

SB

160

SENATE COMMITTEE REPORT

First Committee of Referral

DATE: 4/23/07

FURTHER: Labor and Commerce
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 2/19/08

Health, Education and Social Services Committee considered

SENATE BILL NO. 160

SB 160 MANDATORY UNIVERSAL HEALTH CARE

"An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for all residents of the state; establishing the Alaska Health Care Board to define essential health care services, to certify health care plans that provide essential health care services, and to administer the Alaska health care program and the Alaska health care fund; establishing the Alaska health care clearinghouse to administer the Alaska health care program under the direction of the Alaska Health Care Board; establishing eligibility standards and premium assistance for persons with low income; establishing standards for accountable health care plans; creating the Alaska health care fund; providing for review of actions and reporting requirements related to the health care program; and providing for an effective date."

and recommends:

- be replaced with SCS or CS SB 160 (HES)
- adopt previous SCS or CS _____ (_____)
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

SENATE BILL:	
<input type="checkbox"/> Same Title	
<input checked="" type="checkbox"/> New Title	
<hr/>	
HOUSE BILL:	
<input type="checkbox"/> Same Title	
<input type="checkbox"/> Technical Title Change	
<input type="checkbox"/> New Title w/ SCR # _____	


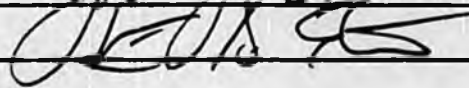
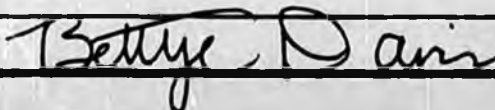
NEW FISCAL NOTE(S):

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Index	Zero	FN#
HSS	1/29/08	✓			

Department	Date	Fiscal	Index	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
	Eldon	✓			
CHAIR: 	PAVIS	✓			

AMENDMENT # 1

OFFERED IN THE SENATE

BY

TO: CSSB 160(), Draft Version "V"

- 1 Page 10, line 23, following "Medicaid":
- 2 Insert "and the potential expansion of the Alaska Medicaid program, including a
- 3 comparison between the costs of expanding the Alaska Medicaid program and the cost of
- 4 providing benefits through the Alaska health care program"


Senator Hollis French
Capitol Room 417
465-3892
465-6595 fax



MEMORANDUM

Date: January 23rd, 2008

To: Senator Bettye Davis, Chair
Senate Health, Education and Social Services Committee

From: Senator Hollis French 

RE: Request for Hearing -- SB 160 Mandatory Universal Health Insurance

This is a request that you schedule a hearing on SB 160 "Mandatory Universal Health Insurance" at the earliest possible date.

I have attached a copy of the Sponsor Substitute of the bill, a sponsor statement, and a bill packet for your use. Please contact Andy in my office at ex. 3892 if you have any questions.

I appreciate your consideration.

Attachments

25-LS0728\V
Bailey
1/25/08

CS FOR SENATE BILL NO. 160()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-FIFTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): SENATORS FRENCH, Ellis, Wielechowski

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing an Alaska health care program to ensure insurance coverage for**
2 **essential health services for residents of the state; establishing the Alaska Health Care**
3 **Board to administer the Alaska health care program and the Alaska health care fund;**
4 **establishing the Alaska health care clearinghouse to administer the Alaska health care**
5 **program under the direction of the Alaska Health Care Board; establishing eligibility**
6 **standards and premium assistance for persons with low income; creating the Alaska**
7 **health care fund; providing for review of actions and reporting requirements related to**
8 **the health care program; and providing for an effective date."**

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

10 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section
11 to read:

12 **FINDINGS; PURPOSE.** (a) The legislature finds that

- 1 (1) the current health care system is unsustainable;
- 2 (2) improving and protecting the health of Alaskans must be a primary goal of
- 3 the state;
- 4 (3) all Alaskans should have access to essential health care services that are
- 5 affordable, that are based on publicly debated criteria, and that consider the well-being of
- 6 individuals across their life spans;
- 7 (4) Alaska has an economic interest in ensuring equitable financing of
- 8 essential health care for Alaskans who do not have access to basic health care;
- 9 (5) health care policies should emphasize public health and encourage the use
- 10 of quality service and evidence-based treatment that are appropriate and safe and that
- 11 discourage over-treatment;
- 12 (6) health care providers and informed patients must be the primary decision
- 13 makers who are accountable for an individual's health;
- 14 (7) health care funding should be explicit, predictable, and economically
- 15 sustainable;
- 16 (8) an economically sustainable health care system requires that providers
- 17 receive fair and adequate compensation;
- 18 (9) health care must be balanced with other programs that also affect health;
- 19 and
- 20 (10) health care must account for the allocation of resources and the human
- 21 consequences of funding decisions.

22 (b) The purpose of this Act is to address the findings and concerns listed in (a) of this

23 section by creating the Alaska health care program.

24 * **Sec. 2.** AS 21.54 is amended by adding new sections to read:

25 **Article 2A. Alaska Health Care Program.**

26 **Sec. 21.54.200. Alaska health care program.** The Alaska health care program

27 is established to

- 28 (1) ensure that residents of the state have access to affordable health
- 29 care insurance;
- 30 (2) require that residents of the state have, at a minimum, insurance
- 31 covering essential health care services:

- 1 (3) reduce unsustainable health care cost increases;
- 2 (4) establish a system of health care insurance that integrates public
- 3 involvement and oversight, consumer choice, and competition within the private
- 4 health care insurance market;
- 5 (5) use models of health care insurance benefits, service delivery, and
- 6 payments that control costs and overuse, emphasizing preventative care and chronic
- 7 disease management within a primary care environment; and
- 8 (6) provide services for humane and dignified end-of-life care.

9 **Sec. 21.54.210. Alaska Health Care Board.** (a) The Alaska Health Care

10 Board is established in the division to manage the Alaska health care program.

11 (b) The board shall consist of 13 members, including 12 members appointed

12 by the governor, subject to confirmation by the legislature, and the commissioner of

13 health and social services or the commissioner's designee, serving ex officio. The

14 members of the board appointed by the governor must include

15 (1) one representative each from two health care insurers licensed to

16 transact health care insurance in the state;

17 (2) two representatives of the business community other than health

18 care insurers, one representing large businesses, and one representing small

19 businesses;

20 (3) one representative each from two Alaska hospitals;

21 (4) one representative of a labor organization;

22 (5) two physicians licensed in Alaska;

23 (6) two health care consumer advocates; and

24 (7) one registered nurse.

25 (c) Except for the commissioner or the commissioner's designee, who serves

26 ex officio, each board member serves for a term of three years beginning on January 1

27 and until a successor has been appointed. A member is eligible for reappointment.

28 (d) If there is a vacancy, the governor shall make an appointment, effective

29 immediately, for the balance of the unexpired term.

30 (e) Members of the board are entitled to per diem and transportation costs

31 under AS 39.20.180.

1 (f) The board shall select a member to serve as chair and a member to serve as
2 vice-chair for a term and with duties and powers necessary to perform their functions.

3 (g) A majority of the board constitutes a quorum for transacting business.

4 **Sec. 21.54.220. Powers and duties of the Alaska Health Care Board. (a)**

5 The Alaska Health Care Board shall

6 (1) administer, as a fiduciary, the Alaska health care fund established
7 under AS 21.54.280 in accordance with the Alaska health care program established by
8 AS 21.54.200 - 21.54.310;

9 (2) establish types or categories of health care insurance plans offered
10 through the Alaska health care clearinghouse;

11 (3) classify each plan offered through the clearinghouse as a
12 comprehensive or basic health care insurance plan, based on criteria including the
13 financial cost of the plan, including premium cost, deductible costs, and co-pay
14 provisions;

15 (4) establish criteria for participation by residents and insurers in the
16 Alaska health care program;

17 (5) establish an Alaska health care voucher system that provides health
18 care insurance to each individual who meets the needs-based participation criteria set
19 out in AS 21.54.240 or who is the beneficiary of contributions made to the fund that
20 specify the individual as the beneficiary under AS 21.54.280(b);

21 (6) ensure that eligible individuals are enrolled in a health care
22 insurance plan that provides essential health care services;

23 (7) prescribe the method for determining individual income for the
24 purpose of the Alaska health care program;

25 (8) establish procedures for enrolling a participant in the Alaska health
26 care program, including enrollment procedures describing when an individual may
27 enroll or select a different health insurance plan offered through the Alaska health care
28 clearinghouse; the procedures established under this paragraph must allow an
29 individual insured by a health care insurance plan offered through the Alaska health
30 care clearinghouse to select a different health care insurance plan from the plans
31 offered through the clearinghouse and to make that selection at least annually;

1 (9) require that participants receive complete information regarding the
2 cost of obtaining health care insurance; and

3 (10) establish procedures for notice and hearings for a person
4 aggrieved by a decision of the board or the Alaska health care clearinghouse.

5 (b) The board may hold regular and special meetings as the board considers
6 necessary; board meetings may be held by teleconference; meetings shall be recorded
7 and made available on request.

8 **Sec. 21.54.230. Alaska health care clearinghouse.** (a) The Alaska health care
9 clearinghouse is established in the division.

10 (b) The clearinghouse shall be administered by the director.

11 (c) The clearinghouse shall

12 (1) administer the Alaska health care program under the direction of
13 the Alaska Health Care Board;

14 (2) disseminate information about health care insurance products
15 available through the clearinghouse; and

16 (3) provide assistance in the enrollment process for a small business or
17 an individual.

18 **Sec. 21.54.240. Essential health care services; eligibility.** (a) Every resident
19 of the state shall participate in the Alaska health care program except a resident who

20 (1) is a beneficiary of a health care plan that provides health care
21 benefits that meet or exceed the benefits for essential health care services;

22 (2) is eligible to be enrolled in a publicly funded medical assistance
23 program providing services that meet or exceed the benefits required as essential
24 health care services;

25 (3) is enrolled in Medicaid or Medicare;

26 (4) is receiving health care benefits under a health benefit plan
27 regulated by 29 U.S.C. 1001 - 1461 (Employee Retirement Income Security Act of
28 1974) that meet or exceed the benefits for essential health care services;

29 (5) has resided in the state for less than one year; however, a person
30 who has resided in the state for less than one year may receive services provided by
31 the Alaska health care clearinghouse under AS 21.54.230;

1 (6) is an individual insured under an individual state plan of health
2 insurance under the Comprehensive Health Insurance Association under AS 21.55;
3 and

4 (7) is receiving health care benefits under a medical care program of
5 the Indian Health Service that meet or exceed the benefits for essential health care
6 services; however, a person receiving health care benefits under a medical care plan of
7 the Indian Health Service may elect to participate in the Alaska health care program.

8 (b) The Alaska Health Care Board shall provide a voucher to a resident with
9 an income that is not more than 450 percent of the most recent federal poverty
10 guidelines, updated periodically in the Federal Register by the United States
11 Department of Health and Human Services under the authority of 42 U.S.C. 9902(2),
12 and who is only eligible for coverage through the Comprehensive Health Insurance
13 Association (AS 21.55). A voucher authorized by this subsection must equalize the
14 cost of insurance under the Comprehensive Health Insurance Association with the cost
15 of purchasing a health care insurance plan that provides substantially equivalent
16 benefits through the Alaska health care clearinghouse. For purposes of cost
17 comparison under this subsection, the Alaska Health Care Board shall determine
18 whether a plan provided under the Comprehensive Health Insurance Association
19 provides substantially equivalent benefits to a health care insurance plan offered
20 through the clearinghouse.

21 (c) A resident with an income that is not more than the most recent federal
22 poverty guidelines, updated periodically in the Federal Register by the United States
23 Department of Health and Human Services under the authority of 42 U.S.C. 9902(2),
24 who is required to participate in the Alaska health care program shall receive private
25 health care insurance coverage for essential health care services at no cost, paid from
26 the fund.

27 (d) A resident with an income between 100 percent and not more than 300
28 percent of the most recent federal poverty guidelines, updated periodically in the
29 Federal Register by the United States Department of Health and Human Services
30 under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska
31 health care program shall pay premiums for health care insurance for essential health

1 care services on a sliding scale established by the board.

2 (e) A resident with an income of 300 percent or more of the most recent
3 federal poverty guidelines, updated periodically in the Federal Register by the United
4 States Department of Health and Human Services under the authority of 42 U.S.C.
5 9902(2), who is required to participate in the Alaska health care program shall pay the
6 premium for health care insurance for essential health care services.

7 (f) A person who is an alien is not eligible for assistance under AS 21.54.200 -
8 21.54.310 unless the person is a qualified alien, as defined under 8 U.S.C. 1641, or an
9 alien excepted under 8 U.S.C. 1612(b). However, a qualified alien may only be
10 eligible for assistance under AS 21.54.200 - 21.54.310 if the person is not precluded
11 by the limited eligibility provision of 8 U.S.C. 1613.

12 **Sec. 21.54.250. Essential health care services.** For purposes of AS 21.54.200
13 - 21.54.310, essential health care services means medical services performed for an
14 individual covered by a health care plan for the diagnosis or treatment of
15 nonoccupational disease or nonoccupational injury. The medical services that must be
16 performed for an individual covered by a health care plan include, as a minimum,

- 17 (1) preventative and primary care;
18 (2) emergency services;
19 (3) inpatient services and hospital treatment;
20 (4) ambulatory patient services;
21 (5) prescription drug coverage; and
22 (6) mental health services.

23 **Sec. 21.54.260. Alternative or additional health care services.** (a) An
24 employer may offer health insurance coverage that meets or exceeds coverage for
25 essential health care services.

26 (b) An individual or employer may purchase health care insurance for health
27 care services in addition to the essential health care services required under
28 AS 21.54.200 - 21.54.310.

29 (c) If an employer does not provide a health care insurance plan for employees
30 or provides a health care insurance plan that meets or exceeds coverage for essential
31 health care services but does not enroll at least 25 percent of the employer's employees

1 in the plan or does not offer to pay at least 33 percent of the premium for health care
2 insurance under the plan, the employer shall pay the department as follows:

3 (1) if an employer has at least 10 and not more than 20 full-time
4 employees, the employer shall pay one percent of the employer's gross payroll; or

5 (2) if an employer has more than 20 full-time employees, the employer
6 shall pay two percent of the employer's gross payroll.

7 (d) An employer that establishes a cafeteria plan under 26 U.S.C. 125 (Internal
8 Revenue Code) that offers employees the option to elect health care insurance
9 coverage that meets or exceeds essential health care services is not subject to the
10 payment requirements under (c) of this section, regardless of whether an employee
11 elects to receive the offered health care insurance.

12 (e) In this section, "essential health care services" means those services set out
13 in AS 21.54.250.

14 **Sec. 21.54.270. Health care insurance plan; children's coverage.** (a) A
15 health care insurance plan that is approved by the director that provides coverage for
16 essential health care services under AS 21.54.200 - 21.54.310 and meets the other
17 requirements established under this title may be offered through the Alaska health care
18 clearinghouse.

19 (b) A health care insurance plan offered through the Alaska health care
20 clearinghouse may not deny enrollment to an eligible individual.

21 (c) A health care insurance plan offered through the Alaska health care
22 clearinghouse may include

23 (1) different benefits for network or out-of-network providers;

24 (2) varied levels of copayment, coinsurance, deductible amounts, out-
25 of-pocket maximums;

26 (3) high deductible health plans as defined by 26 U.S.C. 223(c)(2)
27 (Internal Revenue Code); and

28 (4) special insurance terms applicable only to individuals between 18
29 and 30 years of age.

30 (d) A health care insurance plan offered through the Alaska health care
31 clearinghouse that covers children must provide that the coverage will continue until

1 the earlier of the child's reaching 25 years of age or two years after the child no longer
2 resides with the family.

3 **Sec. 21.54.280. Alaska health care fund.** (a) The Alaska health care fund is
4 established as a separate trust fund of the state. The fund consists of

- 5 (1) state money appropriated to the fund;
- 6 (2) federal money appropriated to the fund;
- 7 (3) private employer and employee health care contributions or fees
8 received by the department and appropriated to the fund;
- 9 (4) health care premiums received by the department and appropriated
10 to the fund;
- 11 (5) other appropriations by the legislature;
- 12 (6) contributions appropriated to the fund from the United States
13 government and its agencies, or from any other source, public or private, provided for
14 purposes that are consistent with the goals of the Alaska health care program; and
15 (7) interest earnings from investments of the fund appropriated to the
16 fund.

17 (b) Contributions may be made to the fund by an employer, employers, or an
18 individual that is specified for a particular beneficiary. If a contribution is made to the
19 fund for the benefit of a particular beneficiary, the beneficiary shall receive a health
20 care voucher in the amount of the contribution that may be used to purchase a health
21 care insurance plan. Money collected under AS 21.54.260(c) is not considered made
22 for the benefit of a particular beneficiary.

23 (c) The board may use the fund for the purpose of administering the Alaska
24 health care program consistent with AS 21.54.200 - 21.54.310.

25 **Sec. 21.54.290. Disputes and appeals.** A person is entitled to notice and an
26 opportunity for a hearing under regulations adopted by the Alaska Health Care Board
27 if

- 28 (1) the board or the Alaska health care clearinghouse denies enrollment
29 to the person;
- 30 (2) an accountable health care plan refuses to enroll an individual or
31 fails to provide essential health care services; or

1 (3) the person is adversely affected or aggrieved by a decision of the
2 board or the clearinghouse.

