HB

22

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. HB 22

Revision Date: March 19, 1993
Dept. Affected: Administration
Title: An Act establishing the Alaska Children's Health Corporation and the Alaska Healthy Start Program, relating to insurance
RU: Children's Health Corporation
Component:
Sponsor: Nordlund
Requestor:
COMPONENT SERIAL NO.

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	151.3	294.8	294.8	294.8	294.8	294.8
TRAVEL	24.2	15.4	15.4	15.4	15.4	15.4
CONTRACTUAL	101.4	151.4	151.4	151.4	151.4	151.4
SUPPLIES	4.8	4.8	4.8	4.8	4.8	4.8
EQUIPMENT	79.7	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	361.4	466.4	466.4	466.4	466.4	466.4

CAPITAL	0	0	0	0	0	0

REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING:

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	361.4	466.4	466.4	466.4	466.4	466.4
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
TOTAL	361.4	466.4	466.4	466.4	466.4	466.4

POSITIONS

FULL-TIME	4	4	4	4	4	4
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: $ zero

ANALYSIS: (attach a separate page if necessary.) This analysis only examines the operating expenses of the corporation. We have insufficient data at this time to make assumptions on enrollments, resulting copayments and eventual State subsidy.

Prepared By: Robert F. Stalnaker *Robert F. Stalnaker*
Phone: 465-4470
Division: Retirement and Benefits
Date: March 19, 1993

Approved by Commissioner: Nancy Bear Usera *NBU*
Date: 3/22/93
Agency: Department of Administration

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Rev 11/92

Fiscal Note - Admin.

House Bill 22
Analysis of Financial Impact
Prepared by the Division of Retirement and Benefits
Department of Administration
Revised March 19, 1993

Analysis: This bill creates the Alaska Children's Health Corporation and the Alaska Healthy Start Program in the Department of Administration. This independent agency, governed by a 7 member board of directors, would purchase and administer a specific health plan for certain children and pregnant women. The corporation would also manage a health fund that would consist of donations and appropriations.

Employing an Executive Director and additional staff as necessary, the corporation would:

- Accept applications for health care
- adopt regulations outlining additional coverage
- establish copayment levels for applicants
- solicit private donations
- procure insurance coverage

The Alaska Children's Health Fund is also created in this bill and placed within the corporation. The fund would consist of money from donations and appropriations. The fund would also be used to pay premiums and board expenses. Copayments would be deposited in the general fund and accounted for separately by the Department of Administration.

During FY 94 it is assumed that only the executive director will be on board for a full year. The administrative assistant, clerk typist and R&B technician are assumed to work for six months. The accounting technician and accounting clerk are assumed to begin in FY 95.

	(full year cost)	FY94	FY95
PERSONAL SERVICES			
Executive Director (12 months)	$90.8		
Administrative Assistant II (6 months)	45.3		
Clerk Typist III (6 months)	33.6		
Retirement/Benefit Technician (6 months)	42.0		
Accounting Technician II (begin FY95)	45.3		
Accounting Clerk III (begin FY95)	37.8		
Total Personal Services...................................		$151.3	$294.8
TRAVEL			
Assume 4 board meetings for FY 94 and 3 each year thereafter	19.6		
Administrative travel for Director:			
Board meetings	2.8		
Organizational meetings	1.8		
Total Travel		$24.2	15.4

House Bill 22
Analysis of Financial Impact
Prepared by the Division of Retirement and Benefits
Department of Administration
Revised March 19, 1993

CONTRACTUAL			
Office space -- 800 sq. ft. @ $2.25 X 12 months	$21.6		
Telephone -- $500 X 12 months	6.0		
Copier -- $400 X 12 months	4.8		
Courier services -- $220 X 12 months	2.4		
Postage -- $550 X 12 months	6.6		
Printing, binding and mailing services	10.0		
Professional services contract(s) such as :			
Health consulting serves (begin FY 95)	50.0		
marketing representative	50.0		
Total Contractual		$101.4	151.4
SUPPLIES			
Office supplies	1.8		
Software	3.0		
Total Supplies		$4.8	4.8
EQUIPMENT			
6 Personal computers, server, printer	$45.0		
Phones (1100/unit)	6.6		
Fax machine	2.6		
Office furniture:			
1 management unit	4.0		
5 support workstations	15.0		
6 chairs	2.4		
7 side chairs	2.1		
2 file cabinets	.9		
bookcase	.5		
storage cabinet	.6		
Total Equipment		$79.7	0
TOTAL projected operating cost		$361.4	$466.4

This fiscal note only addresses potential administrative costs. It does not attempt to address the appropriations that would be needed to cover the cost of providing the health insurance program. That appropriation would depend on the coverage to be provided, the cost of the premium to be borne by participants and the total number of participants.

Alaska State Legislature

House of Representatives

3111 C Street
Anchorage, Alaska 99503-3957
561-7007
While in Session:
Alaska State Capitol
Juneau, Alaska 99801-1182
465-4968

District 11:
Sand Lake
Spenard
Taku-Campbell

Representative Jim Nordlund

HB 22 -- The Alaska Healthy Start Program

Sponsor Statement

Alaska has been blessed with many resources. The most precious of these is our children. House Bill 22 directly addresses the well-being of Alaska's children by providing an affordable health insurance program for all those who are uninsured, as well as for uninsured pregnant women. The target population consists of those citizens who are not "poor" enough to qualify for Medicaid, yet who do not have access to health insurance coverage.

There are two aspects of the health insurance program which are significant. First, the emphasis will be on "bang for the buck"--preventive and emergency services for children and prenatal care for pregnant women. Second, the yearly cost of the package of health services is proposed to be affordable to middle- and lower-income families. This affordable, effective insurance program will be offered through private insurance companies and will be administered by the Alaska Children's Health Corporation, a public corporation legally separate from the state which will be governed by a board of directors.

Except for first-year start-up costs, the program has been designed to require no state funding; all medical services as well as administrative costs will be paid for entirely by premiums which the board will establish.

In its final report to the governor and legislature in January of this year, the Health Resources and Access Task Force recommended that affordable health insurance be made available to uninsured low-income pregnant women and children. HB 22 does exactly that.

Sponsor Statement

CSHB 22 -- The Alaska Healthy Start Program

Sectional Analysis

SECTION 1.

Establishes the **Healthy Start Program** as a new Chapter 55 under Title 21 (Insurance). The Healthy Start Program is administered by the Alaska Children's Health Corporation.

Article 1 of Chapter 55 establishes the **Alaska Children's Health Corporation.** The Corporation's purpose is to:
1) administer the Alaska Children's Health Care Plan,
2) purchase health insurance for eligible participants,
and 3) manage the Alaska Children's Health Fund.

The **Board of Directors** for the Corporation is made up of seven members, including the Commissioners of the Departments of Commerce and Economic Development and Health and Social Services and five other individuals with experience in providing health care, managing large funds, providing health insurance, and promoting child welfare. The Board is allowed to hire staff.

Article 2 creates the **Alaska Children's Health Care Plan.**

Medical services for children which must be provided under the plan are:
1) routine examinations,
2) diagnostic and screening services,
3) immunizations and preventive services,
4) laboratory and x-ray services,
5) outpatient physician services,
6) outpatient surgery,
7) emergency room services, and
8) prescription drugs.

Maternity care is also included for women during pregnancy and for a period immediately following childbirth.

The Board is authorized to adopt regulations to determine the scope of these services and to add additional services. They are also authorized to set deductibles, limits, and other such mechanisms to control the utilization and cost of the plan. (Decisions on level and scope of services would be driven by the desired level of premiums.)

Sectional Analysis CS HB 22

Eligible participants in the plan include:
1) children under the age of 19 or pregnant women
2) who have been Alaskan residents for at least one year and
3) who are not covered under another public or private health insurance plan, or by Medicaid.

Application for coverage under the plan can be made directly to the Corporation or by filling out a relevant section of the child's or woman's Permanent Fund dividend application.

Administration of the plan by the Board includes:
1) soliciting private funds to cover premiums,
2) purchasing insurance to cover eligible participants,
3) marketing the plan to encourage participation, and
4) determining premium requirements of participants.

Premiums may be reduced for lower-income children and pregnant women if private funds are sufficient, or if the Legislature specifically appropriates funds to do so.

Article 3 establishes the Alaska Children's Health Fund as part of the Corporation. Sources for the Fund are:
1) the premiums paid by the insured,
2) money donated from private sources, and
3) appropriations by the legislature.
The Fund is used to pay the insurance premiums for women and children covered by the plan and for expenses incurred by the Corporation.

SECTION 2.

Places any staff employed by the Corporation into exempt (from provisions of the State Personnel Act) service.

SECTION 3.

Requires any insurer bidding for the provision of coverage under the Alaska Employee Group Insurance Plan to also bid on the Alaska Children's Health Care Plan (the Healthy Start Program).

SECTION 4.

Requires the Department of Revenue to include on the child's PFD application questions asking whether the child's parent or guardian wishes to apply for coverage under the Healthy Start Program. This section also requires the

Department to adopt regulations to determine how PFD deductions will be made and premium payments paid on behalf of the child.

SECTION 5.

Sets up staggered terms for the members of the Board of Directors of the Corporation.

SECTION 6.

Establishes an immediate effective date for Sections 1, 2, and 5.

SECTION 7.

Delays the effective date for Sections 3 and 4 until July 1, 1994.

HOUSE BILL 22
FREQUENTLY ASKED QUESTIONS

QUESTION: What does HB 22 do?
ANSWER: This bill provides health insurance for children and pregnant women from families who have no other form of health coverage. This bill fits into a systematic, phase-in approach, endorsed by the Health Resources and Access Task Force, to control costs and ensure that all Alaskans have access to health care.

QUESTION: Why is HB 22 necessary?
ANSWER: Children do not have the ability to provide for their own health coverage. In many cases parents do not have a workplace plan that will cover their children and cannot afford the private plans that are available.

QUESTION: Will this bill save money in the long run?
ANSWER: Yes. Most of the time uncovered kids and pregnant women receive only the medical care they absolutely need. These costs are passed onto everyone else in the form of higher insurance premiums. Under the program of preventive care in this bill, health problems can be prevented or detected early, saving money for everyone while helping many Alaskans avoid the misery of illness.

QUESTION: How many children would be covered under the bill?
ANSWER: There are an estimated 21,000 Alaskan children without health insurance or any other form of health coverage. It is difficult to determine at this time how many families will take advantage of the program.

QUESTION: What medical services are covered?
ANSWER: The plan includes preventive services, emergency services, outpatient services, and prescription drugs for children, and maternal care for women.

QUESTION: Who pays for the coverage?
ANSWER: The families of eligible women and children will pay the premiums. The Corporation may also receive contributions from private sources and special appropriations from the legislature to lessen the burden of premiums on low-income families.

QUESTION: How much would it cost to cover one child?
ANSWER: Based on the services listed in HB 22, and given the advantages of pooling, a preliminary analysis shows the yearly premium for a child to be about $600. Children are the least costly group of uninsured to cover.

Most commonly askid questions - HB 22

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 1, 1993

Representative Cynthia Toohey
Co-Chair
Committee on Health, Education
and Social Services
State House of Representatives
Capitol Building
Juneau, AK 99801

Re: HB 22, Healthy Start Program

Dear Representative Toohey:

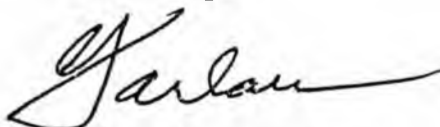
ASHNHA, representing community hositals and nursing homes urges House Hess Committee support of HB 22, establishing the Alaska Children's Health Corporation and the Alaska Healthy Start Program.

We note this legislation is incorporated into SB 114, the Health Resource & Access Task Force recommendations for health reform.

If the Legislature can move this year on an overall health reform program, we support the inclusion of HB 22, as it deals directly with making health insurance available for children.

If it is necessary to wait for 1994, then we would encourage serious consideration of HB 22 and HB 12, small employer health insurance this year as both bills improve access to health care. This is not to forego the importance of the Legislature considering legislation to control health costs as well.

Sincerely,



Harlan R. Knudson
President/CEO

cc: Representative Jim Nordlund

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX,(907) 463-3573

Letters of Support

ALASKA CHAPTER
NATIONAL ASSOCIATION OF
SOCIAL WORKERS

8923 Tanis Drive
Juneau, Alaska 99801
(907) 789-7099
FAX (907) 790-2209

Executive Director
William Diebels, LCSW

BOARD OF DIRECTORS

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Lola Mallette, LCSW
Bethel

AT LARGE REPRESENTATIVE
Cecelia Esparza, ACSW
Kodiak

STUDENT REPRESENTATIVE
Maesha Champion
Anchorage

March 23, 1993

Representative Jim Nordlund
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99811

Dear Representative Nordlund,

The Alaska Chapter of the National Association of Social Workers (NASW) supports House Bill 22, an act establishing the Alaska Children's Health Corporation and the Alaska Healthy Start Program. The NASW recognizes the urgency of providing health coverage to the 20,000 or more Alaskan children who have no access to health care.

