (5) cost containment and cost effectiveness.

All of the above considerations, and others, initiated and continued certain discussions with regard to the prospects of the State of Alaska designing a new system and plan for the delivery and cost distribution of health services.

7. A careful analysis of a part of public spending for health in Alaska on the federal and state levels easily identifies approximately \$212,361,000 budgeted for FY-81 for health programs (excluding capital expenditures) through our Department and the Indian Health Service alone. Other expenditures related to military personnel (active and retired) would be on top of that and would be substantial. In addition, special federal grants to the Native health corporations and other organizations in Alaska

probably would bring the total into the \$225,000,000 annual range during FY-81. Those figures exclude also the health care coverage of State, federal and local government employees covered under health insurance programs. Such costs represent an outlay of public funds on behalf of those employees of government at all levels in Alaska. Excluded also are industry, business and private insurance programs. In 1977, at least \$24,822,000 in health care and accident insurance premiums were paid.

8. Considerable amount of research was deemed necessary before Alaska could develop a definitive statement as to the total actual expenditures for health program services in the state. Such research was planned so that facts could be developed as completely and as accurately as possible as to the status of spending at the present time. Current "health status" of Alaskans would need to be determined. Any proposal for a revised program of health delivery in the state should be based upon sound statistical and fiscal data and should be able to demonstrate an improvement over the present system. Any proposal for change would need to be acceptable to private medical care providers.

9. Alaska's Senator Ted Stevens, in 1979, surveyed certain attitudes of Alaskans with regard to national health assistance programs and published the following summary based on 15,000 participants:

"Question 10:

Health assistance is currently available through Medicare and Medicaid to the indigent and the elderly at a cost to the taxpayers of about \$46 billion annually. Proposals before Congress to expand national health assistance range from Senator Kennedy's proposed comprehensive national health insurance plan costing another \$40 billion, to a limited catastrophic health insurance plan to cover expenses of long term, high cost illnesses, at an additional cost of \$3.5 billion. Which of the following best summarizes your views on our national health assistance programs?

36.0% - Favor an additional limited health insurance program to cover catastrophic illness costs only.

23.2% - Favor a reduction in the current Medicare/Medicaid system.

19.5% - Favor a comprehensive national health insurance plan.

15.1% - Favor the current Medicare/Medicaid system.

5.8% - No opinion/other."

10. Alaska's total health care systems and financing plans, public and private, although not perfect have enormous strengths and generous provisions.

Fundamental and residual concerns include:

- (1) Continuing rise in health care costs
- (2) Effects of spiraling costs on all segments of society - consumers, employees, employers and government
- (3) Although voluntary efforts by health care industry to control costs have met with limited success expenditures will continue to increase until more adequate solutions are found
- (4) Since Congressional National Health Insurance proposals pending do not commend themselves as being beneficial for Alaska; a unique, bold and creative plan is called for to serve Alaskans in a better way than at present.

11. It is possible that one option resulting from the study could include replacement of stringent government regulatory controls with application of "free-market" oriented principles designed to:

- (1) Foster competition among alternative health care plans, including financing mechanisms;
- (2) Replace the government retroactive cost-plus reimbursement systems with fixed-premium financing that reflects competitive pricing in the market-place;
- (3) Provide consumer participation, cost-sharing and informed choice, and
- (4) Rechannel financial resources saved into improved access for medically needy citizens not now covered.

The Planning and Design Consultant will develop several alternative proposals for consideration.

PRELIMINARY CONSULTATIONS, BRIEFINGS AND DEVELOPMENTS

1. Preliminary consultations and briefings were developed with:

State of Alaska:

Department of Health and Social Services' officials,
Office of the Governor and Lieutenant Governor, State
Health Planning and Development Agency, State Health

Coordinating Council, Department of Commerce/
Risk Management, Governor's Office of Policy Planning
and Development

U.S. Department of Health, Education and Welfare:

Region X (Seattle):

Health Services Administration
Health Care Finance Administration
Regional Directors Office

Washington, D.C.:

Health Services Administration
Indian Health Service (U.S. Public Health Service)
Health Policy, Research and Statistics
Health Care Finance Administration

Other:

State of Hawaii, Departments of Labor,
Public Assistance and Health;

Center for Health Services Research,
University of Washington, Seattle

2. On September 19, 1979, Governor Jay Hammond gave formal approval to the project and authorized the Department to take necessary steps to implement the project. The Governor subsequently, formally, delegated the Lt. Governor to represent the Office of the Governor in matters related to the project.

3. The Alaska Legislature appropriated \$170,000 for the Health Care Study project at the session closing June 6, 1980. The Department took necessary steps to initiate the study following the approval of the funds.

4. The Request for Proposals were developed, advertised widely and released on October 15, 1980. Over 125 firms nationwide have requested the proposal. Offers to perform the work proposed will be opened on November 17, 1980. It is planned to award the contract for the work mid-December 1980.

RATIONALE FOR STUDY

The State of Alaska is concerned with the cost and availability of adequate health care for all Alaskans. Health care is a complex mix of government and private coverage financing and delivery systems and programs. Financing of coverages and access to services exists with little or no coordination or cohesion. Since the entry of the federal government into the mainstream of health care with the initiation of the Medicare and Medicaid programs, the cost of health care has increased at an alarming rate. While the proposals

and debates in Washington, D.C. continue through the years over whether there should be a national health care program, state and local governments, industry, labor and private citizens wrestle with the effects of uncontrolled costs and access to services.

Some states have considered the question and decided that the cost of assuring the availability of mainstream health care to all individuals, regardless of ability to pay, is unrealistic and unaffordable. Other states, faced with increasing Medicaid caseloads and declining state revenues, have sought to eliminate fraud and abuse in the programs, reduce payment levels and reduce the amount of services provided. These attempts have met with varying degrees of success and failure. The overall problems of inefficiency, improper utilization, and the inequities of the health care delivery and financing systems have not been solved.

With Alaska's relatively small population and a high percentage of people covered under one or more health care systems or plans, it would appear that Alaska could adjust its present approaches, policies, and programs to create a comprehensive, cost-effective, and efficient health care coverage and financing system, characterized by improved access to health care services to individuals.

TIME SCHEDULE FOR STUDY

- 
1. Selection of advisory committee - September 25, 1980.
 2. Release of RFP - October 15, 1980.
 3. Final date for submittal of proposals - November 17, 1980.
 4. Evaluation of proposals and recommendations - November 21, 1980.
 5. Awarding of consultant contract - December 1, 1980.
 6. Approval of contract and signing: begin Phase I - December 12, 1980.
 7. Completion of Phase I document - March 30, 1981.
 8. Evaluation by DHSS and the advisory committee, selection of alternative approaches; begin Phase II - May 15, 1981.
 9. Completion of Phase II document; submittal of preliminary final draft to advisory committee for evaluation and comments - September 18, 1981.
 10. Completion of public meetings and evaluation by DHSS and the advisory committee - October 30, 1981.
 11. Completion of final document and submittal to DHSS, the Governor, and if deemed necessary, the Legislature - December 11, 1981.

CONTRACT ACTIVITIES

The contractor selected will be required to perform the following major tasks during the two phases of the overall study:

- Phase I
1. Prepare an initial planning document which describes the present modes of public and private health care delivery, access, coverage and financing in Alaska, and which presents in conceptual terms major alternative approaches that the State of Alaska might pursue to reconfigure such modes (particularly as regards access, coverage, and financing), either wholly or in part.
 - Phase II
2. Prepare a final planning document which assesses in detail the feasibility, including financing of, and outlines an implementation plan for, two or three of the alternative approaches identified in Phase I, above, as selected by the Governor, DHSS and the Advisory Committee for further consideration.

It is recognized that the State does not, except in very few instances, directly provide health care services or "service delivery". The focus of the study is therefore primarily on identifying alternative methods of health care coverage and financing, and of improving access to and coverage for health care services. The broad scope of this search for alternatives does necessarily involve scrutiny of the existing services delivery systems, but only insofar as knowledge of those systems is essential for improving coverage, financing and access. References to analyzing or reconfiguring the existing health care delivery system in Alaska, therefore, pertain chiefly to those services currently provided directly by the State of Alaska. While no identified alternative approach, including approaches to services delivery, is beyond the compass of this study, the improvement of health care coverage, access and financing constitute the study's primary goals.

The contractor also will be responsible for presenting these two documents, at specified times and in the manner specified to the Governor, DHSS, the Advisory Committee and the interested public.

PHASE I: INITIAL PLANNING DOCUMENT:

The contractor selected will be responsible for preparing an initial planning document for presentation to the Governor, DHSS and the Advisory Committee not later than March 30, 1981.

The initial planning document will comprise two separate but related reports:

1. A report which describes analytically and separately, for both the public and private sectors, the present modes of health care delivery, coverage and financing in Alaska, as well as the present demographics of access to health care services and coverage. This report will essentially serve as

the data base for formulation and subsequent evaluation of the alternative health care coverage and financing approaches. As such, it should contain the following as a minimum:

- a. A survey of all relevant data describing the providing and cost of health care services in Alaska, both public and private (including but not limited to the State of Alaska, the federal government and the Indian Health Service, military and veterans' health care, and private providers), and a summarized but thorough description of these services and costs;
- b. A survey of all relevant data describing the present systems of health care coverage and financing in Alaska, including the costs involved as well as gaps or duplications in coverage, and a summarized but thorough description of these systems, costs, gaps and duplications;
- c. A determination of the total cost of health care in Alaska under the present systems, with projections for the next five to ten years;
- d. A determination of the number and types of individuals in Alaska with inadequate or no health care coverage (and the cost of providing that care or coverage), duplicate forms of coverage, coverage by no access to health care services, and coverage and access but insufficient financial resources to meet deductible requirements in coverage; and,
- e. A description of the types of data not available at present but needed to decide which alternative health care provision and financing approaches would be desirable and feasible for the State of Alaska to pursue and the cost of obtaining those data.

Besides serving as a data base for the alternative health care access, coverage, and financing approaches, this report is intended to identify gaps, duplications, problems and cost inefficiencies in the present statewide health care coverage and financing system. It is also intended to provide DRSS and the Advisory Committee with information necessary to assess the direction being taken by the contractor, and to provide input into the final Phase 2 product.

2. A report which presents in conceptual terms major alternative approaches that the State of Alaska might pursue to reconfigure present modes of health care delivery, access, coverage and financing in the State either wholly or in part. The report should necessarily emphasize reconfiguration of those elements of the statewide health services system which it is in the interest of the State of Alaska to change, (access, coverage, and financing, as well as those health services directly provided by the State), but also should not exclude necessarily the possibility of more comprehensive reconfigurations.

A broad spectrum of possible involvement by the State of Alaska should be considered in this report, including at least the following potential roles (or combination thereof) which the State might play: (1) as a subsidizer of private health coverage programs: (2) as an intervenor in health care coverage or financing through statutory or regulatory reform: and, (3) as a direct provider and financier in limited cases (as at present) of health care services.

As such, the following possible approaches should be considered, along with preliminary indications of their impact and feasibility, as a minimum:

- a. the possibility of an insurance subsidy program with an established minimum benefits package available from private insurers, with State payment of premiums, based on a sliding fee scale determined by individuals' ability to pay, for individuals for whom the State bears financial responsibility for health care;
- b. the possibility of conventional and high-risk health insurance coverage for wage earners, including part-time employees, through the use of income tax credits and/or employer tax credits in lieu of direct payments;
- c. the possibility of increasing access to medical services and extending health care coverage to individuals currently not covered or inadequately covered;
- d. the possibility of improved alternatives for health care access, coverage and financing for rural areas of the State;

Because of the interrelationship of State, federal and private health care and financing sources, any new approaches to health care delivery and financing suggested in this report should be based on at least the following:

- a. a review of State and federal laws and regulations which could affect an alternative approach to health care delivery and financing in Alaska;
- b. a review of the level of direct health care services provided by the federal government in Alaska for U.S. Civil Service employees and their dependents, active and retired military employees and their dependents, veterans and members of the Merchant Seaman Service, including their expected level of utilization of the private health care delivery system in Alaska in the next five to ten years;
- c. a review of the level of Indian Health Service funding to tribal organizations and non-profit organizations under the federal Indian Health Care Improvement Act, and the effect of that funding on the future delivery of health care services in rural Alaska;
- d. a consideration of the anticipated future levels of federal planning and funding for health maintenance operations and prepaid health plans in Alaska;

e. a consideration of the relative effectiveness and efficiency of State versus federal versus municipal versus private initiative in planning for health care access, coverage, financing and administration; and,

f. a review and analysis of available results of studies completed on "cost sharing" by patients; applicability of "cost sharing" for current Alaska State programs and any proposed revised programs and financial impact of implementation of "cost sharing" by patients at selected levels of payments by the patients.

PHASE 2: FINAL PLANNING DOCUMENT ★

The contractor selected as a result of this RFP will be responsible for preparing a final planning document of preliminary presentation to DHSS, the Advisory Committee and the interested public not later than September 18, 1981.

The final planning document will provide a complete plan for implementing and financing each of the two or three alternative approaches to health care coverage and financing which have been selected by DHSS and the Advisory Committee in Phase I of the overall study.

The final planning document shall be as specific as possible as regards the implementation and financing steps to be taken by the State of Alaska, including at a minimum the following: time-frames; policy and administrative decisions to be made; explanation and uses of the methodologies employed to develop financing costs; feasibility, impact and purposes of approaches developed; sources of conflict and identified competing interests; statutory and regulatory changes necessary; funding sources and fiscal mechanisms to be utilized; and other relevant information necessary to select and implement the health care coverage and financing approaches under study. Options related to each alternative approach developed shall be presented with cost differentials for each option so identified.

On the cost side, the alternatives should be evaluated in each phase as to the potential cost implications of implementing that phase - as it would affect state, local, and federal government, the private health care industry, non-profit health care organizations, consumers and health insuring organizations.

A preliminary draft of the final planning document will be submitted to DHSS and the advisory committee by September 18, 1981. DHSS and the advisory committee will review the material and prepare written comments, criticisms, and recommendations. The final planning document, including substantive public comments and the advisory committee report, will be prepared by the contractor and submitted to DHSS and the advisory committee not later than December 11, 1981. The final planning document will be presented to the Governor and the Legislature.

by DHSS with the participation of the contractor.

DHSS PROJECT ORGANIZATION

The following is a general description of the functions of the advisory committee, the steering committee, and the project coordinator.

1. Advisory committee - the advisory committee will act as the sounding board for the DHSS and the contractor. The advisory committee will not be the decision-making body for the contract. The advisory committee will be responsible for assuring that the contractor is progressing toward the goal of the project and to assure that all facets of the present delivery and financing systems are taken into consideration. The contractor should be prepared to meet with the advisory committee at least bi-monthly over the life of the project.
2. Steering committee - the steering committee will be the decision-making body for the life of the contract. The steering committee will be responsible for assuring that all deliverables are produced on schedule and that they fulfill the requirements of the contract. The steering committee will make modifications to the contract if necessary and will provide the contractor with any entree necessary to secure information from the State to complete the contract.
3. Project coordinator - the project coordinator will be the focal point of all contact between the contractor and the steering committee and advisory committee. The project coordinator will meet regularly with the contractor and will be responsible for assuring that deadlines are not delayed because of scheduling problems with committee members or difficulty in securing needed information from departmental sources. All communications by the contractor should be addressed to the project coordinator.

ATTACHMENTS:

No. 1 : Evaluation Committee Members and Agenda : Criteria

No. 2 : Advisory Committee Members and Agenda

RECEIVED
DEC 22 1980

TO: Lt. Governor Terry Miller
Attn: Jack Fagnoli ✓

LT. GOV'S OFFICE

DATE : December 17, 1980

FROM:

Frederick McGinnis
Deputy Commissioner
Health and Social Services

SUBJECT:

Copy of letter and
attachments mailed
today: For Information:
Alaska Health Care and
Financing Project

Attached herewith for your information and files you will find a copy of a letter one of which was mailed to each legislator today along with the attachment indicated on the letter.

This transmittal is made to you in order to keep you informed as to this particular development related to the project.

Copies of the Memorandum to:

Commissioner Beirne
Deputy Commissioner Korhonen
Deputy Commissioner Tirador
Special Assistant Deborah Behr

Governor Jay Hammond : Attn: Carole Burger
Lt. Governor Terry Miller: Attn: Pete Rouse
Attn: Jack Fagnoli
Mr. Keith Specking: Legislative Assistant

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01 - JUNEAU 99211

December 17, 1980

Senator Arliss Sturgulewski
2957 Sheldon Jackson Street
Anchorage, Alaska 99504

Dear Senator Sturgulewski:

The 1980 legislature appropriated \$170,000 for the Department of Health and Social Services to provide for a "Health Care Study". The funds for the study were recommended by the Department with the strong support of the Governor and Interested legislators.

This letter is sent to all legislators to express appreciation for legislative support and provisions for the study and to furnish you with the enclosed "Status Report" on the project to date. Your review of the Status Report is invited. We believe the study results will provide the needed data and policy options for possible state actions during the 1982 session of the legislature.

You will be interested to know that the Request for Proposals to conduct the study was requested by over one hundred twenty firms. Nine organizations submitted offers to conduct the study. A special nine person Evaluation Committee (see attachment No. 1 to Status Report) reviewed and ranked the offers and recommended award of contract to Battelle Human Affairs Research Center of Seattle provided all the Department's contract terms could be met. The contract should be executed fully within a few days.

The Advisory Committee (see attachment No. 2 to Status Report) has had it's first meeting and will meet next the first week in January.

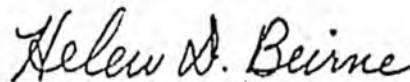
The Phase I of the contractor's work described in the Status Report will be completed March 30, 1981. Phase II is scheduled for completion and submittal December 11, 1981.

December 17, 1980

The Departmental Project Coordinator for the study project is Deputy Commissioner Frederick McGinnis, 214 MacKay Building, 338 Denali Street, Anchorage, 99501. Your comments, recommendations and questions would be welcomed and should be sent to the Project Coordinator at the address indicated.

Your interest in and continued support of the study project are appreciated very much.

Sincerely,

A handwritten signature in cursive script that reads "Helen D. Beirne".

Helen D. Beirne
Commissioner

Enclosure: Status Report

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ATTACHMENT NO. 2

JAY S. HAMMOND, GOVERNOR

ROOM 214 MacKAY BUILDING
332 DENALI STREET
ANCHORAGE 99501

ADVISORY COMMITTEE FOR COMPREHENSIVE HEALTH CARE AND FINANCING STUDY

JANUARY 5, 1981

COMMITTEE MEMBERS:

James M. Armbrust
Statewide Health Coordinating Council
c/o Alaska Area Native Health Service
Box 7-741
Anchorage, Alaska

Tom Mingen
Alaska State Hospital Association
c/o Fairbanks Memorial Hospital
1650 Cowles Street
Fairbanks, Alaska 99701

Tom Morehouse
Institute of Government Research
700 A Street
Anchorage, Alaska 99501

✓ Jack Fagnoli
Office of the Lieutenant Governor
State of Alaska
Pouch AA
Juneau, Alaska 99811

Carole Burger
Office of the Governor
State of Alaska
Pouch A
Juneau, Alaska 99811

Darryl Trigg
Alaska Native Health Board
P.O. Box 966
Nome, Alaska 99762

David E. Johnson
Alaska State Medical Association
3612 Tongass Avenue
Ketchikan, Alaska 99901

ADVISORY COMMITTEE - JANUARY 5, 1981
(Page 2)

COMMITTEE MEMBERS (cont.):

Leslie Goss → *Sharman Haley*
Alaska Public Interest Research Group
P.O. Box 1093
Anchorage, AK 99501

Glenn Hackney (Public Interest Member)
1136 Sunset Drive
Fairbanks, AK 99701

(NOTE: It is anticipated that several additional appointments may be made to the committee - additional Public Interest Member; Region X, Department of Health & Human Services; Insurance Industry; Department of Health & Social Services.)

PROJECT DIRECTOR:

Frederick McGinnis
Deputy Commissioner
Department of Health & Social Services
214 McKay Building
338 Denali Street
Anchorage, AK 99501

STEERING COMMITTEE:

Carole Burger, Special Assistant
Office of the Governor

Jack Fagnoli, Special Assistant
Office of the Lieutenant Governor

Frederick McGinnis, Deputy Commissioner
Department of Health & Social Services

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
334 DENALI STREET
ANCHORAGE 99501EVALUATION COMMITTEE
FOR AN
ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY
PLANNING AND DESIGN CONSULTANTNovember 24-26, 1980
State Office Building
Department of Commerce
9th Floor
Juneau, Alaska

1. Dr. Robert Day, Dean
School of Public Health
Center for Health Services Research
University of Washington
Seattle, Washington 98195
(206) 543-8683
2. Lee Gorsuch (or Designee)
Director
Institute of Social and Economic Research
University of Alaska
707 A Street Room 206
Anchorage, Alaska 99504
(907) 278-4621
3. Janice Rae Cole
Division of Policy Development and Planning
Office of the Governor
State of Alaska
Pouch AD
Juneau, Alaska 99811
(907) 465-3577

--Continued--

4. Fred Mueller
Deputy Commissioner
Department of Administration
Pouch C.
Juneau, Alaska 99811
(907) 465-2200

5. Robert A. Hall (or Designee)
Director
Municipality of Anchorage
Department of Health and Environmental Protection
825 L Street
Anchorage, Alaska 99501
(907) 264-4621

6. Phoebe Lindsey, Director
State Health Planning and Development Agency
Department of Health and Social Services
Pouch H-01A
Juneau, Alaska 99811
(907) 465-3038

7. Carole Burger
Office of the Governor
Pouch A
Juneau, Alaska 99811
(907) 465-3500

8. Jack Fagnoli
Office of the Lieutenant Governor
Pouch AA
Juneau, Alaska 99811
(907) 465-3520

9. Frederick McGinnis
Deputy Commissioner
Resource Individual for Information/Project Coordinator
Department of Health and Social Services
214 MacKay Building
338 Denali Street
Anchorage, Alaska 99501
(907) 278-4668

EVALUATION OF THE PROPOSAL

5-1 EVALUATION COMMITTEE

A committee composed of representatives of government and interested groups will be appointed to evaluate the proposals. The criteria listed below will be used to evaluate the proposals for the purpose of ranking them in relative position based on how fully each proposal meets the requirements of this RFP. Particular emphasis will be placed on the offeror's description of how the activities will be performed.

5-2 OBJECTIVE

The objective of the State in soliciting and evaluating proposals is to ensure the selection of a firm that will produce the best possible results for the expended funds.

5-3 MINIMUM REQUIREMENTS

All proposals will be evaluated first to ensure that they meet the minimum requirements of the RFP. Proposals that fail to address all of the requirements will receive no further consideration.

5-4 EVALUATION METHODPercent

- 25% a. Technical Credibility - Demonstrated understanding of the end product requirements; soundness of technical approach to satisfy these requirements including demonstrated ability to develop a final report.
- 25% b. Management Credibility - Soundness of the management plan for accomplishing objectives in light of technical approach, schedule factors, project control methods, as well as interface with DHSS, reporting, and related relationships.
- 25% c. Technical Resources to be Provided - Quality of expertise that will specifically be brought to bear on this project. This includes evaluation of the experience and qualifications of individuals that will be assigned to the project.
- 25% d. Related Experience - References that demonstrate a capability in performing work similar to the specific objectives in the statement of work of this RFP.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MCKAY BUILDING
333 DEVALI STREET
ANCHORAGE 99501

EVALUATION COMMITTEE - PRELIMINARY AGENDA ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY PROJECT

NOVEMBER 24-26, 1980
CONFERENCE ROOM, DEPARTMENT OF COMMERCE, JUNEAU, ALASKA

1. Introduction of Members and Welcome
2. Review and Revision of Agenda
3. Summary Briefing on Project
4. Selection of Chairperson and Recorder for Committee
5. Opening and Logging of Proposals Received
6. Development of Committee Procedures
7. Development of Standards/Criteria for Evaluation of Proposals
Review PART V 5-1 through 5-4 of the RFP (Attached)
8. Oral Presentations by Offerors (Schedule Attached)
9. Review of Proposals for Evaluations
10. Development of Recommendation to Department
11. Other Considerations as Determined by Committee
12. Future Meetings Discussions and Adjournment

COST PROPOSAL

ALASKA COMPREHENSIVE HEALTH
CARE AND FINANCING STUDY

In response to
a request for proposals from the
Department of Health and Social Services
State of Alaska

November 1980

Battelle Proposal No.: P24187

- Battelle Memorial Institute
Human Affairs Research Centers
4000 N.E. 41st Street
Seattle, Washington 98105

Appendix B-2 Cost/Pricing

Estimated Budget

	<u>Task 1</u>		<u>Task 2</u>		<u>Task 3</u>		<u>Task 4</u>	
	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount
<u>Personnel</u>								
S Malhotra	50	\$1,362	-0-	\$ -0-	50	\$ 1,362	-0-	\$ -0-
E Perrin	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
K McCaffree	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
J Wills	100	2,183	50	1,091	60	1,309	25	545
G Hart	150	1,303	50	434	-0-	-0-	-0-	-0-
Secretary	66	552	-0-	-0-	67	561	-0-	-0-
Total Personnel		\$5,400		\$1,525		\$ 3,232		\$ 545
<u>Travel</u>								
Seattle/Anchorage/Juneau/Seattle								
5 trips, 1 person, 2 days								
Airfare	\$1,141				\$ 570			
Subsistence	248				124			
Ground Transportation	248				124			
Seattle/Anchorage/Juneau/Fairbanks/Seattle								
Airfare								
Subsistence								
Ground Transportation								
Total Travel		1,637				818		
<u>Consultant</u>								
15 days @ \$250/day								
						1,562		
<u>Data Processing</u>		500		500				
<u>Subcontract</u>								
Management and Planning Services/Alaska (see Schedule A for detail)		17,251		1,375		5,130		-0-
<u>Other Direct Costs</u>								
Telephone	\$ 345		\$90		\$165		\$30	
Duplicating	173		45		304		15	
Word Processing	179		47		550		16	
Materials and Supplies	40		10		20		5	
Total Other Direct Costs		737		192		1,039		66
Total Direct Costs		\$25,525		\$3,592		\$11,781		\$ 611
<u>Staff Time Overhead</u>								
36% of Direct Labor		1,944		549		1,164		196
<u>General & Administrative Costs</u>								
42% of Direct Costs and Staff Time Overhead excluding the amount over \$25,000 on any subcontract.		11,537		1,740		5,437		339
Total Cost		\$39,006		\$5,881		\$18,382		\$1,146
<u>Fixed Fee</u>		3,511		529		1,554		103
Total Cost + Fee		\$42,517		\$6,410		\$20,036		\$1,249

Estimated Budget

	Task 5		Task 6		Task 7		Task 8		Total Project	
	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount
<u>Personnel</u>										
S Malhotra	100	\$ 2,723	-0-	\$ -0-	50	\$ 1,362	-0-	\$ -0-	250	\$ 6,809
E Perrin	40	1,535	-0-	-0-	-0-	-0-	-0-	-0-	40	1,535
K McCaffree	40	1,356	-0-	-0-	-0-	-0-	-0-	-0-	40	1,356
J Mills	75	1,636	40	873	-0-	-0-	50	1,091	400	8,728
G Hart	100	868	-0-	-0-	-0-	-0-	-0-	-0-	300	2,605
Secretary	57	561	-0-	-0-	-0-	-0-	100	837	300	2,511
Total Personnel		\$ 8,679		\$ 873		\$ 1,362		\$1,928		\$ 23,544
<u>Travel</u>										
Seattle/Anchorage/Juneau/Seattle										
5 trips, 1 person, 2 days										
Airfare	\$570				\$571				\$2,852	
Subsistence	124				124				620	
Ground Transportation	124				124				620	
Seattle/Anchorage/Juneau/Fairbanks										
Seattle										
1 trip, 1 person, 3 days										
Airfare					656				656	
Subsistence					211				211	
Ground Transportation					161				161	
Total Travel		818			1,847					5,120
<u>Consultant</u>										
15 days @ \$250/day		2,188								3,750
Data Processing		500								1,500
<u>Subcontract</u>										
Management and Planning Services/Alaska (see Schedule A for detail)		12,456		13,855		7,880		2,200		60,147
<u>Other Direct Costs</u>										
Telephone	\$ 405		\$45		\$45		\$135		\$1,260	
Duplicating	203		22		22		508		1,292	
Word Processing	211		23		23		998		2,047	
Materials and Supplies	45		5		5		16		146	
Total Other Direct Costs		864		95		95		1,657		4,745
Total Direct Costs		\$25,505		\$14,823		\$11,184		\$5,735		\$98,806
<u>Staff Time Overhead</u>										
36% of Direct Labor		3,125		314		490		694		8,476
<u>General and Administrative Costs</u>										
42% of Direct Costs and Staff Time Overhead, excluding the amount over \$25,000 on any subcontract		7,315		538		1,593		1,797		10,196
Total Cost		\$35,945		\$15,675		\$13,267		\$8,226		\$127,573
Fixed Fee		3,235		1,111		1,194		745		12,142
Total Cost - Fee		\$39,180		\$17,786		\$14,461		\$9,071		\$140,440

TECHNICAL PROPOSAL

ALASKA COMPREHENSIVE HEALTH
CARE AND FINANCING STUDY

In response to
a request for proposals from the
Department of Health and Social Services
State of Alaska

November 1980

Battelle Proposal No.: P24187

Battelle Memorial Institute
Human Affairs Research Centers
4000 N.E. 41st Street
Seattle, Washington 98105

Appendix B-1 Performance of
Services and Statement of Work
Pages 1 through 47

III. TECHNICAL APPROACH

A. Objectives

The specific objectives of the proposed study are to:

- . identify systemic and financial barriers to access to health care in Alaska;
- . identify problems of inefficiency caused by duplication of coverage or other features implicit in the health care financing system;
- . propose a set of specific actions which the state could take to address the problems identified;
- . evaluate the feasibility of several selected alternatives, as well as their impact on the population and on state and local governments; and
- . prepare an implementation plan for each of the selected alternatives.

We propose a work plan which will meet these objectives by carrying out eight major tasks, described below.

B. Specific Tasks

The specific tasks and subtasks to be carried out in the course of this study are listed below. Immediately following this list is a description of each task.

Task 1: Identify inadequacies in coverage and access to care in Alaska.

- Subtask 1-A: Collect data necessary for description of coverage, access, and costs.
- Subtask 1-B: Identify who is and is not covered by a health insurance or health care plan.
- Subtask 1-C: Identify population with coverage but without access to health care, and evaluate the importance of deductibles and copayments as barriers to access.

Task 2: Estimate current and forecast future cost of health care system in Alaska.

- Subtask 2-A: Estimate current total cost of health care in Alaska.
- Subtask 2-B: Project the total cost of care under the current system into the future.

Task 3: Identify alternative options for achieving comprehensive health care coverage and eliminating barriers to access.

Subtask 3-A: Identify specific problems to be addressed by the State, both in the short and long run.

Subtask 3-B: Examine the salient features of the legal system which define the State's scope for intervention.

Subtask 3-C: Survey approaches used in other states, as well as other innovations which may apply to Alaska.

Subtask 3-D: Delineate a set of options for presentation to the advisory committee.

Task 4: Identify any further data requirement for evaluation of options.

Task 5: Conduct feasibility study of options selected by advisory committee.

Subtask 5-A: Specify new financing mechanisms required to implement the selected options.

Subtask 5-B: Collect any further data required for analysis.

Subtask 5-C: Evaluate the legal and regulatory options.

Subtask 5-D: Estimate fiscal impact on state and local governments.

Subtask 5-E: Identify social/political barriers to implementation.

Task 6: Prepare implementation plans for selected options.

Task 7: Present options to public meetings of interested parties.

Task 8: Incorporate suggested revisions into final planning document.

DRAFT OUTLINE OF REPORTS #1 AND #2
STATE OF ALASKA HEALTH CARE FINANCING PROJECT

REPORT #1:

HEALTH CARE IN ALASKA: FINANCING, COVERAGE, SERVICES, AND COSTS

- I. Executive Summary
- II. Introduction and Overview
- III. Who Pays for Health Services In Alaska?
 - A. Third Party Reimbursement
 1. Private Sector
 - a. Commercial insurers
 - b. Blue Cross/Blue Shield
 - c. Self-insured trust funds
 2. Public Sector
 - a. Medicare
 - b. Medicaid
 - c. General Relief Medical
 - d. Veteran's Administration
 - B. Direct Service Provision
 1. AANHS
 2. Native Corporations
 3. State of Alaska
 4. Military
 - C. Consumer Out-of-Pocket Expenditures
 1. Due to lack of coverage
 2. Due to cost-sharing by covered individuals
 - D. Who finances the third party reimbursers and direct service providers?
 1. Beneficiary premiums
 2. Employer premiums
 3. General tax revenue
 4. Other revenue sources
 - E. Summary

The health care costs of society are always ultimately borne by one or another segment of the general public. In the summary, we will draw out of this chapter:

- a snapshot of the pattern of health service financing as it exists now,
- a discussion of the implicit transfers among groups in the society, and
- an indication of problem areas in health service financing.

IV. Who is covered, and for what benefits?

A. Coverage

1. Who are the uncovered?
2. How is coverage affected by economic conditions?

B. Benefits

1. Among the covered population, what benefits are provided? What gaps in services exist?

C. Summary: Identification of problem areas

V. Health Services and Access to Care in Alaska

A. Service delivery in Alaska: How well does it meet Alaska's special needs?

B. Non-financial barriers to access

- ①. Geographic
2. Administrative
3. Social/Cultural

C. Summary: How can financing or administrative arrangements lower the barriers to access identified in this chapter? (Some barriers will not be affected by financial or administrative arrangements, and so are beyond the scope of this study.)

VI. Current and Projected Health Care Costs in Alaska

A. Current Costs: Two general measures

1. Provider revenues
2. Payer expenditures

B. Projected costs at current service levels

1. Price trends
2. Utilization trends
3. Population trends

VII. Alaska's Health Care Financing Needs

Draws out of the previous chapters a summary of the problems, together with identification of potential problems which cannot currently be verified for lack of data.

Appendix: Backup Data Tables

REPORT #2 OPTIONS FOR STATE ACTION

- I. Executive Summary
- II. Introduction and Overview
- III. Survey of Alaska's Financing Needs
 - A. Review of problems (from Report #1)
 - B. General principles of effective financing mechanisms
 - 1. Insurance vs. income transfers
 - 2. Efficiency vs. equity
 - 3. Social insurance vs. public assistance
 - 4. Actuarial tests
 - 5. Cost containment vs. barriers to access
- IV. The State's Options
- V. Review of Legal Issues
 - A. Brief general review
 - B. Specific issues suggested by the proposed options
- VI. Future Developments Which Bear on the State's Choice of Options
 - A. Growth of health maintenance organizations
 - B. National Health Insurance
 - C. Trends in Medicare and Medicaid
 - D. A changing federal/state relationship
- VII. Further Data Requirements

What additional data, if any, are required to analyze each of the various options?