3 **Sec. 21.54.300. Reporting.** The Alaska Health Care Board shall submit a
4 written report on the operation of the Alaska health care program to the commissioner
5 and to the legislature by January 1 of each year. The report must include

6 (1) the number of individuals enrolled in the Alaska health care
7 program;

8 (2) the cost savings to the state, to employers, and to health care
9 providers;

10 (3) a measure of patient satisfaction;

11 (4) an assessment of patient access to essential health care services;

12 (5) a description of the changes or adjustments made to the program
13 during the period covered by the report;

14 (6) a discussion of the state agencies delivering redundant services, if
15 any, relating to health care benefits;

16 (7) an evaluation of state programs that regulate or deliver health care
17 benefits;

18 (8) recommendations for legislative changes necessary to meet the
19 goals of the program;

20 (9) an evaluation of and recommendations on the following topics:

21 (A) the use of electronic health records;

22 (B) children's health insurance programs;

23 (C) the effectiveness of Medicaid; *Add Amend*

24 (D) the effect of mandated benefits;

25 (E) prescription drug bargaining;

26 (F) evidence-based treatment procedures including a
27 comparison of the use of evidence-based treatment in other states;

28 (G) the recruitment and retention of medical professionals in
29 the state;

30 (H) expanding offerings of the University of Alaska in medical
31 fields;

1 (I) maximizing federal funding to implement the program;

2 (J) innovations that could produce health care cost savings,
3 including waivers under 42 U.S.C. 1315 (sec. 1115, Social Security Act),
4 which allows experimental, pilot, or demonstration projects likely to assist in
5 promoting the objectives of the Medicaid statute.

6 **Sec. 21.54.310. Regulations.** The Alaska Health Care Board shall adopt
7 regulations under AS 44.62 (Administrative Procedure Act) consistent with
8 AS 21.54.200 - 21.54.310.

9 * **Sec. 3.** AS 21.54.500 is amended by adding new paragraphs to read:

10 (30) "alien" means a person who is not a citizen or national of the
11 United States;

12 (31) "board" means the Alaska Health Care Board;

13 (32) "fund" means the Alaska health care fund;

14 (33) "resident" or "residency" has the meaning given in AS 01.10.055.

15 * **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to
16 read:

17 **TRANSITIONAL PROVISIONS.** Notwithstanding AS 21.54.210, enacted by sec. 2
18 of this Act, the initial terms for members of the Alaska Health Care Board, except for the
19 commissioner of health of social services who serves ex officio, are as follows:

20 (1) four members shall be appointed to serve for a term ending December 31,
21 2009;

22 (2) four members shall be appointed to serve for a term ending December 31,
23 2010; and

24 (3) the remaining members shall be appointed to serve for a term ending
25 December 31, 2011.

26 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:

28 **TRANSITIONAL PROVISIONS: REGULATIONS.** The Alaska Health Care Board
29 established under AS 21.54.210, enacted by sec. 2 of this Act, may proceed to adopt
30 regulations necessary to implement this Act under AS 21.54.310, enacted by sec. 2 of this
31 Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not

1 before January 1, 2009.

2 * Sec. 6. AS 21.54.210, 21.54.220, and 21.54.230, enacted by sec. 2 of this Act, and sec. 5
3 of this Act take effect immediately under AS 01.10.070(c).

4 * Sec. 7. Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2009.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

April 24, 2007

SUBJECT: Sectional summary of SB 160, relating to an Alaska health care plan and health care insurance (Work Order No. 25-LS0728M)

TO: Senator Hollis French
Attn: Andy Moderow

FROM: Dennis C. Bailey *DCB*
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. States the findings supporting the bill.

Section 2. Sec. 18.06.010 creates the Alaska health care program to ensure that all residents have access to health care, to require that all residents have health care insurance, to reduce unsustainable health care costs, to establish a health care system that integrates public involvement, consumer choice, and competition in the private market; and to use health care models emphasizing preventive care and chronic disease management in a primary care environment.

Sec. 18.06.020 creates the Alaska Health Care Board.

Sec. 18.06.030 establishes the power of the board to certify certain health care plans, administer the Alaska health care fund, and adopt regulations that define services, establish standards, certify plans, establish criteria for participation in the program, and provide for the administration of the program.

Sec. 18.06.040 creates the Alaska health care clearinghouse to administer the health care program.

Sec. 18.06.050 requires that Alaska residents participate in the Alaska health care program subject to certain exceptions, provides that certain low income individuals receive coverage for essential health care services paid by the Alaska health care fund on a sliding scale, allows employers to provide health care coverage in addition to coverage for essential health care coverage, requires certain employers to pay penalties depending

Senator Hollis French

April 24, 2007

Page 2

on coverage and employee enrollment, and allows individuals to contract for additional coverage.

Sec. 18.06.060 requires plans to enroll individuals holding an Alaska health care card, defines coverage for preexisting coverage and coverage for children.

Sec. 18.06.070 establishes the Alaska health fund consisting of money appropriated from state, federal and private sources, premiums, interest earnings, and other sources. Allows contributions for a particular beneficiary to purchase health care coverage. The fund may be used by the board to administer the health care program.

Sec. 18.06.090 requires the board to report to the legislature regarding the operation of the plan and to provide recommendations for legislation to meet the goals of the plan.

Sec. 18.06.990 defines terms within the chapter.

Section 3. Outlines transitional provisions for the terms of the initial board.

Section 4. Allows the board to adopt regulations before their effective date, January 1, 2009.

Section 5. Provides for an immediate effective date for the bill sections that establish the board, the board's powers, the health care clearinghouse, and for the authority of the board to adopt regulations before the remainder of the bill becomes effective.

Section 6. Provides that the remainder of the Act, not effected by secs. 4 and 5 becomes effective January 1, 2009.

DCB:med
07-266.med

Alaska State Legislature



Senator Hollis French

Sponsor Statement

SB 160 - Affordable Health Insurance for All Alaskans

The time has come for us to begin addressing the health care crisis in Alaska. Increasing costs have made it difficult for businesses and individuals to acquire the health services they need. This crisis is only getting worse; family health insurance premiums have risen 4.6 times faster than the median earnings of Alaskans over the past 6 years. As costs continue to increase, it is likely that additional hard working Alaskans will go uninsured. Employers who choose to provide employee health plans will watch their costs go up, making it difficult to run a competitive business in the state. No longer can we wait for the federal government to take action on this important issue.

Many other states have joined the universal health care debate, but this bill is uniquely Alaskan. This bill puts people in control of their own health, giving them the tools they need to make smart investments. Vouchers, funded by a variety of stakeholders, make the prospect of acquiring health coverage realistic to all Alaskans. By guaranteeing that everyone has coverage, insurance premiums will go down. This bill ensures that everyone can purchase an affordable health plan that they select to fulfill their medical needs.

This bill establishes a framework mandating and ensuring affordable health coverage for all Alaskans. A board of 13 stakeholders will oversee the plan, making certain that residents are able to choose and purchase coverage that provides adequate care. The bill also provides:

A framework for personal choice: This bill facilitates a relationship between health insurance providers and individuals, and doesn't assume that a one size fits all solution will meet the health care needs of all Alaskans.

A unique voucher system: By pooling money from all stakeholders, a sliding scale voucher system will ensure that every Alaskan can take personal responsibility for acquiring health insurance coverage. The system will also make it easy for multiple entities to contribute towards a health plan for an individual.

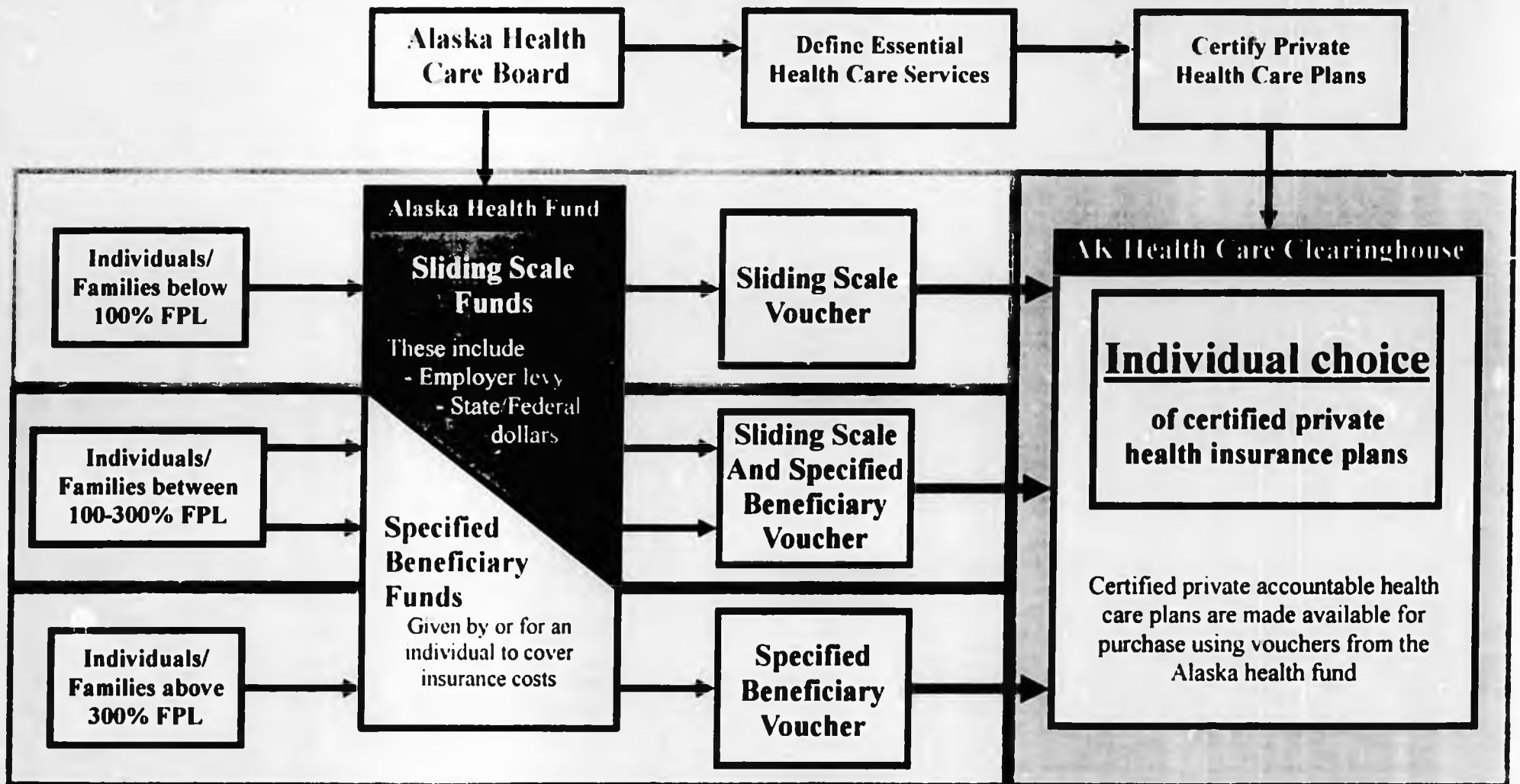
A health care clearinghouse: The clearinghouse will disseminate information about quality health care products, assisting Alaskans who are utilizing vouchers under the Alaska health care plan.

The Alaska health care fund: This fund will receive contributions from individuals, businesses and government to ensure that all interested parties contribute to the health of Alaskans.

Satisfied with your current coverage? This bill will not affect employer based health plans that provide quality health care coverage. In addition, the bill may reduce cost increases for those who currently pay for coverage. A hospital cannot turn down anyone in need of emergency care, and when someone cannot pay their medical costs, those who can pay are forced to subsidize the cost of the uninsured. A recent study estimated that Alaska health insurance premiums are 13.6% higher than they would be if everyone had health coverage (Families USA report). Through ensuring equitable financing of the health care system, SB 160 will reduce the burden on individuals and businesses currently buying coverage.

This bill isn't really about reforming the health care system; it is about ensuring the health of residents across the state. I urge you to consider supporting this bill as we work to improve the quality of life for all Alaskans.

Alaska Health Care: The Framework For Change



Senator Hollis French
Senator Johnny Ellis



Contact: Senator French
State Capitol, Room 417
Juneau, Alaska 99801
Phone: (907) 465-3892
Fax: (907) 465-6595

Affordable Health Insurance for All Alaskans

Frequently Asked Questions

Why is this bill necessary?

As medical costs increase uninsured Alaskans have greater difficulty taking charge of their own health, because the cost of insurance becomes prohibitive. Through a unique voucher system, this bill will allow individuals to purchase coverage that is affordable, putting everyone in charge of their own medical future.

Why is this bill necessary now?

Recent reports show that medical expenses for Alaska's families have increased 4.3 times faster than the median family income. Businesses across the country have expressed concern about rising insurance costs and the difficulty of providing quality health coverage to employees. The time has come to ensure that all Alaskans have access to affordable coverage, since without action things will only get worse.

How many Alaskans currently lack health insurance?

Numbers developed by the Lewin Group estimate that 15.5% of Alaskans lack health insurance, for a total uninsured population of 97,689.

I already have insurance, so why should this bill be of interest to me?

The impact of the uninsured is felt by all Alaskans, not only socially, but economically. When someone cannot pay their medical bills, the costs for their care is essentially covered by hospitals, businesses and the individuals who can pay. A recent legislative research report found that the State of Alaska, as an employer, paid an extra 18.9 million dollars for state employee benefits because of the increased prices caused by uncompensated care.

This bill ensures equitable financing of the health care system while reducing expensive emergency room procedures by encouraging preventative care.

Does this bill change my current employer based health insurance plan?

No - if you are satisfied with your current coverage and it provides essential health services no changes will occur.

Is this bill socialized medicine?

No, and far from it. Socialized medicine is characterized by government run health care; this bill protects consumer choice and encourages competition through a unique voucher system. Under the bill, the government only acts as a facilitator in the health coverage arena, making certain that everyone can afford quality health coverage.

How does the bill work?

This bill would establish the Alaska health care board, which would oversee the Alaska health fund and the Alaska health clearinghouse. The main goal of this bill is to have all Alaskans secure insurance by making basic health care plans affordable. Under the bill:

- The Alaska health care board will define essential health care services and certify private plans which meet the basic criteria
- The Alaska health care fund will enable all Alaskans to purchase insurance, giving vouchers on a sliding scale to those who simply cannot afford insurance on their own.
- The Alaska health care clearinghouse will provide information about health insurance products and will oversee the transfer of vouchers from the fund to an insurance provider, selected by the individual.

Alaska State Legislature

Senator Hollis French
Senator Johnny Ellis



Contact: Senator French
State Capitol, Room 417
Juneau, Alaska 99801
Phone: (907) 465-3892
Fax: (907) 465-6595

Affordable Health Insurance for All Alaskans

Summary of Bill Elements

Alaska Health Care Board ('the Board'):

Under the Department of Health and Social Services, this Board will consist of a broad based group of health stakeholders. The Board will:

- Administer the Alaska Health Fund
- Define essential health care services
- Establish criteria for participation in the Alaska Health Fund
- Establish procedures for enrolling participants in the Alaska Health Care Program
- Provide for issuing Alaska Health Cards to eligible individuals

An Alaska Health Card:

Issued to everyone who applies to use the Clearinghouse and is eligible for services under the Alaska Health Plan (residency is the only requirement).

Essential health care services:

Defined by the Alaska Health Care Board, essential services include the minimum set of benefits that must be included in an accountable health care plan

Accountable health care plan:

A health care plan that is certified as providing the minimum set of essential health care services

Alaska Health Care Clearinghouse:

The Clearinghouse will administer the Alaska Health Care Plan under the direction of the Board. It will also:

- disseminate information about insurance products
- set up a framework for purchasing insurance with pre-tax dollars
- issue sliding scale and specified beneficiary health care vouchers to qualified recipients, as defined below

The Alaska Health Fund:

The Fund will receive dollars from:

- state funds, including money currently allocated for uncompensated care
- federal funds
- private individual, employer and employee contributions

The Alaska Health Fund (cont.):

Dollars will leave the account in the form of health care vouchers, to be used only on accountable health care plans.

Health care vouchers:

Two types of health care vouchers will be issued from the Alaska Health Care Fund;

Sliding Scale vouchers

Paid on a sliding scale to those under 300% of the federal poverty level

Specified beneficiary vouchers

These vouchers are paid to a beneficiary who had contributions to the fund on their behalf, made by any party. The voucher amount will equal the full amount of the contributions made, and can be used to purchase coverage for the beneficiary and/or immediate family members

An individual who qualifies for a sliding scale voucher is also eligible to receive a specified beneficiary voucher.

Universal health care can work for us

By SEN. HOLLIS FRENCH

(Published: March 16, 2007)

A wave is beginning to build in state capitols across the country. In the face of inaction by the federal government, Maine, Massachusetts, Oregon, Vermont and now California are leading the effort to promote universal health care coverage among their citizens. In May 2006, Gov. Mitt Romney signed a bill that ensures health care coverage for all Massachusetts residents. California Gov. Arnold Schwarzenegger recently proposed a similar plan for the people of his state.

In the past, powerful interests have opposed universal health coverage. However, recent policy innovations have convinced many business and political leaders that fears about health care rationing and restricted access to doctors and hospitals are no longer valid.

These new plans do not call for the replacement of the current health care system with a new and untested model. This is not socialized medicine. Indeed, it is not the so-called single-payer system sought by the most progressive reformers. Instead, policymakers are taking the more pragmatic approach of retooling health care delivery methods that are currently in use.

The first principle of this new wave of health care legislation is individual responsibility. These laws impose a duty on each citizen to acquire some minimal form of health insurance coverage. This key idea recognizes that while the government has a role in shaping the health insurance landscape, ultimately it is the individual who must see to his or her own basic needs. This provision also ensures that the cost of health care is shared as broadly as possible.

Another major change in the law calls for employers who do not offer health insurance to their employees to contribute to a fund that would help pay for coverage of the working uninsured. This is a particularly needed reform here in Alaska. While many small business owners would like to offer health insurance to their employees, the cost is often out of reach. Some subsidy will be necessary to help those who work for very small businesses.

A comparison between Alaska and Lower 48 small businesses reveals the necessity of this reform. A March 2006 ISER study showed that only a third of Alaska businesses with fewer than 50 employees offer coverage, compared with 43 percent nationwide. The ISER study noted that 91,500 of the state's 224,500 private industry employees work for small businesses, meaning that over 60,000 working Alaskans do not get health care insurance through their jobs. This study helps defeat the notion that only the lazy or the poor are not covered by health insurance.