NASW is committed to meaningful health care reform efforts that increases access for traditionally underserved populations. Also, failure to provide coverage for screening and routine health care guarantees the need to pay for more expensive, avoidable emergency procedures.

No parent should have to choose between work and affordable health care for their children. The absence of an insurance program for low income working families forces this choice. The Healthy Start Program would eliminate this family crisis. There is no better investment our state can make than assuring access to health care for our children.

Respectfully,

Theresa Tanoury LCSW

Theresa Tanoury, LCSW
Social Action Committee Chair

Health care

A top priority for the legislature

Legislators may be tempted to not do anything about health-care reform this year, what with President-elect Bill Clinton promising to unveil a plan for national reform in his first 100 days. But it would be a mistake to wait.

Even if Mr. Clinton issues his package promptly, it is likely to be tied up for months, if not years, in Congress. In the meantime, medical costs will continue to soar as more and more people will go without adequate health care.

Any state that is able to put even incremental reforms in place will be ahead of the game. Should Congress decide to support pilot projects — such a bill was introduced last session — a state with a plan would be the first in line.

"Over 76,000 Alaskans have neither insurance nor are eligible for Medicaid. They are not deadbeats; almost 90 percent of them hold jobs or are the dependents of workers whose jobs do not provide insurance coverage. Over 21,000 Alaska children are uninsured.

And Alaska has a plan — if the legislature will take it up.

The state's Health Resources and Access Task Force is issuing its final report this week, to be presented formally to Gov. Wally Hickel and the legislature during the last week in January.

But first, the problem. In Anchorage, while consumer prices for all goods and services grew 38.9 percent during the 1980s, medical costs grew by 81.5 percent. And Alaska's per-capita health-care spending was already 27 percent above the age-adjusted national average.

Yet despite all the money spent on health care, not everyone has coverage. Over 76,000 Alaskans have neither insurance nor are eligible for Medicaid. They are not deadbeats; almost 90 percent of them hold jobs or are the dependents of workers whose jobs do not provide insurance coverage. Over 21,000 Alaska children are uninsured.

People without insurance tend to delay medical care. Their health is often poorer as a result, and when they do ask for help, the care is likelier to be more intensive and more expensive.

Who pays? Hospitals and doctors swallow some of the losses. Other costs are shifted to people who do have insurance. So premiums go up. Employers ask their employees to pay a larger share of the premiums or drop coverage altogether. Then more people are without insurance, and more costs are shifted.

Unless you are a millionaire, you are one step away from a medical disaster. You could lose your job or even just change jobs, and lose your insurance. You could get sick or have an accident and see your coverage canceled or your premiums skyrocket.

Moreover, the tight link between health care and jobs is part of the problem with the economy. Businesses are burdened with high premiums, and the legendary mobility of the American work force is hampered because workers don't dare leave their jobs and strike out to be entrepreneurs.

So what's the solution?

The task force report calls for fundamental change. Its most radical recommendation is for Alaska to establish a single-payer system, similar to what Canada has, where health care would be available to all Alaskans.

But the task force knows this is going to be a tough sell. So it also has come up with a series of interim steps that can be taken immediately to hold down costs and increase access.

The task force recommends establishing a health-care authority to set a statewide health-care budget, work with providers to set mutually acceptable reimbursement rates and develop uniform billing and common claim forms.

It recommends insurance reform measures to guarantee renewability, eliminate multiple waiting periods for pre-existing conditions, restrict premium rates and require insurers to disclose rating practices.

It recommends establishing pooling arrangements for individuals and businesses to purchase health-care coverage. And it recommends state subsidies to cover high-priority populations, starting with low-income pregnant women and children.

What will this cost? The state will need a tax — a payroll tax, an income tax. But the tax is a matter of redistributing, rather than increasing, spending. Remember, we are paying now, through cost shifting, administrative waste, high premiums, delayed care.

The task force has come up with concrete recommendations for change. We will be examining these recommendations further as the legislature convenes. If you would like a copy of the task force's report, call the Health Resources and Access Task Force at 465-2933.

Editorial

FEB 27 '92 14:55

Charts - Uninsured - Insured - Poverty Levels - Health Systems Etc.

ALASKA 1986-91
TOTAL POPULATION EXCLUDING NATIVE AMERICANS/ALASKANS

TABLE OF ANYINS BY AGE2

ANYINS AGE2

Frequency / Percent / Row Pct / Col Pct	<18	18-24	25-49	50-64	65+	Total
Uninsured	21301	11330	36669	6750.9	575.8	76627
	5.17	2.75	8.89	1.64	0.14	18.59
	27.80	14.79	47.85	8.81	0.75	
	17.52	27.14	19.41	16.78	2.90	
Insured	100259	30409	152225	33483	19256	335631
	24.32	7.38	36.92	8.12	4.67	81.41
	29.87	9.06	45.35	9.98	5.74	
	82.48	72.86	80.59	83.22	97.10	
Total	121560	41738.7	188894	40233.9	19831.8	412258
	29.49	10.12	45.82	9.76	4.81	100.00

TABLE 1 OF ANYINS BY POVERTY
CONTROLLING FOR AGE2=<18

ANYINS POVERTY

Frequency / Percent / Row Pct / Col Pct	<=100% Pov	101-200%	201-300%	>300% Pov	Total
Uninsured	3877.2	4481.3	6214	6728.5	21301
	3.19	3.69	5.11	5.54	17.52
	18.20	21.04	29.17	31.59	
	31.42	21.72	28.42	10.08	
Insured	8463.3	16153	15648	59994	100259
	6.96	13.29	12.87	49.35	82.48
	8.44	16.11	15.61	59.84	
	68.58	78.28	71.58	89.92	
Total	12340.5	20634.7	21862.4	66722.4	121560
	10.15	16.97	17.98	54.89	100.00

Jim -
(under 18)
# of children 300% of poverty or below:

3877
4481
+ 6214
14,572

ESTIMATES OF ENROLLEES AND COSTS UNDER SUBSIDIZED INSURANCE PROGRAM FOR LOWER INCOME ADULTS AND CHILDREN NOT ELIGIBLE FOR MEDICAID OR IHS COVERAGE

Income		Number of Eligible Uninsureds
Under Poverty		
	Adults	9,290
	Children	426
	Total	9,716
100–200% Poverty		
	Adults	11,935
	Children	3,631
	Total	15,566
200–250% Poverty		
	Adults	5,857
	Children	3,469
	Total	9,326
All Incomes	Adults	27,082
	Children	7,526
TOTAL		34,608

SOURCE: Health Systems Research, Inc.

Blue Cross
of Washington and Alaska

P. O. Box 327
Seattle, Washington 98111-0327

March 25, 1993

The Honorable Jim Nordlund
Alaska State Representative
Alaska State Capitol
Juneau, Alaska 99801-1182

Subject: HB 22 - Healthy Start Program
Alaska Children's Health Corporation

Dear Representative Nordlund:

In our fax to you March 9, 1993 we listed the 1994 annual expected claims costs for each of the covered services itemized in the above referenced bill. With the exception of vision hardware, the services were reimbursable at 100% of allowed charges. Allowed charges are those determined reasonable and customary by the insurer.

The targeted premium looked at was $900 or less per year. This target amount was to cover not only the claims costs but also the administrative costs to pay the claims.

Each covered service was detailed so one could determine which services were the most expensive and also which could be viewed as elective and less emergent in nature. It should be emphasized these costs represent expected claim payments only; expenses for claims processing and customer service would need to be added to these costs and then compared to the target. Lower premiums could be achieved by placing co-pays, coinsurances and annual maximums on these services.

It is our belief this program will, in the long run, help lower overall health care costs in the State of Alaska provided residents purchase the coverage for their children. It accomplishes this by covering preventive type services where the obvious benefit is early detection of serious medical conditions and the resulting corrective treatments. Undetected these conditions could result in higher medical treatment costs down the line. From this position Blue Cross of Washington and Alaska supports your legislation on children's health.

Sincerely,

John Gabriel /H

John Gabriel
Assistant Actuary

Blue Cross - 1994 annual expected claims costs

AK93KIDS.XLS

3/7/93 12:08 PM

HB 22 EXPECTED CLAIMS COSTS FOR 1994

COVERAGE FOR CHILDREN UNDER AGE 19

PHYSICIAN SERVICES, Rx, & VISION		EXPECTED ANNUAL CLAIM COST PER CHILD
PHYSICIAN OFFICE - DIAGNOSTIC SCREENING & MISCELLANEOUS SERVIC		$299.08
PHYSICIAN O-P ER VISITS		$32.16
RADIOLOGY (PROF &TECH IN OFFICE ONLY)		$19.26
PATHOLOGY (PROF & TECH IN OFFICE ONLY)		$20.72
PHYSICIAN O-P SURGERY		$65.17
PRESCRIPTION DRUGS - O-P PHARMACY		$68.35
VISION HARDWARE (LENSES/ FRAMES)		$17.41
PREVENTIVE SERVICES:		
WELL BABY		$27.48
HEARING EXAM		$3.45
PHYSICAL EXAMS		$13.09
VISION EXAMS		$12.54
SPEECH EXAMS		$0.18
IMMUNIZATIONS		$27.63
DENTAL		$366.02
	TOTAL	$972.54
ADULT FEMALE *		
PHYSICIAN PRENATAL VISITS ONLY		$723.79
PHYSICIAN DELIVERY (INCLUDES PRE & POST NATAL VISITS)		$3,424.51

* only pregnant women or women expecting maternity care will purchase this benefit.

* Per page 4, HB 22, LINE 24 & 25 . Premium portion to be detemined by the board.

BC WA&AK ID:206-670-4900 MAR 09'93 0:30 No.001 P.02

PHYSICIAN SERVICES, Rx & VISION SUPPLIES

	DESCRIPTION:
PHYSICIAN O-P ER VISITS	VISITS TO EMERGENCY AREA IN O-P HOSP BY PRIMARY PHYSICIAN OR HOSP STAFF PHYSICIAN (CPT4: 90500-90590,99062-99065)
RADIOLOGY (PROF &TECH IN OFFICE ONLY)	PROFESSIONAL & TECHNICAL COMPONENT OF RADIOLOGY SERVICES BILLED TOGETHER WHEN X-RAY PERFORMED IN CLINIC OR OFFICE SETTING (CPT4: 70010-79999)
PATHOLOGY (PROF & TEC H IN OFFICE ONLY)	PROFESSIONAL & TECHNICAL COMPONENT OF PATHOLOGY SERVICES WHEN BILLED TOGETHER & PERFORMED IN CLINIC OR OFFICE SETTING (CPT4 : 80002-89399)
PHYSICIAN 'O-P SURGERY	PHYSICIAN SURGERY IN O-P HOSP ,OR FREE STANDING SURG FACILITY, OFFICE '& ANESTHESIA. INCLUDES PRE & POST SURGICAL ENCOUNTERS W/ 'SURGEON '(CPT4: 10000-58999,59525,60000-69979,00100-01999) EXCLUDES [00842,,00855,'00946,99100-99140 OR OTHER OB PROCE-DURES] OR 10000-58999,60000-69979 'WITH ANESTHESIA MODIFIER)
PRESCRIPTION DRUGS - O-P PHARMACY	INCLUDES DISPENSING FEE. DRUGS ORDER BY ATTENDING PHYSICIAN
VISION HARDWARE (LENSES/ FRAMES)	LENSES & CONTACTS BUT NOT BOTH ,1 /YEAR @ $200 MAX. FRAMES . @ $75 '(CPT4: 92390-92396)
PHYSICIAN OFFICE - DIAGNOSTIC SCREENING & MISCELLANEOUS SERVICES	PHYSICAN OFFICE & HOME VISITS, INCLUDES THERAPEUTIC INJECTIONS, ALLERGY TESTING & ALLERGY IMMUNOTHERAPY, DIAGNOSTIC TESTING , &OTHER MISC PROF SERVICES AS (BIOFEEDBACK,PULMONARY, NEUR-OLOGY,,'CHEMOTHERAPY,DERMATOLOGY,NON-INVASIVE VASCULAR DIAGNOSTIC STUDIES.'VESTIBULAR FUNCTION TESTS, GASTRO--ENTEROLOGY & OTORHINGOLOGY SERVICES. INCLUDED BECAUSE THEY ARE RELATED TO DIAGNOSTIC TESTING. (CPT4: 90000-90080,90699,90900-98922,99000-99058,99070,90100-90400-90470,'90780-90790170,99,95000-95105,95115-95199,90900-90915,'95805-95999,'96400-96594010-94799,49,96900-96999,93850-93960,92531-92547,91000-91299, 92502-92504,92511-92520