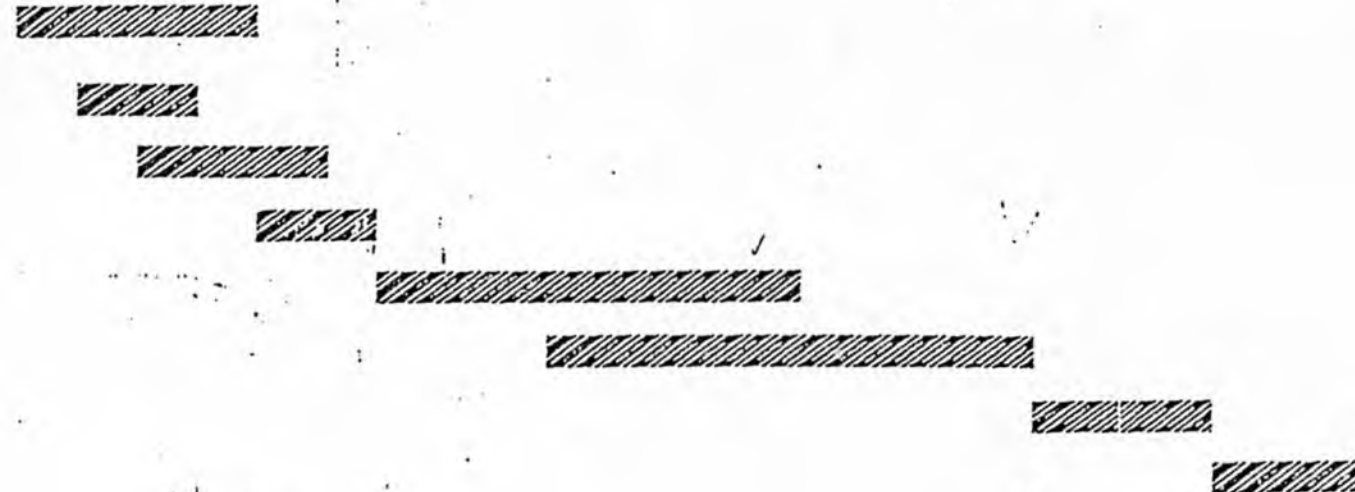
5

Alaska Comprehensive Health Care and Financing Study Project Schedule

TASK

JAN FEB MAR APRIL MAY JUNE JULY AUG SEP OCT NOV DEC

1. Identify Inadequacies in Coverage and Access
2. Estimate Costs of Health Care System
3. Identify Alternative Options
4. Identify Evaluation Data Requirements
5. Feasibility Study of Selected Options
6. Develop Implementation Plans
7. Hold Public Meetings
8. Prepare Final Report



REPORTS

- Interim Report No. 1
- Interim Report No. 2
- Interim Report No. 3
- Final Report

Mar 9

March 30, 1981
March 30, 1981

September 18, 1981

December 11, 1981

MILESTONE MEETINGS/PRESENTATIONS

- Initial Advisory Committee Meeting
- Interim Reports 1 & 2
- Midpoint Review Interim Report No. 3
- Public Meetings
- Final Report

January 6, 1981

March 30, 1981

July 16, 1981

September 18, 1981

October 1981

December 11, 1981

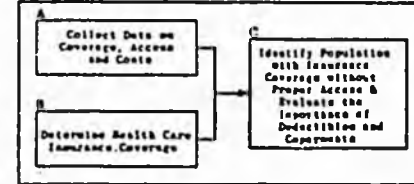
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LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

Alaska Comprehensive Health Care and Financing Study

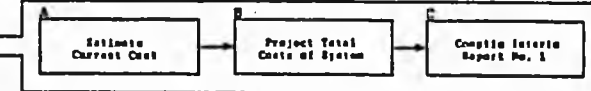
PRODUCTS

TASKS

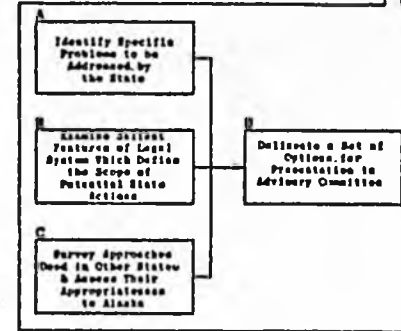
1. IDENTIFY INADEQUACIES IN COVERAGE AND ACCESS TO CARE IN ALASKA



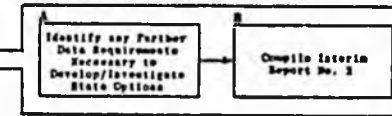
2. ESTIMATE CURRENT AND FORECAST FUTURE COST OF HEALTH CARE SYSTEM IN ALASKA



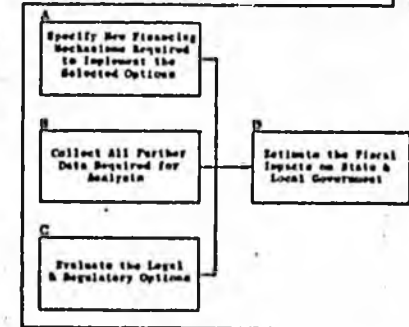
3. IDENTIFY ALTERNATIVE OPTIONS FOR ACHIEVING COMPREHENSIVE HEALTH CARE COVERAGE AND ELIMINATING BARRIERS TO ACCESS



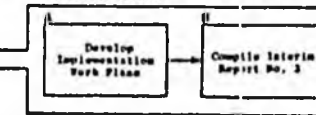
4. IDENTIFY ADDITIONAL DATA REQUIREMENTS



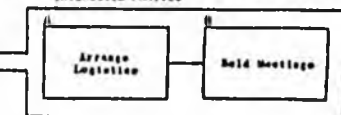
5. CONDUCT FEASIBILITY STUDY OF OPTIONS SELECTED BY ADVISORY COMMITTEE



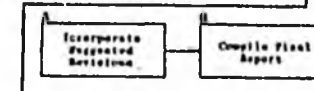
6. PREPARE IMPLEMENTATION PLANS FOR SELECTED OPTIONS



7. PRESENT OPTIONS TO PUBLIC MEETINGS OF INTERESTED PARTIES



8. PREPARE FINAL REPORT



Interim Report No. 1
DESCRIPTION OF HEALTH CARE DELIVERY AND FINANCING IN ALASKA

Interim Report No. 2
POTENTIAL STATE ACTIONS TO REDUCE SYSTEMIC AND FINANCIAL BARRIERS TO ACCESS TO HEALTH CARE IN ALASKA

Interim Report No. 3
DRAFT FINAL REPORT - PRELIMINARY ANALYSIS OF POTENTIAL STATE ACTIONS TO REDUCE SYSTEMIC & FINANCIAL BARRIERS TO ACCESS TO HEALTH CARE IN ALASKA
DRAFT IMPLEMENTATION PLANS

FINAL REPORT
IMPLEMENTATION PLANS FOR STATE ACTIONS TO REDUCE SYSTEMIC AND FINANCIAL BARRIERS TO ACCESS TO HEALTH CARE IN ALASKA

THE PRECEDING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

Minutes of Meeting
Advisory Committee
Alaska Comprehensive Health Care and Financing Study Project
Conference Room, Department of Health And Social Services
December 1, 1980
Juneau, Alaska
8:00 AM

1. Members of the meeting were introduced.

Darryl Trigg Designee	Alaska Native Health Boards, Inc.
David E. Johnson President	Alaska State Medical Association
Leslie Goss Executive Director	Alaska Public Interest Research Group
Tim Mingin President-Elect	Alaska State Hospital Association
James M. Armbrust Chairperson	State Health Coordinating Council
Jack Fagnoli	Office of the Lieutenant Governor
Carole Burger	Office of the Governor
Frederick McGinnis Coordinator	Deputy Commissioner, Department of Health and Social Services

2. Roll Call of Members was held.

3. Jack Fagnoli was named convenor and temporary chairperson.

4. Summary Briefing for members was given by Deputy Commissioner Frederick McGinnis:

Developments leading to RFP
RFP Process and RFP Highlights
Evaluation Committee, Membership, Agenda
Questions and Answers on RFP, Status Report

Ms. Burger departed the meeting at 10:00 a.m.

5. Discussion was held on whether to open the committee to members of the public. (i.e. additional public interest members)

After formal discussion it was moved by Mr. Johnson, seconded by Mr. Mingen and voted by the majority of committee membership that:

"A formal request be addressed to the Lieutenant Governor's office requesting that no more than three but no less than two members of the general public be added to the membership of the Advisory Committee"

6. Mr. Trigg requested comments on a request that alternates be approved to attend for the permanent members of the committee.

After formal discussion it was agreed that alternates would be welcome, with the stipulation that the permanent members brief their alternatives before the next meeting.

Members also discussed the possibility that a member would not be able to attend the majority of the meetings. If that was the case they were asked to notify the committee and a new member would be appointed.

7. A central contact for committee members was decided on. Dr. McGinnis will be the central contact for all committee members for the time being.

Fredrick McGinnis
Deputy Commissioner
Department of Health and Social Services
Room 214 MacKay Building
338 Denali Street
Anchorage, Alaska 99501
278-4668 (contact phone)

8. Discussion was made on the formal procedures of the meetings. It was decided that the procedures would be made as the meetings progressed. A schedule of procedures would be made available to the members with each Minute of the Meeting notice.
9. Discussion was held on the possibility of keeping all committee members informed ahead of time on what will be discussed at the next meeting. Dr. McGinnis stated that he will send all items of interest to the committee members. He will also note whether the items should be brought to the next meeting. Also, an agenda will be sent prior to the next meeting.

10. Dr. McGinnis brought to the attention of the committee members the following correspondence:

1. Memo from Mark S. Johnson, Emergency Medical Services Section
TO: Dr. Frederick McGinnis
RE: Health Care Financing Study.

"Would like the committee to address the problems of payment for air transport of emergency patients from bush and rural areas to hospitals, and the problems of getting medical equipment back to communities after it is sent with emergency patients."

2. Memo from Michael Cushing, Div. of State Health Planning & Dev.
TO: Reed Schonfeldt, SCHSS, Office of Information
RE: Health Cost/Expenditure Project

Question 1: What are the health expenditures in Alaska for the major categories of service (Promotion/Prevention, Information/Referral, Diagnosis & Treatment, Rehabilitation, Maintenance, State, Private, Other)?

Question 2: What are the health expenditures, by service attributed to heart disease & Hypertension in the state of Alaska.

3. Memo from Dean F. Tirador, Deputy Commissioner, Dept. of Health & Social Services
TO: Liz Muktarian, Director, Div. of Adult & Aging Services
RE: Financing of Health Care for the Elderly

"Medicare does not cover dental care, hearing aids, pharmaceuticals or routine refractions or eye glasses in most cases."

"Problems in health care for the elderly include:

- 'lack of coverage for dental care;
- 'lack of coverage under Medicare for costs of drugs and medications
- 'a tendency on the part of people with marginal incomes to delay seeking of health care to the point that when they finally do, they wind up with truly tremendous bills
- 'lack of alternatives to institutionalization'"

4. Letter form Helen D. Beirne, Commissioner
TO: Marlene Johnson, Alaska Native Health Board
RE: Acknowledgement of receipt of Resolution Number 81-17 passed at the October 22, 1980, Alaska Native Health Board Meeting.

11. Dr. McGinnis handed out papers titled:
 1. "Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt"
 2. "Department of Health & Social Services, Division of Public Assistance, Request for Proposals for Systems Planning and Design Consultant"
12. A request was made by Mr. Johnson that a list of committee member names and addresses be made available to all committee members. A list was passed around and a copy is attached to these minutes.
13. Dr. McGinnis suggested that agenda item number 11 on this meeting agenda list be an on-going item. He recommended that the word "Recommendation" be put in the plural form of "Recommendations".
14. Discussion was held on the selection of the contractor. Dr. McGinnis indicated that the final choice would probably be made today in Seattle. All members, on request, would get copies of the contractor's proposals and costs.
15. A suggestion by Mr. Johnson was made to include the University of Alaska's Economics Division as a member of the committee. Discussion was held on this and it was noted that this membership should not be one of the two or three seats made available to the public.
16. A request for reimbursement, from the State of Alaska, was handed to all committee members who would like to be reimbursed for their travel costs.
17. A Motion was made by Mr. Johnson, seconded by Mr. Trigg and approved by committee vote that the next meeting be held in Anchorage, on January 5, 1981, starting at 8:30 a.m., in Dr. McGinnis's offices at the above mentioned address, unless notified otherwise.

This Motion is subject to change by the majority of committee members by a telephone conference call.

The meeting was adjourned at 12:22 p.m.

Attachment No. 1 Names and addresses of current committee members.

Attachment No. 2 Preliminary Agenda for December 1, 1980 meeting.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

JAY S. HAMMOND, GOVERNOR

ROOM 214 MacKAY BUILDING
333 DEHALI STREET
ANCHORAGE 99501

ADVISORY COMMITTEE - PRELIMINARY AGENDA ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY PROJECT

DECEMBER 1, 1980
CONFERENCE ROOM, DEPARTMENT OF HEALTH AND SOCIAL SERVICES
JUNEAU, ALASKA
8:30 AM

1. Introduction of Members and Welcome
2. Review and Revision of Agenda
3. Summary Briefing on Project
4. Selection of Chairperson and Recorder for Committee
5. Review of Evaluation Committee Membership, Agenda and Criteria
6. Report on Evaluation Committee Actions
7. Related Studies:
 - Health Insurance Option: Division of Public Assistance
 - Health Cost Expenditure Project: Region X, Department of Health & Human Services
8. Role of Advisory Committee: DHSS Contract Organization
9. Development of Advisory Committee Procedures
10. Communications and Referred Matters
11. Development of Preliminary Recommendation to Department and Contractor
12. Other Considerations as Determined by Committee:
 - Future Meetings, Discussions and Other Matters

(11)

Minutes of Meeting
Advisory Committee
Alaska Comprehensive Health Care and Financing Study Project
January 5, 1981
Anchorage, Alaska
8:00 AM

RECEIVED
JAN 12 1981

LT. GOV'S OFFICE

1. Members Present: David Johnson, Darryl Trigg, Jack Fagnoli, Carole Burger, Tom Morehouse, Tom Mingen, James Armbrust, Leslie Goss, Frederick McGinnis.
2. Additional Persons in Attendance: John Wills, Daniel Malick, Richard Wells, Jay Cushman, Dean Tirador, Elizabeth Tower.
3. Jack Fagnoli convened the committee as temporary chairperson.
4. Frederick McGinnis distributed the following materials:
 - A. "Cost Proposal" from Battelle dated November 1980.
 - B. "Technical Proposal" from Battelle dated November 1980.
 - C. Copy of the contract for the study between Battelle Human Affairs Research Center and the Alaska Department of Health and Social Services.
5. There was discussion of membership status.
 - 1 ISER Member - named - Morehouse
 - 2 Public Interest Members - to be named
 - Insurance Industry to be named
6. Frederick McGinnis defined the roles of the Evaluation Committee, Advisory Committee, Steering Committee, Project Coordinator, and the Department of Health and Social Services.
7. Frederick McGinnis distributed copies of a letter text sent to all legislators and a letter sent to twenty five organizations and firms inviting and requesting the cooperation of those agencies in assisting the contractor in securing needed information, data, etc.
8. Darryl Trigg raised a question with Mr. Wills as to what mechanisms, programs will be used to be sure that the needs of rural Alaska will be met and this matter was discussed with Mr. Wills and some other members of the committee
9. Dr. Johnson indicated we must deal with what has happened before within Health Systems Agencies to help to gather information on needs of bush Alaska and we must rely on what is being done.
10. Additional sources of information on rural medical needs and problems were suggested as follows:
 - Health Systems Agencies
 - Indian Health Service
 - Alaska Area Native Health Boards
 - Aleutian - Pribiloff Islands Statements of Need Conference Report
 - Alaska Federation of Natives
 - Alaska Health Foundation
 - Alaska Native Health Corporations (Yukon Kuskokwim - Norton Sound)

Minutes of Meeting
Advisory Committee
January 5, 1981

Page 2

11. Leslie Goss indicated she will submit a list of other persons recommended to be included in receiving notices of meetings and minutes of meetings.
12. John Wills reviewed his technical background for leading this study and referred to studies and projects in which he had been engaged previously. He referred to more extensive materials regarding his background in the technical proposal.
13. Mr. Cushman reviewed the experience of his firm, Management and Planning Services Alaska, in the field of management studies.
14. Mr. Wills discussed two reports to be prepared next as called for in the contract, as follows:

Report I: Health Care in Alaska: Financing, Coverage,
Services, and Costs

Report II: Options for State Action

(See Attachment #1 to these minutes for a breakdown of the topics to be covered in these reports)

Mr. Wills presented two charts and discussed them at length as follows:

Chart #1

- A. Products include interim reports, numbers one, two and three and a final report.
- B. Tasks to be accomplished in relation to the products.

Chart #2

Projects scheduled including schedules relating to tasks, reports, meetings, and presentations to the State.

(NOTE: Copies of charts are a part of the record of this meeting.)

Minutes of Meeting
Advisory Committee
January 5, 1981

Page 3

15. John Wills emphasized the need for an insurance representative on the committee, both for input purposes as well as for assisting the contractor in obtaining necessary data from selected insurance carriers. Wills indicated that he would contact the Lieutenant Governor's Office and Martin Tirador of Blue Cross by letter regarding the specific types of data needed.
16. In response to a query from Tom Mingen, John Wills indicated that, because Blue Cross plus 4-5 major private insurance carriers write approximately 70% of all health insurance in Alaska, analysis of that group of insurers seemed an adequate cut-off point for purposes of the study. The committee expressed conceptual approval of that approach as practical.
17. John Wills clarified for the committee the role which Management Planning Services, the study subcontractor, would play in conduct of the project. That role will include: analysis of the fiscal impacts of identified financing options; development of implementation plans for identified options; systems description; and review and collaboration with the major contractor on other aspects of the study.
18. A general discussion was held by the committee with the contractor regarding whether any particular options might be excluded from the study's purview because of unacceptability to specific parties at interest. John Wills indicated that his understanding of the contractor's responsibility was that the contractor would identify any and all potentially feasible operations, and that it would be the business of the advisory committee alone to select specific options for further study in Phase 2 of the project. Wills noted that this probably would be the main business of the committee during the March 30-May 15, 1981 hiatus. Jack Fagnoli noted that one of the specific provisions of the RFP and the study contract is that the contractor will identify interested parties affected by any option, and that in fact a major purpose for the committee itself was to identify and consider any such effects prior to selection of any option or options for possible implementation.
19. Tom Mingen expressed his impression that the scope and purposes of the study may not be well understood by the public. That feeling was echoed by Richard Wells, who noted that the public image of the project may be important to its success.

Minutes of Meeting
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20. Jack Fagnoli inquired whether the contractor's view of the scope of options to be investigated included such possibilities as modifications of state catastrophic illness coverage and expansion of health care coverage for the elderly. John Wills replied that the contractor would try to stratify the data collected so as to allow identification of such groups and their inclusion within the options eventually presented; however, he said, much of this will be determined by the nature of the data available from private carriers and from the state.
21. A tentative schedule for two future meetings of the committee was adopted, as follows:
- | | | |
|----------------------------|-----------|--|
| February 23, 1981 (Monday) | Anchorage | Meeting with contractor;
Preliminary discussion
of options identified. |
| March 9, 1981 (Monday) | | Draft Phase 1 reports to be
mailed to committee members for
review. |
| March 16, 1981 (Monday) | Anchorage | Meeting with contractor;
discussion of draft
reports. |
22. The meeting was adjourned at approximately 3:00 PM.

Attachments:

- No. 1 Draft Outline of Reports #1 and 2: Battelle
- No. 2 Current Membership List: Advisory Committee
- No. 3 List of Additional Persons in Attendance/Interested Parties
- No. 4 Agenda and Meeting Notice for January 5, 1981 Meeting.
- No. 5 Products, Interim Reports and Tasks Chart: Battelle
- No. 6 Project Schedule Chart: Battelle

STATE OF ALASKA

ATTACHMENT NO. 4

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

December 18, 1980

To: Members of Advisory Committee
Alaska Comprehensive Health Care
and Financing Study Project

From: Frederick McGinnis, Project Coordinator

Re: Meeting of Committee

The next meeting of the Advisory Committee for the
Health Care Study Project was decided by the committee
as follows:

Date: January 5, 1981 Monday

Time: 8:30 A. M.

Place: Room 426 McKay Building
338 Denali Street, Anchorage

We will look forward to seeing you at the meeting.

Preliminary Agenda

1. Call to Order : Introductions
2. Discussion of Membership Status
3. Review of Minutes: December 1, 1980
4. Determination of Agenda: This meeting
5. Review of Advisory Committee Role
6. Advisory Committee Procedures
7. Communications
8. Status of Contract Award
9. Review of Contract Provisions
10. Review of Accepted Proposal
11. Discussions with Contractor Representative
12. Recommendations to Department and Contractor
13. Other Business and Deferred Matters
14. Date and Place: Next Meeting
15. Adjournment

Enclosure: Minutes, Agenda, Membership List From meeting
on December 1, 1980

HB 41 TITLE & SPONSOR SUMMARY
AMENDED TITLE: C55SHB 41(FIN)(EFD FAILED)
AN ACT RELATING TO THE HEALTH OF RESIDENTS OF THE STATE;
AND PROVIDING FOR AN EFFECTIVE DATE

13:47 5/15/81 PAGE 1 OF 3

GENERAL DOLLARS: \$2,162,500 (F. NOTE)

PRIME SPONSOR: BUCHHOLDT.

OTHER DOLLARS: \$11,631,800

CO-SPONSORS: CATO, GARDINER, CLOCKSIN, ROGERS, FULLER, ZHAROFF, ADAMS, VASKA.

CURRENT STATUS: 4/30/81 IN (S) HESS

REFERRAL: FINANCE

HB 41 HOUSE ACTION

13:47 5/15/81 PAGE 2 OF 3

DATE SEQ PAGE

LEGISLATIVE ACTION

DATE	SEQ	PAGE	LEGISLATIVE ACTION
02/19/81	01	0296	FIRST READING -- COMMITTEE REPORTS
03/31/81	02	0754	HESS -- CS04, NR01
04/16/81	03	0963	FIN -- DNF02, CS08
04/16/81	04	0963	FIN FISCAL SUMMARY HSE SUPPL #28
04/24/81	05	1065	SECOND READING
04/24/81	06	1066	FIN CS ADOPTED BY UNAN CONSENT
04/24/81	07	1066	ADVANCED TO 3RD READING BY UNAN CONSENT
04/24/81	08	1066	THIRD READING
04/24/81	09	1066	PASSED BY DIV 21-14-05
04/24/81	10	1067	EFFECTIVE DATE FAILED BY DIV 22-13-05
04/24/81	11	1067	NOTICE OF RECONSIDERATION GIVEN
04/27/81	12	1093	FAILED TO RETN 2ND READING BY DIV 19-20-01
04/27/81	13	1094	POSTPONED UNTIL 04/29/81 BY DIV 21-18-01
04/29/81	14	1135	FAILED TO RETN 2ND READING BY DIV 14-21-05
04/29/81	15	1136	FAILED TO RETN 2ND READING BY DIV 14-20-06
04/29/81	16	1137	FAILED TO RETN 2ND READING BY DIV 14-21-05
04/29/81	17	1140	PASSED ON RECONSIDERATION BY DIV 22-14-04
04/29/81	18	1140	EFFECTIVE DATE FAILED BY DIV 23-13-04

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HB 41 SENATE ACTION

13:48 5/15/81 PAGE 3 OF 3

DATE SEQ PAGE

LEGISLATIVE ACTION

DATE	SEQ	PAGE	LEGISLATIVE ACTION
04/30/81	19	0912	FIRST READING -- COMMITTEE REPORTS
			HESS
			FINANCE
			RULES

**** ** **

*** *** ***

Would affect 44,000

House OKs health care

By MICHAEL MULNIX
Empire Staff Reporter

A major health-care bill which would provide state insurance to an estimated 44,000 Alaskans now without coverage or with inadequate health protection passed the House on a 21-14 vote today.

The state would pick up part of an individual's insurance tab as long as he is not enrolled in a group or federal health plan and does not make enough money to pay for complete protection.

According to the Batelle Research Center, of the 44,000 residents currently uncovered, 40 percent are children. The uncovered adult population includes primarily construction, cannery, firefighting and other seasonal workers, as well as fishermen, farmers, miners and employees of small businesses.

A cost-sharing program has been established for state plan participants and others currently without coverage an employer or the federal government helps to finance. The amount of cost sharing available depends on income, family size and the region of the state in which the insured person lives. The program would be targeted toward people not currently covered and not needy enough to qualify for federal assistance.

Initially, Natives were excluded from the program because they are covered under the Indian Health Service program. Rural lawmakers, however, said the IHS program is inadequate. The bill was therefore amended in committee to require the state to study the IHS and come up with ideas for improvements.

The entire program is estimated to cost about \$3.8 million in fiscal 1982 and \$13.2 million in fiscal 1983, skyrocketing to \$69.5

million by fiscal 1986.

Rep. Terry Martin, R-Anchorage, argued against the bill (CSS-SHB41), saying more study is needed.

"I know I'm shooting down motherhood and apple pie here, but I take this whole bill to be a cannon shooting down a mosquito," Martin said.

Martin said state officials should concentrate on reducing "duplication and triplication" and bureaucracy in state insurance programs before instituting yet another one.

Rep. Thelma Buchholdt, D-Anchorage, prime sponsor of the bill, said money spent to formulate the vast insurance program is "a very good way to invest in the people of the state."

"I would go so far as to make health care an inherent right of the people," she said. "We should take care of them."

The health plan would provide alcohol and drug dependency coverage, expand the state's Medicaid program to provide all services allowed by federal law and provide for a study of federal medical programs in the state.

Buchholdt stressed the plan is not a "give-away" program, but is based on an individual's ability to pay. She said the reason for the large, yearly increases in costs for the program would result from people becoming aware the plan was being offered.

The state now spends between \$440-488 million on health insurance yearly, Martin said. He said the new bill "promises nothing but more high expenditures."

Rep. Don Clocksin, D-Anchorage, chairman of the Health,

Continued on Page 2

Jim Empire
April 24, 1981

Health care...

Continued from Page 1

Education and Social Services Committee, argued that since the state now spends billions of dollars on other programs, it should be willing to spend some money on residents.

"We can have no better expenditure of money than to improve our health. There is no more important issue before the Legislature than the health of its people," Clocksin said. "We have existing programs, I agree. We have gaps in those programs, I agree. This bill will fill those in all of those gaps."

Rep. Terry Gardiner, D-Ketchikan, related the health plan to bills which allocate state money for housing, mining, fishing or other special interest groups.

"There's not a lot of equity in it (the insurance bill), but it's better than doing nothing," he said. "It doesn't mean it's wrong just because every citizen doesn't benefit from the program."

page 1, lines 15-18:

(c) The commissioner may contract for the underwriting [of the program] and [may contract for the] administration of the program. A contract entered into under this subsection shall be for a maximum of three years [period] and shall be based on competitive bids.

conversations with representatives in the insurance industry indicate that there may be some hesitancy to underwrite a "social" group whose characteristics are unknown, and that the state may need to underwrite the risk for the initial period of the program until risk factors are proven. Similarly, there may be some difficulty finding a company to sign a three year contract.

page 1. lines 19-23:

(d) The program shall provide for copayments and deductibles, and shall provide for an annual deductible payment for each member and a maximum deductible payment for each family unit.

(e) The program shall provide for the payment of reimburseable institutional and professional charges incurred by a member or covered dependent to a maximum level as determined by regulation. After such level is reached, the program shall provide for 100% of reimburseable charges.

the intent of (d), in addition to guaranteeing the use of copayments and deductibles in the plan, was to insure a type of "catastrophic" coverage to the plan with a limit on the out-of-pocket expenses in any given year to an individual and dependents.

page 3, line 4"

(9) "subsidized medical care" means medical care provided at reduced charge or no charge to an individual and their eligible dependents.

intent is to acknowledge that all types of subsidized care available is not necessarily free of charge.

median income figures for AC:

family of 4

\$ 31,037

family of 3

\$ 26,071

family of 2

\$ 21,105

single indiv.

\$ 16,139

direct costs. Catalog of Federal Domestic Assistance Number is 13.242, Mental Health Research Grants, and support is authorized under the Public Health Service Act, Section 301(c); Pub. L. 78-410 as amended, (42 U.S.C. 241, 242a). OMB Circular A-95 State and local clearinghouse review is not required for this program.

The purpose of this cooperative agreement is to support the development of appropriate data analytic methods for assessing patients' behavioral states and traits which have been measured by the different instruments used in these ongoing studies. More specifically, this will involve constructing and developing appropriate approaches to the analysis of behavioral data associated with subtypes of depression, and examining available data in order to develop reliable measures of outcome in the treatment of depression with tricyclic antidepressants.

Criteria used in the review of applications received in response to this announcement are as follows:

- (1) Adequacy of resources;
- (2) Experience with the different live and video assessment techniques utilized;
- (3) Ability to work with the various collaborating centers;
- (4) Publication history in this area of research.

Availability of Additional Information

The NIMH encourages persons interested in applying for this award to contact Dr. Stephen Koslow, Project Director for this program, (whose address and phone number are given above) for a statement of guidelines for preparing the application. Because this project is intended to assist in the analysis of behavioral data obtained from the current collaborative program on depression, the NIMH believes that information about the program up to now is essential in order to prepare an application.

Application kits (PHS 398) can be obtained from the Grants Operation Section, NIMH, Room 7C-05, Parklawn Building, 5000 Fishers Lane, Rockville, Maryland 20857. All applications should be submitted to Division of Research Grants, NIH, Westwood Building, 5333 Westbard Avenue, Bethesda, Maryland 20205.

Robert L. Trachtenberg,

Deputy Administrator, Alcohol, Drug Abuse, and Mental Health Administration.

[FR Doc. 80-35188 Filed 11-21-80; 8:45 am]

BILLING CODE 4110-66-M

Office of Human Development Services

Family Median Income by State; Eligibility for Social Services

Under the provision of sections 2002(a)(5)(B), 2002(a)(6) (A) and (B), and 2002(a)(14)(A) of title XX of the Social Security Act, promulgation is made of the median income of a family of four for each State, the District of Columbia, and the States as a whole applicable to the period October 1, 1981 through September 30, 1982. For those States whose 1982 fiscal year begins before or after October 1, 1981, this promulgation is also applicable. The purpose of the promulgation is to determine the extent of Federal financial participation (FFP) in State expenditures under title XX.

The above listed sections impose certain limitations with respect to the availability of FFP based upon the relationship of the income of the family of a service recipient to the median income of a family of four in the State.

Estimates of the median income of four-person families for each State and the District of Columbia were developed by the Bureau of the Census. In developing the median income scales, the Bureau of the Census used the following three sources of data:

(1) The March 1980 Current Population Survey; (2) the 1970 Census of Population; and (3) per capita personal income estimates from the Bureau of Economic Analysis. The methodology for adjusting median income for families of different sizes is specified in 45 CFR 1396.60.

The median income for a family of four, by State for fiscal year 1982 with calculation at the 80, 90, and 115 percent levels, is set forth below for use by States in establishing income ceilings and fee schedules under title XX of the Social Security Act:

Median Income for Families of Four for Fiscal Year 1982

State	Median Income ¹	80 percent of median income	90 percent of median income	115 percent of median income
48-Alabama	\$18,613	\$14,890	\$16,752	\$21,405
1-Alaska	31,037	24,830	27,933	35,893
16-Arizona	23,000	18,400	20,700	26,450
49-Arkansas	18,493	14,794	16,644	21,267
4-California	25,109	20,087	22,598	28,875
3-Colorado	25,228	20,182	22,705	29,012
9-Connecticut	24,410	19,528	21,869	28,072
30-Delaware	21,184	16,947	19,068	24,362
27-District of Columbia	21,310	17,048	19,179	24,507
37-Florida	20,757	16,608	18,681	23,871
13-Georgia	21,578	17,262	19,420	24,015
7-Hawaii	24,582	19,668	22,124	28,269
36-Idaho	20,429	16,343	18,388	23,493
12-Illinois	24,265	19,412	21,839	27,905
20-Indiana	22,614	18,091	20,353	26,008
21-Iowa	22,567	18,054	20,310	25,952
18-Kansas	22,048	17,638	20,563	26,275

Median Income for Families of Four for Fiscal Year 1982—Continued

State	Median Income ¹	80 percent of median income	90 percent of median income	115 percent of median income
46-Kentucky	19,138	15,310	17,224	22,009
39-Louisiana	20,166	16,133	18,149	23,191
50-Maine	18,074	14,459	16,267	20,785
5-Maryland	24,688	19,749	22,217	28,389
33-Massachusetts	23,788	19,029	21,407	27,354
9-Michigan	24,422	19,538	21,880	28,085
18-Minnesota	24,409	19,527	21,968	28,070
51-Mississippi	17,672	14,138	15,905	20,223
38-Missouri	21,294	17,035	19,165	24,488
31-Montana	20,051	16,041	18,046	23,059
35-Nebraska	20,749	16,599	18,674	23,881
7-Nevada	25,457	20,366	22,911	29,278
1-New Hampshire	22,335	17,868	20,102	25,685
6-New Jersey	24,640	19,712	22,176	28,338
12-New Mexico	21,032	16,828	18,929	24,187
31-New York	21,082	16,866	18,974	24,244
40-North Carolina	19,648	15,718	17,683	22,595
43-North Dakota	19,520	15,616	17,568	22,448
22-Ohio	22,528	18,022	20,275	25,907
33-Oklahoma	20,852	16,682	18,767	23,980
15-Oregon	24,031	19,225	21,628	27,638
20-Pennsylvania	22,314	17,851	20,083	25,661
25-Rhode Island	21,638	17,309	19,472	24,881
38-South Carolina	20,154	16,123	18,139	23,177
45-South Dakota	19,209	15,367	17,288	22,090
42-Tennessee	19,437	15,550	17,493	22,353
13-Texas	23,418	18,733	21,074	26,928
29-Utah	21,250	17,000	19,125	24,438
44-Vermont	19,214	15,451	17,383	22,211
9-Virginia	22,976	18,381	20,678	26,422
47-Washington	24,410	19,528	21,969	28,072
41-West Virginia	18,876	15,101	16,988	21,707
14-Wisconsin	23,518	18,814	21,168	27,046
47-Wyoming	22,073	17,658	20,406	26,074

¹Median income based on 1979 data.

NOTE.—The median income for a family of four in the 50 States and the District of Columbia, applicable to the period October 1, 1981 through September 30, 1982 is \$22,395.

(Catalog of Federal Domestic Assistance Program No. 13.771 Social Services for Low Income and Public Assistance Recipients)

Dated: November 18, 1980.

Cesar A. Perales,

Assistant Secretary for Human Development Services.

[FR Doc. 80-35188 Filed 11-21-80; 8:45 am]

BILLING CODE 4110-92-M

White House Conference on Aging; Technical Committee Meeting

The White House Conference on Aging Technical Committee was established to provide scientific and technical advice and recommendations to the National Advisory Committee on the 1981 White House Conference on Aging and to the Executive Director of the 1981 White House Conference on Aging in developing issues to be considered and to produce technical documents to be used by the Conference.

Notice is hereby given pursuant to the Federal Advisory Committee Act, (Pub. L. 92-463, 5 U.S.C. App. 1, sec. 10, 1976) that the Technical Committee on Older Americans as a Growing National Resource will hold their final meeting on Wednesday, December 17, 1980 from 9:30 a.m. until 3:30 p.m. in Room 5542 at

(2) Donated funds from private sources must:

- (i) be transferred to the State agency and under its administrative control;
- (ii) be donated to the State agency, without restrictions as to use, except that the donor may specify either or both of the following—

(A) the services, administration, or training for which the funds are to be used, if the donor is not a sponsor or operator of a program to provide such services, administration, or training.

(B) the geographic area in which the services are to be provided

(iii) not be used to purchase services from the donor unless the donor is a nonprofit organization and it is an independent decision of the State agency to purchase services from the donor.

(b) For purposes of this Part, a voluntary federated fund-raising organization is not considered to be a sponsor or operator of a service facility, and member agencies are considered separate autonomous entities so long as control by interlocking board membership or other means does not exist.

(c) In-kind contributions from public agencies, which do not meet the definition of third-party public agency in § 1396.53(d), must be valued in accordance with the cost principles specified in Subpart Q of 45 CFR Part 74.

(d) Under this Part a third-party public agency means any public entity (including Indian tribes) except—

- (1) Units of the State government; and
- (2) Units administering local governments in a State whose title XX program is State supervised and locally administered.

(e) The effective date of paragraph (c) of this section is October 1, 1980.

§ 1396.54 [Reserved]

§ 1396.55 [Reserved]

§ 1396.56 Fifty Percent Rule.

(a) If one-half of the Federal funds to which the State is otherwise entitled is greater than the amount of the aggregate expenditures (combined State and Federal) made under the program for individuals identified in this paragraph, such Federal funds will be adjusted so the total Federal reimbursement does not exceed twice the amount of the total expenditures in behalf of those individuals:

(1) Who are receiving aid and under the plan of the State approved under part A of title IV or who are eligible to receive such aid; or

(2) Whose needs are taken into account in determining the needs of an individual who is receiving aid under

the plan of the State approved under part A of title IV, or who are eligible to have their needs taken into account in determining the needs of an individual who is receiving or is eligible to receive such aid; or

(3) With respect to whom supplementary security income benefits under title XVI or State supplementary payments, are being paid, or who are eligible to have such benefits or payments paid with respect to them; or

(4) Whose income and resources are taken into account in determining the amount of supplemental security income benefits or State supplementary payments being paid with respect to an individual, or whose income and resources would be taken into account in determining the amount of such benefits or payments to be paid with respect to an individual who is eligible to have such benefits or payments paid with respect to him; or

(5) Who are eligible for medical assistance under the plan of the State approved under title XIX.

(b) In accounting for costs for services to meet the requirements of paragraph (a) of this section:

(1) In lieu of accounting for the status of each person receiving a service on the basis of group determination of eligibility, States may use generally accepted statistical sampling procedures.

(2) Regarding services to persons who receive services without regard to income (family planning services, services to prevent or remedy abuse, neglect or exploitation of children and adults, and information and referral services), States may use any appropriate method, including generally accepted sampling procedures or allocation of costs to the services provided these persons in the same ratio as the known cost of all other services distributed for the 50 percent rule.

Subpart F—Limitations: Individuals Served, Eligibility and Fees

§ 1396.60 Persons eligible and access to services.

(a) *Conditions for FFP.* FFP is available in expenditures for services to individuals provided that:

(1) The service is included in the State's services plan;

(2) The individual who receives the service is a member of one of the categories covered by the State's services plan; and

(3) Such individual was eligible under the provisions of this section and those of § 1396.61 at the time of receipt of the service.

(b) *Categories of individuals who may receive services—*

(1) *Income maintenance status.* The following individuals are eligible on the basis of income maintenance status:

- (i) Recipients of AFDC;
- (ii) Those persons whose needs were taken into account in determining the needs of AFDC recipients; and
- (iii) Recipients of SSI benefits or State supplementary payments.

(2) *Income status.* Individuals other than those described in paragraph (b)(1) of this section, are eligible if the family's monthly gross income is less than 115 percent (or, at State option, a lower percentage) of the median income of a family of four in the State adjusted for size of family, subject to the limitations set forth in § 1396.62. Income status individuals include those whose eligibility is determined on a group basis.

(3) *Without regard to income.* Individuals may be provided family planning services under § 1396.63, information or referral services under § 1396.64, or services to prevent or remedy neglect, abuse, or exploitation of children or adults under § 1396.65, without regard to income at State option if the State so provides in its services plan.

(c) *Median income.* (1) On or before December 1 of each year, beginning with calendar year 1975, the Secretary will promulgate the median income for a family of four for each State and for the 50 States and the District of Columbia. This promulgation shall be used for purposes of determining eligibility and establishing fees in the following Federal or State fiscal year.