This reform does not have to be expensive. For example, the California plan requires businesses that do not offer health insurance and that have 10 or more workers to pay 4 percent of their total wages to a state fund that would be used to subsidize the purchase of health policies.

Another innovation redistributes Medicaid coverage in a couple of ways. The first is simply to expand Medicaid eligibility guidelines for children and adults and add enhancements such as dental and vision benefits. The other change is to take the Medicaid dollars currently being spent to reimburse hospitals and other providers for the free care they provide to the uninsured, and use

the money instead to subsidize health insurance for those who cannot afford it. Stop for a moment and consider what a good idea this is: Take the money spent on hospital bills each year for the uninsured, and buy health insurance instead.

These policy changes all lead to the goal of covering every citizen with a basic form of health insurance. I believe it is time for Alaska to take up the same challenge. I plan to introduce legislation that uses these enhanced policy tools to pave the way to universal health care coverage for all Alaskans.

Changing the health insurance system is not easy. Yet I am certain that someday we will look back on this era and ask ourselves, "What took so long?" There is no reason not to begin what will certainly be a spirited debate.

Hollis French is a Democrat who represents northwest Anchorage in the Alaska Senate.

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April 23, 2007

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Tel 907.562.2211

The Honorable Hollis French
Alaska State Senate
State Capitol, Room 417
Juneau, AK 99801-1182

Dear Senator French:

I write today in support of the concepts contained in your legislation establishing the framework to ensure affordable health coverage for all Alaska. I applaud your leadership, and that of the Senate, for bringing this critical issue to the forefront.

Providence Health System remains deeply concerned about the increasing problem of access to affordable, quality health care for the uninsured and the under-insured, as do I personally. As this problem continues to grow, it results in cost increases for medical care. Escalating health care costs are creating great difficulties for Alaska's employers, as I know you are aware.

I believe it is crucial for Alaskans to engage in a public policy debate on this important issue and this legislation provides an excellent forum around which this discussion can be held. Providence stands ready to assist in any effort that stands to improve the quality of health care delivery in our state, improves access to that quality care, and strives to make health care delivery more affordable.

Again, thank you for your willingness to begin a serious debate on this vitally important issue.

Sincerely,



Al Parish

VP/Chief Executive

April 20, 2007

Senator Hollis French
State Capitol, Room 417
Juneau, AK 99801-1182

Honorable Senator French,

I have reviewed your proposed health care bill, and want to wholeheartedly lend my support to your efforts to provide insurance to both the uninsured and the under-insured. It is time for all Alaskans, including legislators, health care providers, and citizens to recognize that there is indeed a health care crisis both nationally and in Alaska. With this bill, you are taking the aggressive step to solve the Alaskan problem with an Alaskan solution.

Your bill begins a discussion that is sorely needed. My experience both in the insurance and provider industry makes me appreciate your out-of-the-box thinking to create a system that relies on a privately funded health care insurance pool, not government-provided health care.

Finally, I want to thank you for addressing the coverage gap for Alaskans frequently and callously referred to as the "working poor." These hard-working Alaskans oftentimes have either no insurance or minimal insurance. The positive choice of maintaining employment comes with the penalty of unattainable health-care coverage.

Please continue your good work and let me know how I can help.

Sincerely,

James W. Shill
CEO



Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

A Bipartisan Solution To Cover The Health Needs Of All Alaskans

Senate Bill 160 Bill Packet—January 2008

Comments about the legislation:

Anchorage Daily News Editorial:

“BOTTOM LINE: Here's a promising, market-based, consumer-driven approach to universal health insurance in Alaska.”

- Published September 23rd, 2007

Al Parrish, VP/Chief Executive, Providence Health Systems Alaska:

“I believe it is crucial for Alaskans to engage in a public policy debate on this important issue and this legislation provides an excellent forum around which this discussion can be held.”

- Written in a letter to Senator French and included in this packet

Laile Fairbairn, Managing Owner, Snow City Café (located in Anchorage, AK):

“I feel that Senate Bill 160 is a very promising solution to a significant problem faced by a large number of Alaskan businesses.”

- Testimony during the September 10th bill hearing in Anchorage, AK

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Legislation Summary

Senate Bill 160 is an innovative, market based solution to the national health care crisis in Alaska. It is not socialized medicine. By maximizing consumer choice and creating a health insurance clearinghouse, this legislation guarantees affordable quality health coverage for all legal Alaskan residents.

Many working Alaskans cannot acquire insurance because the cost of coverage places a plan out of reach. While all Alaskans have legal 'access' to insurance products, those who cannot afford the full cost must hedge their bets on good health. Alaska's unique economy adds additional challenges: seasonal employees, for instance, find themselves outside the traditional 'group' market, lacking an easy route to maintain continuous, portable coverage. And with the amount of uncompensated care rising, the pressure on individuals and businesses who do buy coverage will only increase, because unpaid hospital bills are essentially transferred to those who pay for services. SB 160 will reduce uncompensated care and ensure that all Alaskans have meaningful access to health coverage, regardless of job type.

The solution requires that all Alaskans participate. While individuals will have the responsibility to acquire coverage under the bill, the state will guarantee that a quality insurance product will be affordable. Sliding scale vouchers will assist Alaskans that cannot afford the full price of coverage on their own. The bill allows for unique plans that cater specifically to young Alaskans. This legislation does not assume that a one size fits all solution will work for Alaska.

The health care 'clearinghouse' will give participating Alaskans choices when it comes to health coverage, in a competitive marketplace framework. It allows for unsatisfied consumers to change insurers or plans without a loss of benefits, and provides a private market solution to rising costs. By placing the consumer in control and providing information about comparable products, the clearinghouse should reduce cost increases while increasing customer satisfaction.

In short, this legislation will ensure that all Alaskans have access to health care in times of great need, through an equitably financed system.

Table of Contents:

Frequently Asked Questions	3
Personal Choice Under The Bill	4
Reducing Medical Bankruptcy	5
Vouchers Ensure Affordability/Access	6
Prevention and Innovation	7
Individual Responsibility	8
Proven Concepts	11
Seasonal Employment Issues	12
Small Businesses/Young Alaskans	13
Massachusetts and SB 160 Compared	14
SB 160 and Other State Efforts	15
Summary/Chart/Sponsor Statement	16
SB 160 Compass Article	18
Letters of Support	20

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Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Frequently Asked Questions

Why is this bill necessary?

As medical costs increase uninsured Alaskans have greater difficulty taking charge of their own health, because the cost of insurance becomes prohibitive. Through a unique voucher system, this bill will allow individuals to purchase coverage that is affordable, putting everyone in charge of their own medical future.

Why is this bill necessary now?

Recent reports show that medical expenses for Alaska's families have increased 4.3 times faster than the median family income. Businesses across the country have expressed concern about rising insurance costs and the difficulty of providing quality health coverage to employees. The time has come to ensure that all Alaskans have access to affordable coverage, since without action things will only get worse.

How many Alaskans currently lack health insurance?

The latest numbers developed by the Lewin Group estimate that 15.5% of Alaskans lack health insurance, for a total uninsured population of 97,689.

I already have insurance, so why should this bill be of interest to me?

The impact of the uninsured is felt by all Alaskans, not only socially, but economically. When someone cannot pay their medical bills, the costs for their care is essentially covered by hospitals, businesses and the individuals who can pay. A recent legislative research report found that the State of Alaska, as an employer, paid an extra 18.9 million dollars for state employee benefits because of the increased prices caused by uncompensated care.

This bill ensures equitable financing of the health care system while reducing expensive emergency room procedures by encouraging preventative care.

Does this bill change my current employer based health insurance plan?

No – if you are satisfied with your current coverage and it provides essential health services no changes will occur.

Is this bill socialized medicine?

No, and far from it. Socialized medicine is characterized by government run health care; this bill protects consumer choice and encourages competition through a unique voucher system. Under the bill, the government only acts as a facilitator in the health coverage arena, making certain that everyone can afford quality health coverage.

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Personal Choice Under The Bill

For more than 70 years a majority of Americans have received health coverage through their employer. Some see the system of employer based coverage as an unfortunate historical accident, largely resulting from federal tax loopholes following World War II. Others note that employers worldwide play a large role in providing coverage to their employees. SB 160 works within this country's traditional employer-based framework while guaranteeing portable, consumer centric coverage. This legislation places Alaskans in full control of health care decisions that dramatically affect their lives.

Nothing in SB 160 would require a person to change their health coverage if they are satisfied with the benefits they receive today. However, many Alaskans want more options. Through the health care Clearinghouse, this legislation will facilitate a new relationship between individuals and insurance providers: the bill does not assume that a one size fits all solution will work for all Alaskans.

SB 160 places individuals in control of their coverage decisions. Under the employer based system, the employer is a middleman between an individual and health coverage. Currently 80% of employer offerings give only one plan option to employees, and the individual must either accept or refuse that coverage. When employers decide which insurance company to contract with, the way a plan serves employees is clearly considered but coverage decisions

aren't left to the individual. The clearinghouse under this legislation provides consumers with information, leaving decisions of plan type and provider up to the person who is affected most by the decision.

The health care clearinghouse established under this legislation will create a marketplace where health insurance information is shared. The annual open season encourages competition by allowing individuals to change plan types and providers seamlessly, which has the potential to reduce rates. In short, this legislation will put Alaskans in a new position of control when designing their plan and choosing an insurer, through a competitive, market based framework.

80% of employers who offer subsidized health plans only offer employees one type of plan design.

- Heritage Foundation

References/For More Information:

Edmund Haislmaier - "The Mass. Health Reform: Assessing Its Significance and Progress" - Heritage Foundation 2007

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Reducing Medical Bankruptcy

Half of all personal bankruptcies in America are caused by medical problems. While health insurance alone won't provide perfect protection from large health costs, SB 160 could dramatically reduce the bankruptcy rates of Alaskans who will be faced with high medical expenses.

Coverage through the Clearinghouse separates insurance from employment, making a health insurance plan continuous despite job status. Sliding scale vouchers will exist for those who truly cannot afford the full price of a plan on their own, helping those who haven't had access to health coverage. For seasonal employers who generally don't offer a group plan to employees, the option of contributing some funds towards an employee's plan would become easier, and multiple employers could contribute. By ensuring affordable coverage, individuals will have financial protection in times of great need.

Three out of four people who cite medical problems as a partial reason for declaring bankruptcy had health coverage when their ailment began, but most had a lapse in that coverage before declaring bankruptcy. In an employer based coverage system, a job loss is coupled with a loss of employer subsidized benefits. While options do exist to extend coverage, these options charge an individual the full price of the employer offering, and often leave little or no choice in plan design. As mentioned earlier, over 80% of employer sponsored health plans across the country only offer one type of plan that employees

can either accept or reject. Often, employees with pre-existing conditions must either drop coverage altogether or pay for a 'Cadillac' plan if they want continuation of benefits, since private carriers in the individual market aren't required to provide them with a plan. For people participating in the clearinghouse, this legislation would open up options when it comes to plan design and portability.

To protect Alaskans, SB 160 makes certain that insurance products are of good quality, with the capability to protect the plan holder from a medical catastrophe. Insurance plans come in all shapes and sizes today, and that is a great thing for consumer choice. However, a one size fits all approach won't work in Alaska. As an example, while many Alaskans may prefer a low premium, high deductible health plan, a policy that has a \$10,000 deductible won't be of much use to an individual who makes minimum wage, amounting to approximately \$15,000 a year. By setting deductible, co-pay and out of pocket maximums for plans that qualify for sliding scale vouchers, SB 160 ensures that everyone has access to quality coverage that fits their financial needs.

References/For More Information:

David U. Himmelstein et al - "Marketwatch: Illness And Injury As Contributors To Bankruptcy"-Health Affairs 2005

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Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Voucher System Ensures Affordability, Access

The voucher system in this legislation promotes consumer choice for all Alaskans. Two types of vouchers will be issued under the bill. The first type puts the price of insurance within the reach of all Alaskans by providing assistance, on a sliding scale, to those who cannot afford the full cost of a plan. The funding for these vouchers would come from the levy charged to non-providing employers, as well as from state and federal contributions. Without sliding scale vouchers the individual responsibility component of the legislation wouldn't be meaningful, because insurance is priced out of reach for many working Alaskans.

The second type of voucher is issued to specified individuals, who have had contributions made on their behalf by an employer or another individual, for use on health insurance products. These vouchers create a convenient way for employers to pool health contributions for an individual, whether they have one or many jobs. In particular, specified beneficiary vouchers are particularly appealing for individuals with multiple jobs, because it helps multiple employers share the cost of coverage. The system also gives businesses some certainty of their

Alaskans spent \$5.3 billion on health care in 2005, a 230% increase from 1991.

- ISER

health expenditures in a given year, since expenses can be defined by contribution level and not by benefit package. The choice of plan type is left to the individual, for the obvious reason that he or she is most affected by the selection.

Contributions to specified beneficiary vouchers will not be mandated; instead, that element of the bill promotes equitable financing of health coverage by making it easier than ever for employers to contribute to the health and well being of their employees.

Affordability provides true access

Under current Alaska law any small business can buy private coverage, and every individual can buy an insurance plan, either through the private market or ACHIA (the state high risk pool). However, claiming that this equals access to health insurance is simply false. Access to health care must be more than just the legal right to buy a policy; it should ensure that all Alaskans have coverage in times of need. SB 160 mandates true access to health care through a unique voucher system that makes coverage affordable for all Alaskans.

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SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Prevention, Innovation and The Affordability Guarantee

Prevention and Innovation

This legislation acknowledges that lowering costs while improving quality requires innovative solutions to old problems. Under SB 160, the Alaska health care board will weigh in on potential cost and quality improvements, including but not limited to recommendations on:

- Electronic health records and health information exchanges
- Denali Kid Care/Medicaid effectiveness
- Prescription drug bargaining
- Insurance market reforms
- Mandated benefits
- Evidence based treatment procedures
- Recruitment and retention of medical professionals
- University of Alaska offerings in medical fields

The health care board's suggestions regarding cost and quality improvements will be given to the commissioner of the Department of Health and Social Services and the legislature in an annual report.

This report will get the consideration of both the legislative and executive branches, where substantive health policy changes can be considered, discussed and implemented.

***More than half of Alaska's
uninsured population is
employed.***

- Families USA

The Affordability Guarantee

SB 160 requires that quality basic health insurance is made affordable for all Alaskans. If an individual feels that he or she cannot afford coverage under the legislation's framework, that person has a right to an appeal before the health care board. If the board reviews the case and agrees that an insurance plan places an undue financial burden on the household, the requirement to have coverage will be lifted. While SB 160 should place the price of coverage within reach for all Alaskan families, the affordability clause in the bill provides a guarantee that no one will be forced to purchase coverage they cannot afford.

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Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Individual Responsibility - Financial Relief

Critics of the new type of universal health care efforts being implemented around the country have questioned the necessity of requiring that all residents have some form of health coverage. Yet, judging from these efforts, a consensus has been reached: Until something is enacted on a federal level, mandating coverage is the only responsible option for promoting universal health coverage in a state today. Beyond the social benefit of making certain that all residents have better access to health care, there are also economic reasons why reform efforts must include everyone.

Financial Relief For Current Policyholders

In a sense, universal health care is already provided in America because emergency rooms cannot turn down a person in need of medical attention. While this system may provide emergency care for all Alaskans, it doesn't equal universal access to health care in times of need, nor does it protect the financial concerns of the insured or uninsured alike. In addition to producing less than ideal health outcomes for those who lack coverage, it also places an undue financial burden on people who do buy coverage. And this financial burden is large.

The amount of uncompensated care in Alaska is staggering. Families USA estimate that \$125 million of uncompensated care is provided each year in Alaska, and that only 21% of that bill is reimbursed by federal, state and local governments. That leaves

medical providers with \$100 million of unpaid bills every year. This doesn't mean that hospitals 'lose' money every year: To make up for outstanding bills, hospitals charge more to people who can actually pay for services. Since government health care reimbursement rates are often at or below the actual price of providing care in Alaska, nearly the entire burden of uncompensated care is recouped through inflated insurance premiums.

How much does the cost of an average plan go up? Families USA estimates that 13.6% of an insurance premium in Alaska covers uncompensated care costs, meaning that, for a family of 4 with a comprehensive policy, nearly \$1,500 a year go towards covering uncompensated care. SB 160 ensures that everyone can afford quality basic coverage, potentially reducing the amount of uncompensated care given out by hospitals. This element of the bill will give much needed relief to everyone who currently invests in health coverage.

An estimated 125 million dollars of medical bills aren't paid each year in Alaska.

- Families USA

References/For More Information:

Families USA - "Paying a Premium: The Added Cost of Care for the Uninsured" - June 2005

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Individual Responsibility - Improving The 'Pool'

Improving the 'Pool' to Increase Affordability

An insurance 'pool' is a bundle of risks. It works this way: for the sake of determining premiums, a 'pool' is a group of individuals who are considered together when determining expected medical costs. Once anticipated costs are determined, each member of that pool can be billed for a fair portion of what expenses the 'pool' is likely to incur on their behalf.

Adverse selection occurs when individuals utilize their private knowledge of their own health when deciding whether to buy health insurance. Since an individual has better knowledge of their lifestyle, habits and health than an insurance company, adverse selection has the potential to greatly affect who buys insurance. Simply put, people who expect to be sick want health insurance more than healthy people.

Certain pools are affected by adverse selection more than others. As an example, in the individual market, the decision to buy or forego insurance isn't left to chance – someone must make the conscious decision to buy a plan. Employer provided coverage, on the other hand, doesn't always require that the employee opt in: Often coverage is highly subsidized or provided free of cost.