WELL BABY	NORMAL PERIODIC EXAMS OF WELL KIDS UNDER AGE 2 (CPT4 90753-90757,90763-90764,90778)
HEARING EXAM	HEARING EXAMS (CPT4 92506-92508,92551-92599)
PHYSICAL EXAMS	ROUTINE EXAMS FOR CHILDREN OVER 2 YRS . INCLUDES ASSOCIATED X-RAYS & LAB (CPT4 90750-90753,90760-90763,90774)
VISION EXAMS	1 EYE EXAM /YEAR FOR OPTHTHALMOLOGIST OR OPTOMETRIST (CPT4 92002,92371,92499)
SPEECH EXAMS	SPEECH EXAMS (CPT4 92506-92508)
IMMUNIZATIONS	PROF SVCS & MATERIALS WITH ADMIN IMMUIZATIONS (CPT4: 90701-90749)

2/26/93 4:19 PM AK93KIDS

ALASKA CHILDREN PROGRAM:

PER 2-19-93 MEMO FROM :

M&R HGC ADJUSTED TO ALASKA

SERVICES	MONTHLY CLAIM COST	ALASKA ADJUSTMENT	PER CHILD ANNUAL CLAIM COST
WELL BABY	$1.26	$1.59	$19.06
HEARING EXAM	$0.21	$0.22	$2.65
PHYSICAL EXAMS	$1.42	$1.49	$17.89
VISION EXAMS	$0.74	$0.78	$9.32
SPEECH EXAMS	$0.02	$0.02	$0.25
IMMUNIZATIONS	$1.53	$1.61	$19.28
TOTAL	$5.18	$5.70	$68.44
	SELECTION LOAD		$10.27
	CALENDAR YEAR 1994:		$78.71

(NO ADMINISTRATIVE COSTS FIGURED IN HERE)

	DESCRIPTION OF SERVICES
WELL BABY	NORMAL PERIODIC EXAMS OF WELL KIDS UNDER AGE 2 (CPT4 90753-90757,90763-90764,90778)
HEARING EXAM	HEARING EXAMS (CPT4 92506-92508,92551-92599)
PHYSICAL EXAMS	ROUTINE EXAMS FOR CHILDREN AGE 2 & OVEWR. INCLUDES ASSOCIATED X-RAYS & LAB (CPT4 90750-90753,90760-90763,90774)
VISION EXAMS	1 EYE EXAM /YEAR FOR OPTHTHALMOLOGIST OR OPTOMETRIST (CPT4 92002-92371,92499)
SPEECH EXAMS	SPEECH EXAMS (CPT4 92506-92508)
IMMUNIZATIONS	PROF SVCS & MATERIALS WITH ADMIN IMMUIZATIONS (CPT4 90701-90749)

03/30/93 16:07 001

Aetna Health Plans
Suite 1600 Century Square
1501 Fourth Avenue
Seattle, WA 98101
Mail: P.O. Box 91032 (98111-9132)

Steven M. LeBrun
Account Manager
(206) 467-2803
Fax: (206) 467-2087

March 29, 1993

The Honorable Jim Nordlund
Alaska State Legislature
State Capitol
Juneau, Alaska 99811

Dear Representative Nordland:

Attached is an exhibit outlining expected 1st year (1994) claim cost for coverage made available under the terms of HB22. I have itemized several levels of coverage, beginning with a program of strictly preventive care, and expanded to separate claim estimates for vision, dental and basic medical coverage.

The attached estimates are based on typical charges for services in the Anchorage area. The exhibit includes both a broad description of benefits as well as any payment limits, restrictions, or cost-sharing features that might apply.

Included in the claim cost is a add-on to reflect the possibilities of "adverse selection." This term relates to the design of an insurance program and the extent to which individuals are able to elect the plan only because they have known or expected medical costs. To use vision care as an example, if only those persons with vision problems were allowed to elect coverage, then the true insurance nature of the coverage and the spreading of risk would be compromised. Since this program is entirely voluntary one can expect a higher per participant claim cost than would otherwise be found under a typical employer insurance program, which includes safeguards to minimize adverse selection.

While not included in the exhibit, I did research typical claim costs for maternity and prenatal care. This data is based on a special survey of Alaska physicians performed January 1993
• prenatal care--$600
• delivery-only fees--vaginal $1950; C-section $2,400
• global charge (includes delivery and pre/post natal care--vaginal $2,550; C-section $3100
Timpact of adverse selection would be most severe for this coverage since only expectant mothers would choose the coverage, thereby essentially negating the insurance aspect of the benefit.

The claim cost estimates do not include cost of insurance administration. There are many variable that would need to be better defined before an estimate could be made. These include the specific plan design offered, the service to be provided, the degree of involvement of the Corporation in assuming administrative functions, the projected number of enrollees. However, it should be noted that as a percentage of claim payments, administration costs will be much higher than under a typical insurance plan, in part due to the fixed cost of processing claims of relatively small dollar value. In fact if a minimal benefit program is offered, it is entirely likely that costs of administration will exceed claim costs.

I hope this information is useful; please contact me if I can provide any further assistance.

Regards,

Steve LeBrun

HB 22--Alaska Children's Program
Plan Claim Costs

Assumptions:

- coverage available to children under age 19
- 12 month residency
- not otherwise covered under other public/private insurance plan
- no pre-existing limitations/exclusions
- open rules of entry into and exit from plan

Benefits/Claim Cost Estimates for 1994 (per child/per month)

Preventive/wellness routine care--$4.30

coverage includes immunizations and well baby/routine physical exams

benefits provided for physician office charges as well as disgnostic lab work ordered at time of visit

six visits covered in 1st year of life, two in second year, once per year thereafter

benefit paid at 100% of reasonable and customary (R&C) charge, no deductible

Vision exams--$1.60

one exam covered every 24 months

paid at 100% R&C, no deductible

Vision Eyewear--$2.00

one purchase every 24 months if required due to change in prescription

frames paid at 100% R&C up to $50 maximum payment; lenses at 100% R&C

Dental Coverage--$20.00

covers preventive and basic services

includes exams, x-rays, cleanings, flouride, fillings, extractions, periodontal and endodontic treatment; orthodontia not covered

benefits paid at 80% of R&C, no deductible, up to $1,000 per calendar year

Ambulatory Medical Coverage--$54.00

covers the following services:

- outpatient physician charges--office visits and surgery
- diagnostic lab and x-ray expanses
- medically necessary physical and speech therapy
- drugs that require a prescription (excludes contraceptives and over-the-counter medications)
- rental or purchase of durable medical supplies
- hospital emergency room expenses

The following expenses are excluded:

inpatient hospital expenses, inpatient surgical expenses, inpatient/outpatient psychiatric and substance abuse treatment expenses, ambulance charges, home health care, private duty nursing

benefits paid at 80% after a $100 calendar year deductible;
$1,000 calendar year out-of-pocket limit

8-LS0198\E
Lauterbach
3/15/93

CS FOR HOUSE BILL NO. 22( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES NORDLUND, Brown, B.Davis, Ulmer, Sitton, Finkelstein, Brice

A BILL

FOR AN ACT ENTITLED

1 "An Act establishing the Alaska Children's Health Corporation and the Alaska
2 Healthy Start Program; relating to insurance; and providing for an effective
3 date."

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

5 * Section 1. AS 21 is amended by adding a new chapter to read:
6 CHAPTER 56. HEALTHY START PROGRAM.
7 ARTICLE 1. ALASKA CHILDREN'S HEALTH CORPORATION.
8 Sec. 21.56.010. CREATION OF CORPORATION. The Alaska Children's
9 Health Corporation is created as a public corporation. The corporation is an
10 instrumentality of the state within the Department of Administration, but it has a legal
11 existence independent of and separate from the state.
12 Sec. 21.56.020. PURPOSE OF THE CORPORATION. (a) The corporation's
13 purpose is to
14 (1) administer the Alaska children's health care plan as described in

1 this chapter;

2 (2) purchase health insurance coverage for children and pregnant
3 women who are eligible for the plan under AS 21.56.110; and

4 (3) manage the Alaska children's health fund created under
5 AS 21.56.200.

6 (b) The corporation is not considered an insurer. The directors and employees
7 of the corporation are not considered to be agents of an insurer. Neither the
8 corporation nor a director or employee of the corporation is subject to the licensing
9 requirements of this title. However, the division of insurance may require that a
10 marketing representative used and compensated by the corporation be appointed as a
11 representative of the insurers with which the corporation contracts.

12 Sec. 21.56.030. BOARD OF DIRECTORS. (a) The corporation is governed
13 by a board of directors consisting of the commissioner of administration, the
14 commissioner of health and social services, and five other members appointed by the
15 governor. The five appointed members must include persons who are experienced in
16 providing health care, managing large funds, providing health insurance, and promoting
17 child welfare. At least one member must be a person who resides in a rural area of
18 the state or is familiar with health care delivery in rural areas of the state.

19 (b) Board members shall serve staggered terms of four years.

20 (c) The board members shall select from among themselves a chair and a vice-
21 chair.

22 (d) Members of the board receive no compensation for their services but are
23 entitled to per diem and travel allowances authorized by law for other boards and
24 commissions under AS 39.20.180.

25 (e) The board shall meet at least twice a year at times and locations
26 determined by the chair. Four members of the board constitute a quorum.

27 (f) The board may hire an executive director to assist it in carrying out its
28 duties. The executive director may hire other necessary staff. The executive director
29 and other employees of the board serve at the pleasure of the board and are in the
30 exempt service under AS 39.25.110.

31 ARTICLE 2. ALASKA CHILDREN'S HEALTH CARE PLAN.

1 Sec. 21.56.100. CONTENTS OF PLAN. (a) The Alaska children's health
2 care plan consists of the following medical services for children who are eligible under
3 AS 21.56.110:
4 (1) routine examinations;
5 (2) diagnostic and screening services;
6 (3) immunizations and preventive services;
7 (4) laboratory and x-ray services;
8 (5) outpatient physician services;
9 (6) outpatient surgery;
10 (7) emergency room services;
11 (8) prescription lenses, eyeglass frames, and vision care;
12 (9) prescription drugs; and
13 (10) other services, as approved by the board under (b) of this section.
14 (b) The board may, by regulations adopted under AS 44.62 (Administrative
15 Procedure Act), determine the scope of the services listed in (a) of this section and add
16 other categories of services for children that will be covered under the plan. A new
17 category of service is not covered under the plan until an insurer agrees to cover it.
18 (c) The plan also includes prenatal services and at least three months of
19 postnatal services for pregnant women. The board may, by regulations adopted under
20 AS 44.62 (Administrative Procedure Act), determine the scope of services covered
21 under this subsection, including the duration of postnatal services beyond the minimum
22 set under this subsection. The board may also add delivery services for pregnant
23 women to the plan.
24 (d) In addition to the premium required under AS 21.56.140, the board may
25 require a copayment for a service, establish deductibles, set duration and usage limits,
26 develop and implement procedures related to utilization review, and establish other
27 reasonable conditions relating to the provision of services under (a) - (c) of this section
28 to limit the cost of the plan's operation and to ensure the efficiency and efficacy of the
29 services provided under the plan.
30 (e) When determining the scope of services or adding services under (b) of this
31 section or establishing conditions relating to the provision of services under (d) of this

1 section, the board shall give priority to the provision of preventive services with the
2 fewest conditions practicable.
3 Sec. 21.56.110. ELIGIBILITY FOR THE PLAN. (a) A child is eligible for
4 coverage under AS 21.56.100(a) and (b) if
5 (1) the child is under the age of 19 and has been a resident of the state
6 for the 12 months immediately preceding application for plan coverage or, if the child
7 is less than one year old, at least one of the child's parents has been a resident of the
8 state for the 12 months immediately preceding application for plan coverage;
9 (2) the child does not have health care coverage under another public
10 or private health insurance plan;
11 (3) the child is not eligible for medical coverage under AS 47.07
12 (Medicaid); and
13 (4) the premium for plan coverage is paid on behalf of the child, as
14 determined by the board under AS 21.56.140.
15 (b) A pregnant woman is eligible for coverage under AS 21.56.100(c) if
16 (1) the woman has been a resident of the state for the 12 months
17 immediately preceding the woman's application for plan coverage;
18 (2) the woman does not have coverage for similar services under
19 another public or private health insurance plan;
20 (3) the woman is not eligible for medical coverage under AS 47.07
21 (Medicaid); and
22 (4) the premium for plan coverage is paid on behalf of the woman, as
23 determined by the board under AS 21.56.140.
24 Sec. 21.56.120. APPLICATION PROCESS. (a) A pregnant woman or the
25 parent or guardian of a child may request an application packet for plan coverage by
26 notifying the board directly or by completing the relevant section of the woman's or
27 child's permanent fund dividend application form as provided under AS 43.23.017.
28 (b) Upon direct notification by an interested person or upon notification from
29 the Department of Revenue of the name and mailing address of a person who has
30 requested an application packet for the plan under (a) of this section, the board shall
31 send an application packet to the person requesting it.