(d) *Income levels as baselines for fee imposition.*

(1) Except for individuals whose eligibility is determined on a group basis, individuals whose eligibility is based on income status shall be subject to imposition of a fee for service (in accordance with § 1396.62) if their family's monthly gross income exceeds 80 percent of the median income of a family of four in the State or the median income of a family of four in all States, whichever is less, and does not exceed 115 percent of the median income of a family of four in the State, adjusted for family size.

(2) The median incomes (at 80 percent and 115 percent) as calculated in paragraph (d)(1) of this section for a family of four, shall be adjusted for family size according to the following percentages:

- (i) One person—52 percent.
- (ii) Two person family—68 percent.
- (iii) Three person family—84 percent.
- (iv) Four person family—100 percent.

COMMENTS

The Division of Insurance is limiting its comments to Section 1 of the bill which adds a new chapter to AS 18. The new chapter primarily impacts the Department of Administration but also affects the Division of Insurance.

The new chapter creates a State Comprehensive Health Plan (SCHP) with benefit standards to be established by the Commissioner of Administration. Eligible persons for SCHP are residents of the State.

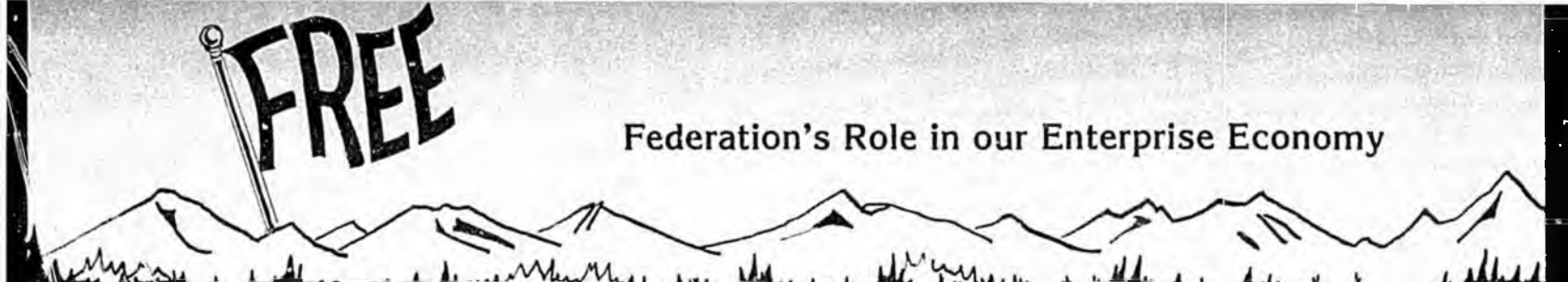
SCHP also provides for a cost sharing program for persons with certain adjusted gross income levels. The program is available for SCHP coverage or certified individual policies.

There is one area in the proposed chapter which affects our program. It is the sole cause of the fiscal impact noted. On page 2, lines 1-5 and 28, there is a reference to certification of individual health insurance policies used to provide coverage under the proposal. This approach would put the Division of Insurance into a paper shuffle that we are trying to avoid in favor of a more effective approach. If the approach is pursued, changes in AS 21.42 would be necessary to give the Director of Insurance authority to adopt the necessary regulations to implement the certification procedure. When an insurer elects to be active in a particular marketplace, it is a voluntary decision. The proposed approach tends to put procedural roadblocks in front of the insurer and tends to delay the time frame between the decision to provide a market and the date they can actually provide a market.

The amendments we have suggested do several things. It takes the fiscal burden off the division thus reducing the fiscal note to zero. It dramatically reduces the time frame between decision to provide a market and the date it can actually be provided. It is a more efficient approach since certification by the director can still result in error thus allowing a policy not meeting the standard to be used in the program. The amendment requires that the insurance company certify that its policy meets the minimum standard under the SCHP. Having done that, the policy provides at least the minimum standard coverage whether the language of the contract specifically provides the standard or not. This new approach would place responsibility for contract content with the insurer and eliminate the need for further paper shuffling by the State.

In addition, to the direct program impacts, we have several observations that may require a clarification of intent or reaction by the Legislature.

1. There is no definition of resident.
2. There is no limitation of coverage for preexisting medical conditions.
3. Adjusted gross income is not defined.
4. Section is silent concerning the mechanics of cost sharing program including timing and proof. Potential fraud in the system needs to be considered so that State supplements will indeed be used for the purpose intended.



FREE

Federation's Role in our Enterprise Economy

April 2, 1982

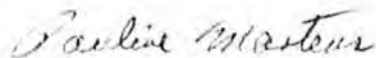
Senator Charles Parr
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Parr:

We would like to commend you on your efforts to maintain a fiscally responsible budget. In line with this thinking, we would like to reaffirm our opposition to HB 41 and SB 417 relating to health insurance for residents in the state.

We know that you recognize that with the recent changes in Federal social programs, this legislation will be of primary focus in the ensuing months. Last year the GFWC FREE Committee drafted position papers on both of these bills which you have in your possession. In light of the recently completed Battelle Study and its inconclusive results, we maintain our opposition to the entire concept of socialized medicine.

Sincerely yours,



Pauline Martens, Chairman
GFWC FREE Committee

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599
Fairbanks, Alaska 99701
(907) 456-5029

Pouch V
Juneau, Alaska 99811
(907) 465-4907

May 18, 1981

Ms. Ann Croswell
P. O. Box 571
Kodiak, Alaska 99615

Dear Ms. Croswell:

Thank you for your letter of May 14.

I am not aware of the contents of the various studies you refer to. If what you say is accurate, the Battelle Study is unnecessary.

I was not a member of the Health, Education and Social Services Committee in the previous legislature, and do not know what went into the decision to fund that study. Since it is ongoing, however, it does seem advisable to wait until we have the results before taking action of the scale required by HB 41.

Sincerely,

Charles H. Parr

CHP:vc

May 14, 1981

Senator Charles Parr
Alaska State Legislature
Pouch V
Juneau, Ak. 99811

Dear Senator Parr:

Thank you for responding to my letter regarding H.B. 41. I recently had the opportunity of speaking to both Representative Zharoff and Senator Mulcahy regarding several bills I have been following. Both Representative Zharoff and Senator Mulcahy informed me that H.B. 41 probably will not be passed during this legislative session. It seems that there is concern that the Battelle study be completed before the State Health Insurance Plan be implemented. My concern is that first, my health might not hold out and that second, a similar study has already been done by the Legislative Affairs Agency in 1978. In this study, much of the research and information regarding the gaps and barriers in health care in Alaska has been gleaned. As an employee of the Kodiak Area Native Association from 1978 to 1980, I assisted in writing the KANA Five Year Health Plan. It was a comprehensive document containing much information regarding health care on Kodiak Island. To my knowledge, all the Native Non-Profits in Alaska completed similar health plans.

It would seem to me that there are many valuable documents available containing the exact information the Battelle study would show. It does exasperate me to think that duplication takes precedence over a desperately needed health insurance plan.

I urge your continued support of H.B. 41. Thank you.

Sincerely,



Ann Croswell

cc: Alaska Health Care Advocates

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599
Fairbanks, Alaska 99701
(907) 456-5029

Pouch V
Juneau, Alaska 99811
(907) 465-4907

May 21, 1981

Mr. Ronald L. Bliss
Secretary
Health Alaska, Inc.
P. O. Box 1239
Anchorage, Alaska 99510

Dear Mr. Bliss:

Senator Fahrenkamp has kindly forwarded me a copy of your letter of May 5 regarding the Individual Practice Association.

The Health, Education and Social Services Committee plans to do a great deal of work during the interim on the Health Care System of the State. Your suggestion will certainly be considered along with others. We will look forward to your assistance as we search for a better way to provide and pay for our health care.

Sincerely,

Charles H. Parr

CHP:vc

SENATOR BETTYE FAHRENKAMP
CHAIRMAN, RESOURCES COMMITTEE

4016 EVERGREEN
FAIRBANKS ALASKA 99701

907-479-3550



Senate

May 18, 1981

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
OFFICE 907-465-3763
RESOURCES COMMITTEE
907-465-3834
HOME 907-789-9182

Ronald L. Bliss
Secretary
Health Alaska, Inc.
P.O. Box 1239
Anchorage, Alaska 99510

Dear Ron:

Thank you for your letter with reference to health care services and the attached draft legislation. I think it is always a good idea to use existing services.

By a copy of this letter I am forwarding your letter and enclosure on to Senator Parr who is chairman of the HESS Committee.

Sincerely,


Bettye Fahrenkamp
Alaska State Senator

BF/ab

✓ cc: Senator Parr w/encl.

AT B 11

Health Alaska, INC.

P.O. Box 1239 Anchorage, Alaska 99510

May 5, 1981

Handwritten note:
The Alaska Health Care Commission is interested in this letter. It is being reviewed by the Commission and will be sent to the Governor's office for his review.

Senator Bettye Fahrenkamp
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

We represent a diverse community group united for the purpose of arresting the alarming rise in health care costs.

The rate of inflation for health costs is approximately double that of the general rate of inflation. Each and every hour the cost of providing health care services in this country rises by approximately one million dollars. These increases are unfortunately not due to providing substantially greater amounts of health care; rather they reflect higher costs for approximately the same level of service.

These staggering figures assume an even more ominous nature when considered in light of the fact that health care cost impacts all sectors of the economy. Public budgets are being eroded to an increasing degree by health care expenditure. Private businesses are forced to pass along higher health related personnel costs in higher prices. Consumers must commit a greater portion of their inflation ravaged income to the purchase of health care.

Health Alaska, Incorporated, a non-profit Alaskan corporation, was formed for the purpose of establishing a health care delivery system possessing the twin attributes of cost efficiency and quality care. We propose to create a prepaid group health plan based on an Individual Practice Association (I.P.A.). Simply stated, under this system a group of consumers prepay a certain fixed amount for a comprehensive health care package. The health services are then rendered by individual health providers who belong to the I.P.A. and practice in their own offices or facilities.

There is no need to develop a complex, costly and cumbersome bureaucratic organization to deliver health care services under this system. We propose to utilize the already existent institutions, facilities and insurance mechanisms which can easily adapt themselves to participate in an I.P.A.

The cost containment advantages of an I.P.A. are based on the unusual nature of the health care market. In the health care market, the supplier, or provider also determines the level of demand by the amount of care they prescribe. Under the current fee for service system, there are no incentives to limit the services, and thus the fees. With an I.P.A., the provider must render all services for a fixed sum of money; this instills the necessary incentive to avoid over-treatment and become more cost efficient.

Due to their cost cutting effectiveness, the number of functioning prepaid group health plans in the nation has increased dramatically over the past few years. There was a 43% increase in the total number of operational prepaid group health plans between 1977 and 1980. Approximately 10 million people are now covered under a prepaid group health plan. We believe the time has come for this state to develop an Alaskan plan for the benefit of Alaskans.

After a few years of research and planning, Health Alaska, Incorporated is ready to embark on initial development of an I.P.A. With the assistance of Health Sector Management, Incorporated, a feasibility study has been completed for the Anchorage area. The results indicate strong financial and demographic support for the development of an I.P.A. While our initial efforts are directed toward Anchorage, our goal would be to eventually function statewide. We will send you a copy of the feasibility study shortly, after the final printing has been completed.

Accompanying this letter is proposed legislation seeking funds for initial start-up costs. We have access to federal funds; however, we would much prefer to make this a wholly Alaskan venture.

At this time, when the state is seriously considering entering the health insurance field, we believe the creation of an I.P.A. would be a positive step forward: controlling state health care expenditures, easing the health cost burden for businesses, and providing relief for the citizens.

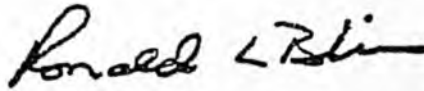
While we are seeking a small amount of public funds for initial development purposes, we are strongly committed to the concept that the solution to this problem lies in effective redirection of private sector resources. We have no desire to become a ward of the state.

All of the Board members are at your disposal to discuss this subject further. We recognize the current press of legislation and the demands on your time. We would greatly appreciate any assistance you could offer in securing passage of our proposed

legislation.

Thank you for your time.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Ronald L. Bliss".

Ronald L. Bliss, Secretary

RLB:bj
enc

DRAFT LEGISLATION
FOR STATE PARTICIPATION IN THE DEVELOPMENT
OF A PREPAID HEALTH PLAN

A BILL

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

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA

Section 1. DEFINITIONS. In this chapter

- (1) "Prepaid health plan" is an organization which, for a predetermined monthly fee, provides a comprehensive range of health services to its enrollment.
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- (4) "Individual practice association" is a form of prepaid health plan which provides physician services to its enrollment through private practitioners located in their existing offices.

Section 2. DEVELOPMENTAL PERIOD.

- (1) Health Alaska, Inc. is a non-profit, locally sponsored Alaskan corporation, chartered to provide quality, cost effective health care services to its enrollment on a prepaid basis using the individual practice association model.
- (2) A feasibility study has been completed which clearly demonstrates market and financial feasibility within the Municipality of Anchorage.
- (3) The prepaid health plan concept has demonstrated that it can have a retarding effect on the rate of increase in the cost of health care. It will provide a benefit package which is at least the equivalent of existing indemnity coverage.

(4) Developmental support funding is required to:

- (a) Hire full time professional staff;
- (b) Put into place the appropriate organizational and contractual documents;
- (c) Cover other costs such as consultants, office space, and travel.

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- (1) The sum of Three Hundred Thousand Dollars (\$300,000) is appropriated to support the cost of bringing Health Alaska, Inc. to the point of beginning operations.

Section 4. EXPANSION TO OTHER PARTS OF ALASKA.

- (1) At appropriate points in time, Health Alaska, Inc. will expand its operations to other population centers within the state.

HealthAlaska, Inc. - 1981

Chairman

Bruce Eliassen, Controller
Hickel Enterprises
The Hotel Captain Cook
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Anchorage, Alaska 99510
(907) 276-7400

Treasurer

Terrence H. Hayden, Vice President
Commercial Loan Review
Corporate Headquarters
National Bank of Alaska
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Member

Stan Howitt, General Counsel
Alaska Electrical Trust Funds
Denali Towers, Suite 200
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(907) 276-1246

Member

Larry Buchholtz
Worker's Compensation
3301 Eagle
Anchorage, Alaska 99503
(907) 264-2424 H 376-3671

Member

Beverly J. Dubie Michaels
c/o Central Alaska Broadcasting Co.
(KIMO 13)
2700 Tudor Road
Anchorage, Alaska 99507
(907) 276-1313 H 349-7167

Vice Chairman

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2801 DeBarr Road
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(907) 276-1131, Ext. 703

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(907) 279-4571

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(907) 276-4334



ALASKA HEALTH CARE ADVOCATES

P.O. BOX 1037 D.T. ANCHORAGE, ALASKA 99510 272-8734

February 24, 1981

Dear Friend,

As you know, the cost of health care in Alaska continues to skyrocket. According to U.S. Labor Dept. figures medical care costs in Fairbanks rose by more than 14% last year, while the cost of medical care in Anchorage rose at a 15.3% rate. Both of these figures are well above the 11.1% average inflation rate among U.S. cities.

Particularly hard hit by these inflationary trends is Alaska's large low-moderate income population. The Alaska Department of Revenue reports that for 1978, 68% of the state's residents had annual incomes of under \$25,000.00.

Yet, there are glaring deficiencies in the state's health care financing programs. The number of uncovered or inadequately covered persons numbers in the thousands. Enclosed is a copy and section by section analysis of House Bill 41, a comprehensive health care financing bill in the current session of the State Legislature designed to make health care more available and affordable.

The bill would establish minimum benefits standards for a comprehensive insurance plan open to all residents who choose to enroll, and are eligible. The state would subsidize, on a sliding fee scale, the insurance premiums and deductibles for moderate income residents who are't covered under an existing plan, and choose to enroll in the state plan.

The bill would also:

- Require state employee health insurance to include coverage and benefits for drug and alcohol dependency. This would be a pilot program to see if it might be feasible to expand such coverage to other groups;
- Mandate the purchase of private insurance for those who are presently covered under Medicaid, if and when the state decides this is cost effective;
- Authorize interim payments to doctors and hospitals who have a large volume of medical assistance clients. The state would also be required to pay an interest on overdue Medicaid bills, 1% per month after 30 days and 2% per month after 90 days.
- Expand Medicaid services and eligibles in Alaska to include physical therapy adult dental care, coverage for unemployed fathers and caretaker relatives of a child over 18 and under 21, among others

- * BUT TO INSURE PASSAGE OF LONG-OVERDUE REFORMS, WE NEED YOUR HELP.
PLEASE SUBMIT WRITTEN TESTIMONY TO YOUR LOCAL REPRESENTATIVE AND GOV. HAMMOND
- * PLEASE TESTIFY AT THE TELECONFERENCE, MARCH 2, at 3 p.m. (Juneau Time), 1:00 p.m. Anchorage time.
- * If you have any questions or comments regarding this, please do not hesitate to contact us at 272-8734. We look forward to hearing from you.

For Health Care Advocates

David Pierce

Susan Johnson



ALASKA HEALTH CARE ADVOCATES

P.O. BOX 1037 D.T. ANCHORAGE, ALASKA 99510

272-8734

A LARGE PROPORTION OF THE PEOPLE WHO WOULD BE AFFECTED BY HB41 ARE WOMEN. THE MEDICAID PROVISIONS WOULD IMPACT WOMEN AS WOULD THE SECTION WHICH WOULD ALLOW THE STATE TO USE MEDICAID FUNDS TO PURCHASE PRIVATE INSURANCE PREMIUMS FOR MEDICAID ELIGIBLES. WHY ?

According to Randy Moore of the State Dept. of Health and Social Services, the number of Medicaid eligibles last December was the highest in four years. This was the last month for which Medicaid statistics were available.

December, 1980

AFDC— Total Medicaid eligible: 15,889 people. That is 5,049 adults and 10,840 children.

March, 1979

The figures for March 1979 are applicable to the 1980 Medicaid population.

93.7% female
4.5% male
1.8% not stated

Children in the AFDC group included:
49.3% female
50.7% male

Open door - limited svcs.
Neighborhood Health - has 1 nurse
practitioner in pre-natal
takes medicaid but seeks
to serve ^{lower} middle income
people.

Health Alaska, INC.

P.O. Box 1239 Anchorage, Alaska 99510

May 4, 1981

Senator Charles Parr, Chairman
Health, Education & Social Services
State Capitol
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

We represent a diverse community group united for the purpose of arresting the alarming rise in health care costs.

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Senator Charles Parr, Chairman
May 4, 1981
Page 3

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All of the Board members are at your disposal to discuss this subject further. We recognize the current press of legislation and the demands on your time. We would greatly appreciate any assistance you could offer in securing passage of our proposed legislation.

Thank you for your time.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Ronald L. Bliss". The signature is fluid and cursive, with the first name "Ronald" being more prominent.

Ronald L. Bliss, Secretary

RLB:bj
enc

DRAFT LEGISLATION
FOR STATE PARTICIPATION IN THE DEVELOPMENT
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Member

Stan Howitt, General Counsel
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How the Health Plan and the cost sharing program would work

The State Comprehensive Health Plan envisioned in section 1 (hereafter referred to as "the Health Plan") would be most attractive to those who have no coverage now, or those who have coverage that provides fewer benefits than the Health Plan would provide. The first group is comprised largely of those with high risk health conditions that make them ineligible for most individual health insurance policies; non-union or seasonal workers such as fishermen, cannery workers, construction workers, and legislative employees; and self-employed individuals. The latter group consists largely of those with individual health insurance plans.

The State Health Insurance Cost Sharing Program in section 1 (hereafter referred to as "the cost sharing program") would be attractive to many Alaskan individuals and families whose income is less than 125% of the median adjusted gross income figure for each family size. As long as a resident is enrolled in the Health Plan or a plan with comparable or better benefits for which no cost sharing is available from an employer or another source, the resident would be eligible for cost sharing under the program. The cost sharing program would also be an incentive to carriers who currently offer nonsubsidized policies with less than comparable benefits to upgrade their policies so that they will be competitive with the Health Plan.

The Department of Administration will report back to the legislature at the beginning of next session on various aspects of the Health Plan and the cost sharing program. After the legislature approves the Department's plans, the Department will engage in extensive advertising of the Health Plan and the cost sharing program, and coverage and cost sharing will commence on July 1, 1982. The advertising is necessary to ensure that as many people as possible know of the Health Plan and the cost sharing program so that they can enroll immediately in July if they wish to.

It is important to recognize the distinction between the Health Plan and the cost sharing program. Although cost sharing under the program is available to all enrolled in the Health Plan who meet the income and other requirements of the program, cost sharing is also available to residents enrolled in individual private plans that are certified as equivalent to the Health Plan. Cost sharing is not available to those enrolled in another form of subsidized health care plan, such as an employer or union sponsored plan, or a federal health program. Thus, the Health Plan offers coverage to anyone and especially to those who are currently without it, and the cost sharing program helps the Health Plan's participants and others defray the costs of health care financing.

The cost sharing program is based on incomes of family units; it helps single individuals and families with incomes less than 125% of median income figures. The subsidy schedule distinguishes between premium cost sharing and out-of-pocket cost sharing. Cost sharing for premium payments is available to all those with income less than 125% of the median income

because a family will automatically incur this cost in order to have insurance without ever getting sick. However, cost sharing for out-of-pocket expenses-----which represent the state's share of the consumer's costs when actually seeking health care-----is only available for those who could not afford to meet such expenses without the state's help. The philosophy behind the cost sharing distinction is that the consumer should be encouraged to seek health care only when necessary, and that the best incentive to achieve this policy objective is to insure that the consumer who can afford it, pays for the bulk of his health care expenses.

Eligibility and determination of the level of cost sharing will be performed by the Department in accordance with statute. An individual wishing to join the Health Plan would present proof of eligibility and proof of his level of cost sharing authorized under the cost sharing program to the insurance carrier, who would enroll the resident in the Health Plan. Every participant then, regardless of their income and subsidy levels, would sign up for the Health Plan in the same manner. They would also present their insurance card or other proof of insurance to a provider of care just as any other insured person would do. Claims payment would also be similar to other health insurance policies. Depending on the provider's usual arrangement, the individual would either pay his share of the bill directly to the provider or be billed for his share by the carrier. This would also be the arrangement for those enrolled in the cost sharing program and not in the Health Plan, when provider visits are necessary.

Provider reimbursement under the Health Plan would be the responsibility of the carrier. The carrier would make reimbursement payments directly to a provider and there would be no need for the state to serve as an intermediary in the performance of this function although some monitoring of the carrier's claims payment procedures would be necessary. The state would establish a running account from which the carrier could make claims payments. Claims data and other fiscal information would be compiled by the carrier and be available for the Department's use. The Department would have to keep records on participant's eligibility and subsidy status and perform certain other administrative functions. However, the private carrier will perform the bulk of administrative tasks in the form of claims payment.

Sponsors' Suggested Amendments to SS HB 41

page 1:

line 20--- "amount of copayments and deductibles for each enrolled resident and the resident's covered dependents for"

page 2:

line 7---"plan or covered under a [state or] federal health program and"

page 7:

line 1---"~~hospital or dental service contracts that provide one or more of the medical~~"

line 12---"Sec. 47.05.080. CONTRACTS WITH [DIRECT PROVIDERS OF CARE AND SERVICE.] FISCAL INTERMEDIARIES."

page 9:

line 2---"participation, not including residents eligible under the medically needy option, are eligible for medical assistance."

line 7---" [Services] Security Act."

line 8--- new section 12 to read as follows: " * Sec. 12. AS 42.07.080 is amended by adding a new subsection (5) to read as follows:
(5) "medically needy" means a person who meets the categorical requirements of eligibility for medical assistance, but whose income exceeds the income standard for categorical assistance and is less than the medically needy income standard." Renumber remaining sections appropriately.

line 10---"* Sec. 14. Sections 5-8 [and 10-12] of this Act take effect January 1,"

line 13---"* Sec. 16. Sections 2, and 3, and 10-12 of this Act take effect immediately in"

CSSSHB 41 (HESS): How it would effect Medicaid in Alaska

To get federal funding for Medicaid services, a state must offer certain mandatory services to certain mandatory groups of eligibles. In addition, it can choose to offer other optional services to other optional groups of eligibles.

Alaska currently offers all mandatory services to all mandatory groups of eligibles. In addition, it offers some optional services to some optional groups of eligibles. CSSSHB 41 (HESS) would require the state to offer all services, mandatory and optional, to all groups of eligibles, mandatory and optional, for which federal funding is available on March 1, 1981, except for those considered "medically needy". The bill does not require the state to pick up the medically needy option because these individuals would be covered under the Plan established in section 1 of the bill; anyone with an income less than 150% of the poverty guideline would receive 100% state subsidy for the cost of the Plan.

This summary describes which services and eligibles are currently provided for in Alaska and which would be added if CSSSHB 41 (HESS) is enacted.

The question of how much will be cut from the federal budget allocation to Alaska for Medicaid is not an easy one to answer. We will not know for sure until Congress acts, since several different ideas are currently being considered. Staff has more information on the different proposals if members are interested.

(IC, using H&SS Medicaid coverage information: 4/2/81)

MEDICAID ELIGIBLES*

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent of AFDC child or other specified relative

Child between 18 and 21 who is a dependent of an AFDC household

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

All children in foster homes or private child-caring institutions

Eligibles added by SS HB 41

Child deprived of support of parent due to unemployment

Spouse of disabled parent

Spouse of unemployed parent

Pregnant woman and unborn child

All other financially eligible children

Caretaker relative of child over 18 but under 21 and not a dependent in an AFDC household

Individuals who would be eligible for AFDC except for child care costs

* In addition to these categorical criteria, a person must also be financially needy

Currently Covered Services

Hospital---inpatient and outpatient

Skilled nursing facility (SNF)

Intermediate Care Facility (ICF)

ICF for mentally retarded persons
and persons with related conditions (ICF/MR)

Laboratory and x-ray services

Physician services

Visual care services, dispensing and
ophthalmic materials

Medical transportation

Speech, hearing, and language services

Psychiatric facility services

Home health care services

Early periodic screening, diagnosis,
and treatment of individuals under 21 (EPSDT)

- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community mental health clinics

Family planning services

Patient surgical care centers

Rural health clinics

Services Added by SS HB 41

Podiatrist services

Chiropractic services

Private duty nursing

Personal care services

*Physical therapy

*Occupational therapy

*Prescribed drugs

Adult dentures and routine dental services

*Adult emergency dental services

*Prosthetic devices and medical supplies

Other diagnostic, screening, preventive & rehab. services

Services to those over 65 in mental institutions

Services to those over 65 in tuberculosis institutions

Other practitioner services

- a. private psychologist
- b. nurse practitioner
- c. physician assistant

Clinic services---other than comm. mental health clinic

Services by Christian Science nurses

Services by Christian Science sanatoria

* Currently available through General Relief Medical

OF COUNSEL
M. E. MONAGLE

R. E. ROBERTSON (1885-1981)
F. O. EASTAUGH
J. B. BRADLEY
WILLIAM G. RUDDY
L. B. JACOBSON
MICHAEL T. THOMAS
JAMES F. CLARK
PAUL M. HOFFMAN
J. P. TANGEN
D. ELIZABETH CUADRA
HAROLD E. SNOW, JR.
PAMELA L. FINLEY

ROBERTSON, MONAGLE, EASTAUGH & BRADLEY

A PROFESSIONAL CORPORATION

ATTORNEYS AT LAW
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May 14, 1981

The Honorable Charles Parr
Chairman, Health, Education &
Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

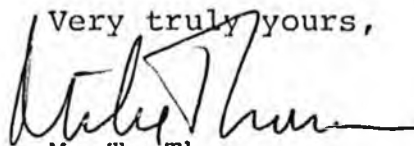
Re: House Bill 41 and Senate Bill 417

Dear Senator Parr:

The Health Insurance Association of America and
the American Council of Life Insurance are interested in the
above bills. This letter is to request that someone in your
Committee notify my office when the above-referenced bills
are to be heard.

Thank you for your courtesy.

Very truly yours,


M. T. Thomas

POSITION PAPER
SPONSOR SUBSTITUTE
HOUSE BILL NO. 41
"An Act relating to the health of residents of the state; and providing for an effective date."
I. DEPARTMENTAL OVERVIEW OF SPONSOR SUBSTITUTE HOUSE BILL NO. 41
Sponsor Substitute House Bill No. 41 is composed primarily of four parts:
a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan to provide health insurance benefits for all Alaskans who are otherwise not covered under a private or public health plan and includes a cost-share program wherein the State may share in paying for insurance of low income persons.
b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that CERTAIN Group insurance plans include coverage for alcoholism and drug dependence.
c. Section 9 allows the Commissioner of Health and Social Services to contract for medical services through insurance companies and other health organizations for the payment and/or delivery of medical services to Department beneficiaries.
d. Sections 10 and 11 expand the Medicaid program by adding new services and beneficiaries.
II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS
The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Department is supportive of the provision or development of this method of health care financing. However, the Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Financing Study" for the purpose of informing all Alaskans of various alternatives to coordinating existing health resources, identifying and filling gaps where health resources currently do not exist and methods of financing services in a comprehensive and coordinated way.
With this study in mind the Department is concerned that the report required in Section 2 of SSHB-41 have the benefit of the comprehensive data and recommendations that will be included in the Governor's study. At present the Governor's study is to be completed by December 15, 1981. This timing does not provide the opportunity to the Department of Administration to consider the information in the Governor's study and report by the 10th day of the 1982 legislative session. Therefore, the Department recommends that line 13, page 3 be amended to read as follows:
"The Commissioner of Administration shall report by the (10th) 90th day of the Second Session of the Twelfth State Legislature on:"

POSITION PAPER

SPONSOR SUBSTITUTE

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The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8, we support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other government units.

We believe such benefits have the potential to be cost-saving for the state, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9 we support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, not just those that have been added piecemeal to the state statutes. We would rather see additional eligible groups phased into the program than all remaining groups being added at a single time. Each group should be evaluated on its own merits, rather than in mass to determine whether it is necessary to include them and what the cost of each might be.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. Again, we would rather phase into additional services than add all services at a single time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) - ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees:

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employees health benefits package and make such coverage optional to employees of governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of need alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organizations around the country (Kennebec Coppin, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structural Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers. The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

IV. SPECIFIC DEPARTMENTAL DISCUSSION OF SECTIONS 9, 10 AND 11 (MEDICAL ASSISTANCE)

Section 9 - Line 25 on Page 6 Through Line 27 on Page 8:

AS 47.05.070 - Provides the Commissioner of DHSS the option of purchasing and paying premiums on policies of insurance or paying the expenses of health maintenance organizations service contracts or medical or hospital service contracts. As indicated we support this concept and would only suggest that "health maintenance organizations" be defined.

AS 47.05.080 -- Recommend deletion of this section entirely. Current federal laws and regulations adequately cover the methods of contracting for health, medical and remedial services, and supplies. Also Alaska's current statutes and regulations concerning uniform purchasing (AS 37.050.220 - 330) provide contracting authority and obligate contractors to make payments promptly as provided in contract. If this portion is left in the bill, the term "remedial care" should be defined.

AS 47.05.100 - We support the intent of this portion of the bill, however, we would like to offer an amendment as follows:

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

- (1) interest at the rate of two percent per penalty month when payment is delayed more than 60 days after presentation of the clean claim. A "penalty month" starts on the 61st day and consists of 30 day increments thereafter until the claim is paid.
- (2) Providers should receive a full month's interest entitlement if the bill is paid after the 15th day of any penalty month.

This change accomplishes the intent of the bill, however, provides less administrative problems and costs for providers and the state in accounting for interest owed and received.

AS 47.04.120 - Add definition of "health maintenance organization", "non-exclusive contract", "medical or hospital service contracts", and "remedial care".

Section 10 - Line 28 on Page 8 through Line 2 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, primarily the unborn child group, the unemployed father, caretaker relatives, individuals under 21 and the medically needy group.

As stated earlier the Department would rather see additional eligible groups phased into the programs instead of all remaining groups being added at a single time. We would suggest the categorical groups be added in the following timeframes:

- (1) July 1982: Unborn Child Group
Caretaker Relatives
Individuals Under 21
- (2) July 1983: Unemployed Father Group

By phasing in the categorical groups in this manner a number of benefits would result:

- (1) The Department will have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented and the added administrative burden will be eased.
- (3) The Department would be prepared in advance with regulations and staff to handle the added recipient volume.

The Department recommends that the medically needy group not be added under Medicaid but instead be included under the state comprehensive health plan portion of SSHB-41.

Medicaid eligibility is broken down into two types: categorically needy and medically needy. Categorically needy includes those individuals whose eligibility is based on their income being below an amount based on cash assistance payments (under the AFDC, APA, and SSI programs). Medically needy goes beyond categorically needy to provide coverage to those individuals who meet the categorical eligibility requirements of the cash assistance programs (age, disability or deprivation of parental support), but who are not eligible for cash payments because their income is too high. Under medically needy they would be permitted to spend a portion of their income on their medical needs and thus become eligible for Medicaid to pay the remaining cost of the covered services. To a certain extent, medically needy coverage under Medicaid would duplicate coverage under the comprehensive health plan and the cost-sharing program, but would permit the State to receive federal funds to provide part of those services. However, at the income levels permitted under the Medicaid medically needy program, individuals who would receive health coverage at no expense under this bill would be required to pay part of their income for health care under a medically needy program.

Section 11 - Lines 3 Through 7 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under the Medicaid program. The Department recommends that each service be evaluated on its own merits, adding only those services that are important to maintaining the general health of Medicaid recipients. It is suggested the following services be specified listed in SSHB-41 rather than the current blanket provisions:

- POSITION PAPER/Department of Health and Social Services
- (1) Physical Therapy
 - (2) Occupational Therapy
 - (3) Prescribed Drugs
 - (4) Prosthetic Devices and Medical Supplies
 - (5) Other Practitioner Services

- a. private psychologist
- b. nurse practitioners
- c. physician assistants

- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and would permit DHSS to claim federal funds for other services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program. It should be emphasized that while a broad category of service under Medicaid permits DHSS to make payment for services, DHSS is required to establish the conditions under which payment will be made. For each category of service, DHSS creates controls to assure that only medically appropriate treatment receives reimbursement.

The creation of a comprehensive health plan with a cost-sharing program as contained in section 1 would permit the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified to assure that GRM is not a disincentive to participation in the comprehensive health plan. One method of doing this would be to limit GRM coverage to one episode during any 12 month period.

The relationship between the comprehensive health plan with the cost-sharing program and the present catastrophic illness program should be clarified. The cost-sharing program requires that beneficiaries of the comprehensive health plan incur some portion of the expenses of the program based on their ability to pay. If the deductible requirements under the catastrophic illness program are nearly as low as or lower than those under the cost-sharing program, there will be little incentive for anyone to participate in the comprehensive health plan, in part defeating the intent of the bill. Since most payments made under the catastrophic illness program are for major medical types of coverage that may be covered under the comprehensive health plan, there is potential for overlap.

SUMMARY OF BUDGET FOR SSHB41

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	18,413.4	11,631.8	6781.6	12
(2) ADDITION OF MEDICAID MEDICALLY NEEDY GROUPS	9,029.7	5,709.3	3320.4	5
(3) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(4,619.1)	-	(4619.1)	-
(4) INTEREST PAYMENTS	<u>667.2</u>	<u> </u>	<u>667.2</u>	<u>-</u>
TOTAL	23,491.1	17,341.1	6150.1	17
TOTAL WITHOUT MEDICALLY NEEDY	14,461.5	11,631.8	2829.7	12
TOTAL WITHOUT INTEREST PAYMENTS	13,794.3	11,631.8	2162.5	

Terry Gardiner

Box 6092, Ketchikan, Alaska 99901 Pouch V, Juneau, Alaska 99811

June 6, 1979

Dr. James Wilson
P. O. Box 8678
Ketchikan, Alaska 99901

Dear Dr. Wilson:

Sorry for the delay in responding to your letter on HB 412.
It got caught in the mail transfer with the end of the session.

This bill was introduced by Rep. McKinnon of Anchorage. It
was passed out of the House HESS Committee and was amended.
The bill has been referred to the House Judiciary committee
chaired by Rep. Charles Parr. I'm forwarding a copy of your
letter to Rep. Parr.

This bill doesn't seem to consider the problems of small
hospitals like so many of the bills introduced by our legislators
from Anchorage. I would oppose this bill unless there were
assurances it would not adversely impact small hospitals like
ours.

Sincerely,

Terry Gardiner
Speaker

cc: Rep. Parr, House Judiciary 

DRS. WILSON AND WILSON, P.C.
ARTHUR N. WILSON, M.D.
JAMES A. WILSON, M.D., F.A.C.S.
ARTHUR N. WILSON, JR. M.D.
TY A. SALNESS, M.D.
P.O. BOX 8678
KETCHIKAN, ALASKA 99901

May 10, 1979

Mr. Terry Gardiner
The House of Representatives
P.O. Box 6092
Ketchikan, Alaska 99901

Dear Terry:

I am writing about House Bill No. 412, an act providing for minimum standards for hospital care. I realize I am writing very late but this bill has just come to my attention. Briefly, we think this is a rather awful punitive bill and is going to create considerable troubles for hospitals such as ours which has 44 beds and is being required to have a physician in the near vicinity of the hospital at all times. Very frankly, we were dropping our active care beds as you may remember, down to 39, so we are falling into this group where the attendant medical physician who is required to be on duty or on call can actually be out of the hospital rather than in the hospital.