The best insurance pool includes both healthy and

sick individuals. If pools are structured to distinguish between people by health, the cost of insurance for those with severe illnesses will be extraordinarily high, and out of reach for most Alaskans. Similarly, if a pool only includes healthy individuals, the costs of a plan may be lower for those who are included, but the amount of uncompensated care would be high, since plans for those with severe health problems would be cost prohibitive. Today the amount of uncompensated care is large, and as discussed earlier, that cost is transferred to Alaskans that do have coverage.

Adverse selection has undoubtedly raised the costs of plans in Alaska's health insurance marketplace through self selection within the individual market. And while the Alaska Comprehensive Health Insurance Association (ACHIA) was created by the state to provide health coverage to individuals with pre-existing health conditions, the offered plans are often cost prohibitive for normal Alaskans. This legislation will reduce adverse selection by ensuring that all Alaskans participate.

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Individual Responsibility - Avoiding Price Spirals

Damaging price spirals are often caused by adverse selection in voluntary participation health reform efforts. When an individual weighs the decision to buy coverage they consider many factors, including the cost of a plan, what they can afford, and the probability of requiring care. This often causes people of good health to forego insurance, since they figure the odds are in their favor. And when healthier individuals don't acquire coverage, the pool of people who do purchase insurance is more likely to require health attention. As a result, premiums increase.

The price of coverage in voluntary state reform efforts that include some individual contributions have often spiraled upward after introduction, with plan costs increasing when the healthiest individuals decide to hedge their bets on good health. Once the healthiest people in the pool leave, the expected cost per member increases. If these price increases are charged to individuals within the pool, additional people may reconsider their participation in a voluntary plan. Maine's Dirigo program ran into this problem, when fewer people than expected signed up, and once the program began, the spiraling effect occurred as the participation price increased. If everyone is required to get 'in the pool' this price spiral will be eliminated.

"The problem is that the individuals in the insurance pools don't cooperate. Guaranteed issue and community rating regulations cause premiums to be higher than would otherwise be the case. As a result, the healthiest individuals drop their coverage, leaving the members with the highest health care costs in the pool. As the cost of care rises, premiums also go up, causing more members to drop out and creating a rising spiral of cost and premium increases."

- Portland Press/Maine Sunday Telegram,
October 28, 2007

References/For More Information:

David U. Himmelstein et al - "Marketwatch: Illness And Injury As Contributors To Bankruptcy"-Health Affairs 2005

Martin Jones - "Rules make health insurance in Maine costly" - Portland Press/Maine Sunday Telegram, published October 28th 2007

Not Socialized Medicine

This legislation does not create a socialized system of medicine in Alaska. Socialized medicine is characterized by government run health care: Under this legislation, the only role of the government is to guarantee that all residents have true access to health coverage.

For more information, contact Sen. French's office:

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www.healthyalaskans.com

Proven Concepts - Learning From Programs That Work

While many critics of consumer centered health reform claim that the ideas haven't been tested, these critics fail to recognize several extremely successful consumer driven programs in place today.

The first is the Federal Employees Health Benefit program. This program provides federal employees, retirees and their survivors with the "widest selection of health plans in the country" through a mechanism much like the clearinghouse under SB 160.

The program provides information about numerous plan providers and types, giving consumers a meaningful role in choosing their health coverage. Plans offered through the FEHB program feature no waiting periods for enrollees, and all participants are guaranteed that a plan will accept them. The health care clearinghouse in SB 160 will provide a similar system which can be accessed by all Alaskans.

The bi-partisan reform effort being implemented in Massachusetts is still young, but the results thus far are encouraging. One year after the legislation was enacted over 200,000 previously uninsured residents gained health coverage in Massachusetts. This effort ensures that similar successes can be seen in Alaska, largely through the Massachusetts inspired sliding scale voucher system under SB 160.

Since the passage of Governor Romney's health reform effort, consumer choice has drastically increased while uncompensated care has decreased in the state of Massachusetts. Over 44 different types

of plans are available in the Massachusetts Connector, which, when compared to the standard employer offering of only one plan type, represents a large improvement of choice for residents of the state. Furthermore, uncompensated care has decreased by almost 13% in the state during the first year, even though the plan was just being implemented during that time. When everyone has coverage further declines should be seen.

By no means is this to say that a silver bullet exists, but, so far, the results of both programs are encouraging. This legislation builds an Alaskan version of health reform practices like these that are working in different parts of the country.

Learn about these successful programs online

Federal Employee Health Benefits Program:
<http://www.opm.gov/insure/health/>

Massachusetts Commonwealth Connector:
<http://www.mahealthconnector.org/>

References/For More Information:

Federal Employee Health Benefits Program:

<http://www.opm.gov/insure/health/about/fehb.asp>

Lisa Eckelbecker - "The Insurance Countdown" - Worcester Telegram and Gazette, published November 18th, 2007

For more information, contact Sen. French's office:

Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us

www.healthyalaskans.com

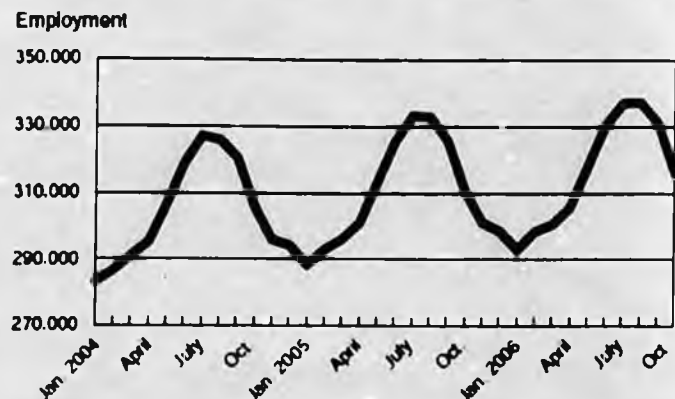
Continuity of Coverage**Seasonal Employment Requires a Creative Solution**

Alaska's natural landscape provides unique employment opportunities in the state. Both the tourism and fishing industries peak during summer months, with relatively little activity during the middle of winter. Judging from historic employment data, there are roughly 45,000 fewer jobs during the peak of winter compared to the busiest months in the summer. While the economic benefits that come with seasonal employment are great for Alaskans – tourism alone brought \$1.8 billion into the state last year - many workers in seasonal industries work for multiple employers over the course of a year. Unfortunately, this doesn't line up with the traditional employer based health insurance model.

The United Fishermen of Alaska have expressed particular concern over this issue, noting that a lack of health insurance options creates a significant barrier of entry for future generations of commercial fishermen. In particular, they note difficulty with the traditional group market structure, because fishing organizations don't fit the traditional mold of a group client. The marketplace solution provided through the health care Clearinghouse should help fishermen, and all other seasonal employees, get many of the group benefits of coverage while maintaining the portability that seasonal workers require. Edmund Haislmaier, a senior research fellow at the Heritage Foundation, noted that few people are unin-

sured for years at a time: In fact, he has found that up to 40% of the national uninsured problem could be solved if coverage was tied to an individual, and not an employer, because the shorter lapses of coverage could be prevented. Alaska's seasonal industries give the state even more reason to tie coverage to the individual, to make certain that benefits are available when they are needed.

Chart from "Making sense of Alaska's unruly numbers":



Source: Alaska Department of Labor & Workforce Development, Research and Analysis Section, *Employment and Earnings Report*

References/For More Information:

Dan Robinson - "Making sense of Alaska's unruly numbers" - Alaska Economic Trends, December 2006

United Fishermen of Alaska - "Alaska Fishermen's Health Care - Challenges and Opportunities" - Aug. 2001

For more information, contact Sen. French's office:

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Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Unique Solutions for Business, Young Alaskans

Structured With Small Business In Mind

Most Alaskans who lack health coverage also work for a living, leaving behind the notion that only the unemployed require assistance when it comes to making health coverage affordable. Even the most successful small Alaskan businesses can have difficulty providing coverage, because of the high costs of health plans. This legislation aims to strengthen businesses around the state by putting coverage in reach for all employees.

Clearly a healthy workforce is more productive, because absenteeism and productivity is tied to the health of an individual. But in addition to health benefits that would arise if everyone had access to basic medical care, Alaska's businesses have much to gain through this legislation economically. Retaining qualified employees is difficult for businesses that cannot afford coverage. This forces high retraining expenses on employers, since they must fill vacancies more frequently than businesses that provide coverage. In addition, recruitment is more difficult for companies that don't offer coverage.

The employer levy under the bill provides for equitable financing of health coverage. For businesses with fewer than 10 full time employees, no non-providing employer levy will be charged. For businesses with 10 to 20 employees, a 1% gross payroll tax will contribute towards health coverage for the uninsured. For businesses with 20 employees or

more, a 2% tax will be levied. However, businesses get a lot from this levy; it includes a state guarantee that all current and potential employees will have health coverage in Alaska. In addition, companies that currently invest even a small amount of money into employee health coverage will be exempt from this levy.

Young Alaskans Have Unique Needs

Young Alaskans have special needs when it comes to their health coverage. Statistically, they require less health services than their older counterparts. They also show less of a willingness to pay for expensive, comprehensive coverage, and even a moderate deductible can be difficult to pay, particularly for college aged students. This legislation acknowledges that young Alaskans have unique needs, and it provides for a special category of plans that are designed specifically to fulfill their health requirements.

For more information, contact Sen. French's office:
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SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Massachusetts and SB 160 Compared

Issue Area	Alaska - SB 160	Massachusetts - Enacted
Sliding Scale Subsidies <i>Definitions:</i> FPL = Federal Poverty Line	<p>Yes: Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage affordable. Residents only eligible for ACHIA coverage will receive vouchers up to 450% FPL.</p> <p>Health care vouchers will put the consumer in control when choosing a plan and a provider.</p>	<p>Yes: Households with income below 300% receive subsidized health coverage through the connector. For individuals who utilize vouchers, one plan type is available to households below 200% FPL and two plan types are available to those earn between 200-300% FPL.</p>
Establishing A New Insurance Marketplace	<p>The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.</p>	<p>The Connector provides information, encourages competition, and helps residents learn about different coverage options. It is a web-based marketplace.</p>
Requirements for Consumers	<p>All Alaskans would be required to have a minimum level of coverage, as defined by statute. If a product isn't affordable a hearing process allows for some exceptions.</p>	<p>All residents must have a minimum level of coverage, as defined by the Connector board. However, some residents have been exempted from the mandate because an affordable product isn't available to them.</p>
Effect on Existing Public Programs	<p>No changes to existing publicly funded programs.</p>	<p>Free care funds will still be available to hospitals, but the program will shift dollars from this account to the reform effort as more people get coverage and don't require free care.</p> <p>Medicaid reimbursement rates were also increased under the legislation.</p>
Financing	<p>Employer payroll tax, varying from 0-2% of payroll, depending on the number of employees.</p> <p>Federal dollars will be pursued through 1115 waivers.</p> <p>State funds will also be used.</p>	<p>Employer payroll tax of up to \$295 per employee for employers with more than 10 full time workers. A free rider surcharge can also be assessed if employers don't help employees get coverage and they utilize free care.</p> <p>Federal dollars from 1115 waivers have been funneled to the project.</p>
Insurance Market Reforms	<p>Yes: Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection.</p>	<p>Yes: By merging the non-group and small group markets, insurance is portable and not tied to employment. Massachusetts already had guarantee issue laws.</p>

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www.healthyalaskans.com

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Other State Reform Efforts

Issue Area	Alaska - Senate Bill 160	California - Governor Schwarzenegger's Plan	Colorado—Legislature's Blue Ribbon Commission
Sliding Scale Subsidies <i>Definitions:</i> FPL = Federal Poverty Line	Yes: Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage affordable. Residents only eligible for ACHIA coverage will receive vouchers up to 450% FPL. Health care vouchers will put the consumer in control when choosing a plan and a provider.	Yes: Households with incomes below 400% of the FPL will receive a tax subsidy to help cover insurance costs, residents below 250% FPL won't pay more than 5% of income for coverage, and individuals below 150% FPL won't pay anything- including co-pays and deductibles - for health care	Yes: Full subsidy of most basic plan for households with incomes below 250% FPL and partial subsidy for households below 300%. Colorado is also proposing a asset test and an additional subsidy to households below 400% of the FPL if a premium will be more than 9% of household income.
Establishing A New Insurance Marketplace	The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.	A purchasing pool will be established for residents who receive sliding scale assistance to cover health insurance costs.	The Coverage Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.
Requirements for Consumers	All Alaskans would be required to have a minimum level of coverage, as defined by statute. If a product isn't affordable a hearing can allow an exception.	All Californians must have a minimum level of coverage, as defined by the Secretary of Health and Human Services, through the regulatory process.	All legal residents of Colorado must have basic plan coverage, with some exceptions if a product isn't affordable. Basic coverage includes plans with benefit caps.
Effect on Existing Public Programs	No changes to existing publicly funded programs.	Expansion of S-CHIP to 300% regardless of immigration status, and Medicaid expansions to certain groups up to 250% FPL.	Expansion of S-CHIP to 250% and Medicaid. Allows for a Medicaid buy in program for households at 200% FPL and up.
Financing	Employer payroll tax, varying from 0-2% of payroll, depending on the number of employees. Federal dollars will be pursued through 1115 waivers. State funds will also be used.	Employer payroll tax, varying from 1-6.5% of payroll depending on payroll size. Hospitals will pay 4% of revenue towards the reform effort. Federal dollars will be pursued through 1115 waivers.	Increases in alcohol and tobacco taxes. In addition, taxes on snacks and soda will be established. Increase the state income tax. Federal dollars will be pursued through 1115 waivers.
Insurance Market Reforms	Yes: Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection.	Yes: Guarantee issue and guarantee renewal to all Californians in the individual market. Rating bands will ensure that only age and geography determine premiums. Health plans will have to spend 85% of premiums on patient care.	Yes: Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. High risk pool will exist for those who currently are uninsured. Premiums will equal the normal price paid in the individual market.

For more information, contact Sen. French's office:

Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us www.healthyalaskans.com

Summary of Bill Elements

Alaska Health Care Board ('the Board'):

Under the Department of Health and Social Services, this board will be a broad based group of health stakeholders.

The Board will:

- Administer the Alaska Health Fund
- Establish criteria for participation in the Alaska Health Fund
- Establish procedures for enrolling participants in the Alaska Health Care Program

An Accountable Health Care Plan:

Health plans that meet minimum benefits defined under the legislation will be certified as accountable health care plans, and be sold through the health care clearinghouse.

Alaska Health Care Clearinghouse:

The Clearinghouse will be a competitive marketplace where Alaskans can learn about different types of health insurance and purchase a plan which best suits their needs.

In addition, the clearinghouse will:

- Disseminate information about insurance products and set up a framework for comparing plans
- Provide information about purchasing insurance with pre-tax dollars
- Issue sliding scale and specified beneficiary health care vouchers to qualified residents
- Hold an open season, once a year, to allow maximum consumer choice of plans

The Alaska Health Fund:

Financing for this legislation will come from:

- The state, eventually including money that is currently allocated for uncompensated care
- The federal government, pursued through a Section 1115a waiver and other routes
- Private individual, employer and employee contributions

Dollars will leave the fund as vouchers, to be used only on accountable health care plans

Sliding Scale vouchers

- Paid on a sliding scale to those under 300% of the federal poverty level
- For Alaskans who only qualify for coverage under ACHIA, vouchers will be issued to individuals under 450% FPL

Specified Beneficiary vouchers

These vouchers are paid to a beneficiary who had contributions to the fund on their behalf, made by any party.