1 (c) An application packet sent under (b) of this section must include
2 (1) a description of the health care coverage available under the plan;
3 (2) a copy of the schedule used by the board to determine the premium
4 responsibility and a description of deductibles and copayment requirements the board
5 has established under AS 21.56.100(d);
6 (3) an explanation of the eligibility requirements for the plan;
7 (4) a form to be returned to the board requesting whether the applicant
8 wishes to pay the plan premium by deduction from the person's permanent fund
9 dividend if the person is found to be eligible for the plan; and
10 (5) an application form to be returned to the board if the person wants
11 to apply for coverage personally or on behalf of an eligible child.
12 (d) Within 30 days after receiving a completed application for plan coverage,
13 the board shall either notify the applicant about whether the plan coverage is approved
14 or request additional information necessary to determine the eligibility. If the board
15 determines that a pregnant woman or a child is eligible for the plan, the notification
16 of eligibility sent under this subsection must include a determination of amount of the
17 premium required under AS 21.56.140.
18 (e) Plan coverage begins on the day the required premium is received by the
19 board except that for a person who indicated with the application form that the
20 premium could be paid by reduction of a permanent fund dividend, plan coverage
21 begins on the date plan coverage is approved for the person. If the board subsequently
22 determines that the person's permanent fund dividend is unavailable or insufficient to
23 cover the plan's premium, the board shall suspend the person's coverage until
24 additional payment is received.
25 (f) The board's denial or withdrawal of plan coverage may be appealed to the
26 superior court.
27 Sec. 21.56.130. ADMINISTRATION OF PLAN. (a) The board shall
28 administer the Alaska children's health care plan by
29 (1) soliciting and accepting funds from private sources for use under
30 AS 21.56.140(d); the board may also accept donations of services, supplies, personnel,
31 and other in-kind donations;

1 (2) soliciting and evaluating bids and purchasing insurance from one
2 or more insurers to provide plan coverage;
3 (3) marketing the plan in a manner designed to make its existence
4 known to pregnant women and the parents and guardians of children who may be
5 eligible for the plan;
6 (4) evaluating applications for plan coverage and determining eligibility
7 for plan coverage;
8 (5) determining the premium that is required under AS 21.56.140.
9 (b) The board shall adopt regulations under AS 44.62 (Administrative
10 Procedure Act) to implement this chapter.
11 Sec. 21.56.140. PREMIUMS. (a) The board shall adopt a schedule of
12 premiums that includes a premium for a child's coverage, a premium for a woman's
13 coverage that includes delivery services if the board chooses under AS 21.56.100(c)
14 to offer that coverage, and a premium for a woman's coverage that does not include
15 delivery services.
16 (b) The board, in cooperation with the Department of Revenue, shall adopt
17 regulations under which a pregnant woman or a parent or guardian may request that
18 a permanent fund dividend to which the woma[illegible] [illegible]il[illegible] [illegible]ntitled be reduced by the
19 Department of Revenue to provide the premium [illegible]a[illegible] [illegible]or the woman's or child's
20 plan coverage.
21 (c) The board shall deposit premiums received under this section into the
22 general fund. The department of administration shall separately account for premiums
23 deposited into the general account by the board. The estimated annual balance in the
24 account may be used by the legislature to make appropriations to the fund established
25 under AS 21.56.200.
26 (d) To the extent that the board receives private funds under
27 AS 21.56.130(a)(1) or an appropriation made specifically for the purposes of this
28 subsection, the board shall reduce the premium levels determined under (a) of this
29 section for pregnant women and children whose household incomes are below 300
30 percent of the income level established under AS 47.25.310 - 47.25.420 for eligibility
31 for aid to families with dependent children.

1 Sec. 21.56.150. CONFIDENTIALITY OF RECORDS. (a) Information
2 received by the board in an application for plan coverage is confidential and is not
3 subject to public inspection and copying under AS 09.25.110 - 09.25.120.
4 (b) A board member or employee of the corporation who divulges information
5 in violation of (a) of this section is guilty of a class B misdemeanor.
6 ARTICLE 3. ALASKA CHILDREN'S HEALTH FUND.
7 Sec. 21.56.200. CREATION OF FUND. The Alaska children's health fund
8 is created in the corporation. It consists of money donated to the corporation from
9 private sources and appropriations made to the fund.
10 Sec. 21.56.210. USE OF THE FUND. The board may use money in the fund
11 (1) to pay insurance premiums for the Alaska children's health care
12 plan; and
13 (2) for the board's expenses incurred in administration of the plan and
14 the fund.
15 ARTICLE 4. GENERAL PROVISIONS.
16 Sec. 21.56.290. DEFINITIONS. In this chapter,
17 (1) "board" means the board of directors of the Alaska Children's
18 Health Corporation established under AS 21.56.010;
19 (2) "corporation" means the Alaska Children's Health Corporation
20 established under AS 21.56.010;
21 (3) "fund" means the Alaska children's health fund established under
22 AS 21.56.200;
23 (4) "plan" means the Alaska children's health care plan described under
24 AS 21.56.100.
25 Sec. 21.56.299. SHORT TITLE. This chapter may be cited as the Healthy
26 Start Program.
27 * Sec. 2. AS 39.25.110 is amended by adding a new paragraph to read:
28 (30) the executive director and other employees of the Alaska
29 Children's Health Corporation (AS 21.56).
30 * Sec. 3. AS 39.30 is amended by adding a new section to read:
31 Sec. 39.30.092. BIDDER REQUIREMENT. An insurer may not submit a bid

1 under AS 39.30.090 for a type of medical care coverage that is included in the Alaska
2 children's health care plan under AS 21.56 unless the insurer also submits a bid to the
3 Alaska Children's Health Corporation to cover that type of medical care under
4 AS 21.56.
5 * Sec. 4. AS 43.23 is amended by adding a new section to read:
6 Sec. 43.23.017. ALASKA CHILDREN'S HEALTH PLAN. (a) The
7 department shall include on the permanent fund dividend application form a question
8 requesting whether the applicant wishes to apply for coverage of a child or pregnant
9 woman under the Alaska children's health care plan established under AS 21.56.
10 (b) Within 30 days after receiving an application form that indicates interest
11 in the Alaska children's health plan, the department shall notify the Alaska Children's
12 Health Corporation of the names and mailing addresses of persons who have indicated
13 on a permanent fund dividend form that they would like to apply for coverage under
14 the Alaska children's health care plan.
15 (c) The department, in cooperation with the Alaska Children's Health
16 Corporation, shall adopt regulations governing how it will honor a request that a
17 permanent fund dividend be reduced by the department to provide the premium
18 payment for coverage under the Alaska children's health care plan.
19 * Sec. 5. TRANSITIONAL PROVISION. Notwithstanding AS 21.56.030(b), enacted by
20 sec. 1 of this Act, the governor shall set the terms of the first five appointed members of the
21 board of directors of the Alaska Children's Health Corporation so that one of the appointed
22 members serves a two-year term, two members serve three-year terms, and two members serve
23 four-year terms.
24 * Sec. 6. AS 21.56.010 - 21.56.030, 21.56.130(a)(1), and 21.56.200 - 21.56.299, enacted
25 by sec. 1 of this Act, and secs. 2 and 5 of this Act take effect immediately under
26 AS 01.10.070(c).
27 * Sec. 7. Except as provided in sec. 6 of this Act, this Act takes effect July 1, 1994.

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The Role of Private Health Insurance in Children's Health Care

John F. Sheils
Patrice R. Wolfe

Abstract

Private health insurance is the primary means of financing health care for America's children and pregnant women. Most coverage is provided under employer plans. Access to private health care coverage, however, is threatened by the increasing cost of health care, cost shifting by providers, and insurance marketing practices that tend to deny coverage to high-risk individuals. These pressures have already led to an increase in the number of uninsured children and pregnant women.

This paper provides an overview of the private health insurance market with a focus on recent trends. The effects of self-funding arrangements by employers and of various cost control arrangements—including managed care plans, patient cost-sharing provisions, and employee premium contributions—are examined for their potential impact on children and pregnant women. Policies that might expand health insurance coverage for children, including a universal health insurance plan, and health insurance market reforms, are explored. Alternative strategies for enhancing universal health insurance coverage for children include mandatory employer-based insurance programs, a program of tax credits to underwrite individual insurance plans, and a single-payer government program financed through the tax system. The authors conclude that efforts should be made to preserve the current private health insurance system by reducing cost shifting from public programs, guaranteeing the availability of coverage to all groups, and controlling costs by means of competition, managed care, and perhaps global spending limits. Such comprehensive reforms might be necessary merely to preserve private insurance coverage for a majority of America's children and pregnant women.

John F. Sheils, M.P.P., is vice president of Lewin-ICF, a research and consulting firm which specializes in health and environmental matters.

Patrice R. Wolfe, M.P.P.M., is manager in the SysteMetrics division of MEDSTAT Systems, Inc. At the time this paper was written, she was senior associate at Lewin-ICF.

Private insurance is the primary source of funding for health care for children and pregnant women in the United States. The March 1990 Current Population Survey (CPS) reports that about 63% of all children are covered as dependents under employer health insurance plans and another 10% are covered under individually purchased non-group insurance. About 60% of pregnant women are covered under employer plans, either as employees or as dependent spouses, and about 6% have non-group coverage.[1]

The extent of private insurance coverage for children declined during the 1980s largely because of an increase in health care costs, a

The Role of Private Health Insurance in Children's Health Care

The purpose of health insurance is to minimize the risk of financial catastrophe that often results from unexpectedly large losses or expenditures by pooling the experiences of a large number of people. In general, large employer groups can predict with reasonable accuracy what their health care expenses will be during a particular year. Although it may be difficult to predict precisely how many people will incur large expenses and how much each person's illness will cost, a group can spread the resulting expenses among a large number of people, thereby creating an average expense that varies far less than an individual's expense. This concept, known as risk pooling, allows a large employer to estimate fairly accurately the cost of offering health care insurance to its employees.[5] Similarly, insurance companies pool the risk of numerous small groups and individuals to predict their overall expenses.

Fully Insured Arrangements

Traditional private health insurance is based on a contractual arrangement between a purchaser (either an employer or an individual) and an insurer where the purchaser agrees to pay the insurer a predetermined amount (the premium) per covered member per time period (typically a month) in return for full assurance that all approved expenditures will be paid by the insurer.[6] In other words, the purchaser is not at risk if expenses exceed the total premium amount. In 1989, American employers and employees spent $36.9 billion on fully insured group health insurance premiums.[7]

Under plans of this type, the insurer is fully responsible for all covered health care expenditures. The insurer's goal, therefore, is to set premiums so that they cover the expected claims payout for the covered population plus a margin for profit, overhead expenses, and reserves to cover unexpectedly large claims.

Self-funding Arrangements

Although insurance companies traditionally performed the risk pooling function for employers and individuals, employers have in recent years increasingly pursued self-funding as an alternative method for financing their health care plans. The percent of medium and large employers who self-funded grew from 19% in 1979 to 66% in 1988.[8] In self-funded plans, the employer assumes all risk for health expendi-

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tures and contracts with a third-party administrator or insurer to handle claims processing and other administrative functions related to the plan.

Self-funding has many advantages for the employer. First, the Employee Retirement Income Security Act (ERISA) of 1974 preempts states from regulating self-insured plans. Thus, employers who opt for self-funded plans can avoid paying for those state-mandated benefits that they do not want to cover. Second, employers can avoid insurance premium taxes. Third, for an employer that perceives its employees to be healthier, on average, than other comparable employers, self-funding provides the opportunity to pay for health care based on the group's own experience, rather than paying an insurance premium that reflects the experience of a larger and sicker employer community. The primary drawback to self-funding is the increased risk of large losses as a result of unexpectedly high medical claims.