Terry, we have looked into the cost of having emergency room coverage with an in-hospital physician on call at all times. The physician services groups that provide this kind of service are currently asking for \$45,000 a month up front, i.e., paid ahead of time before they would consider a contract. This is about the only way we would be able to have in-house coverage that would fall within the minimum standards of care required by this bill.

When I was an intern and a resident at a 500 bed hospital in Portland we had quarters and had a medical resident and a surgical resident and several interns sleeping in quarters adjacent to the hospital. This was part of our training program. When we try to apply this kind of thinking to small isolated hospitals with short staffs of perhaps 7 or 8 physicians such as Ketchikan, this type of bill would present a real hardship and would be fought most bitterly by the various medical staffs. I sincerely hope that this bill somehow gets sidetracked.

Sincerely,

James A. Wilson M.D.

James A. Wilson, M.D., F.A.C.S.

JAW/mc



Federation's Role in our Enterprise Economy

April 28, 1981

POSITION PAPER

TO: Legislators of the State of Alaska

FROM: FREE Committee of the Anchorage Women's Club

RE: Senate Bill No. 417 "An Act relating to health insurance for residents of the state; and providing for an effective date."

The FREE Committee of the Anchorage Women's Club opposes SB 417 for the following reasons:

1. This bill places the State Commissioner of Administration as both the underwriter and the payor.
2. Presentation at this time is ill-advised due to the incomplete report outstanding by the Battelle Human Affairs Research Center. The State of Alaska has contracted with Battell for an indepth study at a cost of \$170,000. The interim report was submitted March 30, 1981, with the final report due December 11, 1981.
3. No specifications are outlined in this bill. Eligibility needs to be spelled out with reference to definition of the phrase "resident of the state". Will this be thirty days, one year, two years, etc.? This question is particularly pertinent in view of the pending suit by Mr. & Mrs. Zobel. Also, the problem of transients in Alaska for periods of six months or more should be addressed.
4. The cost factor involved in providing such a health program would be exorbitant. Given that we currently have ample funds in Alaska, this coverage may be possible at this time. However, such wealth is not guaranteed forever. Oil revenues are subject to environmental factors which could substantially change their presence in Alaska.

A hand holding a flag with the word "FREE" written on it.

Federation's Role in our Enterprise Economy

- 
- A line drawing of a mountain range.
5. Section 1, subparagraph (c) states that "the Commissioner shall pay the premiums of a resident ... if the resident is not enrolled in a group health insurance plan." This would effectively permit and/or encourage employers to terminate such coverage thus allowing employees to be covered under the state plan. This paragraph would also allow those persons who have voluntarily chosen to utilize their available premium dollars for other reasons to be eligible for the state program.
 6. This bill does not specify what types of medical care would be covered. It does state that dental care, eye glasses, hearing aids, prescriptions or fitting of hearing aids and eye glasses are not covered. The range of other less vital and unnecessary treatments is at question.
 7. SB 417 would encourage social irresponsibility of the individual as regarding normal preventative health care. It provides no incentive to maintain a healthful living routine and environment. Abuses of such broad coverage could easily encompass treatment of negligible scrapes, scratches, bruises, etc.
 8. The insurance industry in Alaska has been effectively and competently providing health care coverage to residents. A bill such as this could effectively alter one of our fundamental free enterprise systems.
 9. The \$2,500.00 deductible/coinsurance out-of-pocket limit could be too high for the truly needy resident. This deductible should be carefully evaluated.
 10. No public meetings have been held for open discussion of such a massive undertaking. Input from all sectors must be obtained and considered. A thirteen member advisory committee known as the Alaska Comprehensive Health Care Financing Study Advisory Committee is currently working with the Battelle group regarding Alaska's health care needs. Public education and opinion must be obtained prior to this bill being signed into law.

P.O. Box 4-2955 • Anchorage, Alaska 99509

A committee of the GFWC Anchorage Woman's Club

A hand holding a flag with the word "FREE" written on it.

Federation's Role in our Enterprise Economy

11. SB 417 does not address interest in prevention, equitable access of health services, or cost containment and cost effectiveness.
12. Evaluation by other states has resulted in their decision not to implement this type of health insurance due to cost. Yet to be solved are the problems of inefficiency, improper utilization, inequities of delivery and financing systems.
13. Health care costs have risen dramatically since the federal government entered into health care with Medicare and Medicaid programs and with excessive costs on an administrative level.
14. The present Social Security system is practically bankrupt. The unending "red tape" and ineffective administration is well known. How will SB 417 differ?
15. Medicaid currently fosters family instability, i.e. more dollar coverage is available with the desertion of the supporting male member. The \$300.00 deductible per family or \$100.00 deductible per person could easily be abused by large families via separation of the members.
16. How will this bill help reduce spiraling costs of health care? Sen. Edward Kennedy estimated the first year's cost of Medicare as \$70 million; the actual cost was approximately \$140 million. The normal cost formulas did not work. This bill offers no cost containment provisions.
17. This bill does not address itself to payment to the medical industry. Payments under Medicare/Medicaid are frequently +90 days overdue to hospitals, physicians, nursing homes, physical and occupational therapists, pharmacies, etc. Such delinquent payment for services and prescriptions could effectively force small businesses into bankruptcy and/or force refusal to honor such patients. A detailed method of repayment needs to be outlined.



Federation's Role in our Enterprise Economy

18. A 1979 survey of 15,000 Alaskans by Sen. Ted Stevens regarding national health assistance, indicated that 36% favor additional insurance to cover catastrophic illness costs only; 23.2% favored a reduction of Medicare and Medicaid; 19.5% favored a comprehensive national health insurance plan; 15.1% favor current Medicare and Medicaid programs; and 5.8% were of no opinion or other. The people of Alaska deserve the right to voice their opinion and preference regarding this proposed program.
19. This bill is another form of standardization in which everyone lives in the same house, wears the same uniform, has the same insurance plan. This deprives the individual of his/her free choice.
20. An increase in the bureaucracy to administer this program will be necessary.
21. This bill furthers the direction of socialized medicine. A bill of this type could end up being the prototype to the nation for a national health care program.
22. The General Federation of Women's Clubs opposes all forms of socialized medicine.

We feel that SB 417 is entirely too broad for realistic or practical application. The bill raises more questions than it answers. It does not address many key issues and is premature in view of the outstanding final document of the Battelle Study.

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599
Fairbanks, Alaska 99701
(907) 456-5029

Pouch V
Juneau, Alaska 99811
(907) 465-4907

May 22, 1981

Adrian G. Barber, D.C.
Alaska Chiropractic Society
C Street Plaza Building
Suite 102
1577 C Street
Anchorage, Alaska 99501

Dear Dr. Barber:

I do not expect to act on CSHB 41 this session.
The Committee will do a great deal of interim
work, and will take the bill up in January.

I would appreciate receiving information from
you during the interim or next session.

Sincerely,

Charles H. Parr

CHP:vc



alaska chiropractic society

ADRIAN G. BARBER, D.C.
President
C Street Plaza Bldg., Suite 102
1577 C Street
Anchorage, Alaska 99501
278-6481

GENE A. KREMER, D.C.
Vice President
Z Plaza
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278-2522

MYRON D. SCHWENERT, D.C.
Secretary
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1577 C Street
Anchorage, Alaska 99501
278-6481

BOBBY A. LUCAS, D.C.
Treasurer
P.O. Box 1481
Wasilla, Alaska 99687
378-3478

May 15, 1981

Senator Charles Parr
Pouch V
Juneau, Alaska 99811

RE: CSHB 41

Dear Senator Parr:

Section 11 of CSHB 41 does not provide for Chiropractic coverage.

It is imperative that Alaskans have the opportunity to choose
Chiropractic care if they wish.

I or a representative of the Society would be happy to testify
before your committee on the necessity of Chiropractic inclusion.

Thank you for your consideration.

Sincerely,

Adrian G. Barber, D.C.

AGB:mas



Alaska State Legislature

House of Representatives

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

May 18, 1981

TO THE EDITOR:

We are writing in response to the May 11, 1981, Times editorial, "Socialized medicine". Since the term is so often abused, and since we weren't sure what exactly you intended by the phrase, we consulted the dictionary on the matter:

Socialized medicine. The provision of medical and hospital care for the people at nominal cost by means of government regulation of health services and subsidies derived from taxation.

The insurance plan in HB 41 would not provide for medical and hospital care at a nominal cost. It would provide affordable care for those who are presently without it. Under the plan, a family of four with an annual income between \$14,000 and \$39,000 would pay from 10 to 90% of their health insurance costs. So, the state would not pay the full cost of care for those covered. It would only help participants meet the cost of their insurance coverage.

The bill does not provide for any government regulation of the private health care industry. Also, the money used by the state to help participants meet their insurance costs will come from Prudhoe Bay, not from taxation. Certainly, our oil dollars are everyone's dollars, and we should all share in them equally. But the health bill is no different from any other proposal that targets a specific group of Alaskans. Low interest agricultural loans benefit farmers, low interest home loans benefit home buyers, low interest business loans benefit businesses, hydroelectric projects benefit electricity users in the middle and southern portions of the state, property tax relief benefits property owners, and so on. When viewed as a whole, these programs do benefit all of us equally by making Alaska a more prosperous state. This does not mean, however, that each program separately provides direct and equal benefit to each and every Alaskan.

HB 41 does not meet the dictionary definition of "socialized medicine". Another important aspect of the insurance portion of the bill is not socialistic. The money appropriated by the legislature to help meet insurance costs, plus the money collected from participants for their portion of the cost of the plan would be kept in a fund which could be

PAGE TWO.

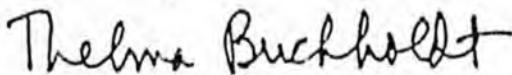
invested just like other investment funds (permanent fund, state employee pension and benefit funds, the general fund surplus) that the state currently maintains. The interest earned on the state's investment of the fund would be used to help cover expenses of the insurance plan and conceivably, the plan could eventually be self-supporting. A venture of this type is usually associated with capitalism, not with socialism.

The state's investment of the fund would help keep costs down. Additionally, your assumption that the plan would provide "nothing short of everything" so that the "cost would be horrendous" is untrue. We envision the plan providing a basic package of services that will ensure a decent standard of health care for all Alaskans. The plan will not pay for unnecessary medical and hospital care, but instead, will provide comprehensively for basic health care needs.

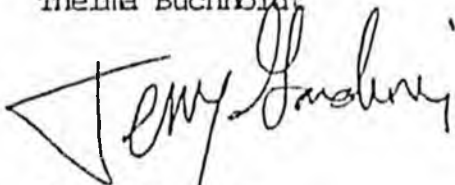
So much attention has been focused on the insurance portion that we wonder if people know that the bill includes funding for alcoholism treatment of state employees, an attempt to improve the provider reimbursement system for government health care programs, expansion of Medicaid coverage, and a study of how the state can complement Public Health Service and Medicare. All of these services are greatly needed to provide more and better health care to Alaskans.

HB 41 does not attempt to take care of every health need of every Alaskan with 100% state money. We are attempting instead to assure that 40,000 Alaskans who currently have no health care financing plan are able to afford health crises and provide for their basic health care needs; that more attention be paid to our obvious and collective alcoholism; that comprehensive health care be available to those who are least able to afford it; and that the state consider partial funding of the health needs of rural Alaskans and older Alaskans. Funding for these services is vital and would be an excellent investment in Alaska's future.

Sincerely,



Thelma Buchholdt



Terry Gardiner



Don Clocksin

Prime sponsors of HB 41

Health care legislation answers diverse range of needs

Alaska Health Care Advocates

Health Care Advocates welcomes the position expressed in your editorial calling for health care as a priority for this state. However, we do not agree with your conclusion that action on health legislation should wait for the results of the Battelle study, currently under way, on health care and financing. We will confine our remarks to three points in support of our position.

(1) House Bill 41 contains much more than just the state health plan referred to in your editorial; it also addresses long overdue Medicaid amendments and alcoholism benefits, each of which are important legislation in their own right.

(2) HB 41 is not a hasty, ill-conceived, unresearched concoction, but the product of three years of research and legislative work.

(3) There is no conflict between HB 41 and the Battelle study; they are in fact complementary.

Let us review the full scope of the bill. To begin with, the bill would expand Medicaid eligibility and coverage to include all optional groups and services qualifying for federal financial participation. It would extend Medicaid coverage to approximately 5600 Alaskans, specifi-

cally low-income women who are pregnant, children deprived of parental support due to unemployment, and certain other members of AFDC (Aid to Families with Dependent Children) households who currently are not covered by Medicaid. Newly covered services would include physical therapy, occupational therapy, prescription drugs, adult dental care, prosthetic devices, nurse practitioners and physician assistants.

Delays in claims processing and payments to providers reached crisis proportions in Alaska's Medicaid program in recent years. The bill addresses this problem by allowing interim or advance payments to large-volume Medicaid providers, and by instituting interest penalties payable by the state on overdue payment of claims. The state could get out of claims processing altogether if it is found to be cost-effective. The bill allows Medicaid funds to be used to pay health insurance premiums or subscriber fees for prepaid health service contracts on behalf of Medicaid eligibles.

Alcohol abuse is Alaska's biggest health problem. It precipitates other illnesses and injuries which require medical treatment. The bill provides

compass

*points of view
from our
community*



benefits to state employees for alcohol and drug abuse treatment as a demonstration project.

The state health plan is actually two separate programs. One is an unsubsidized group insurance plan open to all state residents, including high-risk individuals for whom individual insurance coverage is not available in the private market.

The second program is a cost-sharing program which would help pay for health insurance for Alaskans who have no subsidy from another source, such as private employers or federal programs. The subsidies are graduated by income, reaching 100 percent for needy low-income people not qualifying for Medicaid. Cost sharing may be applied toward either the state plan or a private

insurance plan that is of comparable quality.

The development of this legislation reaches back to 1977, before the Battelle study had been considered, when Rep. Thelma Buchholdt requested that the legislative research agency study third-party health coverage, gaps in coverage and options for state action. The results of the study were published in April 1978. In 1980 major health legislation was introduced a direct ancestor of HB 41.

While the Medicaid portions of the bill have remained very much the same through all subsequent versions of the bill, the health plan has gone through major revisions and refinements. The state health plans of Hawaii, Minnesota, and Connecticut each were

used as models for the Alaska legislation. Each version was drafted, debated, revised, debated and finally rejected in favor of the uniquely Alaskan approach embodied in the current bill. The bill has undergone exhaustive scrutiny by the insurance industry and administrative agencies as well as consumer representatives.

While the framework of a state health plan has been constructed, much more research and preparation is needed to implement the programs. HB 41 directs the Department of Administration to develop and cost out a benefit package, to draw up implementation plans for the two programs, and to recommend any amendments needed to facilitate the smooth implementation of the program.

The bill also calls for a study by the Legislative Council addressing issues surrounding the state's role in providing health coverage for Alaska Native people in light of federal responsibilities in that area. The results of both studies will be delivered to the legislature next session in time for further legislative action before start-up of the plan.

The Battelle study meshes with this timetable perfectly. The first phase of the study,

consisting of an analysis of the existing health care and financing system and identification of gaps and problems, has been completed. While the scope is broader and the research more thorough, the conclusions of the Battelle study with respect to health coverage are not substantially different from the earlier study by the legislative research.

In the second phase of the Battelle study, implications will be more thoroughly analyzed and implementation plans developed in detail for two or three specific options for state action.

One of the options selected for further study by the advisory committee is the coordination of Native and non-Native health services. A second option selected is a state health plan along the lines embodied in HB 41. The results of these two studies will be completed and a draft available for public comment in September 1981. Thus there is plenty of time to incorporate the results of the Battelle study into the implementation plans for HB 41.

To stall passage of health legislation by awaiting the study's results is pointless and would likely delay implementation for at least two years.

Why should Alaskans wait?

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

MEMORANDUM

February 20, 1980

TO: Representative Bill Parker
FROM: Duncan L. Read *DSLR*
RE: State Health Care Programs
Research Request No. 61

Although Jack Kreinheder has been assigned to work on your research request, I have just completed some cursory research related to alternative State health care financing systems in response to another request and thought it appropriate to share the resulting findings that are pertinent to your interests. Mr. Kreinheder will commence work on your request within the near future, as soon as he completes projects assigned to him that preceded yours.

First, you requested any available studies or reports regarding medicaid, State health insurance, and the State's health care program. We have requested a copy of the new State Health Care Plan, which should be available from the Department of Health and Social Services within the next two weeks. After seeing the attached news article, we have also requested from the Anchorage Neighborhood Center a copy of a recent federal Bureau of Health Manpower study. That report should contain information that addresses your second question concerning direct delivery of services by government or government payment for services provided by private, non-profit corporations to medically underserved populations.

While Mr. Kreinheder will address your second question in greater depth, it does appear that there are precedents for direct delivery of, or payment for services by, the government. The attached news article clearly shows the federal government can assume direct responsibility for health care in certain circumstances, as it already has in many Alaska communities through local sponsors. Arizona, as you know from research provided you last year, does not participate in the medicaid program and county governments provide medical assistance, often directly by medical personnel in the county's employment. One municipality in Alaska, Anchorage, has assumed full health powers, though it has not elected to provide the broad range of services that are provided by local governments elsewhere.

Representative Bill Parker
February 20, 1980
Page 2

You have indicated that you are interested in options to continuing State participation in the federal medicaid program. Dr. Fred McGinnis, Deputy Commissioner of the Department of Health and Social Services, has a long-standing interest in health care financing options and has recently attempted to find monies (\$20-30,000) with which to conduct a small, in-house study. Yesterday, Representatives Martin and Hayes had introduced a resolution and accompanying appropriations measure (\$200,000) with Representative Beirne providing for a more comprehensive study to be conducted by the legislature. Representative Martin had earlier indicated a willingness to share information compiled for him with you (although we did not reveal your identity).

Two factors may have to be addressed in direct delivery of services by the State:

- medical malpractice insurance for State-employed doctors
- the implied contractual relationship between providers and patients and the related concept of medical abandonment, which might pose difficulties for the state if it chose to provide services on a limited-term basis.

Mr. Kreinheder will explore these in more detail.

Finally, you may be interested in a mandatory health insurance program recently instituted by the state of Hawaii. The statutory provisions are attached. While Hawaii has not withdrawn from the medicaid program, it is my understanding that they are currently experimenting with a control group who will receive coverage only from their health insurance programs and then will compare costs to those also covered by Medicaid.

This summarizes our information to date. More details will be forthcoming.

DLR/dp

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

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 the 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. Second, 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 paperwork 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 practitioners 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.

Representative Bill Parker
March 18, 1980
Page 6

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.

Representative Bill Parker
March 17, 1980
Page 7

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.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT

Nancy:

I decided to write you a note, since we often cannot get together.

Aside, from minor drafting considerations, I only have three comments:

- (1) the regional median income figures may be a better way to deal with regional cost differences, as we discussed.
- (2) The language in our bill regarding copayments and deductibles may be better because it will encourage competition among bids if you don't specify what the rates have to be. (Similar to the argument against specifying benefits in the bill, but leaving them up to regs after competitive bid process has taken place.) Also, the lower the deductible, the higher monthly premiums will be, as we discussed.
- (3) You and Charlie may want to consider including the section in our bill about underwriting and admin. Our bill says, "The commissioner shall contract for the administration and may contract for the underwriting. . ." The purpose of this is to be sure that they contract out the administration part of it. We felt that Retirement & Benefits can barely handle the state employees program and that they do not need the million and one field offices, employees, etc. that they claim they need to do the program, even if they don't contract it out. We thought it would be better to have Blue Cross do that and open field offices if they like. Of course, Retirement & Benefits disagrees with us on this point. The "may contract for the underwriting" language was to allow the state to underwrite the plan itself if this turns out to be a better deal for us. We can eventually use the interest money in the fund to pay for administration, or a part of it, if all goes well with investing the fund.
You may feel that your language in proposed 18.27.010(c) takes care of all problems. This is fine, unless you feel that the admin. part should be contracted out, as we do.
- (4) Well, I'm going to make one more pitch for the 90-day limitation. At least half the cost of the present bill is covering people who already have coverage and who may switch because they think they'll get a better deal (the side deal scenario). Anything we can do to discourage this switching--since many think it will occur--- is beneficial to the bill, I think, because it makes it more politically palatable because it will cost less money. However, if you are not into this kind of a time limitation, maybe we could be more creative and come up with something else?

I appreciate the opportunity for input, on behalf of Thelma. I would be happy to discuss any of these or other issues with you further, if you like.

- Louann

Hein ✓✓

Original sponsors: Buchholdt, Cato,
Gardiner, et al

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 SENATE CS FOR CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 41 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TWELFTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the health of residents of the
7 state."

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

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

10 CHAPTER 27. STATE HEALTH INSURANCE.

11 Sec. 18.27.010. STATE ~~COMPREHENSIVE~~ HEALTH PLAN. (a) The com-
12 missioner shall establish minimum benefit standards for the state
13 ~~comprehensive~~ health plan and shall provide for the underwriting and
14 administration of the state ~~comprehensive~~ health plan.

15 (b) A resident of the state is entitled to enroll in the state
16 ~~comprehensive~~ health plan.

17 (c) The state ~~comprehensive~~ health plan shall provide for copay-
18 ments and deductibles, and shall provide an annual limit on the total
19 amount of copayments and deductibles for each enrolled resident and the
20 covered dependents of the resident for each year. The annual limit
21 shall be the same regardless of family size.

22 (d) The commissioner shall contract for the administration and
23 may contract for the underwriting of the state comprehensive health
24 plan. A contract entered into under this subsection shall be based on
25 competitive bids and shall be for a three-year period.

26 (e) Notwithstanding the provisions of (c) of this section and
27 AS 18.27.020(c), a resident who is enrolled in the state comprehensive
28 health plan or in a health insurance plan certified under AS 18.27.020-

29 (a)(1)(B); and who is eligible for a permanent fund dividend under

1 AS 43.23.010 may direct the commissioner of revenue to use as much of
2 the permanent fund dividend as is necessary to pay a cost incurred by
3 the resident arising from participation in the state comprehensive
4 health plan or in a health insurance plan certified under AS 18.27.020-
5 (a)(1)(B).

6 Sec. 18.27.020. STATE HEALTH INSURANCE COST SHARING PROGRAM. (a)
7 Cost sharing under the state health insurance cost sharing program may
8 be provided to a resident who

9 (1) is enrolled in

10 (A) the state ~~comprehensive~~ health plan established
11 under this chapter; or

12 *ask*
13 *Ed* (B) a nonsubsidized health insurance plan that the
14 insurer has certified to the commissioner as equivalent to or
15 exceeding the benefit standards of the state comprehensive health
16 plan established by the commissioner under AS 18.27.010(a); and

17 (2) qualifies for cost sharing under (c) of this section.

18 (b) Cost sharing may not be provided if, and to the extent that,
19 subsidized medical care or subsidized health insurance (other than the
20 state ~~comprehensive~~ health plan established under this chapter) is, or
21 during the 90 days preceding enrollment in the state ~~comprehensive~~
22 health plan has been, available and accessible to the resident or
23 would be or would have been available and accessible upon application
24 by the resident.

25 (c) The commissioner shall pay the state share of the costs of
26 health insurance incurred by a resident of the state and his covered
27 dependents qualifying for cost sharing under the following formula:

28 (1) if the total adjusted gross income of the resident and
29 his dependents is at or below 75 percent of the base income, 100 per-
cent of the premium cost of health insurance;

1 (2) if the total adjusted gross income of the resident and
2 his dependents is between 75 percent of the base income and 125 percent
3 of the base income, a graduated percentage of the premium cost of
4 health insurance between 100 percent and zero percent;

5 (3) if the total adjusted gross income of the resident and
6 his dependents is at or below 45 percent of the base income, 100 per-
7 cent of copayments and deductibles;

8 (4) if the total adjusted gross income of the resident and
9 his dependents is between 45 percent of the base income and 95 percent
10 of the base income, a graduated percentage of the copayments and de-
11 ductibles from 100 percent and zero percent;

12 (5) if a resident is enrolled in a health insurance plan
13 certified to the commissioner under (a)(1)(B) of this section, the
14 state share of the cost of health insurance for the resident is limited
15 to the amount that the state's share would have been if the resident
16 had been enrolled in the state comprehensive health plan.

17 *Def. gnd?* (d) The commissioner shall adopt minimum benefit standards and
18 guidelines by which an insurer shall compare its health insurance plan
19 with the state comprehensive health plan for the certification of a
20 plan under (a)(1)(B) of this section.

21 (e) Notwithstanding the provisions of a health insurance plan,
22 an insurer shall provide the benefits that under (a)(1)(B) of this
23 section the insurer has certified are included in the plan.

24 Sec. 18.27.030. DEFINITIONS. In this chapter

25 (1) "adjusted gross income" means the (adjusted gross income)
26 of the resident determined under the regulations of the commissioner;

27 (2) "base income" means

28 (A) family median income for Alaska determined by the
29 United States Bureau of the Census; and

(B) regional adjustments established by the commissioner to the family median income for Alaska determined by the United States Bureau of the Census, that are based on relative costs of living in the state;

(3) "commissioner" means the commissioner of administration;

(4) "copayment" means the portion of covered expenses payable by the resident after the deductible has been met;

(5) "insurance" means prepaid plans or indemnity plans;

(6) "resident" means a person who for 12 consecutive months immediately preceding enrollment in the state comprehensive health plan under this chapter has maintained a permanent place of abode in the state and during that time period has continually maintained his voting residence in the state;

(7) "subsidized health insurance" means health insurance all or part of the premiums of which are paid by an employer of the insured;

(8) "subsidized medical care" means medical care provided free of charge.

* Sec. 2. AS 21.54.060 is amended by adding a new paragraph to read:

(7) under a policy issued to the state to insure residents of the state under AS 18.27.

* Sec. 3. AS 39.30.090(1) is amended to read:

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

* Sec. 4. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a)

1 The group insurance policy under AS 39.30.090(1)

2 (1) shall provide coverage for alcoholism and drug depen-
3 dence to include

4 (A) inpatient detoxification benefits for not less than
5 14 days of benefit each calendar year in a state-approved treat-
6 ment facility or licensed hospital; payment of institutional and
7 professional benefits shall be equal to and payable as any other
8 covered condition, except a covered condition which, by the terms
9 of the policy, has an internal restriction;

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

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

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

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

29 (4) may require a physician's certification of necessity as

1 a condition of payment for alcoholism or drug dependence treatment.

2 (b) The provisions of this section apply to group health insur-
3 ance contracts and group service or indemnity type contracts issued to
4 provide coverage for employees of the state and may apply to contracts
5 for the benefit of employees of other participating governmental units
6 only if the governing body of the governmental unit elects to have the
7 provisions apply.

8 (c) In (a) of this section,

9 (1) "alcoholism" means an illness or condition characterized
10 by the habitual lack of self control in the use of alcoholic beverages,
11 or use of alcoholic beverages to the extent that health is substantial-
12 ly impaired or endangered, or social or economic function is substan-
13 tially disrupted;

14 (2) "drug dependence" means the condition of being physi-
15 cally or psychologically addicted to an opiate, opiate derivative,
16 tranquilizer, amphetamine, barbiturate, or similar substance, but
17 excluding nicotine, caffeine and alcohol;

18 (3) "state" means any state in the United States and in-
19 cludes the District of Columbia.

20 * Sec. 5. AS 39.30.100 is amended to read:

21 Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-
22 30.090]

23 (1) "eligible employee" means

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

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

29 (2) "governmental unit" means the state, a borough, muni-

1 cipal corporation, or other political subdivision of the state, and the
2 North Pacific Fishery Management Council;

3 (3) "insurance", "insurance carrier" and "insurance policy"
4 include health care services, health care service contractors and con-
5 tracts.

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

7 Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CON-
8 TRACTS. (a) The commissioner shall use medical assistance funds to
9 purchase and pay premiums on policies of insurance or pay the expenses
10 of health care service contracts that provide one or more of the ser-
11 vices available under state medical assistance programs.

12 (b) The policy of insurance or the contract financed under this
13 section must guarantee to

14 (1) provide services and supplies under policies of insur-
15 ance or contracts under AS 21;

16 (2) provide the statistical data, records, and reports
17 relating to the provision, administration, and costs of providing
18 services and supplies as required by the commissioner.

19 Sec. 47.05.080. IMPLEMENTATION. The commissioner shall implement
20 the provisions of AS 47.05.070 when he determines that comparable
21 benefits are available at equal or less cost than direct payments by
22 the department to the providers of services and supplies.

23 Sec. 47.05.090. INTERIM PAYMENT. The commissioner may make an
24 interim payment to a provider of medical services before he receives a
25 bill for the services.

26 Sec. 47.05.100. INTEREST ON LATE PAYMENTS. When presented by a
27 provider of medical services with a clean claim, the commissioner shall
28 pay

29 (1) interest at the rate of one percent per month when

1 payment is delayed more than 45 days after presentation of the clean
2 claim;

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

6 (3) the interest for a full month if the overdue clean claim
7 is not paid by the 15th day of a calendar month.

8 Sec. 47.05.110. DEFINITIONS. In AS 47.05.070 - 47.05.110

9 (1) "clean claim" means a claim for payment which can be
10 processed without obtaining additional information from the provider of
11 the service or from a third party; it includes a claim with errors
12 originating in the department's claims processing system, but does not
13 include claims from a provider who is under investigation for fraud or
14 abuse, or a claim under review for medical necessity;

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

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

19 (4) "health care service contract" means a contract with a
20 nonprofit corporation which accepts prepayment for health care services
21 and is sponsored by or associated with a group of physicians or a group
22 of hospitals or both or by a health maintenance organization recognized
23 under federal law;

24 (5) "medical assistance" means Medicaid (AS 47.07), general
25 relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and
26 crippled children's and maternal and child health programs (AS 18.05.-
27 010).

28 * Sec. 7. AS 47.07.020(b) is repealed and reenacted to read:

29 (b) A resident of the state for whom the provisions of the Social

?

Security Act in effect on March 1, 1981, allow optional medical coverage that qualifies for federal financial participation is eligible for medical assistance. A resident of the state qualifying as medically needy under AS 47.07.080(5) is not eligible for medical assistance.

* Sec. 8. AS 47.07.030 is repealed and reenacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include those services eligible for federal financial participation under the provisions of Title XIX of the federal Social Security Act in effect on March 1, 1981..

* Sec. 9. AS 47.07.080 is amended by adding new paragraphs to read:

(5) "medically needy" means a person who meets the categorical requirements of eligibility for medical assistance but whose income

(A) exceeds the income standard for categorical assistance; and

(B) is less than the medically needy income standard after the deduction of allowable medical expenses;

(6) "categorical requirements of eligibility" means the standards established under 42 C.F.R., secs. 435.500 - 435.541;

(7) "medically needy income standard" means the standards established under 42 C.F.R., secs. 435.800 - 435.816.

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

* Sec. 11. By the 30th day of the First Session of the Thirteenth Legislature the commissioner of administration shall submit to the legislature a report on

(1) proposed minimum benefit standards and estimated actuarial costs of the state comprehensive health plan (AS 18.27);

(2) the anticipated number and characteristics of participants in the state health insurance cost sharing program (AS 18.27.020) and the projected cost to the state;

1 (3) a proposed plan for

2 (A) implementation of AS 18.27;

3 (B) eligibility determinations under AS 18.27;

4 (C) payment of the state share of premium costs and copay-
5 ment and deductibles incurred under AS 18.27; and

6 (D) informing the public of benefits under AS 18.27;

7 (4) recommendations for amendments to AS 18.27.

8 * Sec. 12. Coverage under the state ~~comprehensive~~ health plan (AS 18.27.-
9 010) and the state health insurance cost sharing program under AS 18.27.020
10 begins on July 1, 1983.

11 * Sec. 13. The provisions of secs. 3 - 5 of this Act apply to group
12 policies or contracts which provide coverage under AS 39.30.090 - 39.30.100
13 and which are delivered, issued for delivery, or renewed in this state after
14 the effective date of this Act. A policy or contract providing coverage for
15 eligible employees in this state under AS 39.30.090 - 39.30.100 delivered,
16 issued for delivery, or renewed after the effective date of this Act provides
17 the minimum coverage required by this Act even if the language of the policy
18 or contract does not specifically so provide.

19 * Sec. 14. (a) By the 30th day of the First Session of the Thirteenth
20 Legislature the Legislative Council shall study and make recommendations to
21 the legislature

22 (1) for federal improvements in the Indian Health Service delivery
23 system;

24 (2) on the alternatives available to the state to complement the
25 funding of the Indian Health Service;

26 (3) on the alternatives available to the state to complement
27 services available to the senior citizens of the state under Medicare.

28 (b) The Legislative Council shall seek participation in the study by

29 (1) the health, education, and social services committees of the

1 legislature;

2 (2) the Alaska Native Health Board;

3 (3) regional health organizations;

4 (4) other providers and consumers of health care;

5 (5) the Department of Health and Social Services;

6 (6) the Alaska Area Native Health Service, United States Public
7 Health Service.

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PLEASE NOTE: THE PRECEDING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT.

80% of Median Income

Handwritten: 100% of Median Income

INCOME LIMITS FOR SECTION S - LOW INCOME AND SECTION 236
IN ALASKA BY CENSUS DIVISION

As of October 1, 1981

CENSUS DIVISION	NUMBER OF PERSONS IN HOUSEHOLD							
	1	2	3	4	5	6	7	8+
	15,012							
Aleutian Islands	\$12,050	\$13,750	\$15,500	\$17,200	\$18,300	\$19,350	\$20,450	\$21,500
Anchorage	16,350	18,700	21,000	23,350	24,800	26,300	27,750	29,200
Angoon	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Barrow	12,050	13,750	15,500	17,200	18,300	19,350	20,450	21,500
Bethel	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Bristol Bay Borough	14,550	16,650	18,700	20,800	22,100	23,400	24,700	26,000
Bristol Bay	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Cordova-McCarthy	14,050	16,050	18,050	20,100	21,350	22,600	23,850	25,100
Fairbanks	14,500	16,600	18,650	20,700	22,000	23,300	24,600	25,900
Haines	15,600	17,850	20,100	22,300	23,700	25,100	26,500	27,900
Juneau	18,850	21,550	24,250	26,950	28,650	30,350	32,000	33,700
Kenai-Cook Inlet	15,250	17,400	19,600	21,750	23,100	24,500	25,850	27,200
Ketchikan	15,050	17,200	19,350	21,500	22,850	24,200	25,550	26,900
Kobuk	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Kodiak	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Kuskokwim	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Matanuska-Susitna	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Nome	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Outer Ketchikan	13,100	14,950	16,850	18,700	19,850	21,050	22,200	23,400
Prince of Wales	14,000	16,000	18,000	20,000	21,250	22,500	23,750	25,000
Seward	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Sitka	16,600	18,950	21,300	23,700	23,150	26,650	23,100	29,600
Skagway-Yakutat	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Southeast Fairbanks	13,350	15,300	17,200	19,100	20,300	21,500	22,700	23,900
Upper Yukon	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Valdez-Chitna-Whittier	14,450	16,500	18,600	20,650	21,950	23,200	24,500	25,800
Wade Hampton	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Wrangell Petersburg	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Yukon-Koyukuk	15,350	17,550	19,750	21,900	23,300	24,650	26,050	27,400

Nancy; To get 100% of median income: ~~multiply~~ divide all figures by .8. Then you can factor back higher + lower percentages.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM
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ORIGINAL.

DATE: February 22, 1982

TO: Fred McGinnis

FROM: John Wills *JW*

SUBJ: Coverage Estimates and HB-41

Per your request I have gathered together some information from our report which might be useful to you in your hearings this week. The information basically pertains to two items

- clarification and justification of our estimates of the size of the uncovered population in Alaska.
- conclusions from our analysis of a state sponsored health insurance plan which also bear on House Bill 41.

I. Clarification of Coverage Estimates

It seems to me there are four questions that are relevant here:

- What do we estimate to be the size of the uncovered population in Alaska?
- How did we derive this estimate?
- Are there potential problems with the data we used to make the estimates?
- If so, are these problems severe enough to warrant rejecting the estimates?

I will answer each in turn.

- A. What do we estimate to be the size of the uncovered population in Alaska?

We estimate that there are approximately 44,000 persons in Alaska who do not have at least one of the following:

- a private health insurance plan (group or individual policy)
- access to the military health care system
- access to the Indian Health Service Medicare coverage
- other PHS or VA coverage.

Of these 44,000 without private coverage, approximately 15,000 are eligible (not recipients) for either Medicaid or GRH. This leaves approximately 29,000 persons with no source of coverage, including public assistance.

These 29,000 persons are civilian, non-Natives under the age of 65. (We have assumed all Natives to have coverage by virtue of the IHS, and almost all non-Native Alaskans over 65 have Medicare coverage.) Among these 29,000 uncovered persons about 43% are children. Of the adults, about 83% are employed, typically for small firms which do not offer health insurance, or on less than a full-time permanent basis. About 90% are healthy, while about 10% have a health impairment of one sort or another. (For other characteristics of the uncovered, please see pages 75-83 of the Advance Final Report.)

The precise number uncovered fluctuates over the course of a year because of seasonality of employment, being highest in the late winter and lowest in the late summer. Our estimates are for the spring months, which are neither the peak nor the trough of coverage.

B. How were these estimates derived?

Our estimates were derived from data contained in the Survey of Income and Education (SIE), conducted by the U.S. Bureau of the Census in Alaska in 1976. We obtained the raw data tapes from the Bureau of the Census and generated the estimates on our own computers.

The Survey of Income and Education was a lengthy personal interview, covering 7378 Alaskans in 2722 families drawn from 17 of the state's 29 census districts. The survey was designed by the Bureau to generate accurate state level estimates of a number of variables for Alaska and every other state; it has been and continues to be used by the federal government in a number of programs that require state level estimates. It is the only statewide data source in existence which links data on insurance coverage, race, income, and other personal and family characteristics.