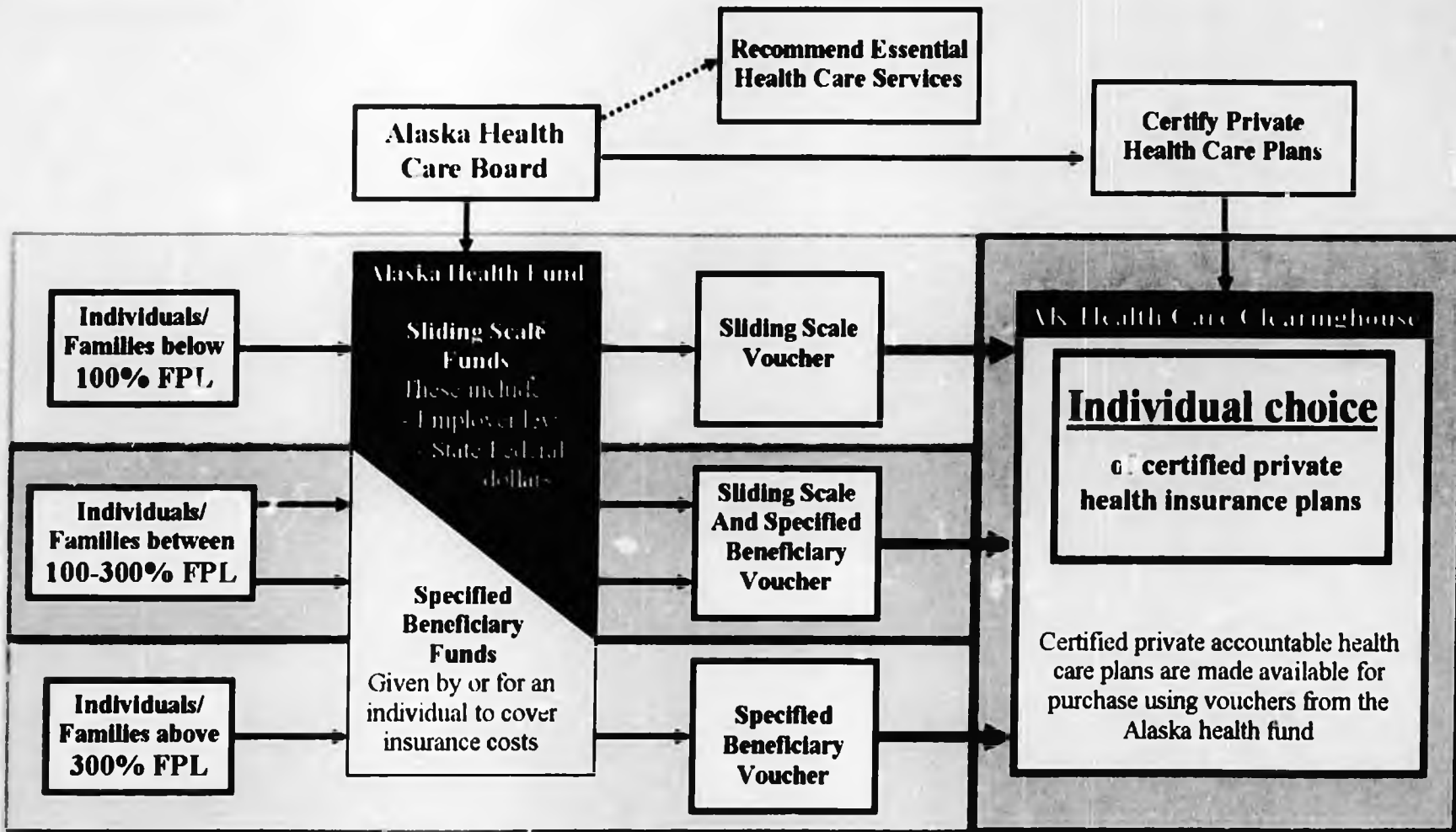
For more information, contact Sen. French's office:

Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us

www.healthyalaskans.com

Alaska Health Care: The Framework For Change

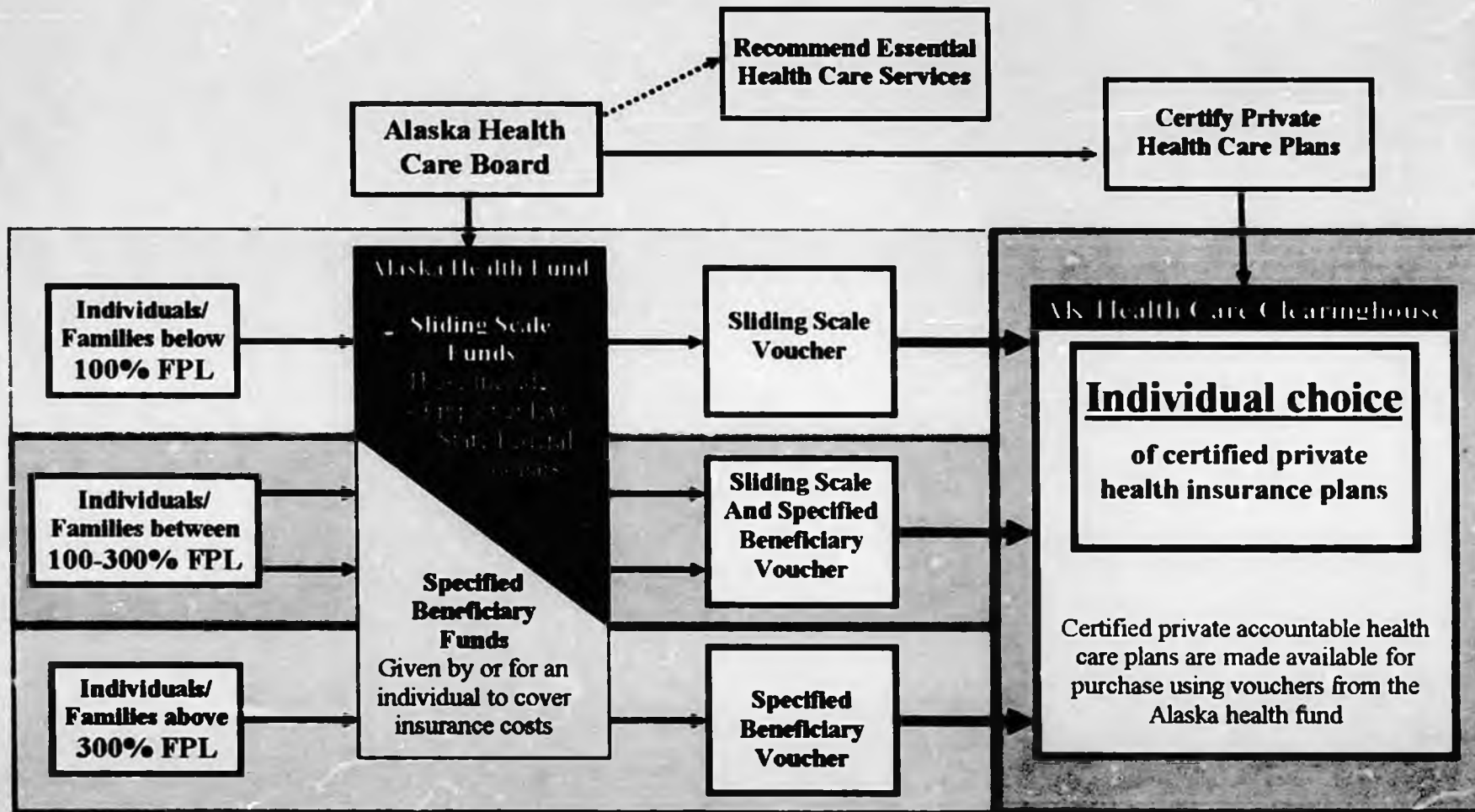
SB 160



Health Insurance For All Alaskans
Senators French, Ellis and Wielechowski

For more information, contact Sen. French's office:
Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us www.healthyalaskans.com

Alaska Health Care: The Framework For Change



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SB 1605

Health Insurance For All Alaskans
 Senators French, Ellis and Wielechowski

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB 160
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Departmental Support Services
 Component: Commissioner's Office

ID(File name) SB160-DHSS-CO-1-28-08
 Title: MANDATORY UNIVERSAL HEALTH CARE
 Sponsor: FRENCH
 Requester: SENATE (HES)

Component No. 317

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation		Information						
	Required		FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
OPERATING EXPENDITURES									
Personal Services	2,880.5		3,393.0	3,393.0	3,393.0	3,393.0	3,393.0	3,393.0	3,393.0
Travel	433.5		445.0	445.0	445.0	445.0	445.0	445.0	445.0
Contractual	2,275.0		1,300.0	1,300.0	1,300.0	1,300.0	1,300.0	1,300.0	1,300.0
Supplies	470.0		520.0	520.0	520.0	520.0	520.0	520.0	520.0
Equipment	416.5		62.0	62.0	62.0	62.0	62.0	62.0	62.0
Land & Structures									
Grants & Claims	164,111.1		328,222.2	328,222.2	328,222.2	328,222.2	328,222.2	328,222.2	328,222.2
Miscellaneous									
TOTAL OPERATING	170,586.6	0.0	333,942.2	333,942.2	333,942.2	333,942.2	333,942.2	333,942.2	333,942.2
CAPITAL EXPENDITURES									
CHANGE IN REVENUES (0)									

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	7,825.5		15,625.0	15,625.0	15,625.0	15,625.0	15,625.0	15,625.0
1003 GF Match	7,825.5		15,625.0	15,625.0	15,625.0	15,625.0	15,625.0	15,625.0
1004 GF	5,824.5		4,470.0	4,470.0	4,470.0	4,470.0	4,470.0	4,470.0
1037 GF/Mental Health								
NEW AK Health Care Fund-GF	147,620.0		295,240.0	295,240.0	295,240.0	295,240.0	295,240.0	295,240.0
NEW AK Health Care Fund-RSS	1,491.1		2,982.2	2,982.2	2,982.2	2,982.2	2,982.2	2,982.2
TOTAL	170,586.6	0.0	333,942.2	333,942.2	333,942.2	333,942.2	333,942.2	333,942.2

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time	43		43	43	43	43	43
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

The purpose of this bill is for all Alaskans to have access to essential health care services. It requires all residents to have health insurance and creates the Alaska health care program. Within the Department of Health and Social Services, the bill establishes the Alaska Health Care Board to oversee the program and the Alaska Health Care Clearinghouse as a division to administer the program, under the direction of the Board. The Board and Clearinghouse are effective immediately and are estimated for a full year for FY2009. The rest of the regulations are not effective before January 1, 2009 and assume 1/2 year for FY2009.

Continued on page 2.

Prepared by: William Streur
 Division: Health Care Services
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone 269-7827
 Date Time 01/25/2008
 Date 01/29/2008

ANALYSIS CONTINUATION

The bill lacks the specifics necessary to estimate accurately the fiscal impact. In this fiscal note, we present one scenario assuming a comprehensive health insurance plan similar to the State of Alaska employee plan.

This fiscal note takes a macro look at potential costs for state financial assistance to low-income persons through benefits provided under Medicaid or premium subsidies.

Costs for insurance premiums and the cost to Medicaid are very preliminary until the "essential health care services" are defined. This fiscal note reflects the high-premium scenario using the State of Alaska employee plan as a model and is not broken out by budget component.

Alaska Health Care Program

Participation is required for every resident who is not enrolled in a public medical assistance program (i.e. Medicaid) or a private insurance program that provides essential health care services. Persons below 100% of the poverty level would have no cost (presumably the state would pay). Persons between 100%-300% of poverty would pay premiums on a needs-based sliding scale. Coverage cannot be denied and persons with preexisting conditions can purchase additional coverage. Eff. Jan. 2009.

Assumptions:

- *The Fund only pays for the non-Medicaid eligible population. State matching funds for Medicaid do not come from the Fund.
- *The estimated cost for insurance premiums is \$11,000 per person per year (based on the State of Alaska employee insurance plan).
- *The cost of premiums to purchase insurance are on a needs-based sliding scale beginning with an individual between 101-125% of poverty paying 10% and increasing until an individual between 275-300% pays 80%. The state share of premiums will be paid from the Fund.
- *Co-pays and deductibles are not addressed in the bill so we assume none are required by any plan.
- *The estimated cost for medical benefits is \$3,000 per person per year (based on analysis of Medicaid claim payments). The federal government will reimburse the state approximately 50% of the cost for Medicaid claims.
- *There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, elderly = 800).
- *Approximately 20% of the uninsured population are Alaska Natives who have access to the tribal health system. Under this bill, they must participate and are included in our estimates.

Continued on page 3.

FISCAL NOTE

**STATE OF ALASKA
2008 LEGISLATIVE SESSION**

BILL NO: SB 160

ANALYSIS CONTINUATION

Cost Estimates for Alaska Health Care Program:

Below 100% of poverty: \$81,000.0 (7,500.0 fed/7,500.0 GF/66,000.0 Fund):

*27,000 persons are below 100% of the poverty level. No cost to the individual.

- 5,000 are children who would likely be eligible for Medicaid x \$3,000 per capita annual Medicaid benefits = \$15,000.0 (7,500.0 fed/7,500.0 GF).

- 22,000 would not qualify for Medicaid. We assume these individuals would have their coverage paid by the Fund in the form of medical benefits rather than more costly insurance premiums. 22,000 x 3,000 = \$66,000.0 Fund.

100-300% of poverty: \$247,222.2 total (7,500.0 fed/7,500.0 GF/232,222.2 Fund)

*43,000 have incomes between 100% and 300% of poverty. They would pay premiums on a needs-based sliding scale.

- 5,000 are children who would likely be eligible for Medicaid x \$3,000 per capita annual Medicaid benefits = \$15,000.0 (7,500.0 fed/7,500.0 GF). No cost to the individual.

- 38,000 would not qualify for Medicaid. The state and the individual share the cost of premiums. The annual per capita cost to the individual would range from \$1,100 (10%) to \$8,800 (80%) for an average of \$5,000. 38,000 x \$11,000 annual per capita premium = \$232,222.2 State pays from Fund; Individuals pay \$185,777.8.

Above 300% of poverty: \$0 total. No cost to the State.

*39,000 are above 300% of the poverty level and would bear the full cost of the mandatory insurance. 39,000 x \$11,000 premium = \$429,000.0 cost to the individual.

Totals

Total the State pays: \$328,222.2 (15,000.0 fed/15,000 GFM/298,222.2 Fund).

Total individuals pay: \$614,777.8

Grand total: \$943,000.0

Summary of Costs for Medicaid Program \$30,000.0 per year (\$15,000.0 federal/\$15,000.0 GF match). Eff. Jan. 2009. Of the 109,500 persons, an estimated 10,000 persons, mostly children below 175% of poverty, could be enrolled in Medicaid SCHIP without changes to the current eligibility guidelines. The 10,000 additional persons who could enroll in Medicaid are estimated to cost an average of \$3,000 annually for medical benefits per person. Options could be explored to expand Medicaid eligibility to maximize federal funding but it would be a lengthy process and as such are not included in this analysis.

NOTE: Additional costs of approx. \$1,250.0/yr (\$650.0 federal \$650 GF match) to administer the additional Medicaid caseload are included in this fiscal note including 18 new positions (12 eligibility technicians, 1 supervisor and 3 administrative support).

Continued on page 4.

ANALYSIS CONTINUATION**Alaska Health Fund**

This bill establishes the Alaska Health Care Fund as a separate trust fund consisting of state and federal appropriations, employer & individual contributions, premiums, and interest. Individual and employer contributions can be designated to a particular person who receives an Alaska Health Care Voucher in that amount to purchase an insurance plan. Employer contributions also come from employers with 10 or more employees that provide coverage to fewer than 25% of employees or pay less than 33% of the employee premiums. Employers with 10-20 employees contribute 1% of the employer's gross payroll. Employers with more than 20 employees contribute 2%.

*We assume the Fund will be comprised of 1% employer contributions in the form of receipt supported services (RSS) and 99% general fund. Massachusetts recently implemented a universal health program partially funded by employer contributions. Massachusetts estimated that less than 2% of their revenue would be come from these contributions. Of the \$24 million expected they are now expecting just \$5 million.

Other Costs

*Alaska Health Care Board = \$940.0 GF/yr including four State positions (350.0), travel (200.0), supplies (120.0), contractual (250.0), commodities/equipment (20.0), and one-time costs (67.0). Eff. immediately.

*Alaska Health Care Clearinghouse = \$3,530.0 GF/yr including 21 positions (2,018.0), travel (220.0), contractual (1,000.0), supplies (250.0), commodities/equipment (42.0), and one-time costs (287.5). Eff. immediately.

*The contractual costs are for a premium collection system. The department does not currently have a system to handle premium collections. The Medicaid program collects premiums only from a few hundred persons. The estimated cost to develop this system is \$2,000.0. The cost to maintain is \$1,000.0/yr.

*There is no known database of employers who provide insurance and to what level they provide it to determine if an employer must contribute to the Fund. This fiscal note does not include the cost of creating or maintaining such a database, which most likely would be under the Department of Labor and Workforce Development.

Alternate Low-Premium Scenario

An alternate premium scenario was prepared assuming a low premium of \$3,600 annual per capita (if similar to Arizona's plan). The cost for medical benefits remains \$3,000 per person per year. The annual per capita cost to the individual would range from \$400 (10%) to \$2,900 (80%) for an average of \$1,600.

Total the State pays: \$172,000.0 (15,000.0 fed/15,000 GF/142,000.0 Fund)

Total individuals pay: \$201,200.0

Grand total: \$343,200.0



Alaska

January 25, 2008

**The Honorable Hollis French
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182**

RE: Senate Bill 160

Dear Senator French,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 160. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

We're reminded weekly, if not daily, that 47 million Americans are uninsured. This hits especially close to home for small businesses, since approximately 27 million of those uninsured are the self-employed and small-business owners, their employees and their families. Many of those are in Alaska. Insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term.

The Honorable Hollis French

January 28, 2008

Page 2

Unfortunately, SB 160 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll. It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers.

The NFIB has adopted **Small Business Principles for Health Care Reform**. I have enclosed a copy for your review. NFIB knows that no one solution will help all the uninsured Alaskans cover health-care costs, but a multi-faceted approach will allow many more to find health care at costs they can afford. This approach should include health-insurance purchasing pools for small businesses, tax-based incentives to assist with the purchase of health insurance and implementing cost-containment measures.

Sincerely Yours



Dennis L. DeWitt
Alaska State Director

Enclosure

cc: **Senator Bettye Davis, Chair, Senate Health, Education, and Social Services
Committee
Senator Joe Thomas
Senator John Cowdery
Senator Kim Elton
Senator Fred Dyson**

Small Business Principles for Health Care Reform

Release Date: 12 / 12 / 2007

Our current system of health insurance and health care is financially unsustainable and threatens the health and financial security of the American people. Small-business owners and their employees are especially vulnerable to the weaknesses of our current system. NFIB supports policy reforms to balance the competing goals of access to quality care, affordability, and predictability and consumer choice. The resulting health care system would be:

Universal: All Americans should have access to quality care and protection against catastrophic costs. A government safety net should enable the neediest to obtain coverage.

Several reasons underlie our support for universal access to care. First, lack of insurance is especially problematic for small businesses and their employees. Second, having millions of uninsured Americans distracts us from focusing on affordability, quality and comprehensiveness of care and coverage. Third, laws already provide some level of insurance for everyone, but coverage is expensive, inefficient and often inadequate - guaranteed access to emergency rooms is one example. Under this piecemeal coverage, costs fall arbitrarily and inequitably on individuals, providers, governments and businesses.

Private: To the greatest extent possible, Americans should receive their health insurance and health care through the private sector. Care must be taken to minimize the extent to which governmental safety nets crowd out private insurance and care.

One-size-fits-all insurance and care are not wise options in a nation of 300 million people. Restoring and invigorating America's health care system requires rapid innovation; history shows that such rapid advances rarely come from government and more often come from private enterprises. America's health care system is far from perfect, but the world's single-payer systems have deep problems of their own. We need better health care delivery models, financial-management systems and risk-sharing arrangements. America remains the world's engine of health care innovation, and entrepreneurship is the key to that innovation. Given the current financial path of health care, governments ought to be wary of taking on the entire burden.

Affordable: Health care costs to individuals, providers, governments and businesses must be reasonable, predictable and controllable.