Employers can reduce their exposure to this hazard by purchasing insurance specifically to cover extraordinarily large expenditures. For example, in a minimum premium plan, the purchaser assumes full responsibility for health care expenditures up to a certain threshold. Beyond that threshold, an insurance company takes over or shares in the payment of all additional claims. Minimum premium plans are often good options for employers that find it economical to self-fund but do not have the financial resources to pay for unexpected high-dollar cases such as low birth weight infants with multiple complications.

ganizations and even with traditional indemnity insurance plans. Under case management, a case manager coordinates health care from a variety of providers for individuals with complex and lengthy or chronic illnesses. Case management can be used to facilitate cost-effective care which integrates health care with the total needs (developmental, educational, and environmental) of a child or a pregnant woman. It can facilitate home placement and reduce overall costs. As advocates for an insurer, however, case managers can also be used to deter utilization of expensive services.

The effectiveness of managed care programs in reducing costs varies with the type of managed care plan. A Rand Corporation study of prepaid health plans indicates that expenditures in an HMO can be as much as 25% lower than in conventional health plans.[9] The more loosely arranged plans such as PPOs show little, if any, overall savings because of their organizational structure. An A. Foster Higgins survey indicates that some utilization review programs save up to 4% on total medical plan costs.[10] Some studies of selected programs indicate that every dollar spent on utilization management results in a reduction in claims of $4 to $9; however, other studies indicate that these programs are barely cost-effective.[11]

While empirical evidence is limited, it is widely believed that managed care is most effective in modifying medical practice when network providers serve exclusively those covered under the plan (as happens in the HMO staff model) and when patients obtain their care exclusively through the network. There is some expectation that the potential for cost savings under managed care will grow as medical effectiveness and outcomes research are further developed to yield cost-effective practice guidelines which can be disseminated through managed care networks.

Cost Sharing Arrangements

Insurance products also vary greatly in how they require employees and their families to share health care costs with the employer. Employee cost sharing takes many forms, including premium contributions, deductibles, and coinsurance. While employee cost sharing traditionally has not been a central feature in most employer-financed insurance plans (especially those that are union-negotiated), it is becoming more popular, in part because of increasing pressure to control health expenditures.

About 45% of employees contribute to the cost of their health insurance premiums.[12] For health insurance plans that require a premium contribution, employees typically pay, on a pretax basis, a percentage of the monthly premium amount. The average employee contribution is 21% of the monthly premium.[13] Under some plans the contribution rate varies by type of policy and may be less for an individual than for a family. Premium contributions are more common for HMOs, in which 54% of enrollees pay a contribution, than they are for non-HMO plans, in which 41% of enrollees pay a contribution.[14]

Deductibles are common features in non-HMO insurance plans, but vary enormously in how they are structured. In 97% of fully insured plans, the insured individual must satisfy an aggregate annual deductible amount for medical expenses. Common deductibles for individual coverage are $100 and $200; for family coverage typical deductibles are $300 or $400 per family per year.[15] Once the insured person or family has incurred and paid for health care expenses equal to the deductible amount, the insurer assumes responsibility for the majority of health expenditures.

Case management can be used to facilitate cost-effective care which integrates health care with the total needs (developmental, educational, and environmental) of a child or a pregnant woman.

Some managed care plans attempt to use the deductible to direct covered individuals to hospitals and physicians with whom the managed care plan has a financial arrangement. For example, many PPOs, EPOs, and point-of-service plans have two sets of deductible rates, one for in-network providers with whom the plan has a contractual agreement and one for out-of-network providers. Typically, these plans use out-of-network deductibles that are much higher than the in-network deductibles in an effort to persuade beneficiaries to use providers who are part of the network.

Table 1. Percentage of Health Insurance Plans Covering Well-child Care and Preventive Diagnostic Services in 1989

Services	Traditional Indemnity Plans	Preferred Provider Organizations	IPA Model Health Maintenance Organizations	Staff Model Health Maintenance Organizations
Well-child care	50	62	98	99
Preventive diagnostics	67	71	94	100

Source: Health Insurance Association of America. *Source Book of Health Insurance Data. 1990.* Washington, DC: HIAA, 1990, p. 33.

factors influence the cost of a private health insurance plan, including the comprehensiveness of the benefits package and the degree to which cost containment programs are used. From the insurer's perspective, a major factor influencing the cost of insurance is the "riskiness" of the group or individual to be covered. Many insurers attempt to exclude high-cost groups and individuals from coverage or design policies to protect the insurer from the consequences of high-cost illness.

Preexisting condition limitations are frequently used to protect the insurer from high-cost illnesses by excluding from coverage for a specified period (often 6 to 12 months) medical care required to treat a condition that was diagnosed and/or treated prior to the commencement of coverage. By covering only new conditions, the insurer can reduce costs and offer a lower premium. These limitations have serious implications for pregnant women and infants. Because pregnancy is typically considered to be a preexisting condition, women who become insured after they have become pregnant or during a waiting period before their insurance becomes effective may find it difficult to obtain reimbursement for the costs of the pregnancy.

Trends in Private Insurance Coverage for Children

Although private health insurance remains the primary source of health insurance for children and pregnant women in the United States, the percentage of children with private coverage declined throughout the 1980s. The erosion in coverage can be traced to the rising cost of health insurance and the growth in insurer risk selection practices that severely restrict the availability of insurance to persons with a history of medical conditions. Moreover, the rising cost of health care has caused many employers to reduce the range of benefits provided and to require additional employee cost sharing in the form of increased deductibles and premium contributions. These trends in private insurance coverage are discussed below.

Trends in Coverage

The March 1990 Current Population Survey (CPS) data indicate that about 74% of all children have private insurance coverage. Nearly two thirds of all children (63%) are covered as dependents under a working parent's employer health plan (table 2). Another 11% of all children are covered under individually purchased non-group insurance plans. In addition, about 27% of all pregnant women are covered as employees under an employer health plan. About 33% are covered as dependents under their spouses' employer health plans, and another 6% are covered under individually purchased non-group insurance plans. Overall, about 60% of pregnant women have employer-sponsored coverage.

The percentage of children with employer health insurance declined from 66% in 1980 to 62% in 1986; however, the percentage with employer insurance increased to 63% by 1990. Although there are differences in the way insurance coverage is measured across surveys, these trends are generally consistent with other survey data.[18] For example, in this journal issue Monheit and Cunningham report that the percentage of children with private health insurance coverage throughout the year declined from 71% in 1977 to 63% in 1987.

The decline in the percentage of children covered under employer plans

shifting may be causing increases in uncompensated and undercompensated care by further reducing the affordability of private insurance.

In response to rising health care costs, many employers have attempted to control spending through a variety of managed care strategies. Industry data show that HMO enrollment has grown steadily during the past decade.[20] In 1988, about 19% of persons insured by benefit plans of firms with 100 or more employees were enrolled in HMOs and approximately 7% were enrolled in selective contracting plans (PPOs and EPOs).[21] In addition, 91% of employer plans surveyed by A. Foster Higgins have some form of utilization review program.[22] For example, 73% of insurers require precertification for selective hospital admissions, and about half require concurrent review of hospital admissions. Despite these efforts to contain costs, however, many employers have found it necessary to reassess the level of coverage provided.

Covered Services

The traditional role of private insurance was to cover costs associated with acute illnesses, not costs associated with services designed to prevent illness. Rapidly rising health care costs have led many employers to broaden that focus. Pregnant women have been a popular target of managed care programs because expenses related to childbirth are the largest single component of a typical employee group's health care costs and may range from 10% to 49% of total expenditures.[23] Employers and insurers now offer services that were rarely covered under traditional insurance plans, including free obstetrical visits, behavior modification classes for smoking cessation and weight loss, preconception health risk appraisals, and extensive prenatal and postpartum educational materials and classes.[24] One employer estimates that its pregnancy health benefits management program saved almost $500,000 in its first year by reducing the frequency of low birth weight babies.[23]

Young children are also a popular target for specialized programs such as case management. For example, a midwestern HMO is implementing a case management program designed to help children with chronic asthma. The program was designed in response to the fact that asthma was the number one reason for school absenteeism in the area and a

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major source of HMO expenditures. In concert with the school nurse, primary care physician, a social worker, the parents, and a combination of other professionals, the pediatric asthma case manager works with the child to help him or her accept the responsibilities associated with asthma treatment. The goal is to keep the child in school and out of the emergency room or hospital inpatient setting.[25]

Another increasingly popular program involves using so-called Centers of Excellence. Centers of Excellence are facilities identified by insurers as high quality, cost-effective providers of specialty care. For example, children's hospitals are often designated as Centers of Excellence for the provision of specialized pediatric care. All cases for specific types of care are then sent to the Center of Excellence for treatment. Currently, the most popular types of Centers of Excellence are those specializing in organ transplants and rehabilitation services.

While many of the trends in children's coverage are positive, coverage for certain services of particular importance to children has declined in recent years. An annual survey of medium and large firms conducted by the Bureau of Labor Statistics (BLS) indicates that the percentage of persons with dental coverage declined from 77% in 1984 to 66% in 1989.[26] The BLS data also indicate that the percentage of participants in plans with limitations on the number of days of inpatient coverage increased from 43% in 1982 to 77% in 1989. In

dependent by another family member (34.3% in 1979 to 31.4% in 1986).[32]

Insurance Rating and Availability

Perhaps the most disconcerting trend in our health care financing system has been the erosion of insurance as a means of pooling risk. In effect, we are rapidly moving to an insurance system that is willing to insure only healthy individuals. In the early days of the health insurance industry, all individuals paid a uniform community-rated premium. Community rating pools the cost of all health services provided in a given region across all community members and sets a single uniform premium for all insured individuals. Under a community-rated system, people who use lesser amounts of health care effectively subsidize the cost of care provided to sicker individuals who use more services. However, if one takes the long view, community rating assures that when healthy individuals become ill they will receive needed health services while paying no greater premium than other members of the community.

Community rating was brought to an end by competition among insurance companies. The typical marketing strategy for an insurer is to attract business by offering competitive premiums to only the healthiest groups and limiting the insurer's exposure by refusing to cover health conditions that were present before the policy was issued. Renewal premiums are adjusted based upon experience so that premiums increase if the health status of the group declines. In today's system, most individuals pay a premium that reflects their health status and typical expenditure patterns rather than the overall average cost of health care in their community.

Furthermore, insurers often engage in a practice known as medical underwriting which analyzes health characteristics of individual group members to identify potentially high-risk individuals. Underwriting occurs primarily in the small group and individual insurance markets with the result that selected people are denied coverage through this process. To date, medical underwriting has been used infrequently by larger employers who are typically self-funded and/or can effectively pool risk to reduce their exposure to large losses.

The demise of community rating has worked to the benefit of some and to the detriment of others. Healthier individuals benefit from this change because they pay a premium that is often substantially lower than what they would have paid under a community-rated system. However, medical underwriting has greatly increased premiums for sicker individuals and, in many instances, has left uninsured those most in need of health coverage. Moreover, as healthier people become sick, they often face dramatic increases in premiums and may ultimately find themselves uninsured.

Insurer risk selection practices can have a dramatic impact on families with chronically ill children. Many parents find that they cannot change jobs without losing coverage for these children because of preexisting condition limitations. In some small groups, the presence of a single chronically ill child can so increase premiums that the employer may terminate coverage. Moreover, as these chronically ill children reach adulthood, they are no longer eligible for coverage as dependents under their parents' employer plans and may not be able to obtain insurance on their own.

The Impact of Benefit Packages on Costs and on Children's Health Status

Using deductibles and coinsurance to increase patient cost sharing is an effective means of reducing employer health plan costs. Cost sharing reduces health benefits costs to the employer in two ways. First, it reduces the share of an individual's total health spending which is paid for by the plan. Second, cost sharing creates an in-

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time. Specifically, the data do not reflect the general trend toward reduced inpatient utilization and increased use of outpatient treatments. Moreover, the HIE reflects the impact of overall family deductibles as well as individual deductibles. Thus, the utilization response under child-only health policies could differ from the HIE experience.

Impact on Health Status

Analysis of the HIE data indicates that the lower utilization associated with cost-sharing plans had no measurable impact on health status.[37] The health status of children in the various cost-sharing plans was compared on the basis of two measures: objective physical examinations administered under the HIE and subjective health status reports provided by the individual. Little difference in health status was observed across the various types of cost-sharing plans under either health status measure.

The results of the HIE study must be treated with caution because the data do not include a sufficiently large sample to measure the impact of cost sharing on at-risk children.[38] For example, the study indicated that poor children with cost sharing were more than twice as likely to suffer from anemia than poor children with free care. This suggests that cost sharing may have a detrimental impact on health status for children in low-income families.