Since the size of Alaska's population changed between 1976 and 1980, we used the SIE to estimate two proportions:

- What proportion of civilian, non-Natives under age 65 are covered by one or more coverage source other than military care or public assistance?
- Of these, what proportion are dependents of active duty servicemen or women, or otherwise eligible for military related care?
(Note that this does not include all military care related eligibles, since some were included in the first cut.)

We then applied these proportions to the 1980 census figures for Alaska to arrive at the 44,000 figure. The 29,000 figure was derived from this by subtracting estimates of Medicaid and GRM eligible (not recipients) under the age of 65.

C. Are there potential problems with these estimates?

Yes. Any estimate has a degree of uncertainty attached to it, if only because it is based on a sample and not a census. More important, however, are fears

that the procedures used by the Bureau of the Census may have led to systematic bias in the results. It has been alleged that the SIE underrepresents Natives. However, these estimates pertain only to the non-Native population, and so even if the allegation is correct it does not bias our estimate.

Finally, the proportions we estimated were those in 1976, the year of the survey. To the extent that these changed significantly between 1976 and 1980 the estimates could differ. At the national level there has been very little change in coverage proportions over the past five years. Obviously, we have no direct evidence supporting or rejecting that this is also the case in Alaska, but it would be surprising for dramatic changes to occur in these proportions over so short a period as five years. It would be our guess that the true number lies within $\pm 10\%$ of the estimate, i.e., between 39,000 to 49,000 persons.

D. Do the problems warrant rejecting the estimates?

In my opinion, no. I base this on three factors. First, every large scale survey can be subjected to criticism. I have worked with many, and find that the SIE to be better designed, documented, and carried out than most. The Bureau of the Census is the premier sampling and surveying organization in the country, probably the world, and this reputation is a factor in my judgment.

Second, the numbers appear to be reasonable. They show that coverage among non-Native Alaskans is reasonably close to--perhaps slightly better than--the figures for the U.S. as a whole.

Finally, if one rejects the SIE then there is no other data source to take its place. I am aware of other efforts to estimate coverage in Alaska, but none that I know of are equally rigorous in method or design, or are as well documented, or permit linking insurance coverage to the other important variables necessary for policy analysis.

II. Implications of Our Study for HB-41

There are two general areas where our study generates information which bears on HB-41.

The first has to do with the implications of the Medicaid aspects of that bill. Our estimates of AFDC-Unemployed Parent coverage and coverage of the so-called Ribicoff children would bear on a part of HB-41. At this time we are working with the Division of Public Assistance to try to reconcile our estimates with them. The details of this are excruciatingly difficult to establish, and at this time we have not decided whether or not, or to what extent, our estimates need revising. Therefore, I cannot comment on this aspect.

The second aspect of HB-41 for which our report has some relevance is the part dealing with a state sponsored health insurance plan. In our report we analyzed a plan similar but not identical to this part of HB-41.

Important points to note from our report in evaluating HB-41 are:

- Unlike HB-41 the proposed state insurance plan retains GRM program--costs and coverage estimates therefore do not include the GRM eligible population (reminder--like HB-41 Medicare population is also excluded from the state plan). Thus, to compare our costs to HB-41's gross costs (before GRM savings are subtracted) you should add the GRM budget to our plan estimate.
- Our premium subsidy schedule is more stringent than that of HB-41--thus our cost and coverage estimates would be relatively lower. (Note--a higher subsidy implies that a higher proportion of potential participants (both uncovered and already covered) would join the state plan).
- Our cost estimates are in 1981 dollars and do not include costs of administering the program or loss of premium tax revenue to the state.
- Our cost estimates are based on per capita premiums of \$130 per month for the subsidized group. This premium is based on:
 - 50% of the potential participants being single individuals, i.e., not seeking family coverage
 - the benefit package described on pages 90-91 of the Advance Final Report, which is less extensive than HB-41 benefit package. This also implies that our plan would be less costly than HB-41.
- Our coverage estimates are for family coverages and should be multiplied by average family size in ~~Alaska (3.26, Source: SIF)~~ ^{the target population (approximately 2.1)} to obtain total number of individual coverages.
- Separate cost and coverage estimates are provided for all Alaskans and non-Natives. Note that assumptions regarding participation levels used to obtain Native and non-Native estimates were the same for both groups. However, we also pointed out that Natives who were eligible only for a partial premium subsidy might elect not to participate, since they already have access to the IHS, and that if this were the case then approximately 1350 fewer Native families would participate and annual costs would be \$1.2 million lower.
- Our plan did not permit persons to obtain state subsidized private individual coverage.
- As we discussed, graduated premiums based on age (or other characteristics) are important for avoiding adverse selection into the plan by high utilizers of health service. HB-41 is silent on this issue.

- Our plan, unlike HB-41, did not subsidize the patient cost sharing portion of reimbursement, which would have increased the cost to the state.
- Finally, we estimated that our plan would result in about 5000 new subsidized family coverages (~~2500~~ individuals) in the non-Native population, and 11,000 new subsidized family coverages (22,500) individuals) in the Native population.

However, the total number of subsidized coverages would be much larger, because of switchover from the private sector. In order to generate one new family coverage, the state would have to subsidize a total of 2.3 to 3.9 families. In other words, between 57% and 75% of the subsidy dollars would go to persons already covered. One could expect a similar but not the same levels of switchover in HB-41 plan. This target inefficiency is a frustrating but unavoidable part of any such plan. We have found no way to avoid it, and believe that it must simply be accepted as a necessary part of the cost of providing insurance under such a plan.

And, finally, we would like to emphasize that our plan is significantly different in detail from the HB-41 plan. As such it is not possible to apply any of our estimates directly to the HB-41 plan.

/sbs

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MEDICARE BUY-IN: COST BENEFIT TO ALASKA

1.	Number of potential buy-in enrollees	1,468
2.	Number of potential enrollees who will receive Medicare services 1/	1,101
3.	Potential payment by Medicare for services 2/	\$220,200
4.	Total number of potential enrollees receiving DPA cash payments 3/	1,298
5.	Total number of potential enrollees receiving medical coverage only--no cash payment 3/	170
6.	Cost to Alaska for 4. above, assuming a 50% FFP rate 1,298 X \$11.00 (Medicare premium for FY 82) X 12 months X 50% FFP	\$ 85,668
7.	Cost to Alaska for 5. above, 170 X \$11.00 X 12	\$ 22,440
8.	Total cost to Alaska: 6. plus 7.	\$108,108
9.	Estimated savings for Alaska as a result of buy-in	\$220,200 -108,108 \$112,092

(Medicaid eligibles only)

85,668
22,440

108,108

- 1/ Based on Washington and Idaho utilization figures for 1979 as compiled by HCFA Region X
- 2/ Based on one-half of the average Medicare cost per buy-in user in Washington and Idaho during 1979 as compiled by HCFA Region X
- 3/ Based on actual DPA case counts for June 1981 adjusted for anticipated participation based on the GAO 1979 buy-in study:
OAA--2,558 X 56.1%, AD--2,350 X 1.4%

Total on OAA and on AD = then by formula determine a percentage who would use service = 1298

STATE OF ALASKA THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

February 23, 1982

SUBJECT: Health of residents of the state
(SCS CSHB 41 (HESS))

TO: Representative Thelma Buchholdt

FROM: Edward H. Hein *EH*
Legislative Counsel

Enclosed is a draft the changes to HB 41 requested by Louann Cutler. I have made several changes to the bill as explained below.

On page 1, lines 26 - 29 and page 2, lines 1 - 5, I have revised this subsection for purposes of clarity, but have not changed the substance of the subsection.

On page 2, lines 6 - 23, I have added new subsections (a) and (b), in accordance with my memorandum of October 26, 1981. The current subsections (b), (c) and (d) have been relettered (c), (d) and (e) respectively and references to those subsections have been changed throughout the bill.

On page 2, lines 17 - 23, I have revised the language of subsection (b) for purposes of clarity. Thus, the language differs somewhat from the language I proposed in the October 26, 1981 memorandum. I have added a 90-day waiting period as an anti-switch over provision.

On page 3, lines 17 - 23, I have revised the language for purposes of clarity.

On page 3, line 29 and page 4, line 3, I have inserted "Bureau of the Census" in place of "federal office of human development service".

On page 4, lines 9 - 16, I have added new definitions for resident subsidized health insurance and subsidized medical care.

On page 7, lines 22 - 24, I have revised this section for purposes of clarity.

On page 8, lines 16 - 17, I have added a definition for department.

On page 9, line 1, I have changed the word "qualifying" to "that qualifies" for purposes of clarity.

On page 9, line 3, after the word "needy", I have inserted the phrase "under AS 47.07.080(5)".

On page 9, lines 21 - 22, I have added language to clarify that the commissioner is to make his report to the legislature.

Louann Cutler also had asked me to insert provisions to discourage switch-over from private insurance plans to the state plan by high risk persons. I have not included that provision in the bill draft because it has not been determined who will constitute high risk persons. If that provision is to be added to the bill, I suggest that the following changes be made:

A new section of the bill should be added containing at least three subsections. The first subsection would provide that the cost of a premium under the state comprehensive health insurance plan established under this chapter for a person in a high risk category is 125 percent of the cost of the standard premium under the state comprehensive health plan. A second subsection would describe the high risk categories according to the persons you want to define as high risk. A third subsection should be included to provide that a person in a high risk category who is otherwise eligible to participate in the state comprehensive health plan may not be excluded from the plan because he is in a high risk category. Another subsection should be added to AS 18.27.020, the cost sharing section. The additional subsection should provide that for purposes of the cost sharing program the commissioner shall pay the state's share of costs of health insurance incurred by a resident in a high risk category under (the section number designated for the new section on high risk categories) in the same dollar amount as for a person who is not in a high risk category. Finally, on page 2, line 24, subsection (c) should be

• Representative Thelma Buchholdt
Page 3
February 23, 1982

amended to provide that except as provided in the additional subsection we add to AS 18.27.020, the commissioner shall pay, etc.

EHH:ljb

Enclosure

SECTION 1: Sets up a state health plan (hereafter referred to as "the Plan") and a state health insurance cost sharing program, by adding a new chapter to Title 18 (Health and Safety) of state law.

Sec. 18.27.010. State Comprehensive Health Plan. Provides for the establishment of the Plan in the ~~Department of Administration~~. The Commissioner is directed to establish ~~minimum benefit standards~~ for the Plan, and provide for underwriting and administration of the Plan. A contract for the underwriting and administration of the Plan shall be for ~~three years~~. A Plan participant may direct that their permanent fund dividend be used to cover their portion of the cost of the Plan.

Sec. 18.27.020. State Health Insurance Cost Sharing Program. A resident enrolled in the Plan, or a private individual health insurance policy with benefits that meet or exceed the Plan's benefits, is entitled to a subsidy to help defray the cost of health care. Residents that are not enrolled in a federal health plan or a private group health insurance policy are eligible for a state subsidy if they meet the income criteria of the cost sharing program.

The subsidy schedule of the cost sharing program is geared to family units, and a distinction is made between the amount of subsidy available for premium and out-of-pocket (copayment and deductible) expenses. The intent of the distinction is to keep down the cost of insurance by requiring those with higher incomes to pay a greater percentage of the cost of actual services rendered (copayment and deductible) than they pay for the cost of being insured before seeking health care (premium). A higher subsidy may be available for a Barrow family than for an Anchorage family due to the higher cost of living in Barrow.

The subsidy schedule can be summarized as follows:

<u>monthly income</u>	<u>family pays</u>	<u>state pays</u>
below 45% of median adj. gross income for Ak. (150% of poverty guideline)	0%	100%
45-75% of median	0% premium, portion of out-of-pocket	100% premium, portion of out-of-pocket
75-100% of median	portion of premium and out-of-pocket	portion of premium and out-of-pocket
100-125% of median income	portion of premium, 100% out-of-pocket	portion of premium and 0% out-of-pocket

By paying 100% of costs for families below 45% of median income, the state will transfer most of the existing Public Assistance General Relief Medical (GRM) program to the Plan. Most of the services currently offered through GRM would then be provided through an insurance model instead of through a welfare model.

A residual GRM program would still exist to pay for certain one-time expenses that would not be covered through the Plan and to pay for such services as long term care that are too expensive to cover through an insurance model.

The state subsidy available for a certified individual private policy is limited to the amount the state would have paid had the resident been enrolled in the Plan.

SECTION 2: Report to the legislature.

The Commissioner shall report back to the legislature at the beginning of the next session on the following items: (1) proposed minimum benefits for the Plan and the actuarial costs anticipated; (2) the number and characteristics of people who are expected to enroll in the cost sharing program and how much it will cost the state; (3) a proposal to implement the Plan and the cost sharing program, to determine eligibility, to pay the state's share of the costs of the Plan and the cost sharing program, and to advertise the availability of the Plan and the cost sharing program; and (4) recommendations for amendments to AS 18.27.

SECTION 3: Effective date for AS 18.27.

Coverage under the Plan and subsidies under the cost sharing program must be available on July 1, 1982.

SECTION 4: Technical amendment to present law.

SECTION 5-8: Alcoholism and drug dependency coverage.

Requires state employee health insurance coverage to include coverage for treatment of alcoholism and drug dependency.

SECTION 9: Provides differing mechanisms for provider reimbursement under federal and state medical assistance programs.

Sec. 47.05.070. Medical Assistance By Insurance or Service Contracts. If the Commissioner (of Health and Social Services) determines that it would be more cost effective to pay for medical assistance services through means other than the current fee-for-service payment mechanism, she may do so. Payment of health insurance policy premiums or expenses of health maintenance organization, medical or hospital service contracts are authorized in this section.

Sec. 47.05.080. Implementation. Requires the Commissioner to implement 47.05.070 only if it would be cost effective to do so. In other words, these mechanisms would be used only if it would cost the same or less than the current fee-for-service arrangement.

Sec. 47.05.090. Interim Payment. The Department of Health and Social Services may make an interim payment to a provider of a large volume of services under state medical assistance programs.

Sec. 47.05.100. Interest on Late Payments. Requires the Department to pay 1% interest on provider claims for services rendered under medical assistance programs that are not paid within 45 days of receipt of a clean claim. The interest rate goes up to 2% for claims that are outstanding after 90 days.

SECTION 10: Requires the state to offer Medicaid to all categories of eligibles for whom services may be provided under federal law as of March 1, 1981.

Alaska currently provides Medicaid services to all categories of people that federal law requires, and additional categories that are considered optional under federal law. This section would require the Department to provide Medicaid services to other categories of people that Medicaid considers optional. The state would then be offering services to all categories of people for which federal match funding is available, except for those considered "medically needy". There is no need for the state to pick up the medically needy option because these individuals would be covered under the Plan established in section 1, since anyone with an income less than 45% of median income will receive 100% state subsidy for the cost of the Plan.

Some of the categories considered optional under Medicaid are presently offered by the state through GRM. The effect of transferring these categories to Medicaid would be to collect 50% of the cost of providing service to certain people from the federal government. In other words, the state would be paying half of the present cost of providing certain services to these categories of Medicaid eligible people.

SECTION 11: Requires the state to offer all Medicaid services allowable under federal law, as of March 1, 1981.

Alaska currently provides all of the services required by federal law, and some that are considered optional. This section would require the Department to pick up the rest of the services that are considered optional. It would then be offering all services available for Medicaid matching funds. The GRM transfer effect described under section 10 would apply to certain of these services as well.

SECTION 12: Definitions.

SECTION 13: Study of federal programs.

This section requires the Legislative Council to make recommendations to the legislature, by next session, about how the state can complement federal provision of services through Indian Health Service and Medicare. The council would consult with various private and state agencies that have knowledge of the Indian Health Service and Medicare programs in compiling its recommendations.

SECTION 14: Deletes section of law that requires the Department to ask the legislature's permission to add any new Medicaid service or eligible categories.

This section of law would no longer be needed since all available categories would be offered or provided for through other means.

SECTIONS 15-18: Effective dates.

Sec. 1-4: 7/1/82

Sec. 5-8: 1/1/82

Sec. 9: 7/1/81

Sec. 2-3, 10-14: immediately.

(LC: 5/3/81)

COST SHARING AVAILABLE FOR HEALTH INSURANCE UNDER HB 41

<u>Percent of median*</u>	<u>Premium subsidy</u>	<u>Out-of-pocket subsidy</u>
125	0%	0%
120	10%	0%
115	20%	0%
110	30%	0%
105	40%	0%
100	50%	0%
95	60%	9%
90	70%	18%
85	80%	27%
80	90%	36%
75	100%	45%
70	100%	55%
65	100%	64%
60	100%	73%
55	100%	82%
50	100%	91%
45	100%	100%

* Refers to percentage of median income for each family size

THE UNCOVERED POPULATION

43,917 Alaskans currently have no health care coverage. Of these 43,917, about 40% are children, 25% are parents, 35% are single individuals. 60% are employed. Of the 60% employed, 29.7% are in business services; 24.7% are in wholesale or retail trade; 18.8% are in construction; 15.3% are in manufacturing, transportation, and utilities; 7.1% are in personal services; 2.7% are in agriculture, forestry and fishing (this figure does not take into account all the fishermen that will be without coverage in October, when PHS no longer plans to provide coverage to seamen with documented vessels); and 1.1% are in mining. About 5% of the 43,917 are categorized as "high risk". (There are about 4,000 high risk individuals in the state; some have private insurance but all would probably be interested in joining the plan created by this legislation because rates may be less expensive for high risk individuals than rates currently available in the market.)

Source: Survey of Income and Education (US Bureau of the Census)
John Wills, Battelle Research Center

(LC: 3/30/81)

CS SS HB 41 (Finance)
Health Care Financing Legislation

Six components of the bill:

- (1) Creation of a state health plan open to all residents but designed primarily to cover the 44,000 Alaskans who are presently without coverage. 40% of the 44,000 are children. The uncovered adult population consists of construction, cannery, firefighting and other seasonal workers; fishermen, farmers and miners; those who work in retail and wholesale trade, manufacturing, transportation, utilities, and personal services industries; many employees of small businesses and many of the self-employed. ¹
- (2) Creation of a cost sharing program for state plan participants and others currently without coverage that an employer or the federal government helps to finance. The amount of cost sharing available depends on income, family size and what region of the state the insured lives in.
- (3) Provision of alcohol and drug dependency health insurance coverage for state employees.
- (4) Enables the state to use alternative methods to reimburse providers of medical services offered through federal and state medical assistance programs.
- (5) Expands Alaska's medicaid program to provide all services to all eligibles allowed by federal law.
- (6) Provides for a comprehensive study of federal medical programs in the state. The study would result in recommendations to the legislature regarding solutions to problems of funding and provision of services through these programs.

Fiscal impact (general fund dollars): ^{*}

FY 82: \$ 3,768,900
FY 83: \$ 13,247,700
FY 84: \$ 28,959,400
FY 85: \$ 57,084,300
FY 86: \$ 69,514,300

¹ This information is from the Batelle Research Center.

* The FY '83-'86 figures are rough estimates.

FISCAL SUMMARY FOR CSSSHB 41 (Finance)

	<u>FY '82</u>	<u>FY '83</u>	<u>FY '84</u>	<u>FY '85</u>	<u>FY '86</u>
Federal funds:					
1. Medicaid match	11631.8	13353.4	15338.3	17619.6	20241.0
General fund:					
DHSS					
1. Medicaid	6781.6	7782.0	8938.8	10268.4	11796.0
2. GRM transfer to 50% federal match	(4619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.9)
ADMIN.					
1. Alcoholism	180.0	414.0	476.1	547.5	629.6
2. Benefits/cost sharing	0.0	8800.0	23950.0	51420.0	63107.0
3. Administration	1426.4	1563.6	1703.1	1873.3	2060.6
REVENUE					
1. Rogers amendment	0.0	0.0	0.0	0.0	0.0
<u>TOTAL GENERAL FUND</u>	<u>3768.9</u>	<u>13247.7</u>	<u>28959.4</u>	<u>57084.3</u>	<u>69514.3</u>
Total of g.f. and fed. funds	15400.7	26601.1	44297.7	74703.9	89755.3

(LC: 4/14/81)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Proposed CSSHB 41 (Finance)Title An ACT Relating to the Health and Residents of the StateRequested by HOUSE FINANCE COMMITTEEDate 4/9/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social ServicesProgram Category Affected Health/Social and Economic AssistanceBRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Deter./Public Assist. Admin.

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		353.9	389.3	428.2	471.0	518.1
200 TRAVEL		12.9	14.2	15.6	17.2	18.9
300 CONTRACTUAL		133.8	147.2	161.9	178.1	195.9
400 COMMODITIES		6.5	7.2	7.9	8.7	9.5
500 EQUIPMENT		13.3	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES		0	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.		17893.0	20576.9	23663.5	27213.0	31295.0
TOTAL		18413.4	21135.4	24277.1	28880.0	32037.0

FUNDING (Thousands of Dollars)

GENERAL FUND		6781.6	7782.0	8938.8	10268.4	11796.0
FEDERAL FUNDS		11,631.8	13353.4	15338.3	17619.6	20241.0
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		12	12	12	12	12
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 2145 new cases under the Medicaid program. Administration of program benefits would require 11 field staff positions and 1 central office position, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care Program which is funded at 100% federal funds.

IV. DATE 4/9/81PREPARED BY David M. DavidsonAGENCY Division of Public AssistancePHONE 405-5317

Original: Legislative Finance

and Management

Fiscal Note No. 41 (FY 81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill Resolution No. Proposed CSSSHB 41 (Finance)

Title An ACT Relating to the Health of Residents of the State

Requested by HOUSE FINANCE COMMITTEE

Date 4/9/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health

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

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)
TOTAL		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)

FUNDING (Thousands of Dollars)

GENERAL FUND	(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)
FEDERAL FUNDS					
OTHER (Specify Fund Source)					

POSITIONS

FULL TIME					
PART TIME					
TEMPORARY					

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

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

IV. DATE 4/9/81

PREPARED BY David J. M. Davis

AGENCY Legislative Assistance

PHONE 263-1234

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

JAY S. HAMMOND, GOVERNOR

POUCH H-07
JUNEAU, ALASKA 99811
PHONE: (907) 465-3355

April 9, 1981

The Honorable Samuel Cotten
House of Representatives
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Document# 98-81

Dear Representative Cotten:

This letter is intended to confirm the Department's estimate of increased Medicaid costs in FY82 based on CSSSHB-41 as amended by Representatives Buchholdt, Adams and Rogers on April 8, 1981.

HB-41 as originally introduced presented \$23,491.1 in additional costs as follows. (See position paper dated 2/27/81).

	<u>TOTAL</u>	<u>FED</u>	<u>STATE</u>	<u>POS.</u>
(1) Addition of all Medicaid Services & New Optional Categorical Groups.	\$18,413.4	11,631.8	6,781.6	12
(2) Decrease of GR Medical	(4,619.1)		(4,619.1)	
(3) Addition of Medically Needy to Medicaid	\$ 9,029.7	5,709.3	3,320.4	5
(4) Interest Payments	<u>667.2</u>	<u> </u>	<u>667.2</u>	<u> </u>
TOTAL	\$23,491.1	17,341.1	6,150.1	17

However, as a result of testimony offered by the Department and others, CSSSHB-41 was modified to delete medically needy coverage (item #3 above) and to resolve the Department's concerns with the interest payments provisions (item #4 above). As a result, only those costs associated with items #1 and #2 above remain at this time, representing an increase of \$13,794.3 as follows. (See position paper dated 4/3/81).

	<u>TOTAL</u>	<u>FED</u>	<u>STATE</u>	<u>POS.</u>
(1) Addition of all Medicaid Services & New Optional Categorical Groups.	\$18,413.4	11,631.8	6,781.6	12
(2) Decrease of GR Medical	<u>(4,619.1)</u>	<u> </u>	<u>(4,619.1)</u>	<u> </u>
TOTAL	\$13,794.3	11,631.8	2,162.5	12

Two final comments are in order:

- * President Reagan's proposed CAP on Medicaid makes it very uncertain whether the State will receive the expected \$11,631.8 in additional federal funds. The State could find itself in the position of paying the entire \$13,794.3 out of the State general fund.
- * These estimates do not include the costs associated with implementation of Sections 1-8 of CSSSHB-41. These costs would be in addition to the \$13,794.3 increase in Medicaid.

Please let me know if I may provide any additional information.

Sincerely,

A handwritten signature in cursive script that reads "Rod Betit". The signature is written in dark ink and is positioned above the printed name and title.

Rod Betit
Director

I. REQUEST
Bill/Resolution No. Sponsor Substitute House Bill 41 (Sections 5-8)
Title Insurance for Alcoholism and Drug Dependence
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Administration - Division of Retirement & Benefits
Program Category Affected Labor Services
BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00 (OTHER BENEFITS)
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)
EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 STATE TRS MATCHING						
100 BENEFITS		180.0	414.0	476.1	547.5	629.6
TOTAL		180.0	414.0	476.1	547.5	629.6

FUNDING (Thousands of Dollars)

GENERAL FUND		147.4	339.1	389.9	448.4	515.6
FEDERAL FUNDS		8.3	19.0	21.9	25.2	29.0
VETERAN'S FUND		0.4	.8	1.0	1.1	1.3
FISH & GAME FUND		1.1	2.5	2.9	3.3	3.8
HIGHWAY FUND		2.3	5.4	6.2	7.1	8.2
AIRPORT FUND		5.2	12.0	13.8	15.9	18.2
CAPITAL FUND		15.3	35.2	40.4	46.5	53.5
PERS						
TRS						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

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

1. Approximately 10,275 State employees are currently covered under the State Group Health Plan.
2. The cost to implement provisions of this bill will be \$2.92 per employee per month.
3. Estimate that the cost to provide continued coverage will increase 15% each year for the immediate future. However, an effective Alcoholism/Drug dependency program should help to reduce overall health care claim experience in the future.

IV. DATE February 26, 1981 PREPARED BY Paul B. Arnoldt, Director
AGENCY Division of Retirement & Benefits
PHONE 455-4400
Original: Legislative Finance
Budget and Management
Prime Sponsor (Must Legislator Named)
Office of the Governor (With Staffing)

Ken Humphreys, for *QC*

ESTIMATION OF FISCAL IMPACT FOR STATE
COST-SHARING UNDER CSSSHB 41 (Finance)

44,000	individuals with no health coverage (Battelle study)
25,000	individuals with individual private coverage (est. by Battelle)
<u>+ 31,000</u>	assumed migration from small group plans (fudge factor)
100,000	individuals eligible for cost sharing (round estimate)
<u>÷ 3.03</u>	average people per household (1980 est. by state demographer)
33,000	households eligible for cost sharing (round estimate)
<u>x \$1,620</u>	average plan cost per household (\$1,320 premium + \$300 out of pocket)
\$53,465	total plan cost (in thousands)
<u>x .564</u>	average subsidy level (analysis of SIE data)
\$30,179	benefit costs of cost sharing program (FY81 dollars)
<u>x 1.166</u>	two years' inflation factor at 8%
\$35,200	cost of full enrollment, FY83 dollars

$\$35,200 \times .25 = \$ 8,800$ est. FY83 benefit costs (assumes 50% of
eligibles enroll by end of FY83-- 25% ann. ave.)

$\$35,200 \times 1.08 \times .63 = \$23,950$ est. FY84 benefit costs (assumes 75% of
eligibles enroll by end of FY84)

$\$35,200 \times 1.166 \times .88 = \$51,420$ est. FY85 benefit costs (assumes 100% of
eligibles enroll by end of FY85)

$\$35,200 \times 1.793 \times 1.0 = \$63,107$ est. FY86 benefit costs (assumes 100%
enrollment all year)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS SS HB 41 (Finance) (partial)Title State Comprehensive Health PlanRequested by House Finance

Date _____

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement & BenefitsProgram Category Affected General GovernmentBRU, Program, or Subprogram(s) Affected Retirement & Benefits and Administrative Services

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		329.7	965.5	1051.1	1156.2	1271.8
200 TRAVEL		6.0	6.0	6.6	7.3	8.0
300 CONTRACTUAL		1001.0	572.6	629.9	692.8	762.1
400 COMMODITIES		3.5	9.5	10.5	11.5	12.6
500 EQUIPMENT		86.0	10.0	5.0	5.5	6.1
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		1426.4	1563.6	1703.1	1873.3	2060.6

FUNDING (Thousands of Dollars)

GENERAL FUND		1426.4	1563.6	1703.1	1873.3	2060.6
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		25	29	29	29	29
PART TIME						
TEMPORARY			4			

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

Assumption:

1. 35 thousand accounts first year with 85,000 covered individuals.
2. Field offices in Anchorage, Fairbanks, Nome and Juneau.
3. Staff costs increase by 10% after FY83.
4. Does not include benefit costs under the cost sharing program or the cost under Sections 5-8.
5. Eligibility for resident status and co-payments determined by Division of Retirement & Benefits.

This fiscal note addresses only the estimated administrative costs to the state for the comprehensive health plan and state health insurance cost sharing program and producing the report called for in Sec. 2 of the bill.

IV. DATE _____ PREPARED BY Ken Humphreys, Deputy DirectorAGENCY Division of Retirement & BenefitsPHONE 465-4462

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 3

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	\$32,588	\$2,716	0%	0%
120	\$31,284	\$2,607	10%	0%
115	\$29,981	\$2,498	20%	0%
110	\$28,677	\$2,390	30%	0%
105	\$27,374	\$2,281	40%	0%
100	\$26,070	\$2,173	50%	0%
95	\$24,767	\$2,064	60%	9%
90	\$23,463	\$1,955	70%	18%
85	\$22,160	\$1,847	80%	27%
80	\$20,856	\$1,738	90%	36%
75	\$19,553	\$1,629	100%	45%
70	\$18,249	\$1,521	100%	55%
65	\$16,946	\$1,412	100%	64%
60	\$15,642	\$1,304	100%	73%
55	\$14,339	\$1,195	100%	82%
50	\$13,035	\$1,086	100%	91%
45	\$11,732	\$978	100%	100%

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 4

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	\$38,800	\$3,233	0%	0%
120	\$37,248	\$3,104	10%	0%
115	\$35,696	\$2,975	20%	0%
110	\$34,144	\$2,845	30%	0%
105	\$32,592	\$2,716	40%	0%
100	\$31,040	\$2,587	50%	0%
95	\$29,488	\$2,457	60%	9%
90	\$27,936	\$2,328	70%	18%
85	\$26,384	\$2,199	80%	27%
80	\$24,832	\$2,069	90%	36%
75	\$23,280	\$1,940	100%	45%
70	\$21,728	\$1,811	100%	55%
65	\$20,176	\$1,681	100%	64%
60	\$18,624	\$1,552	100%	73%
55	\$17,072	\$1,423	100%	82%
50	\$15,520	\$1,293	100%	91%
45	\$13,968	\$1,164	100%	100%

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 1

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	\$20,175	\$1,681	0%	0%
120	\$19,368	\$1,614	10%	0%
115	\$18,561	\$1,547	20%	0%
110	\$17,754	\$1,480	30%	0%
105	\$16,947	\$1,412	40%	0%
100	\$16,140	\$1,345	50%	0%
95	\$15,333	\$1,278	60%	9%
90	\$14,526	\$1,211	70%	18%
85	\$13,719	\$1,143	80%	27%
80	\$12,912	\$1,076	90%	36%
75	\$12,105	\$1,009	100%	45%
70	\$11,298	\$942	100%	55%
65	\$10,491	\$874	100%	64%
60	\$9,684	\$807	100%	73%
55	\$8,877	\$740	100%	82%
50	\$8,070	\$673	100%	91%
45	\$7,263	\$605	100%	100%

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 2

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	\$26,388	\$2,199	0%	0%
120	\$25,332	\$2,111	10%	0%
115	\$24,277	\$2,023	20%	0%
110	\$23,221	\$1,935	30%	0%
105	\$22,166	\$1,847	40%	0%
100	\$21,110	\$1,759	50%	0%
95	\$20,055	\$1,671	60%	9%
90	\$18,999	\$1,583	70%	18%
85	\$17,944	\$1,495	80%	27%
80	\$16,888	\$1,407	90%	36%
75	\$15,833	\$1,319	100%	45%
70	\$14,777	\$1,231	100%	55%
65	\$13,722	\$1,143	100%	64%
60	\$12,666	\$1,056	100%	73%
55	\$11,611	\$968	100%	82%
50	\$10,555	\$880	100%	91%
45	\$9,500	\$792	100%	100%

GLOSSARY

- (1) premium--- monthly payment by insured person to insurance carrier for insurance policy
 - (2) deductible--- the amount of covered health expenses that the insured must pay in full, before carrier begins to assist with payment of expenses
 - (3) copayment--- the percentage of covered health expenses that the insured person is expected to pay in addition to the deductible payment
 - (4) out-of-pocket--- deductible and copayments
 - (5) benefits--- two common meanings: (a) the types of medical services that a health insurance plan covers, i.e. hospital stay, doctor visit, x-rays, ambulance service, etc. (b) the portion of covered expenses that the insurance carrier pays
 - (6) maximum lifetime benefit--- the maximum dollar amount of health insurance benefits that a carrier will pay to a participant in a health insurance plan
- Example using (1), (2), (3), (4b), (5), and (6): A plan costs \$50/month (premium). A participant must pay the first \$200 of covered expenses each year (deductible) in addition to the monthly premium payment. The participant must also pay 20% of covered expenses (copayment) up to \$2000, in addition to deductible and premium payments. After the participant has incurred \$2000 in copayments and deductible payments (out-of-pocket expenses), the insurance carrier will pay 100% of future expenses (benefits) up to \$250,000 (maximum lifetime benefit).
- (7) provider--- One who furnishes medical services, i.e. a doctor, dentist, chiropractor, hospital, etc.
 - (8) Medicaid--- A program that pays for medical care for public assistance recipients and certain other needy persons, jointly funded by the state and federal governments. It is important not to confuse Medicaid with Medicare which is a federal health insurance program primarily for the elderly.
 - (9) GRM--- General Relief Medical is a wholly state funded program that pays for medical care that is not provided under Medicaid to Medicaid recipients and to certain other needy persons.
 - (10) prepaid health plan--- This is a generic term that refers to an insurance plan, a hospital or medical service contract, or a health maintenance organization service contract.
 - (11) hospital or medical service contracts--- Prepaid health plans that provide subscribers with hospital or medical services under contract with the provider. Blue Cross and Blue Shield are the major examples.

GLOSSARY

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- (12) HMO--- A health maintenance organization is a prepaid health plan in which the carrier is also the direct provider of covered health services. Group Health in Seattle and the Kaiser Permanente Plans in Oregon, California, Hawaii and elsewhere are the major examples.
- (13) insurance--- While insurance technically refers to indemnity coverage, for purposes of this bill it is defined to include prepaid plans as well.
- (14) poverty guideline--- The income figure for each family size for Alaska that is intended to approximate the minimum income needed to provide the basic necessities of living. It is the income guideline used in certain federal programs.
- (15) median income--- The middle adjusted gross income figure for each family size for Alaska used by certain federal programs. While the formula by which it is calculated does approximate the real median income, it is not a true statistical median.
- (16) medical assistance programs--- Medicaid, GRM and other state programs that help needy people meet their medical expenses.
- (17) high-risk uninsurable--- This term refers to a person who has difficulty obtaining insurance. He is considered a "high risk" because he has had a serious accident or medical condition in the past that requires continuous monitoring, in the form of expensive and on-going health services. Most carriers do not want to provide insurance for such individuals at the same rate as healthier people, and some do not wish to cover them at all.

(IC: 2/81)



JUNEAU, ALASKA

Alaska State Legislature Senate

Comprehensive health care proposed in bill

By The Associated Press

Rocky Plotnick Weller did not invest in health insurance when her benefits as an administrative assistant ended with the legislative session in 1979. "I couldn't afford it. I was young. I never thought I'd get sick," she said.

But she was wrong. Ms. Weller had to spend three days in the hospital that fall. The bill: \$4,200. It took all of her savings and help from her parents to pay off the debt.

Doug Jordan has cancer. His illness caused him to lose his job, and with it his health insurance. Now, he said, no one will sell him a policy. "I'd cost them too much," he said.

Michael Thomas was installing a set of cabinets when he fell off a ladder and broke his wrist. He owned his own carpentry business and did not have health insurance to foot his sizable hospital bill.

Ms. Weller, Jordan and Thomas are among an estimated 43,000 Alaskans who do not have health insurance. Most of the uninsured have jobs at least part of the year, many are self-employed, and some are considered high insurance risks and cannot get policies.

In a plan targeting those who are not needy enough to qualify for present state or federal health insurance policies, Reps. Thelma Buchholdt, D-Anchorage, and Terry Gardiner, D-Ketchikan, have introduced a bill (SHB41) to set up a comprehensive health insurance program bankrolled by the state.

"Everybody has a wild scheme for throwing money away, but health care is a basic need like education," Gardiner said.

The bill had its first hearing today in the House Health, Education and Social Services Committee. Chairman Don Clocksin, D-Anchorage, said state health insurance is a priority this session.

Under the bill, residents could sign-up for the state-funded health insurance if they are not already covered by a group, state or federal policy. Because they are already covered by a federal program, natives would not be eligible.

According to the proposal, the state would pay for part or all of the individual's premium payments and medical bills, based on income. For example, an individual making up to \$7,263 a year or a family of four with an annual income of \$13,968 would be fully covered. Half of the monthly premium and no additional expenses would be paid for individuals earning \$16,140 a year and families making \$31,040.