America's health care costs are high and growing more rapidly than earnings. The burden of costs often falls arbitrarily on individuals, businesses, providers and governments. Wages stagnate as health care costs eat further into take-home pay. Employers and governments struggle to balance budgets as health care costs rise. Health care uncertainties paralyze long-term financial planning. Through excessive malpractice judgments, we penalize good doctors practicing good medicine when their patients happen to experience bad outcomes.

Unbiased: Health care and tax laws should not push Americans into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Small employers should be treated the same as large employers, who can already pool across state lines. A health care system built on employer mandates or on play-or-pay taxes is unacceptable.

Today, our tax and insurance laws riddle the health insurance market with inefficiencies. An employer who buys insurance for employees can write off the cost on its taxes. But if employees wish to purchase different policies on their own, they receive no tax benefit. Thus, an oddity of the tax code, not economic efficiency, artificially herds businesses and workers into the employer-based market. Current laws allow large employers to build large interstate risk pools and enjoy a reasonable level of regulatory oversight. Laws deny small employers the same opportunities, forcing them to offer insurance with inadequate risk pools. The result is to arbitrarily load a competitive disadvantage on the small firms that are an engine of America's productivity. Employer mandates compound the problem, penalizing the most vulnerable firms and workers, including cutting-edge startups, lower-income workers striving to rise and companies operating in economically disadvantaged markets. These mandates can force a promising enterprise out of business, sweeping away jobs and future economic growth.

Competitive: Consumers should have many choices among insurers and providers. Policymakers must alleviate the limitations that state boundaries and treatment mandates place on competitiveness.

In the next decades, America's capacity to deliver high-quality health care will face increased financial pressures. Maintaining or improving upon our current quality of care will depend critically upon our ability to develop newer and less expensive modes of treatment and delivery systems. Innovation is unlikely to come from a system where insurers or providers face little risk of competition. Under our current system, restrictions on interstate purchases of policies place powerful limits on choice. Some states are left with close to monopoly control on the issue of insurance as fewer and fewer insurers offer coverage in the small-group market. A cautionary note is in order: Any competitive system must guard against adverse selection—a situation in which some individuals purchase policies only after learning that they are likely to face high medical costs. Adverse selection can render insurance too expensive for healthier individuals. (In property insurance, an example would be someone who buys fire insurance only after he moves dangerous, combustible materials into his house.)

Portable: Americans should be able to move throughout the United States and change jobs without losing their health insurance.

Our current health-insurance system locks people into jobs and localities. An existing health problem may make it impossible for an individual to change jobs. Employer-based health insurance and restrictions on purchasing insurance across state lines limit a worker's ability to seek higher pay, greater opportunity, or a better locality for his or her family. This phenomenon of

job lock is not only a tragedy for the locked-in worker. It harms the overall economy by preventing workers from discovering their own entrepreneurial talents or accepting more productive jobs. It creates a significant impediment to those who wish to leave positions as employees and start small businesses of their own. Health care reform must maximize the mobility of American workers by eliminating health insurance as an impediment to changes in job and residence.

Transparent: Information technology should enable all parties to access accurate, user-friendly information on costs, quality and outcomes. Providers must be able to obtain relatively complete medical histories of patients. At the same time, patients' privacy must be guarded zealously. The private sector must play a vital role in developing the new technologies.

In any market, buyers and sellers need accurate and useful information on costs, quality and performance of the product. Health care is no different in this respect. Well-functioning health insurance and health care markets require information that is easy for consumers, providers and insurers to obtain and that is comprehensible to all. Today, information is often difficult to obtain and incomprehensible to consumers and providers alike. This is a function of the system we have, and not an inherent characteristic of health care data. Governments will have a role in the development of new and better information technologies, but many of the breakthroughs can come only from the private sector.

Efficient: Health care policy should encourage an appropriate level of spending on health care. Laws, regulations and insurance arrangements should direct health care spending to those goods and services that will maximize health. Adequate risk pools throughout the health care system are vital to accomplishing these goals.

Today's health care system encourages misallocation of resources. All parties lack access to vital information for making medical decisions. Providers can give too little guidance on cost-effective treatments because they lack access to accurate, comprehensible, comparable cost data that provide true "apples-to-apples" comparisons of services and treatments. Reimbursement systems encourage excessive spending on health care and poor spending choices within health care. Medical delivery systems are poorly structured. American health care is on an impossible path, with costs rising much more rapidly than the country's real economic output. To avoid catastrophe, incentive structures across the system need to be reconfigured to give consumers, providers and insurers the educational tools and the motives to use their dollars wisely and efficiently.

Evidence-based: The health care system must encourage consumers and providers to accumulate evidence and to use that evidence to improve health. Appropriate treatment choices and better wellness and preventive care should be key outcomes.

Current information and decision systems make it difficult to accumulate, interpret and use evidence affecting treatment decisions. One result is overspending on treatments and underspending on prevention. Decision-makers must understand the impact of their decisions on both costs and outcomes. Such an understanding must be based on solid clinical and economic evidence.

Realistic: Health care reform should proceed as rapidly as possible, but not so quickly that firms and individuals cannot adjust prudently. It is important to assure that no one's quality of care suffers as we move to provide coverage for all Americans.

Reform is a delicate balancing act. Moving too slowly will allow costs to rise too far and too fast. In the process, the health of Americans will suffer, and the financial security of some will be disastrously impacted. But excessive speed is also risky. Thus, we must assure that reform does not allow some Americans to slip through the cracks—to lose coverage or see their costs rise too rapidly. Somewhere in between is a seamless transition from the status quo to a more efficient and equitable system.

**CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR
ALASKA**

P.O. Box 240976, Douglas, AK 99824

Phone: (907) 789-1544 Fax: (907) 364-2468 Email: bevsmith@gci.net

January 2008

**Amendments to Sponsor Substitute For SB160
Universal Health Care - Spiritual Care Amendment**

To meet the health care needs of Alaska residents, health care reform legislation should include coverage for spiritual care similar to other state and federal government plans that currently do so. To accomplish this, we request that the following amendments be incorporated into such legislation to provide for consideration of spiritual care benefits as follows:

Amend Section 2 of the bill, "Sec. 21.54.250. Essential health care services", to read as follows:

"Sec. 21.54.250. Essential health care services. For purposes of AS 21.54.200 - 21.54.310, essential health care services means ~~medical~~ services performed for an individual covered by a health care plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury. The ~~medical~~ services that must be performed for an individual covered by a health care plan include, as a minimum,
... (5) prescription drug coverage; ~~and~~
(6) mental health services; ~~and~~
(7) spiritual care services."

Explanation

Access to effective health care is a vital issue for us all. As our society is reaching out for solutions to the problem of effective, affordable health care, access to spiritual care and treatment can serve as one of the solutions to that problem and can benefit everyone.

Alaska has an opportunity to shape health care reform for the future, and set the bar on access to health care, including recognition that a spiritual approach to health care has been, and remains, both practical and beneficial to the public. Spiritual care already meets the health care needs of many Alaskans. This care is both reliable and effective, and makes bodies - and communities - healthier. If people are achieving complete healing through spiritual care without incurring large medical bills, society is benefited.

The goal of any mandated universal health care system should be to provide access to care that meets the needs of the entire community that is being asked to support it, encourages participation, and seeks to minimize the costs associated with such care. Spiritual care and treatment can do just that. If a health insurance mandate is imposed on Alaskans, it is crucial for the mandate to embrace access to the diversity of approaches to health care, including spiritual care, and not just a medical approach.

We applaud you for your efforts in bringing solutions to the health care challenges in Alaska and appreciate the desire to make humanity safer and healthier. We respectfully request that the inclusion of spiritual care as a covered benefit be expressed clearly within this legislation, so that legislative guidance is provided concerning the inclusion of coverage for spiritual care.

Don Burrell

From: Russell Sherfick [rusdeb@mtaonline.net]
Sent: Wednesday, January 30, 2008 9:02 AM
To: Sen. Bettye Davis
Subject: SB 160

I am interested in SB 160, the "Universal Health Care" bill, because I, like many others, want to be assured that "universal" includes coverage for, not only health care provided by the AMA, but alternative methods of healing also... methods that have been proven effective and affordable for many people around the country and the world.

Personally, I am a Christian Scientist and have enjoyed a healthy life through the care and treatment of Christian Science Practitioners and Christian Science Nurses. I hope that coverage for these services, and other alternative methods of treatment and healing, will be included in this bill as well.

Debbie Sherfick
Willow, AK



January 20, 2008

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 160 (French)

Dear Chair Davis:

On behalf of the 93,000 members of AARP in Alaska, we ask that you and your colleagues on the Senate Health, Education and Social Services Committee welcome SB 160, authored by Senator Hollis French and co-sponsored by Senators Wielechowski and Ellis.

We understand this is a "work in progress" and that you will be dealing with a Committee Substitute today.

We applaud Senator French's efforts to develop a health care plan that works toward access to adequate coverage for all residents of all ages.

AARP pledges that we will work with Senator French and your colleagues in the Legislature to support efforts to provide high quality, accessible and affordable health care that offers reasonable choices for all Alaskans.

Let the discussion begin!

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Marie Darlin".

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas
Senator John Cowdery

Senator Kim Elton
Senator Fred Dyson

Senator Hollis French

Don Burrell

From: Patricia Wilder [pcwilder@gci.net]
Sent: Tuesday, January 29, 2008 5:30 PM
To: Sen. Bettye Davis
Subject: Re: SB 160

Dear Senator Davis,

I understand that the above Bill regarding mandatory health insurance for Alaskans will be the subject of a hearing tomorrow, Wednesday.

As one of a number of practicing Christian Scientists in the State, I would want to be sure that language is included in the Bill that allows coverage for spiritual treatment and care. This would mean treatment by a Christian Science practitioner and care by a Christian Science nurse. During my lifetime, I have found that such spiritual care services have been very effective as well as affordable for myself, my husband, and our children.

So, my hope and request is that the final form of the healthcare plan will include coverage for spiritual care services in recognition of the rights of many members of the public to receive this effective, special form of health care treatment.

Thank you for your work for the public welfare.

Sincerely,
Patricia Wilder
Attorney at Law



April 23, 2007

3200 Providence Drive
P.O. Box 198804
Anchorage, Alaska
99519-6804

Tel 907.562.2211

The Honorable Hollis French
Alaska State Senate
State Capitol, Room 417
Juneau, AK 99801-1182

Dear Senator French:

I write today in support of the concepts contained in your legislation establishing the framework to ensure affordable health coverage for all Alaska. I applaud your leadership, and that of the Senate, for bringing this critical issue to the forefront.

Providence Health System remains deeply concerned about the increasing problem of access to affordable, quality health care for the uninsured and the under-insured, as do I personally. As this problem continues to grow, it results in cost increases for medical care. Escalating health care costs are creating great difficulties for Alaska's employers, as I know you are aware.

I believe it is crucial for Alaskans to engage in a public policy debate on this important issue and this legislation provides an excellent forum around which this discussion can be held. Providence stands ready to assist in any effort that stands to improve the quality of health care delivery in our state, improves access to that quality care, and strives to make health care delivery more affordable.

Again, thank you for your willingness to begin a serious debate on this vitally important issue.

Sincerely,

Al Parrish
VP/Chief Executive

Comments on SB 160

Lawrence D. Weiss PhD MS

Executive Director, Alaska Center for Public Policy
Editor, Alaska Health Policy Review

February 18, 2008

First, I want to congratulate the senators who have introduced Senate Bill 160: Senators French, Ellis, and Wielechowski. By introducing this bill, these legislators have shown serious interest in a very difficult problem, and they have put the whole question of access to health care for all Alaskans on the table for wide discussion. In light of that, I wanted to say a few words about the process of health policy formation. A sound, comparative, fact-based assessment of policy alternatives is more likely to lead to a policy that is actually effective and efficient. Policy driven by ideology and expedience is not.

Effective Public Policy

Based on the lack of any documented analysis, it appears that SB 160 was developed entirely in the absence of systematic comparison with other health reform approaches that might be less expensive, more effective, better able to meet the policy goals, and perhaps more likely to engender political support.

A few years ago, for example, the state of California was considering significant health care reform and state policy analysts invited nine different organizations to submit comprehensive proposals. On one side of the spectrum, were proposals that recommended minor tinkering around the edges of the health-care industry. On the other end of the spectrum, was a proposal that would create the California Health Service, a health plan in which all health care facilities would be publicly owned, and all health care providers would be civil servants. Here is a summary of the process and the criteria:

A competitive process was used to identify a contractor with experience in

microsimulation modeling to conduct an economic analysis of the reform options developed by health policy experts. The State selected the Lewin Group from among the bidders. Their final report provides a detailed discussion of the cost and coverage implications of each of the proposals. To assist readers in comparing reform options, each option is modeled as if it were fully implemented in 2002. A ten-year budget for each proposal also is presented. Substantial additional analysis also is provided in the report, including information about changes in individual out-of-pocket costs (by demographic category), changes in costs to employers (by size), and changes in costs for safety-net programs. The final report, including separate appendices providing additional analysis of each option, can be found at the HCOP website,

[\[http://www.healthcareforall.org/studies.html\]](http://www.healthcareforall.org/studies.html) www.healthcareoptions.ca.gov.

The State selected a second contractor, AZA Consulting, to conduct a more qualitative analysis of the reform options. The report looked at potential impacts of the reform options in four areas: access, utilization and continuity of care; quality and appropriateness of care; safety net; and vulnerable groups. In performing the analysis, the contractor identified key questions and issues in each area of interest and reviewed how each proposal addressed the questions and issues identified.

[Source: Report by The Health Resources and Services Administration, U.S. Department of Health and Human Services on the state of the uninsured, the overall health care environment, the Healthcare Options Project, and recommendations for a federally run healthcare program.]

Senator French has stated in public that the SB 160 proposal was specifically designed by the bill sponsors to minimize political opposition to a substantial health reform proposal, and it was based on a similar plan in another state. I will leave the discussion to others about the assessment of political opposition to various approaches to health reform. However, I question the wisdom of basing health care reform in Alaska on the Massachusetts plan. The Massachusetts plan itself appears to have several serious structural problems and to be underperforming in terms of its goals. It also appears to be far more expensive than projected. This requires serious review because it may very well be that the Massachusetts plan is not a

good health plan; and therefore, basing the Alaska plan on the Massachusetts plan would likewise not be a good idea.

Alternative Approaches to Consider

Finally, there is the question of what alternative approaches to health reform in Alaska could and should be compared with SB 160? In light of the costs to the state and the social consequences for Alaska families, a systematic and comprehensive analysis of various health policy alternatives is crucial to the development of good health reform policy. I suggest an approach that, in and of itself, could have a huge impact on the real issues of access to health care for tens of thousands of Alaskans—and I suspect would cost a fraction of what SB 160 is going to cost. In short, I suggest taking a serious look at the expansion of programs that we already have, that we know work, that we know are cost effective, and that have some quality of care elements built in:

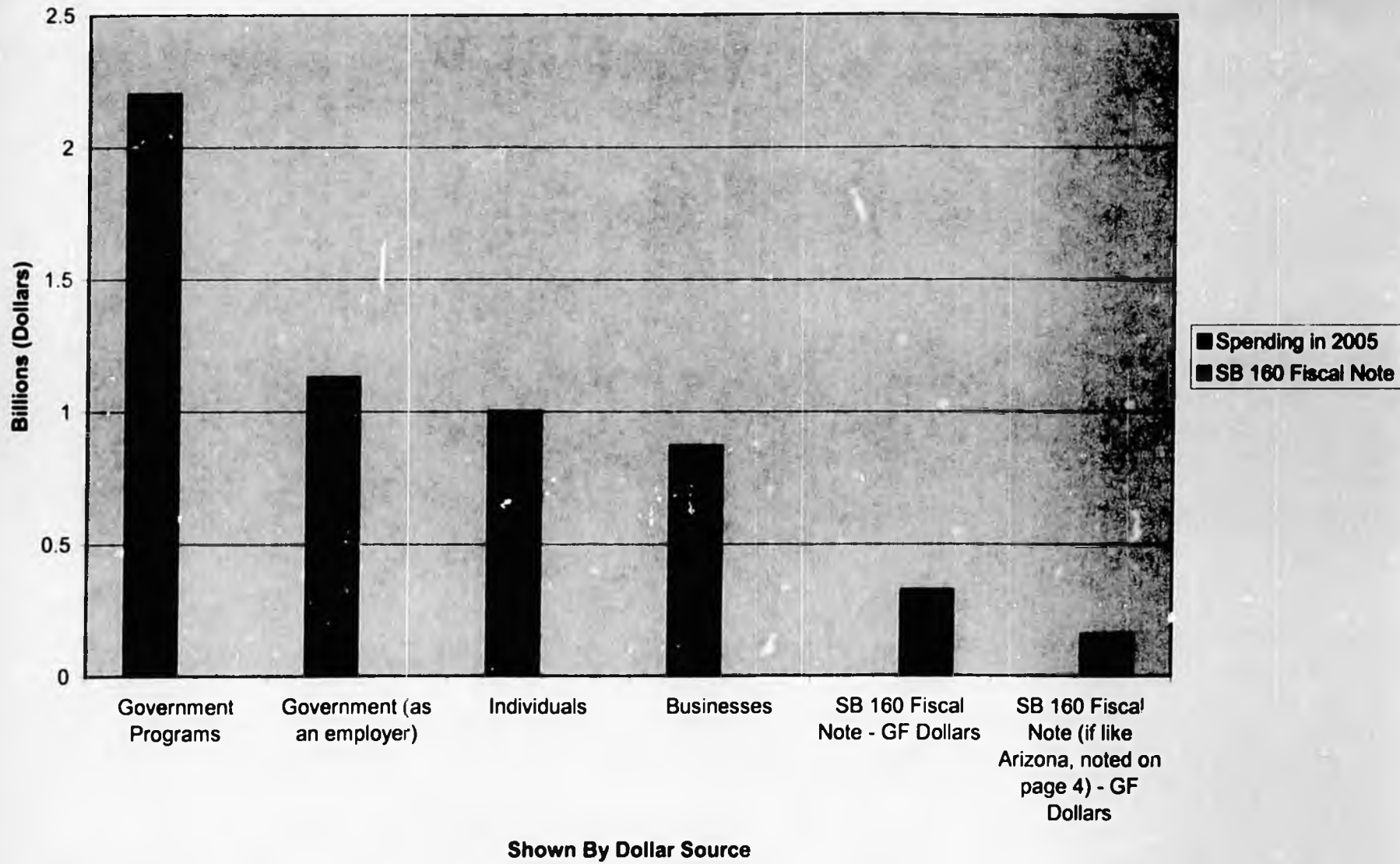
- Expand Medicaid to the maximum extent possible to serve Alaskans. A Medicaid insurance policy is much less expensive for the state than a comparable private health insurance policy, it costs the recipient nothing, co-payments and deductibles are minimal, and the federal government pays at least half of all the state's Medicaid costs.
- Expand Denali KidCare to the maximum extent possible, to serve as many Alaska children as possible. This has all the benefits of expanding Medicaid as noted above. In addition, recruitment for Denali KidCare was seriously hampered under the Murkowski administration by the firing of all five state recruiters for the program. As a result, there are perhaps 10,000 children who qualify for Denali KidCare but remain uninsured because they are not in the program. Hire back the recruiters.
- Develop a comprehensive package of funding for the 130 community health clinics scattered across Alaska to enable these nonprofit, federally-subsidized clinics to recruit and retain staff, and to directly serve those who need health care. This approach would completely eliminate the unnecessary administrative and other costs of private health insurance, and at the same time directly provide medical care to those in need. Patient care costs have been documented to be far below those in a for-profit health care setting.