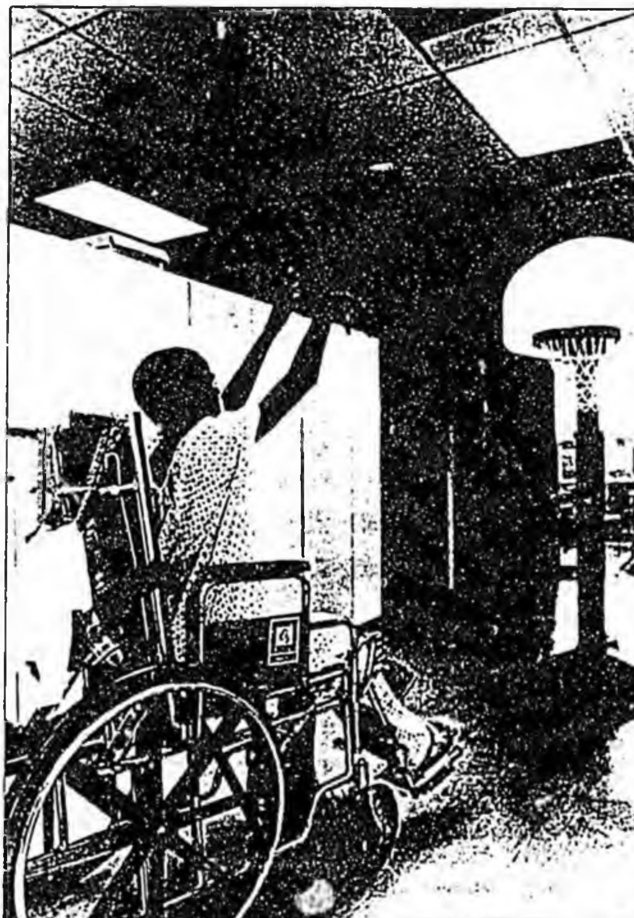
These results are generally consistent with the results obtained in other studies of service utilization and health status. These studies provide little evidence that additional medical services result in improved health status for children, except for the poor. However, a study by Dutton and Silber of alternative ambulatory care settings with different cost-sharing requirements indicated that small improvements in health status were observed among children that do not face cost sharing.[39]

Policy Issues Concerning Private Health Coverage for Children

More than 30 health care reform bills have been introduced in Congress. Several other proposals have been developed by insurers, provider groups, and business associations. While some of these proposals would eliminate private insurance and cover all persons under a single government program, most of these proposals would build upon the existing private insurance system. Nearly all of the proposals that build upon the existing private insurance system would regulate insurance marketing practices so that coverage is available to all regardless of health status. Some plans would provide incentives for employers and/or individuals to purchase private insurance while others would require that all individuals obtain insurance. These proposals typically emphasize access to insurance for children and pregnant women and often stress prenatal and well-child care.

Universal Coverage for Children

The American Academy of Pediatrics (AAP) has proposed to require insurance coverage for all pregnant women and children through the age of 21. The AAP plan would provide a comprehensive benefits package covering preventive services, inpatient care, prescription drugs, developmental disabilities, substance abuse treatment, nutritional supplements, and counseling services related to parental education and child abuse.[40] The plan also would require physician-directed case



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duces administrative costs. In fact, average costs could actually increase as high-risk individuals who do not now have insurance obtain coverage and enter the broader private insurance risk pool. Although the pooling of risk implied by these reforms can be expected to reduce premiums for high-risk individuals who now purchase insurance, risk pooling will inevitably result in premium increases for lower-risk individuals who now enjoy favorable premium rates. Thus, a restoration of risk pooling in our insurance system will move us back toward a system where lower-risk individuals subsidize health costs for high-risk cases and may actually increase the overall average cost of health insurance and health care.

Toward Universal Coverage

Most health reform plans are intended to extend coverage to all uninsured persons regardless of age. Although plans vary in significant ways, they can be classified into three basic approaches: (1) mandated employer responsibility; (2) tax incentive programs; and (3) single payer approaches. Although these plans would extend coverage to all children, the benefits provided under these proposals are typically less well tailored to the special needs of children than are child-only plans such as the one proposed by AAP.

Employer Responsibility

In 1988, Sen. Edward Kennedy (D-MA) and Rep. Henry Waxman (D-CA) jointly introduced a bill that would require all employers to cover their workers and their dependents.[42] Since that time, the authors of the bill have shifted their support to the pay-or-play approach, which gives employers the option of paying a tax and having their workers covered under a public plan in lieu of providing employees with private insurance. However, both the employer mandate and the pay-or-play approach establish that employers are responsible for covering their workers. The pay-or-play approach is now embodied in the Health America Act currently under consideration by Congress.

The Health America Act (S. 1227) specifies a minimum standard benefits package to be provided to all individuals which includes well-child care, prenatal care, and substance abuse treatment. The bill also includes insurance market reforms that are designed to extend coverage to all individuals while substantially restricting variations in premiums resulting from changes in health status. Indeed, an employer mandate could not be effective unless accompanied by regulations making insurance available to all individuals.

Tax Credit Program

The Heritage Foundation has developed a program that would replace our existing system of employer-based coverage with a requirement that all individuals purchase insurance.[43] Employers would be required to convert their current contributions to wages, which would then become taxable to the employee. The increase in tax revenues would be used to finance a tax credit to individuals, which would vary with income and the cost of insurance. This proposal also includes insurance market reforms designed to assure the availability of insurance coverage and limit the variation in premiums by health status.

The purpose of the Heritage Foundation proposal is to make individuals more conscious of the cost of care they consume by requiring that they purchase insurance out of their income. The plan does not specify a minimum benefits package so that individuals would be permitted to delete coverage for selected benefits. This may result in reductions in coverage for important child health services such as preventive care.

Single Payer

Several bills have been introduced which would eliminate private insurance and cover all Americans under Medicare[44] or cover all Americans under a single government program modeled on the Canadian system.[45] However, a publicly financed national health insurance plan does not necessarily mean the end of private insurance. For example, the Health USA Act introduced by Sen. J. Robert Kerrey of Nebraska would establish a publicly financed national health insurance program in which individuals choose among insurers competing on the basis of price and quality.[34]

Cost Containment

The share of our gross national product devoted to health care increased from 9.1% in 1980 to 12.2% by 1990. Yet, despite this dramatic increase in the share of our national wealth devoted to the health sector, the number of persons without health insurance increased by 9 million during this same period.[46] As costs have risen, fewer and fewer employers and families have been able to afford insurance coverage. Indeed, controlling costs is widely

Global Budgeting

Global budgeting is the process whereby some portion of total health expenditures is paid according to a prospectively determined (typically negotiated) annual budget. Global budgets are commonly implemented in countries with national health insurance, particularly in the hospital sector, where operating budgets are used also for planning purposes. It is harder to impose budget ceilings on physician services, although West Germany has successfully done so for many years. A recent study by the General Accounting Office (GAO) estimated that global budgets reduced health care spending in real terms by 9% in the hospital sector in France and by 17% in the physician sector in West Germany.[49]

While global budgets appear to be effective in controlling health care costs, there is some evidence that they may lead to non-price rationing of services and shifting of costs from the payers (for example, the federal and regional governments) to the citizens, primarily in the form of the long waits associated with access to many services. Queuing is most common for nonemergency services such as diagnostic tests and elective surgeries. There is little evidence, however, that children are adversely affected by queuing. In fact, infant mortality rates in other developed countries using global budgeting tend to be far lower than those in the United States.[50]

Conclusions

Private health insurance is the primary source of coverage for America's children and pregnant women. Access to private health coverage is threatened by the spiraling cost of health care, cost shifting, and insurance marketing practices which tend to deny coverage to high-risk individuals. These pressures threaten to increase the number of uninsured persons and reduce the level of coverage for persons who remain insured. These changes will ultimately result in increased pressure on government programs to care for our nation's uninsured children.

Efforts should be taken to preserve the stability of our private insurance system. Reimbursement under public programs should be sufficient to reduce the cost shifting that is compounding the growth in private insurance costs. Insurance marketing practices should be reformed to guarantee the availability of coverage to all groups by restoring insurance as a means of pooling risk. Aggressive cost containment efforts should also be initiated involving competition, managed care, and possibly global spending limits.

The rising cost of health services threatens to transform health care into a luxury good affordable only by higher-income Americans. This will represent a particular hardship for America's children, a disproportionate share of whom are living below the poverty line. Though typically thought of as a means of expanding insurance coverage, extensive reforms of the health care system may be needed just to preserve the existing level of private insurance coverage.

1. Lewin-ICF analysis of the March 1990 Current Population Survey (CPS) Data.
2. Kronick, R. Health insurance, 1978–1989: The frayed connection between employment and insurance. *Inquiry* (Winter 1991) 28:318–32.
3. American Academy of Pediatrics. *Children first: A legislative proposal.* Washington, DC, 1990.
4. Health Insurance Association of America. *Source Book of Health Insurance Data, 1990.* Washington, DC: HIAA, 1990, pp. 29–30.
5. Although risk pooling minimizes a large group's need to insure against large unanticipated expenditures, most employers choose to pass on some or all of the risk associated with unexpected costs to an insurer that can reduce risk even further by pooling the experiences of many large groups.
6. Approved services are those that are (1) considered covered by the policy guidelines (for example, most policies do *not* cover experimental procedures) and (2) determined to be medically necessary or appropriate (for example, cosmetic surgery is considered medically necessary only in specific situations). In some managed care arrangements, services must be performed by a select group of providers to be approved for payment.
7. See note no. 4, HIAA, p. 29.

36. Leibowitz, A., et al. Effect of cost-sharing on the use of medical services by children: Interim results from a randomized controlled trial. *Pediatrics* (May 1985)75,5:942–50.

37. Burciaga Valdez, R.O. *The effects of cost sharing on the health of children.* RAND Corporation, March 1986. Prepared for the U.S. Department of Health and Human Services.

38. Another reason the HIE may not be useful in assessing the impact of cost sharing on poor children is that the experimental insurance package had annual expenditure ceilings that were fixed as a proportion of family income. This diluted the effects of cost sharing on poor families, who reached the expenditure ceilings more quickly than higher income families and then were eligible for free care the rest of the year. Most real-world insurance plans have expenditure ceilings nominally fixed for all beneficiaries regardless of family income. As a result poor families could face substantial cost-sharing requirements for most of a year which might serve as a more substantial deterrent to utilization than modeled in the HIE. Starfield, B., and Dutton, D. Care, costs, and health: Reactions to and reinterpretation of the Rand findings. *Pediatrics* (October 1985)76,4:614–21.

39. Dutton, D.M., and R.S. Silber. Children's health outcomes in six different ambulatory care delivery systems. *Medical Care* (1980)18,7:693–713.

40. American Academy of Pediatrics. *Children first: A legislative proposal.* Washington, DC: AAP, 1990.

41. Executive Office of the President. *The President's comprehensive health reform program.* Washington, DC., February 6, 1992.

42. The Basic Health Benefits for All Americans Act, S. 768 (1988) introduced by Sen. Edward Kennedy (D-MA) and Rep. Henry A. Waxman (D-CA).

43. Butler, S.M. *Assuring affordable health care for all Americans.* Washington, DC: The Heritage Foundation, 1991.

44. The Medplan Act of 1991, H.R. 650 (1991) introduced by Rep. Pete (Fortney) Stark (D-CA).

45. The Universal Health Care Act, H.R. 1300 (1991) introduced by Rep. Marty Russo (D-IL).

46. Sheils, J. The impact of the Health America Act on health spending. Testimony before the Senate Finance Subcommittee on Health for Families and the Uninsured, September 23, 1991.

47. The health care delivery system of the Department of Veterans' Affairs is probably the only exception to this rule. Its sole source of revenue is the federal government, which determines a global budget for the VA system prospectively.

48. Moran, D. W., and Wolfe, P.R. Can managed care really control costs? *Health Affairs* (Winter 1991) pp. 120–28.

49. General Accounting Office, *Health care spending control: The experience of France, Germany, and Japan.* Gaithersburg: GAO, November 1991, pp. 46–47.

50. Aaron, H. *Serious and unstable condition.* Washington, DC: The Brookings Institution, 1991, p. 79.

THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE

FINAL REPORT

to

the Governor and Legislature

January 1993

Alaska State Legislature
Health Resources and Access Task Force
State Capitol
Juneau, Alaska 99801-1182

Portions of Health Resources + Access Task Force 1/93

Finding #4: In spite of significant spending on health care, many Alaskans lack coverage for even the most basic health care services.