The insurance plan would be purchased by the state from a private carrier. The state would also subsidize residents' private policies if the benefits provided are at least as good as those available under the state plan.

It is not known how many people would be eligible for the program.

The bill would extend the health insurance are now provided state employees to cover alcohol and drug addiction. Mrs. Buchholdt said those benefits are being partially extended as a pilot program.

Mrs. Buchholdt said the need for a state insurance is great — especially among residents with moderate incomes because they earn too much to qualify for state and federal health insurance programs, but not enough to pay for a private policy.

Juneau Empire 2-27-81

Health program hit as premature

By KARIN DAVIES
The Associated Press

JUNEAU — Amid charges that lawmakers are acting too quickly, the House voted 21-14 Friday in favor of legislation intended to make health care affordable to all Alaskans.

Rep. Terry Martin, R-Anchorage, said lawmakers should wait until an ongoing health care study is finished in December, and should give the state bureaucracy time to straighten out existing health care programs.

In a speech from the House floor, Martin urged lawmakers to "be patient. Let's see what that \$250,000 study is going to bring." Martin said the health program hammered out by Rep. Thelma Buchholdt, D-Anchorage, promises nothing but a \$70 million expense to the state by 1986.

But Ms. Buchholdt said, "Health care is almost a basic necessity . . . and a very good way to invest in the people of this state." She added that adequate health care should be an inherent personal right.

Republicans and Libertarians voted against the measure. Rep. Dick Randolph, L-Fairbanks, gave notice of reconsideration on his vote, which means the legislation may come up for another vote on Monday.

Randolph charged that lawmakers are guilty of "developing in Alaska an absolutely socialistic society" by approving the health care program.

Ms. Buchholdt disagreed. "Isn't it ironic," she asked, "that whenever we talk about education or health care" charges of socialism are lev-

eled, but not when low-interest loans are discussed.

Rep. Terry Gardiner, D-Ketchikan, said the bill simply guarantees a badly needed minimum level of health care service for all residents.

The measure is expected to gain some support in the Senate, although a streamlined plan introduced by Senate President Jalmar Kerttula, D-Palmer, is preferred.

Under Ms. Buchholdt's bill, the state would underwrite a comprehensive health insurance program targeting those not covered by an employer or an existing federal policy.

Alaska Natives would be excluded from the program, which has evoked criticism from many rural lawmakers who said the federal Indian Health Service program for natives is inadequate. As a result, the bill was amended in committee to require the state to study the Indian Health Service program, and suggest ways for the state to complement its funding.

The state would spend an estimated \$3.8 million next year for start-up costs of the health care program, which would take effect in July, 1982. An estimated \$13 million would be required during 1983; the program would cost \$69 million a year by 1986.

An estimated 43,000 Alaskans do not have health insurance, according to studies done for the state. Most have jobs at least part of the year, many are self-employed, and some are considered high insurance risks and cannot buy policies.

*Andy D. News
Sat. April 25, 1981*

①

5-2-81

NCSL Workshops

Sandy Goldin

IHS

I. Clinical

hos. & clinic

M.H.

alcohol

maintenance & repair

dental

contract health care (to sup. hos. & clinic)

II. Preventative

sanitation

P.H. nurse

health education

CHC program (community health rep.)

III. Urban Health Projects

IV. Indian Health Manpower

V. Tribal Management

VI. Program Management

(2)

Bill Penn

Is IHS a "plan"? (Penn says no.)
(as used in IHS 41)

Alaska Native

64,047 1980 pop. estimate includes
74,611

@ 20% Al. Native served by Al. Native
Native Regional Health Corps, except Natives
are assuming responsibility
community health aides / @ 70% health care
usually low paid & mostly women

@ 35% ~~to transfer~~ a year
to qualify for ^{medicine} medical, the tribal entities
must accept all persons in their region, not
just Al. Natives -

Regional corps getting alcohol & M.H. ^{state} \$
to get IHS \$; entire board must be Native

* expenses: patient travel - patient pays 1/2
& M.H. provided - food & exp 4.50 & while in
prison - no long term care no hospital - no
eye glasses -

dental is maintenance, which means no
cavities but does not include dentures, crowns
etc.

Damn continued -

③ Reagan's Budget -
94 million 81 - all.

into: H₂O/waste

supplies

contract

monitors (inflation, fuel, etc.)

travel

re HB41: establish objectives

insurance scheme } not always
all over } guaranteed the other

Article - financing

re - pay - each level

reimburse - costs higher } medical costs

also complaint of co-payment plan (3rd party)

266 dent.

297 doc

795,000 "Indian" people (1970 census)

(4)

Shawman -

Battelle study -
minimum disruption

44,000 dollars spent health ins. coverage

1) state health comp. insurance plan

2) preventive care

3) high risk individuals (?)

4) system b.k. Med & medical

IHS has no defined benefits
very ambiguous

(5)

Russ Herford
H & SS → states
reduce Fed. exp.

Rocky = call David Davidson

Fed. act @ 200,000 for Alaska's
share in preventative health \$

"Catastrophic" health insurance— a misguided prescription?

CHRISTOPHER J. ZOOK, FRANCIS D. MOORE
RICHARD J. ZECKHAUSER

WHEN the economy was sound and medical care more affordable, comprehensive national health insurance was a top priority measure on the liberal political agenda. The straitened circumstances and escalated medical costs of recent years, however, have compelled analysts and officials to lower their sights. Seeking something short of national health insurance that would nevertheless insure people against the crippling costs of severe accidents and illnesses and long-term hospitalization, they have hit upon the simple idea of "catastrophic health insurance." Such coverage, it is believed, would provide Americans appropriate care for unavoidable high-cost illness at a fraction of the cost of any comprehensive care program. But is this the case?

Proposals for catastrophic health insurance characteristically have a simple benefit structure whereby medical expenditures above some annual dollar threshold would be fully paid for all illnesses and conditions. This approach is justified by the assumptions that high-cost illness strikes individuals at random and accounts for a small share of total resources, and that a large portion of its costs cannot be controlled by either the patient or the institution delivering care.

These perceptions are often influenced by first-hand knowledge of a small group of tragic cases. For example, during the 1978

Kennedy hearings on national health insurance, the stories of 68 high-cost users attracted the spotlight. Similarly, personal testimony had a major impact on the Kidney Disease Amendments of 1971, after hearings during which patients were actually dialyzed in front of Congressional committees. However compelling these scenes may be, they simply do not adequately represent what might now be called, and under national health insurance surely would be considered, "catastrophic" illnesses.

Study of the available evidence has convinced us that many common perceptions of the nature of high-cost illness and the characteristics of patients are either too simple or plainly wrong. First, the costs of treating high-cost illness account for a much larger part of all health costs than is generally believed. Second, its characteristics and financial implications vary widely across patient groups. Third, it is more often long-term and repetitive than short-term and acute. Fourth, some costs of care appear to be, in part, controllable with appropriate incentives. This new evidence requires a new and more complex understanding of the nature of medical "catastrophes." On that basis, proposals for insurance should be reformulated to protect people from financial ruin while maintaining incentives to contain the cost of medical care. Comprehensive national health insurance is considered too expensive and as giving the wrong incentives. Catastrophic health insurance will be little better if the nature of high-cost illness is not properly diagnosed and understood.

Diagnosing the nature of high-cost illness

Case-by-case review of patient medical records in selected hospitals in California and Massachusetts have been conducted recently by Zook and Moore, and Schroeder. These studies, together with the work of Birnbaum, provide the principal sources of detailed information on the identity of high-cost patients.¹ They reveal important and sometimes surprising facts about five facets of high-cost illness: its total cost, its typical time span, the role of medical technology, the importance of unexpected medical complications, and the frequency of potentially harmful personal habits among some expensive patients.

¹ Christopher J. Zook and Francis D. Moore, "The High Cost Users of Medical Care," *New England Journal of Medicine*, 302, 1980, pp. 996-1002; Stephen Schroeder, et al., "Frequency and Clinical Description of High Cost Patients in 17 Acute Care Hospitals," *New England Journal of Medicine*, 300, 1979, pp. 1300-1309; and Howard Birnbaum, *Catastrophic Illness in the United States* (Boston: Lexington Press), 1978.

1. *Medical expenditures are highly concentrated.* National medical care expenditures are concentrated in a small fraction of patients. In any given year, about half of the resources in a typical hospital are consumed by only 13 percent of the patients. The most expensive one-fifth of patients accounts for nearly 70 percent of total resources. Since one person in ten is hospitalized each year, this implies that 1.3 percent of the nation's population may account for half of all charges in short-stay hospitals. This skewness is not primarily a function of patient age. Though the aged account for nearly 40 percent of high-cost patients, there is a similar pattern of concentration within each age cohort. (In fact, some of the most expensive patients begin their "careers" at birth with non-lethal congenital abnormalities.)

Of all patients in the five hospitals in the Zook-Moore study, the high-cost 10 percent had direct hospital charges in 1976 averaging \$30,000.² All of the high-cost patients had expenses above \$15,000. Inclusion of charges for professional services, outpatient care, home care, drugs, and institutional services would further increase these amounts. Though there was considerable variation across hospitals in the average level of expenses, the distribution of medical resources was highly skewed in every hospital.

Though our data are derived from short-stay hospitals, there is evidence that a substantial additional portion (one study suggests half) of high-cost patients are in nursing homes, special disease hospitals, terminal illness facilities, or mental institutions. Each year, 1.6 million people spend some time in an institution of this sort. Together, they represented a total institutional care budget of over \$17 billion in 1976, implying an average expense per capita of over \$15,000, with some patients consuming many times this quantity of medical resources. Including both long- and short-stay institutions, approximately 2 percent of the United States population accounts for over 60 percent of all hospital and institutional care resources in a given year. If high-cost "institutional" (e.g., chronic domiciliary) users disproportionately overlap with high-cost users of a short-stay hospital, as they surely must, the concentration is even greater.

This significant concentration of medical resources appears to be increasing over time. One study has shown that the average medical expenses for the high-cost 1 percent of persons in the population in a year are growing at a rate that is 5 percent greater

than those of the least costly 25 percent of persons. Thus, the most expensive patients are becoming both absolutely and relatively more expensive to treat.

2. *High-cost illness is seldom a single episode.* Discussion of catastrophic health insurance often depicts patients in intensive care or "brain death" as typical of high-cost illness. In contrast, we find that high-cost illness is most often longitudinal in nature, comprising a series of treatments and hospital episodes over time rather than one medical emergency. In the Zook-Moore study of six populations in five hospitals of varied nature, the highest-cost 10 percent of the illnesses treated in a year were classified into several categories: single cost-intensive illness ("intensive care"), single prolonged hospitalization, repeated hospitalization for the same disease, and combinations of these categories. Repeated hospitalization for the same disease was by far the largest of these groups, accounting for 50 to 90 percent of high-cost patients in the different populations.

A large proportion of high-cost illnesses are not imminently terminal, but rather extend over many months or years. The recidivists in the high-cost group were 15 years younger on average than other high-cost patients with cost-intensive or prolonged hospitalizations and frequently suffered from a degenerative or irreversible long-term illness, such as advanced coronary artery disease or cirrhosis of the liver. Only 12 percent of the recidivists died in the hospital or were judged to be imminently terminal at discharge. The one-year hospital charges of the recidivists averaged \$15,800.

In contrast, half of the patients with single cost-intensive hospitalizations died in the hospital or were judged terminal at discharge. The average cost (excluding physician fees) of this type of stay was \$15,000. Twenty-two percent of patients with a single prolonged hospitalization died or were terminally ill, and the average cost of their stay was \$18,700. Previous studies of intensive care have shown even higher in-hospital fatality rates and expenses. There is no doubt that these illnesses have a tremendous financial impact on the hospital and they have understandably drawn a great deal of public attention. However, neither intensive care nor prolonged hospitalization was the most frequent type of high-cost utilization over periods of a year or longer, that distinction belonging to patients who underwent repeated hospitalizations for the same disease.

3. *Medical technology is not the primary source of rising costs.*

² All figures are inflated to 1980 dollars.

Technological advances are often thought to be the principal cause of the high costs of individual "catastrophic" illnesses. (Coronary artery bypass grafting, kidney dialysis, and hyperalimentation are commonly cited examples.) Yet there is evidence to suggest that high daily hospital charges and high costs per illness typically reflect the use of a large total volume of standard resources—often fairly simple—rather than the application of a new technology.

Among the high-cost patients in the Zook-Moore study, a major procedure or treatment seldom accounted for a large share of total costs. Only 1 percent of this group had a cardiac pacemaker, 4 percent had a recent coronary artery bypass graft, 6 percent were on dialysis, 1 percent had open heart surgery, less than 1 percent required hyperalimentation, 2 percent required radiotherapy, and 2 percent required care in a neonatal intensive-care unit. (Since two of the hospitals studied had large kidney disease services, the incidence of dialysis may be higher than in the population overall.) These figures resemble the results of a study of 17 California hospitals which concluded that high-cost patients differed from their low-cost counterparts more in the amount than in the kind of care received.

Therefore, for high-cost patients (as for others) most days spent in the hospital do not include major tests or procedures, let alone intensive care. Though high-cost patients have more complex days somewhat more often than low-cost patients, the difference was much less than one might expect. The Zook-Moore study classified hospital days into four categories, depending upon their complexity. Briefly, the categories were: (1) routine dwelling days; (2) days of minor testing, blood work, physician consultation, and special intravenous medications; (3) days of major diagnostic testing, minor operations, or special precautions; and (4) intensive care, operations over three hours, emergency admission for major trauma, or life-support services. So-called "intensive care" days were more than twice as common for high-cost patients than for other patients, but they still accounted for only one day in eight for this highest-cost category. Routine dwelling days represented a quarter of the time spent in the hospital by the highest-cost group as compared to 40 percent of the time spent by the lowest-cost group. Thus, for many high-cost illnesses, treatment does not consist predominantly of intensive bursts of the most high-technology care. Patients suffering from alcoholism, diabetes, obesity, certain neurological disorders (e.g., multiple sclerosis), mental disease and stroke for instance, incur high costs primarily by consuming large

quantities of hospital days and many hours of professional services. They may never reach the operating room, nor be assessed by a CAT scanner.

4. *Complications during treatment raise costs.* Hospitals are complex institutions where hundreds of difficult judgments are made, orders are interpreted, and technical procedures are undertaken every hour. In such an intricate environment, many forms of accident, error, and unforeseen health events may arise to prolong or increase the costs of treatment. Some complications during treatment are simply bad outcomes of well-informed gambles (prosthesis failure or digitalis toxicity in heart disease). Some are natural but unforeseen progressions of disease; others may be due to misapplication of diagnostic equipment; some are due to reactions; others are due to infections acquired in the hospital; still others are due to errors by physicians and other care providers. In any case, unexpected complications during treatment are an important cause of high-cost illness.

Unexpected complications, which other studies have shown to strike one patient in five, are most common among high-cost patients—both per day and per hospitalization. The Zook-Moore study identified 22 forms of unexpected complication during hospitalization in the five hospital populations. On average, 1.8 such events occurred during each cost-intensive hospitalization, 1.3 during each prolonged hospitalization, and 3.2 during stays that were both prolonged and cost-intensive, but only .2 in other types of hospitalization. By virtue of their illness, high-cost patients seem particularly susceptible to medical complications which further raise costs.

5. *Harmful habits lead to high costs.* Persons with a potentially harmful habit are hospitalized substantially more than are others. (This is not to imply inevitable causality. In any particular case, the condition requiring hospitalization may have developed independently of a harmful habit.) The high prevalence of alcoholism among patients in general hospitals illustrates the link between habits and hospital costs. Though 4 to 5 percent of the overall adult population is alcoholic, it has been estimated that 9 to 14 percent of the general hospital population (15 to 29 percent of males in that group) is alcoholic. Our data confirm these high levels of alcoholism in the general hospital population and the overwhelming recidivist tendencies of these patients. When hospitalized, patients with unhealthy habits like alcoholism are more expensive to treat and become high-cost patients. In the Zook-Moore study, poten-

tially harmful habits were noted in the records of high-cost patients more than 40 percent more often than in the records of other patients.

The picture of high-cost illness that emerges from consideration of the factors discussed above is not entirely consistent with the "catastrophic" stereotype of life maintenance in intensive care, problems of when to declare brain death, or advanced high-technology treatment. Rather, high-cost illness is usually long term and often mundane or recurrent, embodying costs due, in part, to unexpected complications during treatment or to persistent unhealthy personal habits. Though random medical tragedies are an important component of the high-cost patient group, they are isolated elements representing only a small part of the picture. Unfortunately, proposals for catastrophic health insurance are based primarily on this rather simple notion of the source of high medical costs.

Problems with the current plans

From this profile of the high-cost users of medical care emerge three important considerations for the design of health insurance programs. First, high-cost illnesses differ widely in terms of clinical options, controllability of resource utilization, and predictability (the repeaters). Insurance schemes should reflect those differences. Identical insurance structures for the very different illnesses described above may make no more sense than identical plans for fire and life insurance. In fact, the potential for identifying chronic repeaters suggests a form of prospective reimbursement to a specialist institution (e.g., in spinal cord injury) for some patients.

Second, the data suggest that "catastrophic health insurance" is unlikely to be as economical as is often asserted. In fact, the high-cost 10 percent of patients accounted for 40 to 50 percent of hospital charges in one year and cost over \$13,700 apiece. Methods are still needed to instill cost efficiencies while insuring against genuine cases of financial hardship.

Third, some utilization by the high-cost users may be more "optional" or elastic than is generally thought; this possibility is suggested by the surprising prominence of harmful habits, of treatment complications, of "routine," low-intensity care, and of repeated hospitalization (as opposed to emergency intensive care).

These three themes—marked patient differences, surprisingly high costs (often predictable over several years), and the potential for controllability of some cost components—put current proposals for

health insurance in a new light and point towards new and more workable policy approaches to health insurance.

The front-running alternatives for national health insurance are built upon the premise of relieving the financial burden of high-cost illness for all Americans. The Catastrophic Health Insurance Bill that has received tentative approval from the Senate Finance Committee, employing what is called the Long-Dole approach, provides federal payment of all medical expense for a person beyond a \$3,500 annual threshold. (The threshold is lower for poor people.) Consumer Choice Health Plan, a leading pro-competitive option put forward by Alain Enthoven, would require any private plan approved for federal support to include "catastrophic coverage." Major-risk health insurance is also central to a plan put forth in *The Public Interest* in 1971 by Martin Feldstein. This scheme would use public loans to patients as well as co-insurance and deductibles to hold down costs from "first dollar" coverage while relieving some of the fiscal burden imposed on the individual by high-cost illness. Proposals by Senator Edward Kennedy for a comprehensive national health insurance plan under the Health Care for All Americans Act were presented in a series of 1978 hearings where experiences of patients with high-cost illness dominated the testimony. The Carter Administration proposal, National Health Plan, also included retrospective payment for high-cost illness, with uniform reimbursement provisions across all providers and diagnoses.

The findings described above suggest that major improvements are needed in the catastrophic coverage provisions of these plans. Though few proposals contain incentives for providers to develop long-term care programs to reduce readmissions, repeated hospitalization for the same disease is the most frequent utilization mode defining high-cost illness. In addition, no plan contains incentive provisions to reduce the frequency of potentially harmful habits, such as higher premiums for the heavy smoker, the obese overeater, or the noncomplying clinic "no-show." No plan considers how patients at high risk of complication may reach the most efficient providers. Patient profiles are very different, but no plan considers how we can overcome repeated treatment failures in hospitals, an important source of high medical costs and poor medical outcomes.

High-cost illnesses for the most part are not random "bolts from the blue," yet many proposals for catastrophic health insurance are based on this misconception. They fail to confront key cost components of high-cost illness and neglect important differences across categories of patients.

There is no reason why insurance plans cannot address separately the different segments of high-cost users, identified above, in more carefully tailored ways. The terminal cancer patient, the non-complying diabetic, the repeatedly hospitalized alcoholic, the paraplegic, and the elderly widow with severe peripheral vascular disease are similar in their status as high-cost users of medical care, but dramatically different in their care requirements, their financial needs, and the lower-cost treatment alternatives that are available. Health insurance proposals should and can take these differences into account if they are to meet the patients' needs within reasonable costs. Since catastrophic health insurance, as embodied in present proposals, does not recognize differences it is unlikely to be inexpensive or fully equitable, nor will it offer a "quick fix" to the most pressing health problems.

For example, the Long-Dole bill features full federal reimbursement for in-patient, post-hospital, physician, and home health services after a deductible (\$3,500 in the present version) is exceeded during a calendar year. Payments would be open-ended and determined retrospectively on the basis of hospital charges. Such a plan unfortunately perpetuates the sort of program design that has raised current health costs to such a high level. By tempting hospitals to get the patient's bill up to \$3,500 whenever possible (to reach a range in which there is full federal payment) it may exert a further inflationary impact on medical costs.

Financial rewards or penalties applied at the appropriate leverage point can greatly affect the behavior of patients, doctors, and hospitals, and could reduce total costs. One recent study of California Medicaid experience, for instance, found that the institution of a one-dollar charge per physician office visit decreased demand for those visits and increased demand for hospital services (which remained "free" to the consumer). Patterns of charges and payments have also been shown to be influential for dental care and other out-patient services. When the dollar amounts are large, both consumer and provider behavior may be modified dramatically. The treatment of kidney disease provides a particularly graphic example. Federal legislation enacted in 1972 provided 100 percent coverage for dialysis treatment and associated physicians' fees. This discouraged kidney transplantation, and favored dialysis in centers over dialysis at home. In the next five years, private firms steadily entered the market for dialysis services. As a result, by 1978, 37,000 patients were being dialyzed—up from roughly 10,000 in 1974—with a 50 percent increase in this number predicted by the mid-1980's.

Moreover, the share of patients on home dialysis declined from 40 percent to 13 percent in the 1972-1976 period. In cases such as renal dialysis, where there are therapeutically-competitive alternatives, financial and service-support incentives to employ lower-cost methods are especially promising.

By misunderstanding the nature of high-cost illness, the one-year deductible proposed by catastrophic insurance plans is terribly inequitable. Approximately 20 percent of all patients in the Zook-Moore study had been hospitalized at least four times in the previous five years for the same disease; many had recurrent illnesses over much longer periods. A longer-term benefit structure could reflect more adequately the extremely high year-after-year costs of illnesses such as vascular disease, certain congenital defects, some cancers, cirrhosis of the liver, intractable anemia, diabetes, or major stroke. It is possible to account for costs over a series of years, with appropriately tailored co-insurance and deductible provisions. The single, short, cost-intensive episode, so well covered by a one-year, open-ended insurance plan, is neither the most frequent type of high-cost illness, the most socially disruptive or financially ruinous, nor the case that needs greatest societal attention. A newborn with certain congenital anomalies might never "qualify" in one year, yet from birth to age 15 might require 10-20 hospital admissions. This would have a greater long-term impact on the family budget than would most serious accidents or severe burn incidents, misfortunes which would be adequately covered under current proposals for catastrophic insurance coverage.

A reassessment of high-cost illness also makes it clear that catastrophic plans seldom give appropriate incentives to hospitals and insurers to control costs. Insurance provisions that pay for all patients' expenses once they exceed a threshold (e.g., \$3,500) will affect the way that hospitals decide to price their services. In fact, it may become advantageous to hospitals to reverse the present practice of subsidizing high-cost days by low-cost days and to charge higher prices for intensive care and complex forms of care. This would make the expensive appear even more expensive and would also magnify the total bill for high-cost illness. Open-ended reimbursement after a one-year deductible also gives providers and insurers little financial incentive to develop preventive programs or long-term management services. Major-risk insurance as now conceived will be able to forestall financial ruin for a small percentage of patients, but will do little to promote a more cost-effective organization of medical treatment which would benefit everyone.

Considering new remedies

Recent surveys of high-cost patients allow a more sophisticated understanding of the potential impact of catastrophic health insurance. We have found that high-cost illnesses differ widely but are mainly concentrated among a small number of long-term patients, that insurance will not be as economical as some have imagined, and that some components of high costs can be controlled. Our assessment suggests several improvements for catastrophic health insurance.

1. *Different groups need different plans.* Study of the high-cost users revealed several categories of patient, each with different needs, treatment alternatives, and behaviors. For instance, nearly 50 percent of childhood high-cost illnesses were traceable to a congenital defect; about 40 percent of the high-cost adult users had a potentially harmful habit noted in the record; over 20 percent of high-cost users were over 70 years of age; and nearly 10 percent had cancer. Patients defined by clinical parameters such as these would have very different incentives to use medical services. Just as physicians would counsel these groups differently as to their care, insurance plans should guide them differently into the most appropriate pattern of health services utilization.

Alcoholism and mental disease were both important among high-cost patients. In the institutions studied, these patients were confined to the hospital for many days. A much lower-intensity setting (i.e., not a hospital), if reimbursed in appropriate fashion, might prove to be equally effective and less costly. The treatment of diabetes mellitus provides another example of the possibility of developing a more cost-effective approach to a single diagnosis. One study at Stanford has shown that appropriate education and substitution of ambulatory services can reduce re-admissions of diabetics by as much as 56 percent. This approach has apparently succeeded in reducing costs while maintaining or increasing quality of care.

There are currently few financial incentives in the insurance plans to employ the most cost-effective modes of care for these illnesses. By insuring against hospitalization—the highest-cost setting—we lower its relative cost and make it a more attractive mode of care to the patient. Proposals for undifferentiated catastrophic illness coverage could worsen this problem. Distinctive modes of reimbursement for particular high-cost use groups, by contrast, may foster the growth of geographically clustered services for similar diagnoses, thereby making possible significant economies of scale.

Attempts to regionalize near surgery ...
tent economies. One study found that unit costs were related strongly to the number of procedures done per year, suggesting large savings may be realized through "learning by doing." Another study estimated that if 50 operations were performed a year, the cost per patient would be \$21,500, but with a tenfold increase in scale, the cost per patient would drop to \$8,700.

2. *Prospective reimbursement can control costs.* A shift from current patterns of reimbursement for providers also offers possibilities for considerable savings. Control over the costs of care is possible only when the provider or patient is a primary decision maker and has a direct stake in the conservation of scarce medical resources. Under cost-based reimbursement after the fact, neither consumer nor provider has an incentive to control cost in a single episode or to foster the most cost-effective modes of long-term care (e.g., early use of ambulatory services to forestall the need for later emergency hospital admission).

Planning for long-term care is especially important, since almost two-thirds of the high-cost 20 percent of patients in our study experienced repeated hospitalization for the same disease (often predictable) in a single year, and many repeat visits in earlier (and later) years. Early interventions to lower the probability of future hospitalizations could provide major cost savings. For example, giving known hypertensives effective rewards for compliance and careful follow-up after screening can reduce later rates of hospitalization. The medical care system has an important opportunity to design similar cost-effective programs for other illnesses.

One way to provide incentives for cost-effective care of the high-cost patient group might be through "prospective reimbursement." Under such a system, certain institutions would be promised a predetermined annual payment to assume responsibility for the care of a patient with a long-term, high-cost illness. (Short-term illnesses with potentially high-cost consequences could be handled differently.) The magnitude of the payment would depend on the illness diagnosed, and might change over time for a given patient. A spinal cord injury center, for example, might be granted a fixed payment on the first of the year for each paraplegic whose care it assumed. Appropriate medical centers would be given similar payments for each child with cystic fibrosis, hemophilia, or other severe, predictable and repetitive illness. The same approach (perhaps with additional categorization of patient condition) could be undertaken for mental disease, renal failure, or even alcoholism.

The value of this system is that the health care provider assumes responsibility for costs above the expected level. At the same time, if costs can be held below the expected level, the provider retains the cost savings. Thus incentives to conserve resources are built into a system which at the same time guarantees the provider a level of reimbursement that, across the range of patients treated, should adequately cover the costs of appropriate care. Such a program would shift responsibility for designing and implementing cost reductions from the regulators of medical care to its deliverers. Physicians would retain control over detailed clinical decisions. This is in contrast to command and control methods of cost containment imposed by outside public agencies, which operate through regulation of capital investment and, in some cases, as with Professional Standards Review Organizations, with assessments of patient care on a case-by-case basis. Widespread prospective reimbursement would probably also give rise to new forms of provider organizations, and group practices specializing in certain types of patients or illnesses. Their success would depend on their ability to deliver care less expensively than do existing institutions.

Quality assurance must be a continuing concern in any system for financing medical care. For certain classes of high-cost users this problem might be particularly acute. Strong, readily implementable sanctions should be available to maintain acceptable quality of care, thereby avoiding the exploitation of possibly helpless groups such as the mentally ill, the senile, and the very sick. Financial penalties for inadequate care might well be linked directly to the reimbursement system. Because of the cost-quality tradeoff, there is also a danger in placing unduly strong cost-reducing incentives on physicians. The objective should be to create a climate or ethos of cost reduction, and of more fervent inquiry into "how much is enough." This sort of indirect encouragement to improve performance is often cited as a principal benefit of profit-sharing plans for workers in private companies. Something similar could perhaps be achieved in health services. (The proponents of health maintenance organizations claim that it already has been.)

The most important feature of prospective reimbursement in the context of the high-cost users is that it provides a strong incentive to deliver health care on a cost-effective basis over the long term. Attention to costs on an episode-by-episode basis is hardly sufficient (it may even be counterproductive in circumstances where rehabilitation or prevention is a possibility), especially when all the evidence suggests that those who use medical resources most ex-

tensively utilize them on a continuing basis over a period of years.

3. *There must be incentives for prevention.* We have seen that high-cost users are more likely than other patients to have potentially unhealthy habits. Persons with a documented adverse lifestyle were found to be more often in the hospital, more costly to treat per illness, and more repetitive in hospital utilization than others. Any public program to finance care of high-cost illness must inevitably confront this problem. Given the interdependence created by any system of health insurance, if individuals are to have sufficient incentive to take care of themselves—to reduce their levels of risk and thereby their expected medical expense—they must be "penalized" in some way for engaging in unhealthy behavior.

There have been relatively few documented attempts made on a significant scale to modify risk factors. Where the attempt has been made it has often met with success, especially in reducing risk factors related to coronary disease: smoking, obesity, and certain dietary habits. The Stanford Heart Disease Project, for instance, sponsored a highly successful voluntary campaign of education and counseling for those most at risk in three California communities. National trends also show that risk factors can be modified and that they can make a difference in personal health. The rate of coronary death in the population for males aged 45 to 54 has declined by 20 percent since 1970, possibly due to improvements in smoking habits and diet within this group. The North Karelia project in Finland also focused on providing information and counseling with regard to cardiovascular risk factors. In four years it achieved substantial reductions in smoking, cholesterol levels, blood pressure, and hypertensive drug noncompliance rates at a modest cost.

Programs in the workplace have also shown some success. In fact, 30 percent of major United States companies now conduct some form of non-smoking program, and 3 percent of these businesses pay their employees not to smoke. Though few reliable statistics are available at present, early results suggest that even small rewards for, or assistance in, smoking or weight reduction can affect behavior and health outcomes. If voluntary community campaigns and relatively small programs in the workplace can reduce unhealthy behaviors, it seems likely that more vigorous approaches, including direct financial incentives for low risk-factor levels, may do even better.

The prevalence of potentially harmful habits noted in the medical records examined by the Zook-Moore study underscores the potential importance of preventive measures, promoted in part by

educational programs, but encouraged strongly by insurance-plan design. Thus a high-cost patient who fails to control the habit of alcoholism or smoking might be required to pay a higher premium until his physician testifies the problem has been solved. The incentive need not be applied at the time of the high-cost illness. The fearful lifestyle consequences of many high-cost illnesses are a far more powerful deterrent to risk-taking behavior than the possibility of high medical costs. Charging after the illness sets in offers little in the way of additional incentive, yet subjects a class of individuals to a significant financial risk, assuming that only a small fraction of people with bad habits get "caught." Moreover, in many instances, it might prove infeasible to charge after the high-cost illness has set in. If we wish to charge individuals for taking increased risks of incurring high-cost illness, and sensible policy would suggest that we should, the most propitious time to do so is while they are taking the risk, before they enter the high-cost user statistics. Severe penalties for speeding and substantial taxes on cigarettes are more appropriate, and probably more feasible, than an actuarially based charge on paraplegics and lung cancer victims for their illnesses.

Problems that could yield to preventive measures are found in their most extreme forms in the most costly illnesses. This is the finding that most forcefully dispels the common misperception of high-cost illness as a random catastrophe. At a minimum, any major-risk health insurance plan should consider: (1) greater taxation of tobacco (perhaps at varying rates dependent on the characteristics of the cigarette) and alcohol, with the proceeds helping to finance the insurance program, (2) insurance premium incentives to lose weight, to stop smoking and drinking, and to adhere to medical regimens, (3) development of new approaches to chronic repeaters especially those with lifestyle-disease involvements, (4) incentives to channel certain categories of patients to hospitals where rates of unexpected complications for their particular problem are lower, and (5) more widespread use of successful community education programs such as the Stanford Heart Project.

Treating the "high-cost" users

While discussions of catastrophic illness conjure up images of unforeseen accidents and disease, insurance proposals currently before Congress would really cover all forms of very expensive medical care. Relief for its citizens from the financial burden of high-cost

illness is a... little doubt that high-cost patients often need and merit financial assistance and large quantities of medical resources. Many of the tragedies that befall the high-cost users are precisely the types of events for which organized insurance can provide its greatest benefits. But there are numerous ways to insure and many ways to aid those in need. If high-cost illness in all its forms is really the concern, Congress and the new Administration must understand the nature of the problem, its causes, and the treatments to which it might yield. Any program to cover high-cost illness should not only achieve the primary function of insurance (the spreading of risk), but should also build incentives into the health-care system for the most competent care by doctors, adherence to life-preserving lifestyles by patients, and cost-effectiveness by those who provide care.

Major mistakes are not uncommon in health-care programs partly because the health-care system works in mysterious ways. A broad-based insurance program to cover high-cost illness should not be mandated until we develop a deeper understanding of the problem. Observing its responses to policies in place can often change our conceptions dramatically, and convince us that quite different policies would be desirable. For instance, the "doctor shortage" of ten years ago is seen now, by many, as a "doctor surplus." Actions are now being taken to reverse this trend. Hospital reimbursement provides another example. During the 1970's the state of New York penalized hospitals financially for excess bed capacity. Yet it was recently decided that this did not hold down costs and that payment incentives will now need to be given to hospitals to encourage empty beds, precisely the opposite policy.

Reversal is likely to prove much more difficult, however desirable in concept, where coverage for high-cost illness is concerned. Entitlements are always difficult to reduce, especially when the target group appeals to our sympathies. Moreover, health-care delivery institutions adapt themselves to any new reimbursement mechanism and tend to become dependent upon it. Should policy in this area prove to be more expensive than estimated, or merely poorly designed, we might repent at leisure.



ALASKA HEALTH CARE ADVOCATES

P.O. BOX 1037 D.T. ANCHORAGE, ALASKA 99510
907-272-8734; 272-6652

copy to Nancy

Senator Charlie Parr
Pouch V
Juneau, Alaska 99811

May 19, 1981

Dear Senator Parr:

Rocky tells me you are concerned by HB41 because of the research presently underway by the Battelle group. It seems there has been a great deal of misconception regarding the goals of the Battelle study and HB41. The two are, in fact, complimentary.

Enclosed please find an article which explains the goal of the Battelle study and HB41, and how they interface. I think you will find several of the major items in HB41 entirely consistent with your campaign theme of representing the disenfranchised.

I will be in Juneau the last week in May, and hope to talk to you about the importance of the passage of HB41 for the low-moderate income consumer. Thank you for your time and attention; I look forward to seeing you at the end of May.

Sincerely,

Susan Johnson
Executive Director

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

MEMORANDUM

April 18, 1980

TO: Representative Joe McKinnon

FROM: Jack Kreinheder, Betty Barton
Issues Analysts

RE: Cost of Statewide Health Insurance
Research Request No. 128

You have requested that we: 1) estimate the cost to the State of providing universal health insurance equivalent to the current Blue Cross State employee health plan for all residents of the state, regardless of other federal or private insurance coverage; and 2) determine the probable savings to the State which might result from reduced expenditures for Medicaid, catastrophic illness, general relief medical, and other State health programs. Your second question is still being investigated, and will be addressed in a separate memo as soon as we complete our research.

We have estimated that if the State were able to extend its current State employee insurance coverage at the current premium rate (\$106.16 per month for each family unit) to all residents of the state, the total additional cost would be about \$175 million per year. However, Blue Cross personnel stressed that the premiums for such extended coverage could be substantially higher and cannot be predicted with confidence at the present time. A number of undetermined factors were cited which preclude the accurate estimation of premium costs for statewide health insurance coverage, including family size, risk characteristics of the total Alaska population, and transportation costs for medical treatment in rural areas of the State.

Our contacts at Blue Cross were not able to provide even a maximum probable premium cost for universal coverage, but indicated that the premiums could be 50% higher than for the current State employee program. Thus, the total cost to the State for universal coverage could be \$263 million or more, depending on the factors cited above, and others.

Representative Joe McKinnon
April 18, 1980
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It is important to note that the total cost of statewide health coverage could be substantially lower if residents eligible for various federal health programs were excluded from the program. Nearly one-third of the state's population is estimated to be eligible for health care coverage under the U.S. Public Health Service and CHAMPUS programs. Costs for statewide health coverage might therefore be reduced by roughly one-third if persons already eligible for these federal programs were not included in the State program.

We regret that we could not provide a more precise cost estimate for statewide health insurance, but we hope our "ballpark" figures are of some use to you. Our research on your second question, pertaining to cost savings from statewide health coverage, will be transmitted shortly, hopefully later this afternoon. Please let us know if we may be of further assistance.