Additional Supplementary Approaches

- **Require all commercial health insurers to submit documents for public review and to attend public hearings justifying premium raises.**
- **Require all health care providers, all pharmacists, all medical implement providers, and others in related health industries to publicly post prices.**
- **Sponsor a website that aggregates all available quality of care data for the public to evaluate.**
- **To the greatest extent justified, coordinate and support the training and recruitment of health care providers and public health professionals in the state of Alaska.**
- **To the greatest extent justified, support and expand the traditional preventive public health programs such as clean air, clean water, food inspections, job safety and health, etc.**

There is available factual information, and often formal research on all these proposals. It makes sense to spend a million dollars on health policy evaluation alternatives rather than hundreds of millions of dollars on a program that may prove to be expensive, inept, and unworkable.

Health Care Spending in Alaska during 2005 - \$5.3 Billion
(Source: ISER 2006)





Health Care in Massachusetts: Key Indicators

January 2008

**Deval Patrick, Governor
Commonwealth of Massachusetts
Timothy P. Murray
Lieutenant Governor**



**JudyAnn Bigby, Secretary
Executive Office of Health and Human Services
Sarah Iselin, Commissioner
Division of Health Care Finance and Policy**

About this Report

Health Care in Massachusetts: Key Indicators is a new quarterly report from the Division of Health Care Finance and Policy. *Key Indicators* provides an overview of the Massachusetts health care landscape through data reported by providers, health plans, government, and through surveys of Massachusetts residents and employers.

This report reviews the progress of statewide efforts to expand health insurance coverage, the financial performance of hospitals, community health centers and health plans, health insurance costs, and consumer access to health care. These indicators provide an important framework for measuring our progress as we continue implementation of health reform in 2008. A common baseline provides an opportunity to reflect on our course so far and to consider the opportunities and challenges that lie ahead.

The indicators in this report draw on data from many different sources. Notes at the bottom of each page describe the data source, methodology, and time period. We want to make this report as useful as possible and welcome your feedback on *Health Care in Massachusetts: Key Indicators*.

The Division would like to thank Nancy Turnbull of the Harvard School of Public Health for her strategic and analytic support in the conception and development of this report, and staff at the Department of Public Health, including Monica Valdes Lupi, Bruce B. Cohen, Gerald O'Keefe and Zi Zhang for their significant contributions to the health care access section. We also thank Robin Callahan and Ben Walker in the Office of the Medicaid Director; Bob Carey at the Commonwealth Health Insurance Connector Authority; and Catherine Moore at the Group Insurance Commission for their support and review of the data. Finally, we thank the staff at the health plans for their timely responses to our requests for enrollment data.

About DHCFP

The Mission of the Division of Health Care Finance and Policy (DHCFP) in the Executive Office of Health and Human Services is to improve the delivery and financing of health care by providing information, developing policies, and promoting efficiencies that benefit the people of Massachusetts.

The goals of the Division are to assure the availability of relevant health care delivery system data to meet the needs of health care purchasers, providers, consumers, and policy-makers; advise and inform decision-makers in the development of health care policies; develop health care pricing policies that support the cost-effective procurement of high-quality services for public beneficiaries; and improve access to health care for low-income uninsured and underinsured residents.

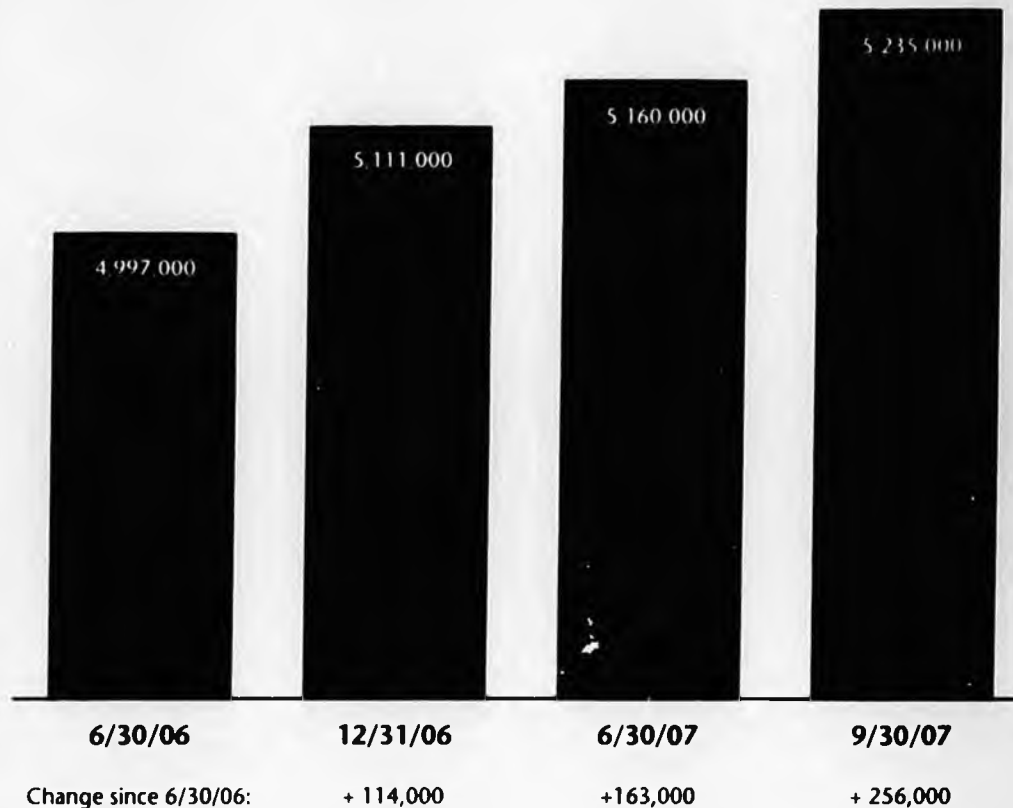
Contributing Staff: Han Huang, Rebecca Balder, Linda Green, Caroline Minkin, Kate Nordahl, Beth Perry, and Meenakshi Verma Agrawal
Design, Editing, Layout, and Distribution: Shelley Fortier, Harry O. Lohr, Jr., Emily O'Brien, Heather Shannon, and Rick Vogel

Table of Contents

Health Insurance Coverage	2
Employer Survey	4
Uncompensated Care Pool/ Health Safety Net	7
Health Insurance Premiums	10
Provider and Health Plan Financial Performance	12
Health Plan Financial Performance	12
Acute Hospital Financial Performance	16
Community Health Center Financial Performance	22
Access to Health Care	25

People with Health Insurance

Excludes Medicare Enrollees Ages 65+

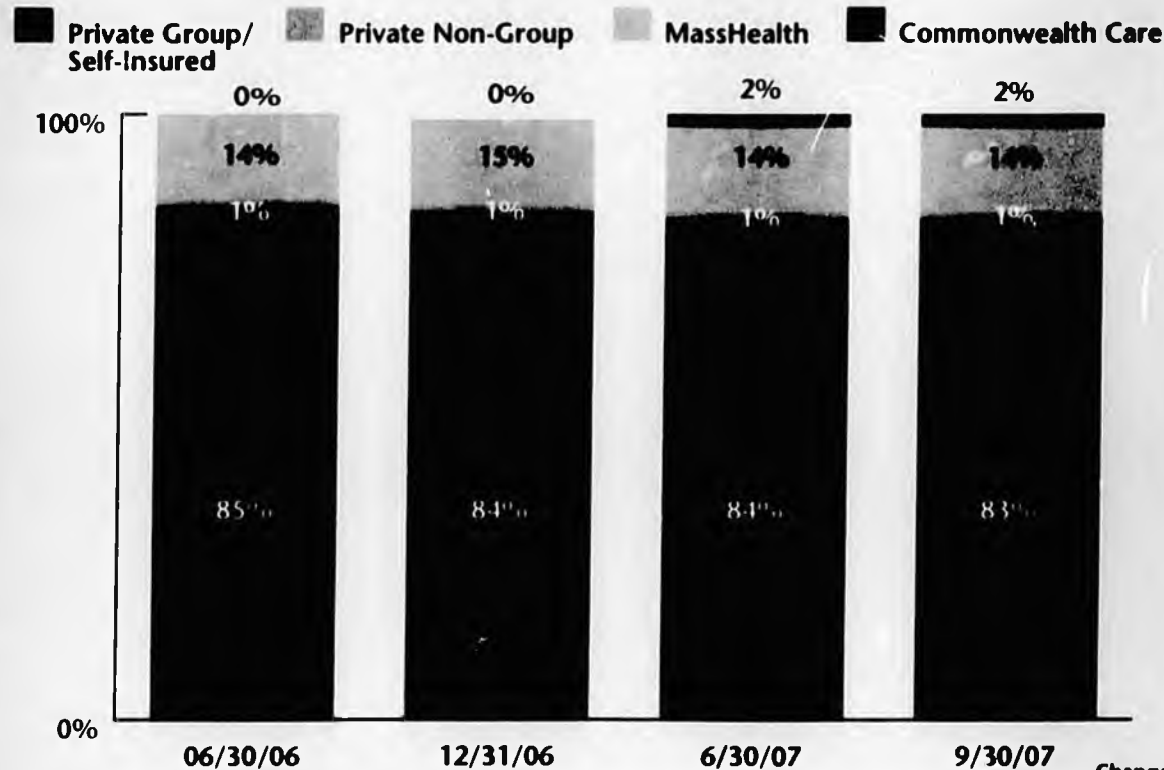


The number of people enrolled in private or subsidized health insurance products has increased by 256,000 people since health care reform began to be implemented.

Note: Data reflect total enrollment, rounded to the nearest thousand, as of the specified date. These data do not include approximately 18,000 people insured through small employers who purchase coverage from health plans that are not required to report quarterly enrollment statistics to the Division of Insurance. DHCFP intends to track enrollment in these plans in future versions of this report. Recent public announcements on new enrollments includes enrollment that took place after September 30, 2007.
Source: Membership reported to DHCFP by health plans, MassHealth, and the Group Insurance Commission; Commonwealth Care enrollment data are from the Connector.

Insured Population by Type of Insurance

Excludes Medicare Enrollees Ages 65+



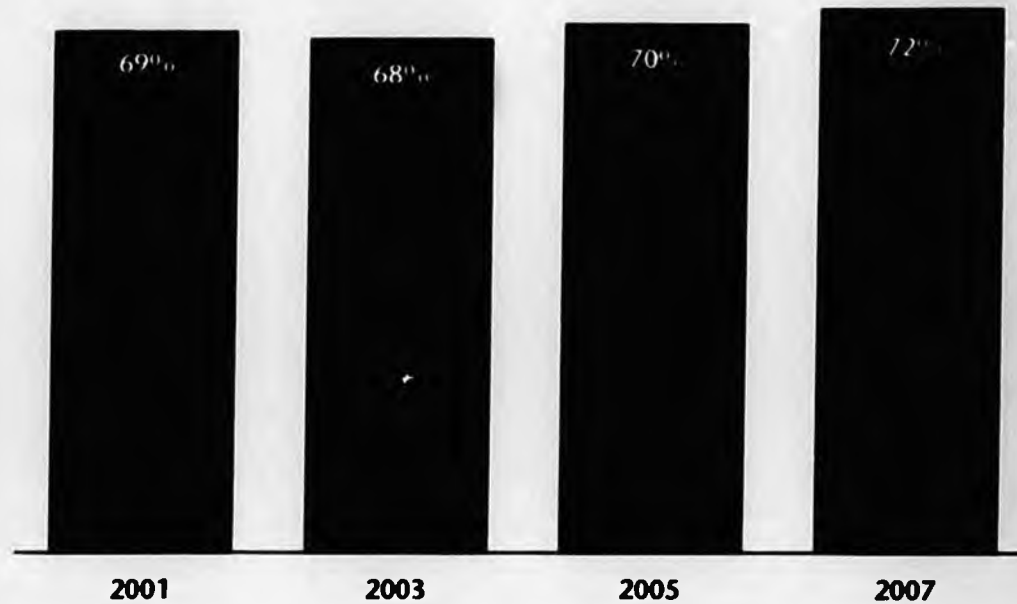
The distribution of the insured population by source of insurance has not changed significantly since health reform began to be implemented. However, private group insurance has grown by more than 100,000 enrollees.

Number of Members (rounded to the nearest 1,000):

	06/30/06	12/31/06	6/30/07	9/30/07	Change Since 6/30/06:
Private Group	4,235,000	4,297,000	4,297,000	4,341,000	+ 106,000
Private Non-Group	57,000	55,000	51,000	43,000	- 14,000
MassHealth	705,000	741,000	732,000	753,000	+ 48,000
Commonwealth Care	0	18,000	80,000	115,000	+ 115,000
Members under Age 65	4,997,000	5,111,000	5,160,000	5,253,000	+ 256,000

Note: Data reflect total enrollment, rounded to the nearest thousand, as of the specified date, excluding Medicare enrollees over age 65. Private Group includes group, small group, Commonwealth Choice, self-insured, and GIC members. Private Non-Group includes individual members. MassHealth includes members with comprehensive coverage and excludes those with partial coverage or premium assistance, such as Seniors, MassHealth Limited, individuals with third party liability (e.g. disabled with Medicare), and Family Assistance/Insurance Partnership. Commonwealth Care includes all private plans. These data do not include approximately 18,000 people insured through small employers who purchase coverage from health plans that are not required to report quarterly enrollment statistics to the Division of Insurance. Recent public announcements on new enrollments includes enrollment that took place after September 30, 2007. Source: Data reflect membership reported to DHCFP by health plans, MassHealth, and the Group Insurance Commission; Commonwealth Care enrollment data are from the Connector.

Employers Offering Health Insurance Percent of Employers

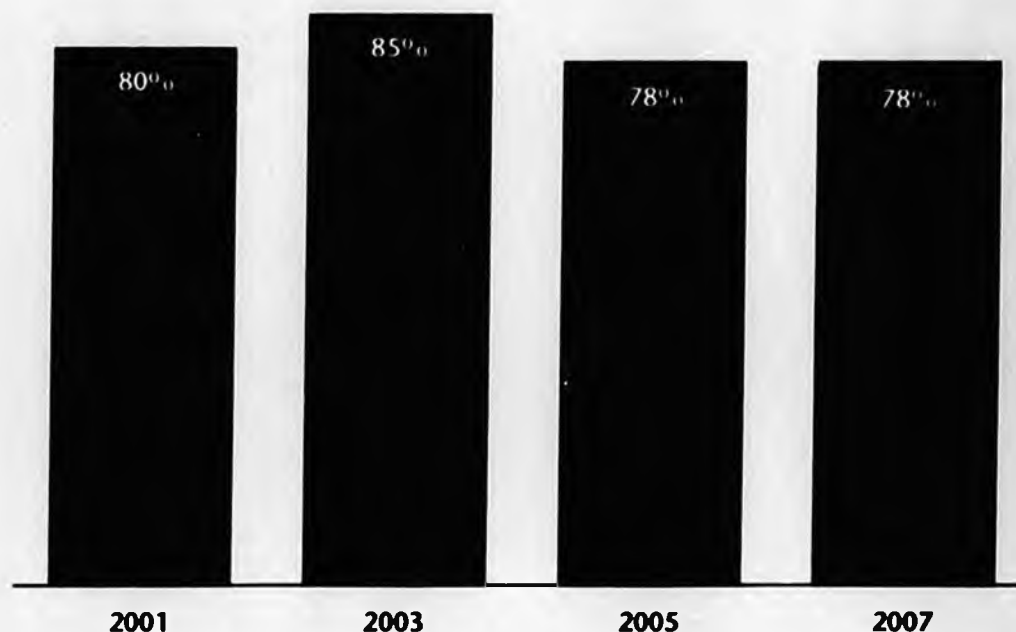


Nearly three-quarters of Massachusetts employers offer health insurance to their employees. The Massachusetts employer offer rate has held steady, even as the employer offer rate nationally declined from 68% to 60% between 2001 and 2007, as reported in the Kaiser/HRET survey.

Note: The changes from year-to-year are not statistically significant.