While $1.6 billion (the estimated total health care spending in Alaska in 1991) seems like it should be sufficient to provide a basic level of care to all Alaskans, the Task Force observed that:

- **In the late 1980s, over 76,000 non-elderly Alaskans had no health care coverage.**

An analysis of Alaska-specific data from the 1988 through 1991 Current Population Surveys revealed that approximately 76,000 non-elderly Alaskans had no health care coverage. That means that they had no coverage for any service, whether it be private insurance, Medicaid, Medicare, Indian Health Service coverage, or any other type of third-party health care coverage.[6]

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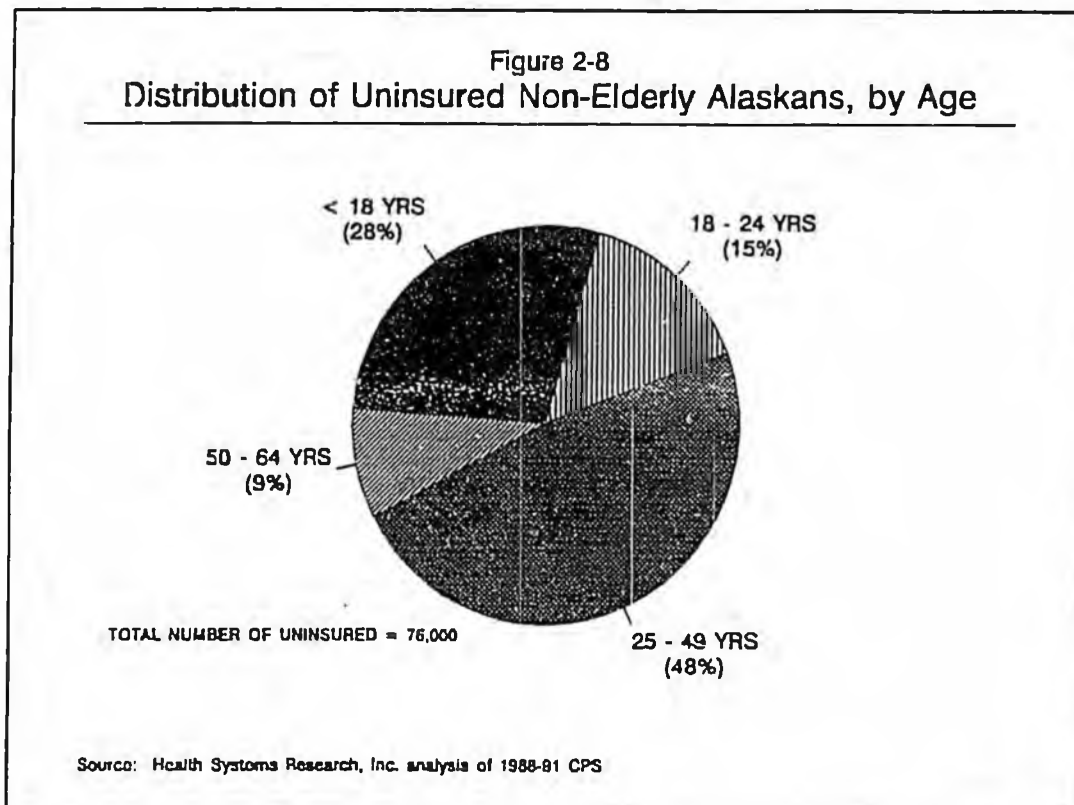
[6] The Current Population Survey is a national survey conducted each year by the U.S. Bureau of the Census. While the number of persons included in the CPS from states with relatively low populations (such as Alaska) is small, most states nonetheless rely on CPS data to provide rough estimates of the number of uninsured because better estimates are expensive and difficult to generate. One technique used to compensate for the small sample size is to analyze survey results over a several year period. This approach was used in the analyses conducted for the Task Force. We would also note that in the Task Force's Interim Report (January 11, 1992), 90,000 Alaskans were reported as being uninsured. This number included a certain number of Alaska Natives who responded in the survey that they had no health care coverage, despite the fact that they are eligible to receive care through the AANHS/IHS system. Dr. Bartlett of Health Systems Research, Inc., in response to the Task Force's request to develop an estimate using the "assumption that all Alaska Natives have health care coverage through the Indian Health Service system," removed the Alaska Native respondents from the sample and reanalyzed the data. This reduced the estimate of the number of uninsured Alaskans from 90,000 to 76,000. For complete results of Dr. Bartlett's analyses, see Appendix D.

- **Over 21,000, more than one in every four, uninsured Alaskans are under the age of 18.[7]**

Figure 2-8 presented below displays the distribution of Alaska's non-elderly uninsured population by age. Because of the nearly universal coverage provided by Medicare to the elderly population, our analysis focuses on the characteristics of the non-elderly uninsured population. As can be seen from this chart, over a quarter (28 percent) of uninsured persons in the state are children, while another 15 percent are young adults aged 18 - 24. The remainder of the state's uninsured population are adults aged 25 - 49 (48 percent) and older adults aged 60 - 64 (9 percent).

Figure 2-8
Distribution of Uninsured Non-Elderly Alaskans, by Age



Source: Health Systems Research, Inc. analysis of 1988-91 CPS

- **In the late 1980s, many uninsured Alaskans did not have sufficient income to purchase health care coverage on their own.**

A 1989 study by the National Health Care Campaign found that, in most states, it is only when families earn more than 250 percent of the poverty level that they begin to accumulate the disposable income required to contribute toward a portion of

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[7] In the Task Force's Interim Report, we reported that there were 28,000 uninsured children. When Dr. Bartlett removed Alaska Native respondents from the CPS sample, the estimate of the number of uninsured children was reduced to 21,000. See Appendix D.

premium costs (Appendix D). When the Task Force compared this finding to its analysis of the incomes of uninsured Alaskans, it discovered that a significant portion of the state's uninsured population could not afford to purchase coverage on their own. For example, the Task Force realized that even though the federal and State governments together spent over $214 million in 1991 in Alaska for the Medicaid program, more than 13,500 uninsured Alaskans lived in households in the late 1980s with incomes below the federal poverty level.[8] An additional 16,000 uninsured Alaskans lived in households with incomes between 100 and 200 percent of poverty (with incomes between $15,120 and $30,240 for a family of four).

> **PERSONAL STORIES . . .**
>
> *"When my daughter and son-in-law were expecting their first child, my daughter was unable to work . . . Our son-in-law was making just enough to pay for essentials. The state welfare system declined their request for medical coverage claiming our son-in-law's income was too high, wasn't making more than $6 per hour . . . I was informed that (a particular) hospital would help. The hospital charged according to income. They paid all of the hospital bill."*
>
> – Anchorage Resident

Of particular concern to the Task Force was the fact that so many thousands of low income children were without basic health care coverage. We found that of the more than 21,000 uninsured Alaskan children, about 3,900 lived in households with incomes below the federal poverty level, while another 4,500 were in families with incomes between one and two times the poverty level.

Given the financial risks of being uninsured, the Task Force also found it disturbing that nearly 30,000 uninsured Alaskans were in families with incomes in excess of 300 percent of poverty. Of these, roughly 18,000 were employed full-time for the entire year. The Task Force concluded that, under the current system, there may be a number of reasons why persons with adequate incomes are without coverage. Some may be uninsured because they wish to avoid the expense or consider themselves to be "immortal." Others have significant health care needs and cannot find an insurer who will offer them a policy at an affordable price. The Task Force further recognized that as long as some Alaskans remain uninsured and continue to incur health care expenses which they cannot afford, providers will continue to shift the costs of caring for the uninsured and underinsured to employers who provide health care benefits to their employees.

> **PERSONAL STORIES . . .**
>
> *"I can't get health insurance because I have been diagnosed recently with MS. I was working in a full-time position (for a large employer), I was pregnant at the time I was diagnosed. Unfortunately, the employer is here in the state and felt a need to lay me off, when I was pregnant and recently diagnosed. I have contacted several health insurance companies in the private sector and to my disbelief, people with tuberculosis, any form of cancer within the last ten years, diabetes, overweight, MS, AIDS, or even having open heart surgery cannot obtain health insurance in the private sector, even though we are willing to pay the premium, we are unable to get health insurance."*
>
> – Anchorage Resident

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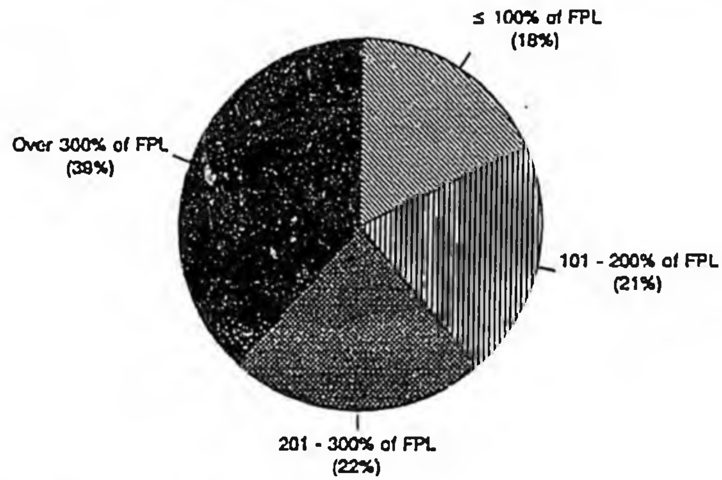
[8] The 1989 federal poverty level for a family of four in Alaska was $15,120.

Figure 2-9
Distribution of Uninsured Non-Elderly Alaskans, by Poverty Status



TOTAL NUMBER OF UNINSURED = 76,000

Source: Health Systems Research, Inc. analysis of 1988-91 CPS

Table 2-3
Breakdown of Insurance Company Administrative Expenses

(Percentage of Incurred Claims)

Number of Employees			General*	Profit & Risk	Commission	Total
1	to	4	23.1	8.5	8.4	40.0
5	to	9	21.0	8.0	6.0	35.0
10	to	19	17.5	7.5	5.0	30.0
20	to	49	14.9	6.8	3.3	25.0
50	to	99	10.0	6.0	2.0	18.0
100	to	499	8.9	5.5	1.6	16.0
500	to	2,499	7.8	3.5	0.1	12.0
2,500	to	9,999	5.9	1.8	0.3	8.0
10,000	or	more	4.3	1.1	0.1	5.5

* Includes claims administration, general administration, interest credit, and premium taxes.

Source: Congressional Research Service

RECOMMENDATION # 6:

The Task Force recommends the establishment of State-sponsored health insurance pooling arrangements.

During its deliberations, the Task Force reviewed information indicating that nationwide as much as 40 percent of premiums charged to very small businesses may be attributable to administrative costs. While the small group market reform provisions included in earlier recommendations are expected to reduce the administrative costs associated with providing coverage to small businesses, the Task Force also considered it appropriate for the State, through the newly established Health Care Authority, to establish one or more pooling arrangements through which both individuals and businesses, small and large, could purchase health care coverage. It is anticipated that certain additional efficiencies and economies could accrue to the members of these pool arrangements that would further reduce their premium costs. In designing these pools, the Task Force noted the importance of considering their medical underwriting and premium setting practices in relation to those of other insurers governed by the small market reform proposals to ensure that these State-sponsored pools are not damaged by the adverse selection that would result from other insurers subtly "dumping" undesirable risks into these pools.

RECOMMENDATION # 7:

The Task Force recommends the passage of legislation providing for publicly-subsidized coverage of uninsured low-income pregnant women and children who are not eligible for Medicaid.

Even with the recommendations concerning cost containment, market reform, and pooling measures in place, the Task Force recognizes that it would be necessary to provide some level of public subsidy to certain low-income uninsured persons if they are to be able to afford health care coverage (see Finding #4).

The Task Force determined that the populations to be given highest priority for receiving subsidized coverage should be low income pregnant women and children in families with incomes too high to be eligible for Medicaid but too low to be able to

purchase private health insurance on their own.[8] Priority was given to these groups because of the documented improvements in birth outcomes and the cost savings associated with the receipt of prenatal care by pregnant women and the positive lifelong benefits associated with providing adequate primary and preventive care to children. The Task Force also determined that the positive health improvements resulting from public health care subsidies for these populations could be maximized by providing coverage of comprehensive services (e.g., prenatal and other preventive services, plus other ambulatory and inpatient care) for low income pregnant women and ambulatory care services for low income children.

Given these priorities, the Task Force recommends that legislation be enacted to establish a program providing State-subsidized insurance coverage for low-income children who are not eligible for Medicaid or Indian Health Service coverage and who are in families with incomes below 300% of the federal poverty level. In order to make the program more affordable at the outset, coverage would be provided for primary and preventive and/or ambulatory care services, but not for inpatient care.