JK:BB/dp

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

MEMORANDUM

April 23, 1980

TO: Representative Joe McKinnon

FROM: Jack Kreinheder/Betty Barton

RE: Costs of Statewide Health Insurance
Research Request No. 128

This memorandum responds to your request concerning the reduction of State health care expenditures which might be realized from the provision of statewide health insurance. To accomplish this, we first determined which State programs currently are providing payment for health care services rendered. We then examined the types of health care services eligible for reimbursement under these programs and compared them against allowed health care under the State's Comprehensive Medical Plan for employees of the State of Alaska. To determine the amount of State money that would be saved through statewide health insurance, we reviewed the Division of Public Assistance budget and subtracted program and related overhead costs for administrative and space expenditures for health care services that probably would be available through a statewide plan. Our figures do not include indirect costs such as overhead costs for administrative and space expenditures that may be charged by the Departments of Health and Social Services and Administration for management of these programs. We have included for your review budgetary allocations for those Medicaid and General Relief Medical services that we feel would be unaffected by statewide health insurance.

Summary

Our research indicates that \$21.5 million State dollars are committed for expenditure to purchase health care services in FY 80. This figure includes \$12 million from the State's general fund and \$9.47 million from the State's federal revenue sharing entitlement. If statewide health insurance were provided, it appears that \$11.5 million of these expenditures could be saved and that \$10.0 million would remain for payment of services most likely not covered in an insurance program.

Please bear in mind that our calculations are estimates derived in part from hypothetical constructions, and so, should be judged with a degree of caution. The basis for our conclusions is detailed below:

Medicaid

This State-administered program is funded federally with a 50 percent match requirement of State dollars (in recent years, the State has combined State general fund dollars with a portion of its federal revenue sharing entitlement, which may be used as such, to meet its contribution requirement). Medicaid is a program of "final resort;" payments are made to providers for health care services delivered to eligible clients only after all other funding sources, such as Workman's Compensation and the Fishermen's Fund, are exhausted. The State reimburses providers for "reasonable costs" incurred in hospital, physician, and nursing home care. Cost determinations are made based on the findings of the federal government's fiscal intermediary (Blue Cross) and the State's Medicaid auditors. Medicaid payments are also made for the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) as well as for other services, such as the Anchorage Home Health Care Program. As we will discuss later, Medicaid also reimburses for services provided at Harborview and the Alaska Psychiatric Institute, which we have not included in our computations.

As is detailed in the attached charts, it appears that the effect of statewide health insurance on the Medicaid program would be a savings of \$4.95 million. This finding assumes that the insurance plan would provide the same payment to participating hospitals and physicians currently provided by Medicaid. It further assumes that Medicaid's other services would be considered allowed costs (excluding \$63,500 expended on home health care). A statewide insurance plan probably would provide payment for a portion of EPSDT but would regard screening as a nonreimbursable service. A major health category that would not be covered by statewide insurance is nursing home care. The State's Comprehensive Medical Plan does not provide coverage for long-term care provided by an intermediate or skilled nursing facility, which means that the \$7.9 million in State funds used to reimburse nursing home providers probably would remain as an expenditure.

General Relief Medical

This program is funded solely through the State's general fund. The program provides medical assistance to financially needy individuals having specific medical problems and lacking the resources, including insurance, to provide themselves with adequate care. Obviously, this

Representative Joe McKinnon
April 23, 1980
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program would be impacted significantly by a statewide insurance program. However, also included under this program, albeit with less stringent eligibility requirements, is the Catastrophic Illness Program. This program provides assistance to individuals after their third party coverage is exhausted and after no less than \$1,000 in health expenses in a twelve-month period have been accrued. Because of the program's special function, we have treated it as an expenditure which would remain unchanged by the provision of statewide health insurance. In fact, whether it would appear as a savings or an unchanged cost depends on the number of uninsured individuals utilizing the program. Unfortunately, there is no available data that categorizes Catastrophic Illness beneficiaries.

It appears that the impact of statewide health insurance on General Relief Medical would be a reduction of \$6.5 million in State expenditures, primarily the result of savings in hospital, physicians', and other service costs. As with Medicaid, service expenditures remaining unchanged include those for nursing home care. In addition, a relatively small program entitled Residential Nursing probably would be ineligible under statewide insurance coverage.

Problems/Limitations

As noted earlier in this memorandum, Medicaid also generally provides coverage to Harborview and API. Services at Harborview for FY 81 are projected to cost the State \$4.1 million for the care of its patients. The facility is licensed for 96 beds and 97 percent of the beds are occupied by Medicaid beneficiaries. Medicaid rates (based on the facility's occupancy rates and cost of care) currently have been set at \$153.75 per day, or \$56,118 per patient annually. Under the State's Comprehensive Medical Plan, only limited coverage is extended for treatment of mental or emotional disorders. Insurance is restricted to short-term, treatable illness, defined as neurosis, psychoneurosis, mental or emotional disorders, or psychopathy. No coverage is provided for adolescent behavioral disorders; learning disabilities, or marital, family, sexual, or other counseling. (Apparently, some consideration is occasionally given in favor of short-term, one-on-one counseling.) Custodial care also is excluded from coverage under the State's plan. It is doubtful then that statewide health insurance, under the current State policy's design, could supplant State expenditures at Harborview.

Representative Joe McKinnon
April 23, 1980
Page 4

Some insurance coverage could be extended to eligible patients at API, although probably not on the level of reimbursement provided by Medicaid. Physician's services for mental and nervous disorders are covered, in part, with 50 percent of a patient's eligible expenses reimbursed in an amount not to exceed \$2,500 for each covered member per benefit year. The Medicaid program reimburses services provided to eligible patients "reasonably classified" aged 21 years or younger "who are receiving treatment in an inpatient psychiatric facility." The current Medicaid rate for API is \$196.00 per day. However, the amount of Medicaid projected for receipt by the institution for FY 80 is unknown.

The eligibility determination for Medicaid reimbursement at API was recently the subject of a federal audit; and, consequently, staff at the Department of Health and Social Services are uncertain of the amount of Medicaid billings which will be approved. The State has authorized \$7.58 million for API in FY 80; however, included within this figure are unrestricted federal receipts (for Medicaid and third party payments. As a result, it currently is not possible to derive an estimate of the effects of statewide health insurance on State health care expenditures in this program.

We have limited our scope of research in this memorandum to services eligible for reimbursement by Medicaid and General Relief Medical. Following transmittal of this information to your office, we will explore the effects, if any, of statewide health insurance on other State programs offering health care services similar in nature to those provided through the State's insurance plan, e.g., alcoholism treatment.

We apologize for the delay in preparing this memorandum for you. Compiling the data was more problematic than we had originally anticipated. We hope the information contained herein is suited to your needs.

JK:BB/dp

Attachments

PROJECTED COST SAVINGS OF STATE HEALTH CARE EXPENDITURES
RESULTING FROM A STATEWIDE HEALTH INSURANCE PROGRAM*

*Savings of State Funds (in thousands) by Source

	<u>General Fund</u>	<u>Federal Revenue Sharing</u>	<u>Total</u>
<u>Medicaid</u>			
Hospitals	\$1,160.7	\$1,648.9	
Physicians	621.9	787.7	
Other Services	213.1	90.95	
EPSDT	<u>427.9</u>	<u>-0-</u>	
	\$2,423.6	\$2,527.55	\$4,951.15
<u>General Relief Medical</u>			
Hospitals	\$4,147.9		
Physicians	1,150.3		
Other Services	<u>1,224.1</u>		
	\$6,552.3	-0-	\$6,522.3
<u>Administrative Overhead</u>			
Medicaid	\$22.8		
General Relief Medical	<u>22.8</u>		
	\$45.6	-0-	\$ 45.6
TOTAL SAVINGS			\$11,519.05

* Based on FY 80 Authorized Budget

State Funds (in thousands) by Source

* Based on FY 80 Authorized Budget



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

MEMORANDUM

May 22, 1980

TO: Representative Joe McKinnon

FROM: Betty Barton *BB*

RE: Costs of Statewide Health Insurance: Addendum to Research Request No. 128

In an earlier memorandum to you, we determined the probable savings to the State that could occur from reduced expenditures for Medicaid and General Relief Medical were statewide health insurance made available. At that time, we speculated that there could be added, less apparent savings realized in other health programs, such as those administered by the State Office of Alcoholism and Drug Abuse. We stated that we would conduct additional research in this area and notify you of our findings. Our research indicates that no reductions in cost, beyond those already submitted to you, would be realized through the provision of statewide health insurance. Other programs are not structured to purchase health services provided to beneficiaries by health care providers, as are Medicaid and General Relief Medical, and so, would not be affected by payments of third party carriers.

We apologize for the delay in transmitting this information to your office.

BB/dp



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

February 13, 1981

MEMORANDUM

TO: Representative Charles Anderson

FROM: Peter B. Froehlich *PBF*

RE: Hawaii No-Fault Insurance Statute
Research Request 81-16

You have asked for information concerning the Hawaii no-fault insurance statute. In response to your request, we have assembled the following materials which are attached to this memorandum:

- a copy of the Hawaii no-fault insurance statute, Chapter 294 Motor Vehicle Accident Reparations. (For your convenience, we combined the chapter as it existed after the 1976 session of the Hawaii legislature with the amendments enacted in 1977, 1978, and 1979 sessions.)

- a copy of the digest summary of the eight amendments to the chapter enacted by the 1980 session;

- copies of two companion sections of the Hawaii statutes updated to the present (Sections 286-116 and 806-13); and

- a copy of an information pamphlet for Hawaii drivers which was published in the fall of 1978, and despite subsequent amendments to the act, is still in use.

In addition, we have contacted the Hawaii Assistant Commissioner of Insurance, David T. Ishikawa who has headed the no-fault section of the insurance division since 1974, shortly after the no-fault law was enacted.

Mr. Ishikawa stated that after many amendments had been made to the Hawaii no-fault statute over the past seven years, it was generally felt that all major problems had been eliminated. Only one or two minor housekeeping amendments are anticipated this year. He stated that a primary reason for the success of the Hawaii statute is the threshold of \$2,500 damages or death or permanent disability, above which a tort suit is permitted. This threshold has kept 90% of those injured in car accidents within the no-fault system and out of court.

The only real problem Hawaii's system is experiencing is the rapidly rising premium costs of coverage. However, this is a problem which

arises not from the system itself, but from inflation and the increasing number and severity of accidents.

According to Mr. Ishikawa, the most controversial aspect of the Hawaii statute is the coverage provided by the state, free of charge, to welfare recipients. He stated that some people object, on philosophical grounds, to subsidizing low-income drivers, but that others feel that the poor will drive regardless, and the state-funded coverage protects the public in the case of accidents involving an indigent driver. No proposed changes are expected to this part of the Hawaii law.

In response to your question concerning the potential difficulty of drivers obtaining proof of insurance and then cancelling their coverage, Mr. Ishikawa stated that it was something which could only be minimized, never eliminated. In Hawaii, it is minimized in two ways: numerous "checkpoints" and severe penalties. Every time a driver and/or vehicle owner has any contact with a government employee, agent or officer, he must show a no-fault insurance identification card. This includes renewal of driver's licenses, renewal of vehicle registration and license plates, annual safety inspections and so on. The penalties for not having a card, which is issued on purchase of insurance, or for using a false card, are strikingly severe. They include all of the following:

- 1) suspension or revocation of driver's license;
- 2) suspension or revocation of vehicle registration or license plates;
- 3) impoundment of vehicle;
- 4) up to 30 days imprisonment;
- 5) mandatory fine of at least \$100 and up to \$1,000.

While these checkpoints and penalties have not resulted in 100% compliance, they have been effective, according to the Assistant Commissioner.

In addition to the information included in this memorandum, we have requested copies of the regulations which have been adopted to implement the Hawaii statute and the 1981 report to the legislature on its implementation. We will forward these and other general materials we have requested from the National Conference of State Legislatures immediately upon receipt.

If we can provide any further information concerning the no-fault insurance system in Hawaii or any other state, please do not hesitate to contact us.

PBF/dp

DIGEST of 1980 AMENDMENTS TO
HAWAII NO-FAULT INSURANCE STATUTE
(CHAP. 294)

ACT 5
(SB 1115, SD 2, HD 2)

PUBLICATION OF INSURERS AND PREMIUMS CHARGED FOR MOTOR VEHICLE INSURANCE. Requires the state commissioner of motor vehicle insurance to publish annually in a newspaper of general circulation a list of all insurers with representative annual premiums for motor vehicle insurance. (SSCR 350, 481; HSCR 8-80, 424-80)
Effective April 9, 1980.

ACT 6
(HB 1802)

MILITIA, SERVICE BY GOVERNMENT EMPLOYEES. Amends law providing for the reporting of government employees to military service by deleting limitation to "male" employees and eliminating specific male gender reference to the governor. (HSCR 70-80; SSCR 822-80)
Effective April 9, 1980.

ACT 7
(HB 1803)

HAWAII STATE GUARD, COMPOSITION OF. Provides the military forces of the State be composed of all able-bodied citizens instead of only able-bodied male citizens who volunteer for service and supplemented, if necessary, by members, rather than men, of the unorganized militia. (HSCR 78-80; SSCR 823-80)
Effective April 9, 1980.

ACT 8
(HB 1826)

EMPLOYEES' RETIREMENT SYSTEM APPLICABILITY TO MEMBERS' SURVIVING SPOUSES. Amends law which makes other state or county pension or retirement laws inapplicable to members covered by the employees' retirement system of the State to include a member's surviving spouse of either sex, not just widows. (HSCR 606-80; SSCR 816-80)
Effective April 9, 1980.

ACT 9
(HB 1957)

CERTIFICATION OF ADDITIONAL ELIGIBLES WHEN MORE THAN 1 VACANT CIVIL SERVICE POSITION IN A CLASS. Allows the director of personnel services to certify an

ACT 44
(SB 2007, HD 1)

VENDING FROM STATE HIGHWAYS; PROHIBITED; PENALTY. Provides that any vehicle or structure parked or placed wholly or partly within the right-of-way of any state highway for the purpose of selling the vehicle or structure or things therefrom, creates a hazardous condition or is a public nuisance, and the department of transportation may remove or require the immediate removal of the vehicle or structure from the highway.

Provides that any person violating this provision is guilty of a misdemeanor. (SSCR 94-80; HSCR 806-80)
Effective April 25, 1980.

ACT 45
(SB 2070, HD 1)

NO-FAULT INSURANCE; ELIGIBILITY FOR JOINT UNDERWRITING PLAN AMENDED. Amends eligibility provisions of joint underwriting plan in Hawaii no-fault law by providing automatic no-fault insurance coverage to all bona fide public assistance recipients upon the issuance of joint underwriting plan certificates by the department of social services and housing. Deems certificate a policy for purposes of insurance law upon the issuance of a valid no-fault insurance identification card. (SSCR 105-80, 551-80; HSCR 804-80)

Effective April 25, 1980.

ACT 46
(SB 2081, SD 1, HD 1)

HAWAII INSURANCE LAW; LIFE INSURANCE POLICY LOANS. Amends life insurance policy loan provision in Hawaii Insurance Law by raising from 6 to 8 per cent the maximum rate of interest that life insurance carriers may charge on policy loans.

Provides insurance commissioner with authority to require life insurance carriers to raise dividends or lower premiums to policyholders when holder's policy provides a rate of return exceeding 6 per cent a year. (SSCR 133-80; HSCR 784-80, 833-80)
Effective June 1, 1980.

ACT 71
(HB 2698, HD 1, SD 1)

UNIVERSITY OF HAWAII'S OVERSEAS OPERATIONS AND ASIAN STUDIES PROGRAMS; REPEALED. Repeals statutory provisions relating to the University of Hawaii's overseas operations and Asian studies programs. (HSCR 459-80; SSCR 854-80) Effective May 17, 1980.

ACT 72
(HB 2703, HD 1, SD 1)

COLLEGE OF EDUCATION; CLARIFICATION OF LANGUAGE. Amends provision of University of Hawaii law by replacing the term "teachers college" with "college of education". Provides that in the matter of the curriculum, the university authorities may, instead of being required to, obtain the approval of the department of education. Repeals the section giving recognition to normal school students and section regarding the status of teachers employed on 9/1/31. (HSCR 463-80; SSCR 855-80) Effective May 17, 1980.

ACT 73
(HB 2789, SD 1)

NO-FAULT INSURANCE, CUSTOMER'S POLICY PRIMARY OVER REPAIRER'S POLICY. Clarifies that if a temporary substitute vehicle is made available to a customer by a repair shop or a motor vehicle dealer repairing or servicing the customer's insured vehicle, the no-fault policy on the customer's insured vehicle shall be primary over the policy on the temporary substitute vehicle whether or not a charge is made by deleting no charge requirement. (HSCR 590-80; SSCR 989-80) Effective May 17, 1980.

ACT 74
(HB 2842, HD 1, SD 1)

ANIMAL SPECIES ADVISORY COMMISSION; INCREASE MEMBERSHIP AND AMEND DUTIES. Includes the recommendation of the forestry division of the department of land and natural resources, in addition to the department's fish and game division as presently required, prior to authorization by rule of the deliberate introduction of a species of animal by the department of land and natural resources into any habitat within the State, whether the introduction is from without the State into the State or from 1 area in the State into another area in the State.

ACT 85
(SB 2197, SD 1)

PURCHASE OF GOODS PRODUCED BY INMATE LABOR BY STATE AGENCIES AND POLITICAL SUBDIVISION; REPEAL OF CERTAIN REQUIREMENTS. Deletes requirement that purchases of all articles or products manufactured by the department of social services and housing, by inmate labor, by state agencies or its political subdivisions shall be made through the department of accounting and general services.

Abolishes the requirement that exceptions to the purchase of such products be made by a board consisting of the director of social services, the state comptroller, and the director of finance. Provides instead that all such exceptions shall be made by the director of social services. (SSCR 117-80; HSCR 749-80, 919-80)
Effective May 21, 1980.

ACT 86
(SB 2214, SD 1)

INSURANCE; COMMISSIONER, APPOINTMENT OF ASSISTANT COMMISSIONER, ESTABLISHMENT OF INSURANCE DIVISION, SALARY. Amends no-fault motor vehicle insurance law by amending the definition of "commissioner" from the state commissioner of motor vehicle insurance to the insurance commissioner provided for by the Hawaii Insurance Law.

Amends the Hawaii Insurance Law by establishing an insurance division within the department of regulatory agencies under the supervision and control of the assistant insurance commissioner. Requires director of regulatory agencies to appoint, with approval of the governor, an assistant insurance commissioner to serve at director's pleasure, who shall supervise the performance of the duties of the division.

Repeals provisions establishing office of, providing for appointment of, and granting of powers and duties to, the commissioner of motor vehicle insurance.

Amends salary provisions for motor vehicle insurance commissioner and making them applicable instead to the assistant insurance commissioner and providing that the director of regulatory agencies instead of the insurance commissioner has the authority to set such salary, and provides the salary shall not be more than \$37,500. Deletes reference setting salary ceiling for motor vehicle insurance commissioner as of 7/1/75 and 7/1/76.

Provides that the incumbent commissioner of motor vehicle insurance on effective date of Act shall serve as the assistant insurance commissioner until termination of incumbent's term and requires director of regulatory agencies to thereafter appoint assistant insurance commissioner pursuant to this Act. (SSCR 134-80; HSCR 721-80, 924-80)
Effective May 21, 1980.

abetting or entering into a contract with unlicensed persons or contractors to be fined \$200 for the first offense, \$600 for the second offense, and not less than \$800 or more than \$1,000 for any subsequent offense. (SSCR 560-80; HSCR 832-80)

Effective May 22, 1980; except that penalties incurred and proceedings initiated before May 22, 1980 are not affected.

ACT 103
(SB 2676, SD 1)

MOTOR VEHICLE INSURANCE; PERMISSION FOR USE OF CAR. Clarifies that under a no-fault policy, coverage of an operator of the insured motor vehicle means one using such vehicle with the express or implied permission of the named insured. (SSCR 506-80; HSCR 879-80)
Effective May 22, 1980.

ACT 104
(SB 2770, SD 1, HD 1)

HAWAII VISITORS BUREAU EXECUTIVE BOARD MEMBERSHIP; PROHIBITION AGAINST STATE OR COUNTY OFFICER OR EMPLOYEE SERVING; REPEALED. Repeals law prohibiting an employee or officer of the State or its political subdivisions or any member of a county advisory committee created under the law relating to county advisory committees to the department of planning and economic development from serving as a member of the Hawaii Visitors Bureau executive board or committee. Prohibits instead only employees or officers of the department of planning and economic development from serving as members of the Hawaii Visitors Bureau executive board. (SSCR 589-80; HSCR 844-80)
Effective May 22, 1980.

ACT 105
(SB 2870, SD 1, HD 1)

ARREST WITHOUT A WARRANT. Authorizes a police officer or other officer of justice to arrest a person without a warrant, and detain for examination when there is probable cause for the arresting officer to believe, instead of having reasonable suspicion, the person arrested has committed an offense in the officer's presence or has committed a felony or misdemeanor whether in the officer's presence or otherwise. Deletes reference to seaport or town and to cases where it is not certain an offense has not been committed. Deletes reference to intention to commit an offense.

Provides an arresting officer has probable cause when the facts and circumstances within the officer's knowledge and of which the officer has reasonably trustworthy information are sufficient in themselves to warrant a

ACT 143
(SB 209, SD 2, HD 2)

NO-FAULT INSURANCE FOR PUBLIC ASSISTANCE RECIPIENTS. Adds provision to no-fault law providing insurance for public assistance recipients to provide that only one vehicle per public assistance unit will be insured unless extra vehicles are approved by the department of social services and housing as being needed for medical or employment purposes. (SSCR 344, 464; HSCR 9-80, 815-80)

Effective May 28, 1980.

ACT 144
(SB 1370, SD 2)

JUDICIARY PERSONNEL; COMPENSATION. Adds provision to employee compensation law that no position shall be classified and paid in salary ranges SC-1, SC-2, and SC-3 in the judiciary unless recommended by the administrative director of the courts and approved by the chief justice. Provides further that not more than one position shall be classified and paid in these ranges in the judiciary.

Requires the administrative director of the courts to report annually to the legislature as to the manner in which the positions assigned to these ranges are being used. (SSCR 43, 47-80; HSCR 700-80, 1040-80)
Effective May 28, 1980.

ACT 145
(SB 1838, SD 3, HD 1, CD 1)

HAWAII CRIME COMMISSION; DUTIES; POWERS; COMPOSITION. Provides that the presently existing Hawaii crime commission shall remain in existence instead of ending on 6/30/80 as established in the office of the lieutenant governor from 7/1/80 to 6/30/81. Provides that commencing 7/1/81, there is established within the office of the lieutenant governor for administrative purposes only the Hawaii crime commission and that this commission shall have its existence terminated, if not renewed by the legislature on 1/30/84.

Provides that the commission shall be composed of 9, instead of 12, members appointed by the governor with the advice and consent of the senate. Deletes exception for chairperson from appointment provisions, deletes reference to the 7/1/77 to 6/30/80 term, and deletes provisions that the members shall be representative of the State's population and provisions for appointment of chairperson by legislature and filling of vacancies. Provides that the term of each member shall be from 7/1/81 to 1/30/84. Requires the governor to appoint a chairperson and fill all vacancies for the unexpired term with the advice and consent of the senate. Provides that a vacancy for chairperson shall be filled the same as for initial appointments. Provides that the

dynamite or other explosives, blasting caps, bombs, or bombshells, by changing the penalty from a 2 to 5 year term of imprisonment without probation to a class C felony and imprisonment for 5 years without probation.

Amends provisions on issuance of licenses to carry firearms, prohibitions on such licensing, and the carrying of pistols or revolvers, by changing the penalty for violating such provisions from imprisonment for 2 to 5 years without probation to a class C felony.

Amends provisions which prohibit the wilful alteration, removal, or obliteration of the name of the make, model, manufacturer's number, or other mark of identity of any firearm or ammunition by changing the penalty from imprisonment for a term of 1 to 2 years without probation to a misdemeanor. (HSCR 315-80; SSCR 964-80; HC 28-80; SC 30-80)
Effective June 7, 1980.

ACT 234
(HB 1986, SD 1, CD 1)

MOTOR VEHICLE ACCIDENT REPARATIONS; NO-FAULT. Amends definition of no-fault benefits in Motor Vehicle Accident Reparations law to include only the monthly earnings loss equal to the lesser of (1) \$800 a month, or (2) the monthly earnings for the period during which the accidental harm results in the inability to engage in available and appropriate gainful activity, deleting existing 3rd option of a monthly amount equal to the amount by which the lesser of (1) or (2) above exceeds any lower monthly earnings at the time the injured person resumes gainful activity.

Deletes commencement date of 9/1/74 in provision requiring the motor vehicle insurance commissioner to accumulate experience data on a yearly basis. Deletes specific reference to claims filed and tort claims filed, settled, or litigated in provision requiring tabulation of amounts of benefits paid and adds requirement of tabulation of benefit amounts reserved. Requires the commissioner to perform such actuarial evaluations of these data necessary (instead of arranging the claims made by dollar value from maximum to zero) in determining annually the specific dollar value figure below which 90 per cent of all, non-zero (added), medical rehabilitative claims, arising from motor vehicle accidents occurring during the next no-fault policy term year are expected to fall (instead of claims made or paid during the year). Provides that this specific figure shall be used annually as the medical rehabilitative limit for all accidents occurring during the next no-fault policy term year for the purpose of the exception to abolition of tort liability provision. Deletes prior reference applying limit to 3rd and succeeding years and deletes provision that for 9/1/74 to 8/31/76 the medical rehabilitative limit shall be \$1,500. Adjusts the period that the commissioner shall make the tabulation to compute the medical rehabilitation limit from 7/1 to 6/30 to 4/1 to 3/31 preceding the 9/1 start of the no-fault policy term year.

Clarifies that each violation of the Motor Vehicle Accident Reparations law by the operator, owner, or registrant of a motor vehicle shall be deemed a

separate offense and subject to a fine of not less than \$100 nor more than \$1,000 and such fine shall not be suspended irrespective of the Hawaii Penal Code and deletes the alternative penalties of 30 days in jail, suspension of driver's license, or forfeiture of vehicle registration, or any combination of penalties. Adds provision that in the case of multiple violations, the court shall in addition to any other penalty impose:

- (1) Imprisonment of not more than 30 days;
- (2) Suspension or revocation of driver's license of the driver and the registered owner;
- (3) Suspension or revocation of the vehicle's registration plates;
- (4) Impoundment or impoundment and sale of the motor vehicle for storage costs and other charges incident to seizure of the vehicle or other costs involved pursuant to the required policy coverage provision; or
- (5) Any combination of penalties.

Amends criminal procedure law on motor vehicle insurance violations to clearly provide for multiple violations and to add to the penalties the court shall impose, the penalty of imprisonment of not more than 30 days.

Adds new section to no-fault law that if an insurer or self-insurer elects to deny a claim for no-fault or optional additional insurance benefits in whole or in part, it shall within 5 business days thereafter notify the claimant in writing of the denial and reasons therefor. Provides that if the claimant objects to the denial, the claimant shall file with the motor vehicle insurance commissioner 2 copies of the denial, a written request for review and a statement of specific reasons for the claimant's objections, filed within 60 days after denial. Provides that the commissioner shall not review any denial in which the disputed amount is less than \$5,000.

Requires the commissioner to conduct a hearing to review the denial under the Administrative Procedure Act with the hearing powers under the law conferring that power on boards to conduct hearings. Provides that after granting an opportunity for hearing to the insurer and claimant, the commissioner shall affirm or reject the denial and order the payment of benefits as the facts may warrant. Provides that the commissioner may assess the hearing cost upon either or both of the parties. Provides that the commissioner's final order may be appealed under the Administrative Procedure Act. (HSCR 123-80; SSCR 983-80; HC 5-80; SC 6-80)
Effective June 7, 1980.

least one general partner. (HSCR 443-80; SSCR 767-80, 1008-80; HC 36-80; SC 46-80)

Effective June 13, 1980.

ACT 271
(SB 1960, SD 1, HD 1, CD 1)

NO-FAULT INSURANCE; PREMIUM DISCOUNTS, SURCHARGES, AND DRIVER EDUCATION FEES FOR MOTORCYCLES, MOTOR SCOOTERS, AND RELATED VEHICLES. Amends insurance rates provision in no-fault motor vehicle insurance law by requiring all insurers of motorcycles, motor scooters, or vehicles with less than 4 wheels, notwithstanding existing law requiring each insurer to establish own rate schedule, to provide a 10 per cent discounted premium to operators who successfully complete a safe driving course approved by state director of transportation.

Permits any insurer of such vehicles to provide a 10 per cent or less discounted premium to operators who submit affidavits stating intent to wear approved safety helmet during operation of vehicle. Adds proviso permitting insurers providing discounts to levy a surcharge, equal to discount, on premiums of operators failing to submit affidavits. Prohibits any insured operator with discounted premium from operating such vehicle unless operator wears approved safety helmet.

Adds proviso to law requiring 1/2 of all driver education underwriter fees collected to be expended for a driver retraining program and 1/2 to support a high school driver education program to provide that all such fees collected from insurers of motorcycles, motor scooters, or related vehicles shall be expended for educating operators of such vehicles. (SSCR 636-80; HSCR 828-80; SC 51-80; HC 41-80)

Effective June 16, 1980.

ACT 272
(SB 2927, SD 2, HD 1, CD 1)

MENTAL HEALTH PATIENTS; INFORMED CONSENT AND RIGHTS. Requires informed consent, as required by the medical torts law and as defined by the board of medical examiners, to be obtained from a patient, or the patient's guardian, if the patient is not competent to give informed consent, before any non-emergency treatment for mental illness can commence. Requires a signed consent form reflecting the proceeding to be obtained and maintained as part of the patient's record.

Affords any patient in a licensed psychiatric facility the following rights, as provided by the institution. Qualifies all such rights of in-patients by reasonableness, in view of the circumstances and the availability of resources. Includes, but is not limited to, the following: (1) access to written rules and regulations with which the patient is expected to comply;

NO-FAULT INSURANCE FALL 1978

THE LAW

On September 1, 1974, a new system of automobile insurance was established in Hawaii which affected anyone who owned a car or who might be injured in an automobile accident. It is a law which provides prompt payment of medical bills, loss of wages and any other appropriate economic losses resulting from injuries in an auto accident *regardless of whose fault it is*. This law is known as the *Hawaii No-Fault Law*.

WHAT IS NO-FAULT?

First of all, when we speak of "no-fault", we are talking about *injuries as a result of an auto accident* — and not damages to cars or property. Before Hawaii's no-fault law came into effect, we operated completely under a *tort or fault system* of insurance.

For example, if you were involved in an accident and were injured, you had to worry about whose fault it was and whether your insurance company or the other person's insurance company was going to pay you. If the other driver was at fault, then you may have had to either hire a lawyer or appear in court before getting any money from the other driver or his insurance company.

Under today's no-fault law, your insurance company pays you *directly* for your losses as a result of injuries in the accident and regardless of fault. Similarly, the other driver collects the losses for his injuries from his insurance company without his company having to determine who was at fault.

Thus, no-fault is a system of insurance which provides fast and adequate payment of claims for injuries and financial losses resulting from accidents *without the need to resort to lawsuits*.

DOES NO-FAULT COVER ALL YOUR LOSSES?

The Hawaii No-Fault Law was primarily designed to take care of first things first — to make sure that protection through insurance is provided for *personal injuries* since this is where most major problems occur.

The basic no-fault automobile insurance policy will at least provide you with the minimum protection required by law. This coverage includes *no-fault benefits* (or personal injury protection) up to \$15,000 per person, *residual bodily liability* of \$25,000 per person, and *property damage liability* of \$10,000 for each occurrence.

These basic requirements must be offered and purchased in a package form, but of course, you still have the option to add other coverages based on your individual needs.

To better understand the protection no-fault insurance offers, you

need to know a little about the kind of losses people normally claim after an accident.

First, there are losses that you can measure, the kind that actually cost you money, such as doctor and hospital bills, x-rays and therapy, lost wages, nursing and housekeeping care, funeral and child care expenses.

Then there are other losses hard to measure which do not really cost you any money but which you feel you should be compensated for. Examples of these are inconvenience, pain and suffering, disability, disfigurement and death.

With no-fault insurance, *except* for losses you cannot measure accurately — primarily the "pain and suffering" you may have due to an accident — *almost all of your out-of-pocket losses* would be covered up to the limits of your policy regardless of fault.

DOES NO-FAULT TAKE AWAY THE RIGHT TO SUE?

Although having a no-fault policy ensures payment by your insurance company for all losses arising from injuries received in an auto accident *regardless of fault*, this does not mean that your right to sue the wrongdoer has been completely eliminated under the law. The law recognizes that some people will experience pain and suffering after an accident, and because of this, your right to sue has simply been *restricted*.

This means that you can sue or be sued *but only under certain conditions*.

Since Hawaii's no-fault law does not completely eliminate a person's right to sue, the possibility of your being sued is very real in the event you are the driver at fault in an accident which causes serious injury to others. You still need protection from suits and part of your basic no-fault policy will give you this protection.

REQUIRED AUTOMOBILE INSURANCE COVERAGES

No-Fault Benefits or Personal Injury Protection Coverage

The basic no-fault benefit coverage will pay you, your relative, or any other person riding in your car up to \$15,000 per person for injury *regardless of fault*.

The following are the types of benefits you can get if injured in an auto accident:

medical expense benefits — all reasonable charges for medical, hospital, surgical, professional nursing, dental, optometric, ambulance, prosthetic services, x-rays and religious remedial care and treatment;

rehabilitation expenses benefits — includes charges for psychiatric, physical and occupational therapy and rehabilitation;

work loss benefits — includes loss of wages up to \$800 a month due to injury;

substitute service expense benefits — all reasonable charges up to \$800 a month for necessary services, such as caring of children, housekeeping or yardwork, which would have been performed by you had you not been injured;

funeral expense benefit — all reasonable charges up to \$1,500 for funeral services including burial and cremation expenses;

survivors' loss benefits — payment to your surviving spouse or dependents up to \$15,000;

attorney's fees and cost benefits — reasonable sum for attorney's fees and costs you are entitled to unless the court determines otherwise;

other reasonable and appropriate costs.

Residual Bodily Injury Liability Coverage

Although most of the injury claims will be taken care of under the no-fault benefits coverage, there will be situations when you can be sued. The *residual bodily injury liability coverage* will protect you, your family and anyone else driving your car with your permission in the event that you may be sued because of injury caused to others.

What are the situations under which you can be sued? You can be sued by the person you injured under any of the following conditions:

If his medical bills exceed \$1,500 (the current limit set by the Automobile Insurance Commissioner);

If his total no-fault bills exceed \$15,000;

If his injury consists of permanent and serious disfigurement which causes that person's mental and emotional suffering;

If his injury results in permanent loss of use of part of his body;

If his injury results in death.

Property Damage Liability Coverage

This coverage protects you or any driver of your car for damages to the property of others. Remember, the no-fault law applies only to injuries and does not affect the "fault system" for accidents involving property damage, such as damage to a fire hydrant, a guardrail, a traffic lightpost, a fence or even a house. If you are at fault in such an accident, you will be held liable and can be sued for these losses.

Furthermore, this particular coverage does not pay for damage to your car. You must buy a separate "collision coverage" to take care of this.

YOUR POLICY

Your no-fault auto insurance policy is a contract. It is written so that your rights and responsibilities as well as that of the insurance company are stated clearly.

A no-fault auto policy usually consists of the following:

declarations — the declarations sheet, usually the first page of the policy contract, shows your name, address, policy number, the date and time your policy begins and expires, the coverages and the limits you selected, the description of your vehicle, the cost of each coverage and the total premium or cost you pay for the coverages involved;

Insurance agreement — this is what your insurance company promises to pay and what losses it agrees to cover;

definitions — these basically explain who is covered and the meaning of words used in your policy contract;

exclusions — this part explains the situations under which the policy will not cover you or your car;

conditions — this section explains how and under what conditions the company can cancel your policy; how you can cancel your policy; your duties in reporting to the company in the event of an accident;

endorsements — these are forms attached to your policy which are used to change certain terms of your policy, to increase or decrease your existing coverage or to add new coverage to your policy. For example, if you purchase a new car and sell the other, you can make this change simply by an endorsement without buying a new policy.

HOW MUCH INSURANCE DO YOU NEED?

The Hawaii No-Fault Law requires you to buy the *basic no-fault auto policy* which contains the minimum limits of no-fault benefits, bodily injury liability and property damage liability coverages. But, *you have the right to seek and obtain additional coverage to suit your needs.*

All insurance companies are required to offer higher limits of protection, but the decision to buy higher protection is up to each individual buyer. For instance, you may wish to purchase higher no-fault benefits coverage if your income is more than \$800 a month, which the basic no-fault benefits pays you. Or, you may want higher limits for bodily injury or property damage liability coverages for protection against lawsuits.

Higher limits over the basic limits can be bought for an additional cost as follows:

	Basic	Higher Limits
No-Fault Benefits Coverage	15,000	30,000; 50,000
Residual Bodily Injury Liability Coverage	25,000	50,000; 75,000
Property Damage Liability Coverage	10,000	15,000; 20,000

No-Fault Benefits Coverage — Deductibles

In addition to offer higher limits of protection, all insurance companies must give you a choice of selecting a deductible amount on your no-fault benefits coverage. The deductible amounts which you can select — \$100, \$300 or \$500 — will be the amount which will reduce the no-fault benefits payable to you for your injuries. Of course, your premium for this coverage will be correspondingly reduced if you choose a deductible.