Experience in other states has shown similar programs to be more attractive to families if they were perceived to foster self-sufficiency and were similar to private insurance in design. Therefore, the Task Force recommends that the program be given an identity apart from Medicaid, particularly the eligibility system. This would not preclude the Medicaid agency from administering the program if it proves most cost-effective, however serious consideration should be given to having a private insurer administer the program under contract to the State. The Task Force was heartened by expressions of interest from two major carriers in Alaska in being involved in such a program.

While coverage would be substantially subsidized by the State, premium sharing requirements in the range of $50 - $300 per year per child should be established on an income-related sliding scale basis. This premium sharing will not only reduce the required level of State subsidy, but also will give parents of enrolled children a sense of involvement and participation in contributing to coverage for their children.

As illustrated in Table 4-2 on the following page, approximately 14,600 uninsured Alaskan children would be eligible for coverage under this program. The Task Force estimates that roughly 8,200 children would actually enroll in the program, with nearly 90 percent of these children having no previous health care coverage. The remaining enrollees are expected to be children with private insurance that provides inadequate coverage of primary and preventive care. The annual cost of the program is estimated to be $6.1 million, of which $4.2 million would be financed by State subsidies. The remaining $1.9 million would be paid by families in the form of premium contributions.

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[8] It should be noted that the Task Force identified high-risk individuals as another high priority population and in our interim recommendations we endorsed the establishment of a statewide high-risk insurance pool for this population. Legislation establishing such a pool was enacted last year by the Alaska State Legislature.

Table 4-2
ESTIMATES OF ENROLLEES AND COSTS UNDER SUBSIDIZED AMBULATORY CARE PROGRAM FOR LOWER INCOME ALASKAN CHILDREN NOT ELIGIBLE FOR MEDICAID OR IHS COVERAGE

Income	Number of Uninsured Children	Number of Enrollees	Costs (in millions of $)		
			State	Family	TOTAL
Under Poverty	3,900	300	$0.2	$0.0	$0.2
100-200% Poverty	4,500	2,900	$1.8	$0.4	$2.2
200-300% Poverty	6,200	5,000	$2.2	$1.5	$3.7
TOTAL	14,600	8,200	$4.2	$1.9	$6.1

Source: Health Systems Research, Inc.

With respect to the coverage of low income pregnant women, the Task Force recognizes that, while federal laws enable the State of Alaska to extend Medicaid eligibility to pregnant women and infants in families with incomes up to 185% of poverty, the State currently has elected to provide coverage only to pregnant women and infants in families with incomes below 133% of poverty. The Task Force recommends that the State expand its Medicaid coverage for pregnant women and infants up to 185% of poverty. The FY 1994 cost of this expansion to the State is estimated to be $3.8 million, which will be matched by an equal amount from the federal government. For uninsured women with incomes above this income level but below 300% of poverty, the Task Force recommends the establishment of a publicly-subsidized private insurance program providing comprehensive services.

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: MARCH 31, 1993

PLACE: Capitol Room 106

SUBJECT OF MEETING:
CONFIRMATION HEARINGS - AK BOARD OF EDUCATION
STOWELL JOHNSTONE
*HB 195: AUTHORIZING YOUTH COURTS
*HB 22: AK HEALTHY START PROGRAM
(*HB195 AND *HB 22 TO BE TELECONFERENCE

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Valerie M Therrien	Fairbanks North Star Borough	779 8th Fairbanks	99701	456 8113	452 6194	(Y)	N	HB 195
Ken Sykes	Insurance	SOB 9th				Y	(N)	HB 22
Bob Sims	" "	SOB 9th				Y	N	HB 22
Caren Robinson	League of Women				586-1107	(Y)	N	HB195
Patty Merritt		4581 Drake St. FBKS	99709	479-0900	474-0841	Y	N	
Randall Hines	DHSS	Box 110630 Juneau	99811		465-3187	(Y)	N	HB195
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

3/31/93

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   TCN: 30412     DATE & TIME: 03/31/93 15:00 TO 16:00  STATUS:7  STATS. IN

**** ORDER SUMMARY ****
SPONSOR: HHES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY
PURPOSE: PUB  PUBLIC HEARING                                   BUNDE
CONTACT:      LYNNE SMITH       TEL#: (907)465-6825
CHAIRING SITE: JUNEAU           CAPITOL           CAP106

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED         5 MINUTE LIMIT
TCN REQUESTED ON 03/31/93 AND HAS  8 UPDATES

**** AGENDA ****
   1  HB 195 AUTHORIZING YOUTH COURTS
   2  HB  22 ALASKA HEALTHY START PROGRAM

**** PARTICIPATING LIOS ****
   ANC ANCHORAGE          3111 C STREET                       LOCATION STAFF
   BAR BARROW             COURTHOUSE #305                     LOCATION STAFF
   FBX FAIRBANKS          119 N CUSHMAN ST                    LOCATION STAFF
 * JNU JUNEAU             CAPITOL             CAP106          LOCATION STAFF

**** VOLUNTEER & OFFNET SITES ****
  ZZZ OF1 OFFNET 1         SEATTLE              STEVE LEBRUN     (206)467-2803
  ZZZ OF2 OFFNET 2         HOONAH               MAXINE SANLAND   (907)945-3668

PARTICIPANTS IN ANCHORAGE          ANC
 1       MARY        MCGINNIS                                  OBSV. HB  22
         1000 MULCHATNA            ANCHORAGE           AK 99654 (907)373-7569
 2       BRYAN       CLARK                ANCH YOUTH CRT       TSFY. HB 195
         1981 COMMODORE            ANCHORAGE           AK 99507 (907)344-4486
 3       JESSE       KICHL                ANCH YOUTH CRT       TSFY. HB 195
         6301 TRAPPER TRACT        ANCHORAGE           AK 99516 (907)345-3394
 4       ROBERT      BUTTCANE             ANCH YOUTH CRT       TSFY. HB 195
         2600 PROVIDENCE DR.       ANCHORAGE           AK 99508 (907)562-2285
 5       THELMA      LANGDON              ACTION OF CHILD      TSFY. HB  22
         2363 CAPT. COOK DRIVE     ANCHORAGE           AK 99517 (907)248-0834
 6       SHARON      LEON                 ANCH YOUTH CRT       TSFY. HB 195
         5205 STRAWBERRY RD        ANCHORAGE           AK 99502 (907)274-5986
 7       BLYTHE      MARSTON                                   TSFY. HB 195
         3001 MC COLLIE AVE        ANCHORAGE           AK 99517 (907)248-7739
 8       JON         EALY                 AYC ANCH BAR         TSFY. HB 195
         5245 E. 147TH             ANCHORAGE           AK 99516 (907)345-7119
 9       MARY        BRISTOL              ANCH SCHOOL          TSFY. HB 195
         3305 GLENN DON DR.        ANCHORAGE           AK 99504 (907)333-6725
10       CAROLE      CLARK                ASD TEACHER          OBSV. HB 195
         1981 COMMODORE DR.        ANCHORAGE           AK 99507 (907)344-4486
11       ROBERT      OWENS                ANCH BAR             TSFY. HB 195
         PO BOX 105035             ANCHORAGE           AK 99510 (907)274-5152
12       JOSHUA      WALTON               ANCH YOUTH CRT       TSFY. HB 195
         PO BOX 221166             ANCHORAGE           AK 99522 (907)248-1323
13       JUSTIN      WALTON               ANCH YOUTH CRT       TSFY. HB 195
         PO BOX 221166             ANCHORAGE           AK 99522 (907)248-1323
14       BRYAN       MERRELL              ANCH BAR-YNG LAW     TSFY. HB 195
         17613 RACHEL CIRCLE       EAGLE RIVER         AK 99577 (907)272-6474
15       MARIGH      HUGHES               AK BAR FND           TSFY. HB 195
         509 W 3RD                 ANCHORAGE           AK 99501 (907)263-8359
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TCN: 30412 DATE & TIME: 03/31/93 15:00 TO 16:00 STATUS:7 STATS. IN

PARTICIPANTS IN:ANCHORAGE ANC

No.	Title	First Name	Last Name	Organization / City	State / Zip	Phone	Status
16		ROYH	HENDERSON	JUV DIVERSION			TSFY. HB 195
		PO BOX 213-649		ANCHORAGE	AK 99521	(907)338-5548	
17		STEVEN	PRADELL				TSFY. HB 195
		715 L ST		ANCHORAGE	AK 99501	(907)279-4529	
18		SCOTT	ANDREWS				OBSV. HB 195
		3951 FURROW CRK RD		ANCHORAGE	AK 99516	(907)345-3601	
19		DID NOT	SIGN IN				OBSV. HB 195
					AK	(907)000-0000	
20		DID NOT	SIGN IN				OBSV. HB 195
					AK	(907)000-0000	

PARTICIPANTS IN:FAIRBANKS FBX

No.	Title	First Name	Last Name	Organization / City	State / Zip	Phone	Status
1	MS.	KAREN	PERDUE				TSFY. HB 22
		204 FRONT ST.		FAIRBANKS	AK 99707	(907)000-0000	
2	MS.	JANE	DEMMERT	FNA			TSFY. HB 195
				FAIRBANKS	AK	(907)000-0000	
3	MS.	ELLEN	GANLEY				OBSV. HB 195
					AK	(907)000-0000	
4	MR.	MARK	BOYER				OBSV. HB 195
				FAIRBANKS	AK	(907)000-0000	

PARTICIPANTS IN:JUNEAU JNU

No.	Title	First Name	Last Name	Organization / City	State / Zip	Phone	Status
1	REP.	CON	BUNDE				TSFY. HB 195
					AK	(907)000-0000	
2	REP.	CYNTHIA	TOOHEY				TSFY. HB 195
					AK	(907)000-0000	
3	REP.	PETE	KOTT				TSFY. HB 195
					AK	(907)000-0000	
4	REP.	AL	VEZEY				TSFY. HB 195
					AK	(907)000-0000	
5	REP.	GARY	DAVIS				TSFY. HB 195
					AK	(907)000-0000	
6	REP.	HARLEY	OLBERG				TSFY. HB 195
					AK	(907)000-0000	
7	REP.	BETTYE	DAVIS				TSFY. HB 195
					AK	(907)000-0000	
8	REP.	IRENE	NICHOLIA				TSFY. HB 195
					AK	(907)000-0000	
9	REP.	TOM	BRICE				TSFY. HB 195
					AK	(907)000-0000	
10	REP.	JOE	SITTON				TSFY. HL 195
					AK	(907)000-0000	
11	REP.	JIM	NORDLUND				TSFY. HB 195
					AK	(907)000-0000	
12		TESTIFIER	1				TSFY. HB 195
					AK	(907)000-0000	
13		TESTIFIER	2				TSFY. HB 195
					AK	(907)000-0000	
14		TESTIFIER	3				TSFY. HB 195
					AK	(907)000-0000	

AK (907)000-0000

15	SHERRIE	GOLL	T		TSFY. HB 195
				AK	(907)000-0000
16	TESTIFIER	5			TSFY. HB 195

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PARTICIPANTS IN:JUNEAU JNU

			AK	(907)000-0000
17	TESTIFIER	6		TSFY. HB 195
			AK	(907)000-0000
18	TESTIFIER	7		TSFY. HB 195
			AK	(907)000-0000
19	OBSERVER	1		OBSV. HB 195
			AK	(907)000-0000
20	OBSERVER	2		OBSV. HB 195
			AK	(907)000-0000
21	OBSERVER	3		OBSV. HB 195
			AK	(907)000-0000
22	OBSERVER	4		OBSV. HB 195
			AK	(907)000-0000
23	OBSERVER	5		OBSV. HB 195
			AK	(907)000-0000
24	OBSERVER	6		OBSV. HB 195
			AK	(907)000-0000
25	OBSERVER	7		OBSV. HB 195
			AK	(907)000-0000
26	OBSERVER	8		OBSV. HB 195
			AK	(907)000-0000
27	OBSERVER	9		OBSV. HB 195
			AK	(907)000-0000
28	OBSERVER	10		OBSV. HB 195
			AK	(907)000-0000
29	OBSERVER	11		OBSV. HB 195
			AK	(907)000-0000
30	OBSERVER	12		OBSV. HB 195
			AK	(907)000-0000
31	OBSERVER	13		OBSV. HB 195
			AK	(907)000-0000
32	OBSERVER	14		OBSV. HB 195
			AK	(907)000-0000

PARTICIPANTS IN:OFFNET 1 ZZZ OF1

1	STEVE	LEBRUN		TSFY. HB 195
			AK	(907)000-0000