The optional coverages including the required basic no-fault coverages are shown below:

Physical Damage Insurance

Although Hawaii's no-fault law does not require you to purchase insurance protection to cover losses to your car, all insurance companies must offer you physical damage insurance if you want it.

This type of insurance is important to have when your car is new, or while you are still paying a note for it. Suppose your new car is totally wrecked in an accident. Without such insurance, you could be left with a big bill to pay — and no car.

Physical damage insurance covers two kinds of losses, collision and comprehensive:

Collision Coverage

This coverage pays for damages to your car when it is involved in any type of collision. Your own insurance company pays for such damages, regardless of who is at fault. You can still sue the other driver at fault, but it may be easier to let your company fix your car under your collision coverage and let them collect the amount they paid you from the other driver or his insurance company.

Deductible Collision

When buying collision coverage, your insurance company will offer you a choice of deductibles of \$50, \$100 or \$250. The deductible amount you select is the amount you agree to pay first from your own pocket toward the damage to your car. Your company will then pay the rest. Of course, the higher collision deductible you choose, the cheaper your premium for this coverage will be.

Comprehensive Coverage

Comprehensive insurance pays for losses like theft of your car, and damages by fire, windstorm, vandalism, flood and falling objects. It pays for almost all unusual damages to your auto *other* than collision damage. For example, it would pay for the cost of repair or replacing your car if a tree falls on it. If you are an owner of a new or expensive car, comprehensive insurance would be an important coverage to have.

Uninsured Motorists Insurance

This additional coverage is for protection against uninsured motorists up to a minimum of \$25,000 per person. This insurance will cover your own injuries or those of occupants in your car when you are involved with an uninsured car or a hit-and-run driver. The same applies to you and your family if struck and injured as a pedestrian in a crosswalk or sidewalk by an uninsured car or hit-and-run driver. *This coverage is for injury only and does not pay for damage to your car.*

Keep in mind that your own *no-fault benefits* for medical expenses will apply first to any injuries in a car accident. To qualify for uninsured motorists coverage benefits, the condition stated earlier under which you can sue must still be met.

This particular coverage is an insurance required by law, but you may reject it in writing. Nevertheless, it is highly recommended that it is purchased as part of your no-fault auto insurance package.

HOW YOUR POLICY WORKS

Now that you are familiar with the requirements of the Hawaii No-Fault Law, let's see how your policy works. Examples of typical accidents are given to illustrate how the various coverages would apply.

Example: While driving, you hit a traffic lightpole and knock it down, causing damage to your car. Since you were at fault, your *property damage liability coverage* pays for damage to the pole. Damage to your car can be taken care of under your *collision coverage*, if you had purchased it. You pay the deductible amount and your company pays the rest.

Example: In the second accident above, you were also injured and treated for minor cuts and bruises. You incur a \$100 bill and remain at home from work for two days. Under your *no-fault benefits coverage*, your insurance company pays the doctor bill, including any x-ray or surgical costs, and for two days' loss of wages.

Example: A car in front of you stops suddenly at a stop sign. Following too closely, you rear-end that car. The driver of that car endures minor cuts and bruises, four days of lost work and damage to his car. Your car was also damaged, and you and your spouse suffer minor cuts and bruises.

In this situation, the other driver will be reimbursed for his medical expenses and lost wages by *his* insurance company under *his* no-fault benefits coverage, even though you were clearly at fault. But your *property damage liability coverage* pays for his car damage.

You and your spouse's medical bills will be paid from your no-fault benefits coverage. Your car damages will also be paid under your own collision coverage, with your company paying over the deductible you had selected. For instance, if the damage costs \$400 and you have a \$100 deductible collision coverage, your company will pay \$300 towards the repair after you put up the first \$100.

Example: While driving through an intersection, you are hit by a driver running the red light. You are taken to the hospital by ambulance, suffering a broken arm and a facial laceration which requires stitches that result in permanent scarring.

Your no-fault benefits coverage will cover your medical, surgical, hospital, nursing and ambulance bills, and up to \$800 a month in lost wages for the time you are unable to work. Remember, your company will pay up to \$15,000 for all the benefits provided under this basic coverage.

You can also sue the other driver for your injuries, including pain and suffering due to the permanent scar which caused your mental and emotional distress. And payment for your car damage will come from the other driver's insurance company under his *property damage liability coverage*.

Example: You are hit by an oncoming car while crossing the street and sustain serious injuries. As a pedestrian, you are entitled to all no-fault benefits in each of the following situations.

First, the insurance company of the car that struck you must pay for all no-fault benefits you claim. But if that car carried no insurance, then your company will pay you under your no-fault benefits coverage, providing you own a car and have a basic auto insurance policy.

On the other hand, if you do not own a car, then you can get paid under a relative's no-fault benefits coverage, providing he owns a car and is a resident of your household.

Finally, if none of the above situations apply and no benefits are readily available to you, you can file a claim with the Hawaii Joint Underwriting Plan Assigned Claims Program through the State Motor Vehicle Insurance Division. Your claim will then be assigned to an auto insurance company and handled just as if you had a no-fault policy with that particular company.

In conclusion, buying the kinds and amounts of insurance you need is difficult because you cannot predict the future. You do not know if, or when, you will be involved in an accident or the amount of damages or injuries you might cause. Therefore, it is important that you consider the following guidelines when buying insurance:

The more you have to protect, the more insurance you may need. It

you own a home and earn good wages, consider buying more insurance than the minimum coverages required by law.

Buying insurance to cover your own smaller losses may be wasteful. You may save money if you take a higher collision deductible or do not buy collision coverage on an older car. The key to this guideline is to decide what amount of money you could pay if your car is damaged in case of an accident without causing yourself financial hardship.

Always discuss your insurance needs with your agent or company representative. It is the job of this person to help you select the types and amounts of insurance coverage you need.

BUYING A POLICY

In passing the no-fault law, the Hawaii State Legislature determined that competition among insurance companies would be the best way to minimize and stabilize auto insurance rates. Thus, each insurance company is required to set its own rates, based on its own auto experience. This is called *open-rating*.

Open-rating makes for *open competition* among the companies and this means each company will charge you its own price for your business. Because of competition, you will notice differences in rates when you shop around for insurance.

THE COST OF YOUR AUTO INSURANCE

When you buy no-fault auto insurance, you should know what things are considered by insurance companies in arriving at your premium. The process of pricing insurance is called *rating* and the factors generally considered by companies in rating are:

Where You Live

Most companies use the four-territory system: Honolulu, Maui (Lanai and Molokai included), Kauai and Hawaii counties. Rates within each territory are based on the losses involving autos garaged within that area.

How Your Car is Used

If your car is used for pleasure purposes only, you will pay the lower rate offered by your insurance company. If you drive to and from work or use your car for business, your rate will be higher. Some companies will also consider the annual mileage as a rating factor.

Accidents and Violations

Your driving record and those of the members in your household who drive are important considerations. Many companies use a surcharge system based on the number of acci-

dents and traffic violations occurring in the most recent three-year driving period. So the poorer the driving record, the higher the premium.

Your Car Type

The year, make, model and engine size of your car are also important factors. Rates are usually higher if you own a high performance or sports car. The value of your car is also significant; the less it costs to repair or replace your car, the lower the cost of your premiums for comprehensive and collision coverages.

Coverages, Limits and Deductibles

If you purchase higher limits of protection and more coverages, your premiums will be higher. Purchasing a low deductible on your collision coverage and no deductible on your comprehensive coverage also results in higher premiums.

Discounts

Most companies have various discounts as part of their rating plan. Some types of discount offered are: two or more cars discount if insured with the same company; driver education course discount; carpool discount; bumper discount on later model cars which have improved bumpers; student discount, and senior citizen discount.

HOW TO SAVE MONEY ON YOUR AUTO INSURANCE

The best way to save money on your auto insurance is to *drive safely*. The cost of medical expenses, legal settlements and auto repairs all influence the cost of auto insurance. Therefore, driving safely is the key to keeping your premiums down.

Here are some other suggestions which may help lower your costs:

Think twice before buying a high performance, high-powered, expensive or sporty car. Cars with smaller engines cost less to insure.

Don't buy unnecessary physical damage insurance. For instance, the premium for collision coverage on an older car may cost more than the car is worth.

Increase the amount of your deductible when purchasing collision coverage. Higher deductibles will reduce your premium, so decide how much of a loss you can pay and then buy the deductible for it.

Buy comprehensive coverage with a deductible instead of full coverage. This will also reduce your premium.

Have every teenaged driver in your household complete a driver education course approved by the State Department of Education. Most high schools offer such courses. Some companies give a discount for driver training, but more importantly, your teenager will be a safer driver.

If you own two or more cars, insure them with one company. You may be entitled to a multi-car discount.

Notify your insurance company promptly if you sell a car or if a driver leaves your household. It could lower your premium.

Pay the whole premium at once, if you can afford it. Most companies have installment payment plans or a plan to finance your premium. You may have to pay extra charges when you pay through these plans.

Above all, maintain a good driving record. No accidents and a clean driving record will mean lower rates for you.

SHOPPING FOR AUTO INSURANCE

Since the Hawaii No-Fault Law calls for an open competition rating system, remember that rates will be different among companies. However, although price is important, it should not be the only consideration. The *quality* and *service* you get from the company and agent are all part of what you will be buying. Therefore, it is important that you shop around.

Where to Shop

Many insurance companies and agents advertise. Check the newspapers and yellow pages of your telephone directory for companies and agents in your area. Contact your relatives, neighbors and friends for recommendations or information about the price, quality and service of their company or agent. Ask what kind of claim services they are getting.

Price Quotations

When asking for premium quotations, be sure you provide the *same information* to each company or agent. The company or agent will usually request: a description of your vehicle, its use, driver's license numbers and records of all drivers in your household and the limits of the coverages you want. Save time and effort by having this information ready when you begin to shop.

Quotations by telephone may not be as accurate as when you personally visit the company or agent. And, remember, most companies or agents *do not guarantee* quotations by telephone.

When calling agents for quotations, also inquire how many companies that agent represents. Many agents represent several companies and may be able to provide you several quotes. Other agents represent a company belonging to a group of companies going under one name, and they too can provide quotes of all the companies in that group. In this manner, you can make easy price quotations.

Why You Need a Good Agent

Even though you think you have chosen a good insurance company, you still have to depend on an agent for service. A good agent is one who will be able to serve you in many ways. He will be able to answer your questions on insurance, assist you in processing your claim with

the company, and help you determine how much insurance is needed. It would be worth your while to look around for a good agent, one whom you can always depend on.

SETTLING YOUR CLAIM

A prime reason for passing the Hawaii No-Fault Law was to speed up payment of claims to injured persons of auto accidents regardless of fault. With this in mind, all insurance companies are mandated by law to pay no-fault benefits within 30 days after you supply proof of loss.

In filing your claim, give your company details regarding the accident — specifically, your injuries, the treatment and care you are receiving, your income, your doctor's name and the hospital.

Once your company verifies the treatment with your hospital and doctor, and the loss of time from your job with your employer, it must pay you the benefits you are entitled to within 30 days. A 1.5 percent interest is also required on all amounts not paid to you within this period.

WHAT TO DO IN CASE OF AN ACCIDENT

At the Scene

The first thing to do is help the injured person by giving first aid if qualified and calling an ambulance.

Second, notify the police. To the police and the other drivers involved, identify yourself. Give your name, address, driver's license number and name of your insurance company.

Be sure you also get the names and addresses of the owners or drivers and passengers of the other cars, as well as the names of their insurance companies.

Just as important is obtaining names and addresses of witnesses who may be valuable in settling your claim.

In the instance of damaging a parked car or someone's property, you are responsible for locating the owner and identifying yourself. If this is not possible, you should attach a note to the property giving your name, address and telephone number.

After the Accident

Contact your insurance company immediately and give as many details as possible. It is important that you do not delay. Witnesses may disappear, evidence may be destroyed, memories may fade and injured parties may exaggerate their injuries. Give your *complete cooperation* to your insurance company and the agent assigned to your case for full protection and prompt payment of all entitled benefits.

YOUR RIGHTS

The Hawaii No-Fault Law requires every owner of a car, bus, truck or motorcycle to have insurance. Without insurance, vehicle registration papers and license plates must immediately be surrendered to the county director of finance.

Any uninsured owner may be fined \$1,000 for each violation of driving without insurance and receives no compensation if involved in an accident. Furthermore, he runs the risk of being sued.

As a policyholder of no-fault insurance, it is good to know your legal rights and where you stand with your insurance company and agent.

No insurance company can refuse to sell you a no-fault insurance policy if you are an owner, unless the principal driver of your car does not have a valid driver's license or unless you do not pay the premium.

No company can refuse to renew your policy unless the principal driver of your car does not have a valid driver's license or unless you do not pay the premium.

No company can cancel your policy, once issued, unless you do not pay your premium or your driver's license has been suspended or revoked. Furthermore, your company must give proper notice of its intent to cancel your policy.

No company can refuse the benefits you are entitled to should you become involved in an accident.

FILING A COMPLAINT

If you believe that any of your rights have been violated or that you were treated unfairly, or that a claim with your company was not handled properly, you have a right to file a complaint with the State Motor Vehicle Insurance Division.

However, your first step should be to contact your agent or company representative since many complaints are simply a result of a mistake or misunderstanding that can be corrected upon polite inquiry.

Complaints to the State *must be in writing*. Request standard complaint forms by calling 548-5450. Completed forms should then be mailed to:

Motor Vehicle Insurance Division
State Department of Regulatory Agencies
P. O. Box 2399
Honolulu, Hawaii 96804

Coverages:	\$15,000	Basic Personal Injury Protection
	\$25,000	Bodily Injury Liability
	\$10,000	Property Damage Liability
	\$25,000	Uninsured Motorists Coverage
Actual Cash Value		Comprehensive
\$ 100		Deductible Collision
		1977 Plymouth Volare, V-8

1977 Plymouth Volare, V-8 }

Approximate Annual Premiums for the Above Coverages
for Rates in Effect as of July 1, 1978

Company (alphabetical order)	Terr. Use	OAHU		MAUI		KAUAI		HAWAII	
		Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work
CLEAR RECORD									
Aetna Casualty & Surety Co.	c	242	277	168	192	165	189	194	222
Aetna Fire Underwriters Ins. Co.		237	273	167	192	165	189	195	224
Aetna Insurance Co.		237	273	167	192	165	189	195	224
Allstate Indemnity Co.		742	847	585	673	559	642	622	716
Allstate Insurance Co.		462	527	367	421	348	400	388	446
American Automobile Ins. Co. (FAP)		362	417	264	303	291	334	291	334

Company	Terr.	OAHU		MAUI		KAUAI		HAWAII	
	Use	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work
American Automobile Ins. Co. (SAP)		266	306	180	207	214	246	212	243
American Casualty Co.		229	263	160	183	159	181	203	232
American Employers' Ins. Co.		331	381	251	289	246	283	299	344
American & Foreign Ins. Co. (FAP)		396	455	351	403	305	350	351	403
American & Foreign Ins. Co. (SAP)		362	416	322	371	282	324	322	371
American Home Assurance Co.		251	289	160	183	159	181	188	215
American Manufacturers Mutual Ins. Co.		334	383	291	335	256	294	294	338
American Motorists Ins. Co.		334	383	291	335	256	294	294	338
American Mutual Liability Ins. Co.		358	411	241	277	241	277	266	306
American National Fire Ins. Co.		225	259	147	169	146	167	171	196
American Star Ins. Co.		232	267	161	184	161	184	187	214
Amica Mutual Ins. Co.		229	263	160	183	159	181	187	214
Argonaut Ins. Co.		368	423	317	364	280	322	321	369
Argonaut-Midwest Ins. Co.		368	423	317	364	280	322	321	369
Associated Indemnity Corp. (FAP)		362	417	264	303	291	344	291	334
Associated Indemnity Corp. (SAP)		266	306	180	207	214	246	212	243
Assurance Company of America		384	441	268	308	266	306	322	371
Carriers Ins. Co.		288	331	202	232	200	230	249	286
Centennial Ins. Co.		229	263	160	183	159	181	187	214
Charter Oak Fire Ins. Co.		554	638	401	460	395	454	471	540
City Ins. Co.		360	414	311	356	275	316	315	362
Colonial Penn Ins. Co.		149	193	97	126	97	125	115	149
Commercial Ins. Co. of Newark, N.J.		384	442	267	307	264	304	318	365

Company	Terr.	OAHU		MAUI		KAUAI		HAWAII	
	Use	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work
Commercial Union Ins. Co.		331	381	251	289	246	283	299	344
Continental Casualty Co.		229	263	160	183	159	181	203	232
Continental Ins. Co.		384	442	267	307	264	304	318	365
Criterion Ins. Co.		358	372	268	276	265	274	280	290
Cumis Insurance Society, Inc. (FAP)		189	217	133	153	132	152	155	178
Cumis Insurance Society, Inc. (SAP)		146	168	108	124	108	124	128	147
Employers' Fire Ins. Co.		331	381	251	289	246	283	299	344
Employers Mutual Liability Ins. Co.		401	461	288	331	282	324	342	393
Federal Ins. Co.		211	242	131	150	131	150	155	177
Fidelity & Casualty Co. of New York		384	442	267	307	264	304	318	365
Financial Security Life Ins. Co. (FAP)		261	300	180	207	178	205	208	239
Financial Security Life Ins. Co. (SAP)		260	300	180	207	180	207	216	248
Fireman's Fund Ins. Co. (FAP)		362	417	264	303	291	334	291	334
Fireman's Fund Ins. Co. (SAP)		266	306	180	207	214	246	212	243
Fireman's Ins. Co. of Newark, N.J.		384	442	267	307	264	304	318	365
First Ins. Co.		370	426	253	291	250	288	301	346
General Accident Fire & Life Assurance		263	302	190	218	188	215	224	257
Glen Falls Ins. Co.		384	442	267	307	264	304	318	365
Globe Indemnity Co. (FAP)		396	455	351	403	305	350	351	403
Globe Indemnity Co. (SAP)		362	416	322	371	282	324	322	371
Government Employees Ins. Co.		303	330	227	247	223	243	271	296
Grain Dealers Mutual Ins. Co.		414	476	284	326	278	319	345	397
Great American Ins. Co.		225	259	147	169	146	167	171	196

HAWAII NO-FAULT AUTOMOBILE INSURANCE QUOTATION WORKSHEET

MINIMUM RATING INFORMATION REQUIRED:

A. List All Drivers in Household:

Driver No.	Name	Within Last 3 Years	
		No. of Accidents (at fault only)	No. of Moving Violations
1.			
2.			
3.			
4.			

B. Automobiles to be Insured:

	Make	Model & Year	Uses: Car Most (Driver No.)	Car Used For: (P) Pleasure (T&F) To & From Work (B) Business	Annual Mileage
Car 1					
Car 2					

C. Cost of your Insurance:

ANNUAL PREMIUMS

Coverages Required by Law:

Select Limits
or Deductible

Company Company Company Company
A B C D

1. NO-FAULT BENEFITS (Personal
Injury Protection)
(Required Min. - \$15,000)

____ per pers.

2. BODILY INJURY LIABILITY
(Required Min. - \$25,000)

____ per pers.

3. PROPERTY DAMAGE LIABILITY
(Required Min. - \$10,000)

____ per acc.

4. UNINSURED MOTORISTS
(Required Min. - \$25,000)

____ per pers.

Additional Optional Coverages:

5. Comprehensive

Deduct.
____ per acc.

6. Collision

Deduct.
____ per acc.

7. Other Coverages

TOTAL ANNUAL PREMIUM

8. Company membership fee (if any)

9. Service Fee or Finance Charges

TOTAL ANNUAL COST OF INSURANCE



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3591

February 13, 1981

MEMORANDUM

TO: Representative Charles Anderson
FROM: Betty Barton, Issues Analyst
RE: Auto Insurance
Research Request No. 81-16

As a component of your request on liability insurance for motor vehicles, you have asked that we compile proposed legislation, introduced in past legislative sessions, that is pertinent to the subject. An additional request made by your office for information regarding Hawaii's statutory provisions on compulsory liability insurance is addressed in a separate memorandum.

For this project, we have collected bills introduced from the Ninth Legislature, convening in 1975, through the current session of the Twelfth Legislature. These bills are attached to this memorandum; a listing of their titles, sponsors, and final status follows:

NINTH LEGISLATURE

<u>Number</u>	<u>Abbreviated Title</u>	<u>Sponsor</u>	<u>Final Status</u>
HB 38	Motor Vehicle Insurance	Urion	In (H) Judiciary
HB 44	Motor Vehicle Insurance	Swanson	In (H) Commerce
SB 657	Motor Vehicle Insurance	Croft	In (H) Commerce

TENTH LEGISLATURE

<u>Number</u>	<u>Abbreviated Title</u>	<u>Sponsor</u>	<u>Final Status</u>
HB 217	Motor Safety Responsibility Act	Urion	In (H) Commerce
HB 594	Motor Vehicle Insurance	Commerce	In (H) Judiciary

<u>Number</u>	<u>Abbreviated Title</u>	<u>Sponsor</u>	<u>Final Status</u>
HB 614	Motor Vehicle Insurance Policies	Rules	In (H) Commerce

ELEVENTH LEGISLATURE

<u>Number</u>	<u>Abbreviated Title</u>	<u>Sponsor</u>	<u>Final Status</u>
HB 402	Re/Motor Vehicle Insurance, E.D.	McKinnon	In (H) Commerce
SB 274	Re/Motor Vehicle Safety Responsibility Act, E.D.	Commerce	In (S) Commerce
SB 280	Re/Motor Vehicle Insurance	Commerce	In (S) Commerce
SB 460	Authorizing Municipalities to Establish Requirements for Motor Vehicle Security Deposits	Bradley	In (S) Judiciary
SB 461	Tax Credit for Auto Insurance Premiums	Bradley & Stimson	In (S) State Affairs
SB 542	Financial Responsibility Regarding Motor Vehicles	Commerce	In (S) Judiciary

TWELFTH LEGISLATURE

<u>Number</u>	<u>Abbreviated Title</u>	<u>Sponsor</u>	<u>Final Status</u>
SB 70	Authorizing Municipalities to Establish Requirements for Motor Vehicle Security Deposits	Stimson & Bradley	In (S) Community & Regional Affairs

As you will note, SB 70, cosponsored by Senators Stimson and Bradley, is the only bill which has been introduced this session thus far related to the financial responsibilities of owners and operators of motor vehicles. A similar bill, SB 460, sponsored by Senator Bradley, was introduced in the Eleventh Legislature. If we can provide you with additional information regarding the enclosed materials, please do not hesitate to contact us.

BB/bf



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 4, 1981

MEMORANDUM

TO: Representative Charles Anderson

FROM: Betty Barton
Research Staff

RE: Auto Insurance
Research Request No. 81-16 (Additional Material)

We have received additional materials concerning Hawaii's program for compulsory no-fault/liability insurance. We have enclosed the following for your review:

Rules and Regulations of the Motor Vehicle Insurance
Division, State of Hawaii

Annual Report to the Legislature, Motor Vehicle Insurance
Division, State of Hawaii, July 1, 1979-June 30, 1980

Annual Report to the Legislature, Motor Vehicle Insurance
Division, State of Hawaii, July 1, 1978-June 30, 1979

In addition, we have enclosed materials, which you may find helpful, compiled for us by the National Conference of State Legislatures. These materials outline the key components of auto insurance programs in other states.

If you have any questions regarding these materials or other aspects of auto insurance, please do not hesitate to contact us.

BB/bf
Encls.



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 catastrophe. 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, physicians 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 physician 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

* 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-

* 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.

Coverage for Non-Wage Earners and the Marginally Employed

State sponsored health insurance for defined groups of people who have no practical access to private health care coverage is the most limited approach to state sponsored health insurance. Under this ap-

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 largest 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 satisfactorily 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.

VII APPENDIX

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

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

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

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

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

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

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

ESTIMATED ANNUAL PREMIUM \$86,800,000

TABLE IIIESTIMATED RANGE OF INITIAL¹ PREMIUM COSTS OF HEALTH
COVERAGE FOR THE UNCOVERED POPULATION

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

-
1. These costs would approach the cost of universal coverage over time, as private subscribers opt for state subsidized coverage.
 2. The estimated premium rate for state wide coverage, +50 to 75%. See Blue Cross memo which follows.

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

Unemployed	18,300
Self-employed	15,000
Non-labor Force	244,000
Wage earner dependents	(105,000)
CHAMPUS eligibles	(46,000)
Medicaid eligibles	(14,800)
U. S. Public Health Service Eligibles	(<u>51,500</u>)
TOTAL	60,000

	<u>High (+30%)</u>	<u>Low (+20%)</u>
19 and Under (32.5%)		19,500
Premium Rate	<u>\$16.12</u>	\$14.88
Monthly Premium	\$314,000	\$290,000
Over 19 (67.5%)		40,500
Premium Rate	<u>\$44.33</u>	<u>40.92</u>
Monthly Premium	\$1,795,000	\$1,657,000
TOTAL ANNUAL PREMIUM	\$25,300,000	\$23,400,000

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

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



John M. Hopkins
Vice President, Marketing

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

November 30, 1977

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

Dear Sharman:

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

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

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

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

Sincerely,

A handwritten signature in dark ink, appearing to read "John M. Hopkins".

John M. Hopkins
JMH:br

EXHIBIT 'A'

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

- I. A resident is a person whose primary residence has been within the State of Alaska for a continuous period of at least six months.
- II. An eligible resident is a resident not eligible for medical care benefits available through the following entities:
 - a. Federal Employee Health Programs
 - b. United States Armed Forces
 - c. CHAMPUS
 - d. Medicaid
 - e. United States Public Health Service
- III. Healthcare benefits would be provided as primary coverage, with the sole exception that the Program be coordinated as secondary coverage to Medicare. Any persons eligible for Medicare and not enrolling in the Medicare Program will receive the same coordinated benefits had they been covered under Medicare.
- IV. The State of Alaska would identify all eligible residents and submit necessary eligibility data to the Blue Cross Plan monthly on a computer tape in order that an updated eligibility file could be maintained for the Program. Administration and enforcement of eligibility rules would be the responsibility of the State of Alaska.
- V. The State of Alaska would remit, monthly, funds due the Plan based on the eligibility file and contract rates.
- VI. At the end of each contract year the Plan would provide a summary of income, incurred claims and administrative expenses under the Program. Any surpluses would be refunded to the State of Alaska. Any deficits would become due and payable to the Plan by the State of Alaska. The Plan would provide monthly reports to the State of Alaska during each contract year, itemizing year-to-date income and expense data.
- VII. During the initial years of the Program it is likely that abnormally high rates of inflation and increases in utilization of healthcare services will occur. In an attempt to control these anticipated trends and their effects on the cost of the Program, it would be desirable for the State of Alaska to enact legislation to control the expansion of healthcare facilities and to set reasonable limits on the rate of return healthcare providers may be allowed.

continued . . .

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

A. Rates by eligible resident-

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

B. Rates by type of family unit-

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

C. Rate for any Family Unit = \$71.40/month

Each family unit would coincide with one of the categories itemized in section VIII, B., above. Children must be unmarried and meet the IRS definition of a dependent to be considered an eligible member of any covered family unit.

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

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

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

SS HB 41: Section-by-section analysis

SECTION 1: Sets up a state comprehensive health plan and a state health insurance cost sharing program, by adding a new chapter to Title 18 (Health and Safety) of state law.

Sec. 18.27.010. State Comprehensive Health Plan. Provides for the establishment of the Plan in the Department of Administration. The Commissioner is directed to establish minimum benefit standards for the Plan, and provide for underwriting and administration of the Plan through competitive bidding. Any resident is eligible to enroll in the Plan. The Plan shall include an annual limit on the amount of copayments and deductibles that a resident will pay, and the limit must be the same for each family size. The contract for the Plan shall be for a period of three years.

Sec. 18.27.020. State Health Insurance Cost Sharing Program. A resident enrolled in the Plan, or another health insurance policy with benefits that meet or exceed the Plan's benefits, shall receive a subsidy to help defray the costs of health insurance. Every resident with health insurance, except those enrolled in a group health insurance policy or those covered under a state or federal health program, is eligible for a state subsidy, if they meet the income criteria of the subsidy schedule. The subsidy schedule is geared to family units, and a distinction is made between premium and out-of-pocket (copayment and deductible) subsidies. The subsidy schedule can be summarized as follows:

<u>monthly income</u>	<u>family pays</u>	<u>state pays</u>
below 45% of median adj. gross income for Ak. (150% of poverty guideline)	0%	100%
45-75% of median	0% premium, portion of out-of-pocket	100% premium, portion of out-of-pocket
75-100% of median	portion of premium and out-of-pocket	portion of premium and out-of-pocket
100-125% of median income	portion of premium, 100% out-of-pocket	portion of premium and 0% out-of-pocket

(The attached charts describe the subsidy available to each family income category in a more detailed fashion.) The state subsidy available for health insurance other than the Plan is limited to the amount the state would have paid had the resident been enrolled in the Plan

SECTION 2: Report to the Legislature.

The Commissioner shall report back to the legislature at the beginning of the next session on the following items: (1) proposed minimum benefits for the Plan and the actuarial costs anticipated; (2) how many people are expected to enroll in the cost sharing program and how much it will cost the state; (3) a proposal to implement the Plan and the cost sharing program, to determine eligibility, to pay the state's share of the costs of the Plan and the cost sharing program, and to advertise the availability of the Plan and the cost sharing program; and (4) recommendations for implementation of AS 18.27.

SECTION 3: Effective date for AS 18.27.

Coverage under the Plan and subsidies under the cost sharing program must be available on July 1, 1982.

SECTION 4: Technical amendment to present law.

SECTIONS 5-8: Alcoholism and drug dependency coverage.

Requires state employee health insurance coverage to include coverage for treatment of alcoholism and drug dependency.

SECTION 9: Provides differing mechanisms for provider reimbursement under federal and state medical assistance programs.

Sec. 47.05.070. Medical Assistance By Insurance or Service Contracts. If the Commissioner (of Health and Social Services) determines that it would be more cost effective to pay for medical assistance services through means other than the current fee-for-service payment mechanism, she may do so. Payment of health insurance policy premiums or expenses of health maintenance organization, medical or hospital service contracts are authorized in this section.

Sec. 47.05.080. Contracts With Direct Providers of Care and Service. This section authorizes the Commissioner to enter into a contract with a computer firm to reimburse providers for services rendered under medical assistance programs. The firm would pay providers directly.

Sec. 47.05.090. Implementation. Requires the Commissioner to implement 47.05.070 - .090 only if it would be cost effective to do so. In other words, these mechanisms would be used only if it would cost the same or less than the current fee-for-service arrangement.

Sec. 47.05.100. Interim Payment. The Department of Health and Social Services may make an interim payment to a provider of a large volume of services under state medical assistance programs.

Sec. 47.05.110 Interest on Late Payments. Requires the Department to pay 1% interest per month on provider claims for services rendered under medical assistance programs that are not paid on time. The interest rate goes up to 2% for claims outstanding after three months.

page three.
SS HB 42

SECTION 10: Requires the state to offer Medicaid to all categories of eligibles for whom services may be provided under federal law.

Alaska currently provides Medicaid services to all categories of people that federal law requires, and additional categories that are considered optional under federal law. This section would require the Department of Health and Social Services to provide Medicaid services to other categories of people that Medicaid considers optional. The state would then be offering services to all categories of people for which federal matching Medicaid funding is available.

SECTION 11. Requires the state to offer all Medicaid services allowable under federal law.

Alaska currently provides all of the services required under federal law, and some that are considered optional. This section would require the Department to pick up the rest of the services that are considered optional. It would then be offering all services available for Medicaid matching funds.

SECTION 12: Deletes section of law that requires the Department to ask the Legislature's permission to add any new Medicaid service or eligible categories.

This section of law would no longer be needed since all available categories would be offered.

SECTION 13-16: Effective dates.

Secs. 1-4: 7/1/82

Secs. 5-8, 10-12: 1/1/82

Sec. 9: 7/1/81

Secs. 2-3: immediately in accordance with AS 01.10.070(c), or the day after the bill is signed by the Governor.

Section 1. As 18 is amended by adding a new Chapter to read:

Chapter 21
18.27.010

State Health Insurance Program (a) The Commissioner of administration shall establish a state health insurance program for residents of the state.

(b) The Commissioner shall establish by regulation minimum benefits for the state health insurance program.

(c) The Commissioner shall provide for the underwriting and administration of the plan. A contract entered into under this ~~plan~~ subsection will be for a three year period and shall be based on competitive bids.

(d) The State Health Insurance Program shall provide for copayments and deductibles. The annual deductible may not exceed \$100 for each enrolled resident ~~and may not be~~ \$500 for each enrolled family. The total cost of copayments may not exceed \$2,000 per year for any resident/family enrolled in the State Health Insurance Program ~~or \$400 per year for a family enrolled~~.

State Health Insurance Cost Sharing Program.

(a) Cost sharing under the State Health Insurance Program may be provided to a resident who

- (1) is enrolled in the State Health Insurance Program established under this chapter;
- (2) qualifies for cost sharing under (c) of this section.

(b) Cost sharing may not be provided if, and to the extent that, subsidized medical care or subsidized health insurance (other than the State Health Insurance Program established under this chapter) is available and accessible to the resident or would be or would have been available and accessible upon application by

The resident.

(C) The commissioner shall pay the state share of the ~~cost~~ of premium costs of the State Health Insurance Program incurred by a resident of the state and his covered dependents qualifying for cost sharing under the following formula:

(1) If the total adjusted gross income of the resident and his dependents is at or below 75 percent of the base income, 100 percent of the premium cost of the program.

(2) If the total adjusted gross income of the resident and his dependents is between 75 percent and 100 percent of the base income, a graduated percentage of the premium cost of the program between 100 percent and zero percent.

Definitions. In this Chapter

(1) "commissioner" means the Commissioner of administration;

(2) "copayment" means the portion of covered expense paid by the resident after the deductible has been met.

(3) "insurance" means prepaid plans or indemnity plans.

(4) "subsidized health insurance" means health insurance, all or part of the premiums of which are paid by an employer or trade union of the insured.

(5) "subsidized medical care" means medical care provided free of charge.

(6) "adjusted gross income" means the income of the resident determined under the

regulations of the commissioner
(7) "Base income" means.

(A) family median income for Alaska determined by the United States Bureau of the Census, and

(B) regional adjustments established by the commissioner to the family median income for Alaska determined by the United States Bureau of the Census that are based on relative costs of living in the state.

(8) "resident" means

Coverage under the State Health Insurance Program and the State Health Insurance Cost Sharing Program under AS begins on July 1, 1983.

Parthasarathi
2218
789-44002

130/mo with estimate of monthly premium

have people in group you spread your insurance over more people - (groups up to 100-150 have enough to spread risk in group)
individual plans they see - benefits along the course -
choice of deductible amount; cap rate

- Can we give a plan w/ 2-3 different levels of benefit/premium?
- Is it better to negotiate deal/agency for better?
- Do we need special advice for high-risk individuals?
- Can many people must be in group to get lower premium/mo? Don't know

Sec 1

(c) The Commissioner shall contract for the administration and may contract for the underwriting of the plan. A contract entered into under this subsection shall etc.

(D) The State Health Insurance Program shall provide for copayments and deductibles, and shall provide an annual limit on the total amount of copayments and deductibles for each enrolled resident and the covered dependents of the resident for each year. The annual limit shall be the same regardless of family size.

Sec 2

(2)(b) Cost sharing may be provided if and to the extent that, subsidized medical care or subsidized health insurance (other than the state health insurance program established under this Chapter) is, or during the 90 days preceding enrollment in the state health insurance program, has been, etc.

Arch. Sch. Dist.
Can insurance
re: insurance
benefits

Call
Thurs am

Gaumer (2016) 361-3408
Joan?? Blue Cross.

How many people must be
in group before cost effective?
Can several plans be offered?
negotiate - Ded./Cofay./Benefits

Sally Sadler - D.L. Census Info.

Alaska CMB

Workers' Wages Samples

Alfreda Mullin - 4519 - UI

broken down by \$200 increments in wages.

SB 256 - Monday - Pioneers Home
3:00 -

State fire Marshall - 272-2406
Fed. retirement.

Emil Kowalchuk 586-7193
Dan Anderson - 586-7188

10 reports
Committee Elvason
Kettulla
Price
back report to
all Senators

Jean Summer 3-31

variable plans -

— core program offered to all — then additional options. (would need health statement & age for add-ons and bunnies)

How will we handle those "variable" plans?

who is going to determine categories.

this type - social insurance group - may be high risk.

State needs to self-insure

seasonal people - high risk job -
high risk health cond.

call Martin when bill comes in —

OMB Poverty guidelines for Alaska - April 1981

<u>Family size</u>	<u>Nonfarm</u>	<u>Farm</u>
1	\$5,410	\$4,610
2	7,130	6,070
3	8,850	7,530
4	10,570	8,990
5	12,290	10,450
6	14,010	11,910

add \$1,720 for each additional nonfarm family member and \$1,400 for each additional farm family member

Per capita personal income in Ak. 1980 (US Dept. of Comm.)
\$12,790 (highest in the country)

Avg. industry earnings 1980 - Unemployment Insurance

Annual - \$23,380

monthly - \$1,948

* Annual mean income \$12,081
annual income median \$6,940 } TOTAL ALL INDUSTRIES

* Dept. of Labor - annual mean income is the most accurate reflection of the earning level of individual Alaskan workers.