Source: DHCFP Employer Survey for 2001, 2003, 2005, and 2007. National data from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey, 2001-2007.

Employees Enrolled in Health Insurance Percent of Eligible Employees

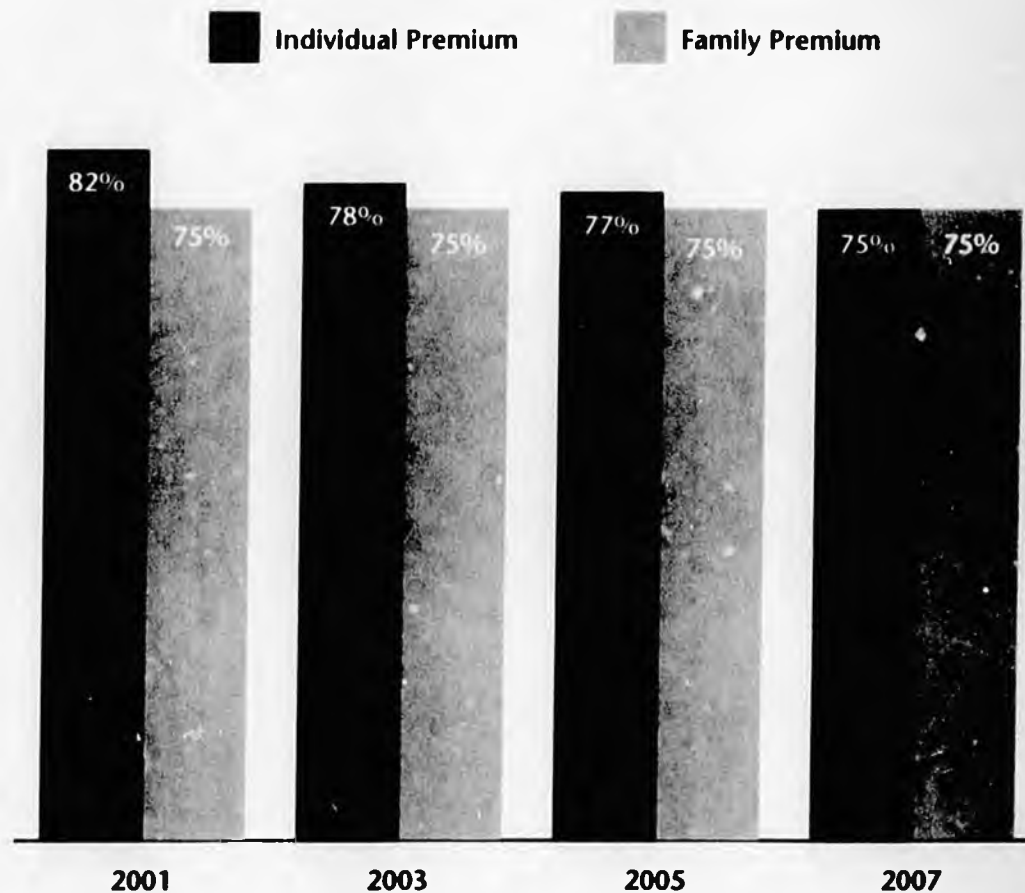


More than three-quarters of employees eligible for health insurance enrolled in their employer's health plan in 2007. Nationally, the take-up rate for employees eligible for health insurance was 82% in 2007 as reported in the Kaiser/HRET survey. While Massachusetts employers are more likely to offer coverage than employers nationwide, employees are less likely to enroll.

Note: Data reflect medians.

Source: DHCFP Employer Survey for 2001, 2003, 2005, and 2007. National data from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey, 2001-2007.

Employer Contributions to Health Insurance Percent of Individual and Family Premiums

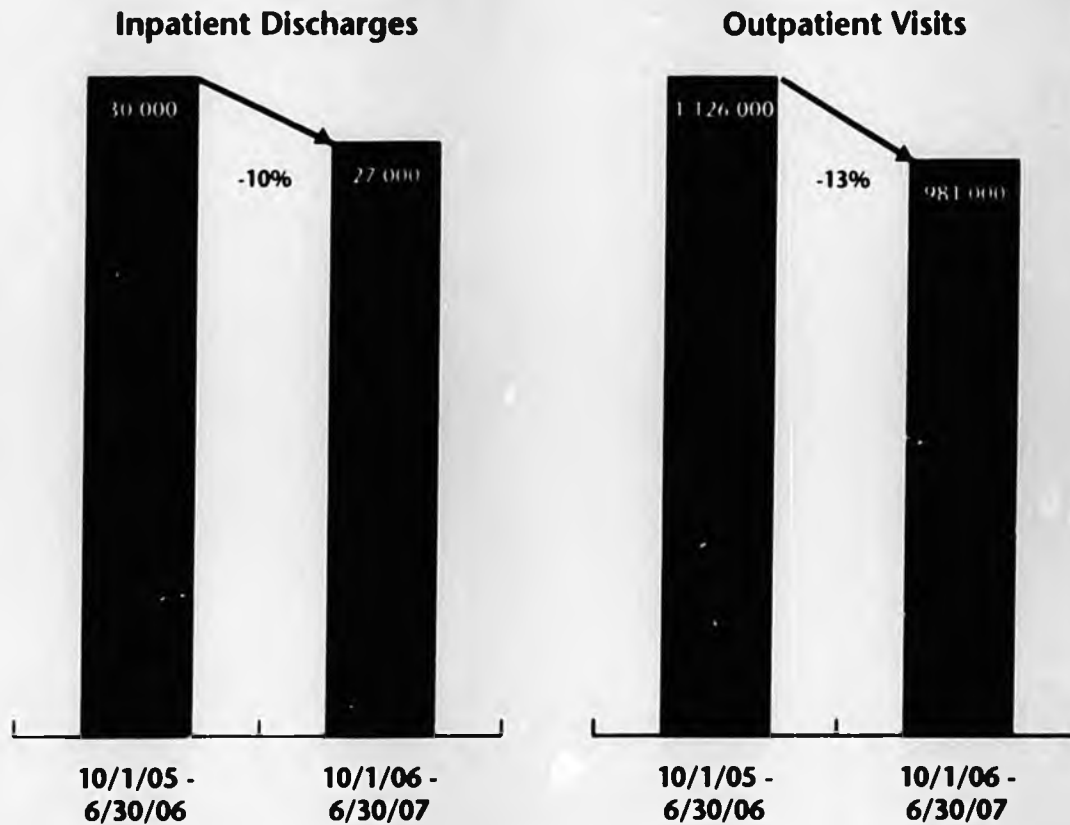


Most Massachusetts employers contribute at least 75% toward their employees' health insurance premiums. While Massachusetts employers' contributions are comparable to employers nationwide for family plans (75% in Massachusetts versus 73% nationally as reported in the 2007 Kaiser/HRET survey), contributions are significantly lower for individual plans (75% in Massachusetts versus 85% nationally).

Note: Data reflect medians.
Source: DHCFP Employer Survey for 2001, 2003, 2005, and 2007. National data from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey, 2001-2007.

Hospital Volume

Inpatient Discharges and Outpatient Visits

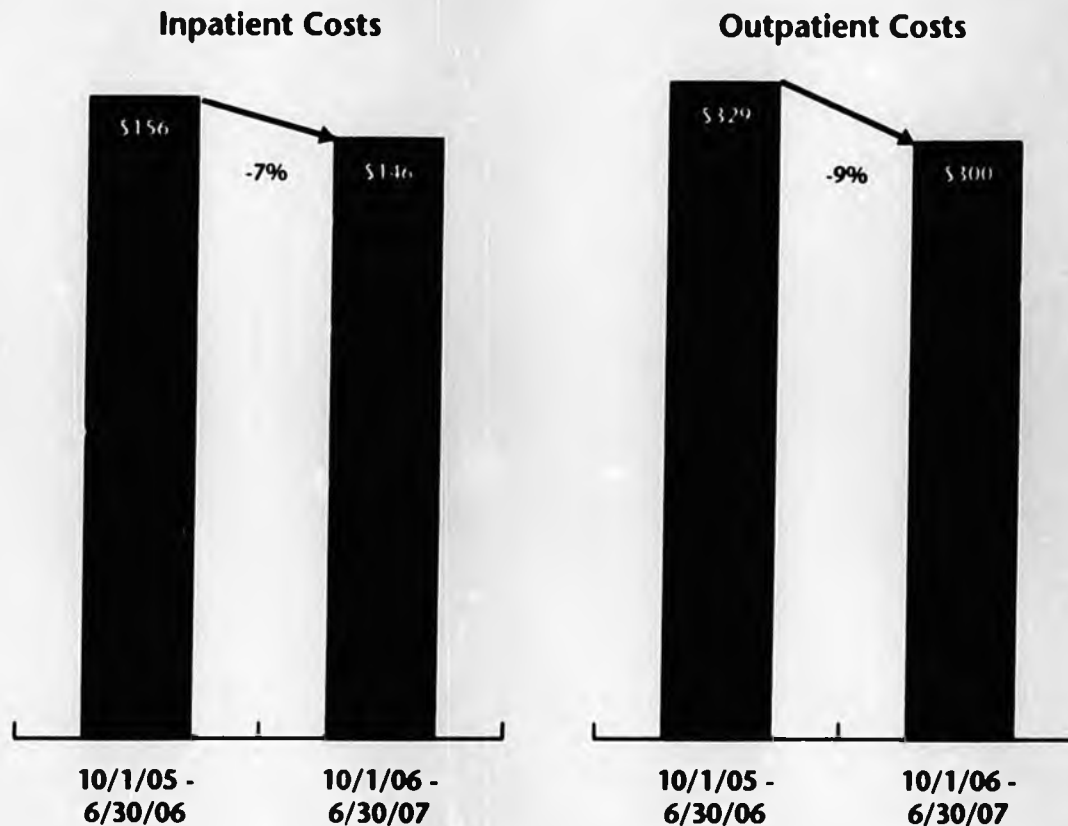


The number of hospital inpatient discharges and outpatient visit claims submitted to the Uncompensated Care Pool declined by approximately 13% overall during the first nine months of Pool fiscal year 2007 (October 1 through June 30) compared to the same period in Pool fiscal year 2006.

Note: The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year, e.g., PFY06 ran from 10/1/05 through 9/30/06. Numbers are rounded to the nearest thousand. Source: DMCFP UCP Claims Database, data reported as of 11/27/07.

Hospital Costs

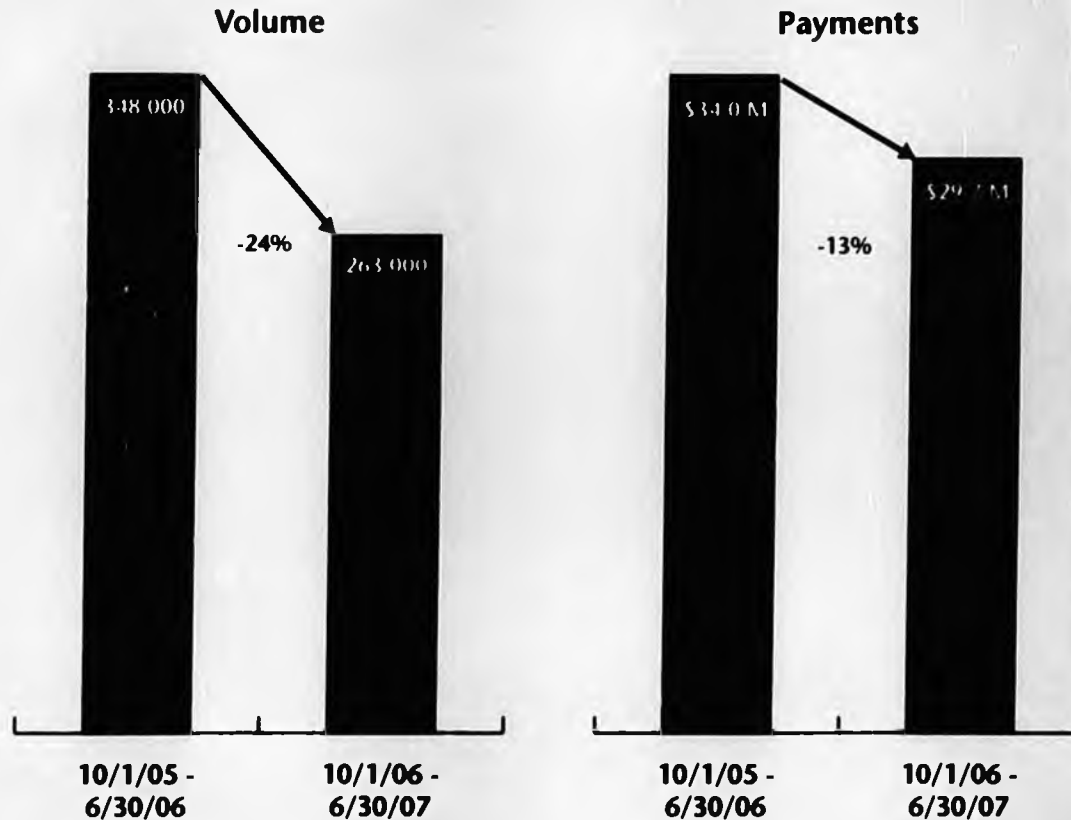
Inpatient and Outpatient (in millions)



The cost of acute hospital claims submitted to the Uncompensated Care Pool declined by 8% overall during the first nine months of Pool fiscal year 2007 (October 1 through June 30) compared to the same period in Pool fiscal year 2006.

Note: The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year, e.g., PFY06 ran from 10/1/05 through 9/30/06.
Source: DHCFCP UCP Claims Database, data reported as of 11/27/07.

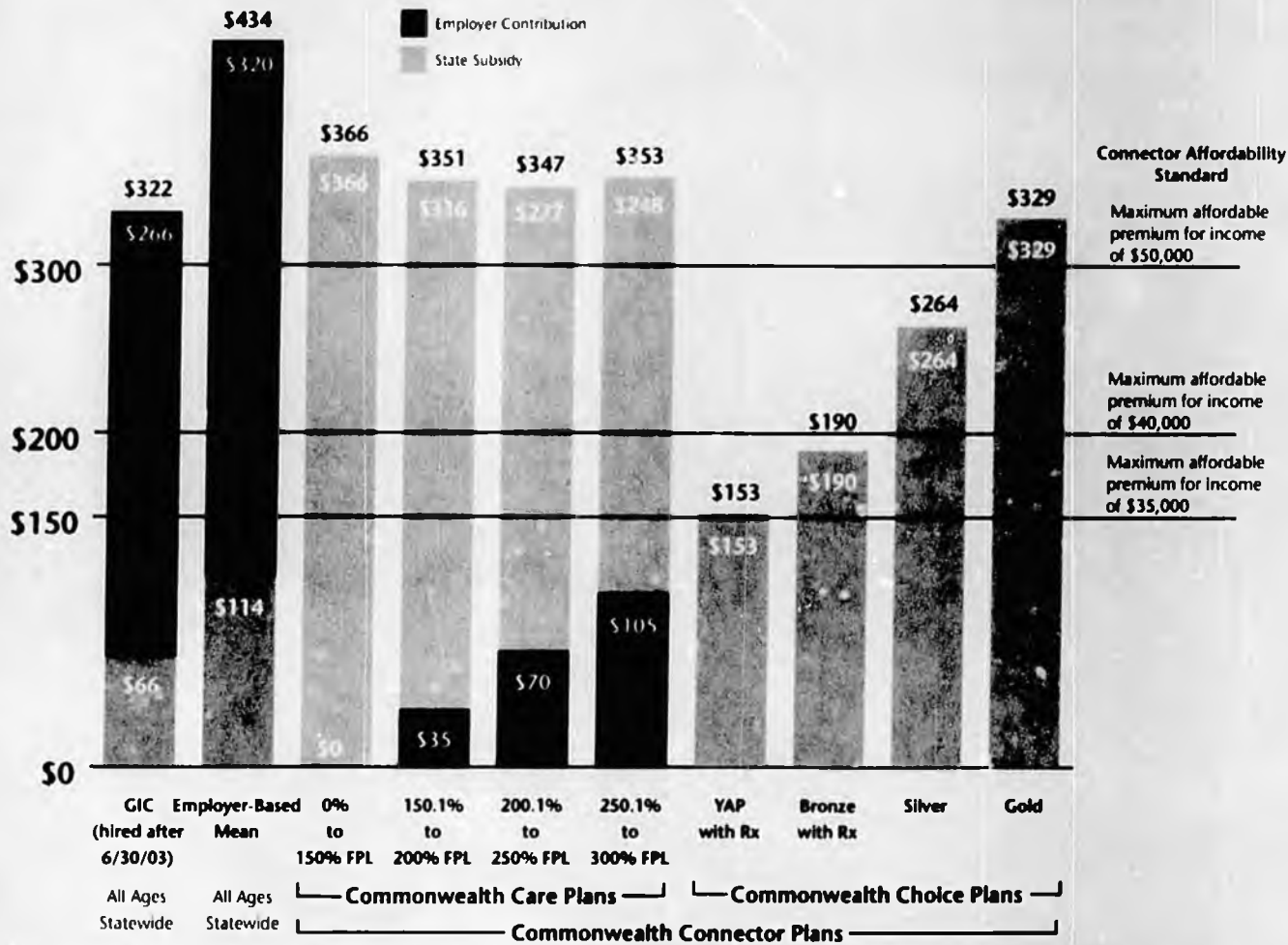
CHC Volume and Payments



Community health center (CHC) Uncompensated Care Pool visit volume and payments decreased by 24% and 13%, respectively, for the first nine months of Pool fiscal year 2007 compared to the same period in Pool fiscal year 2006.

Note: The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year, e.g., PFY06 ran from 10/1/05 through 9/30/06. CHC volume is rounded to the nearest thousand. Source: DHCFP UCP Claims Database, data extracted 11/27/07

Lowest Monthly Cost of Health Insurance Employer and Connector Plans for Individuals

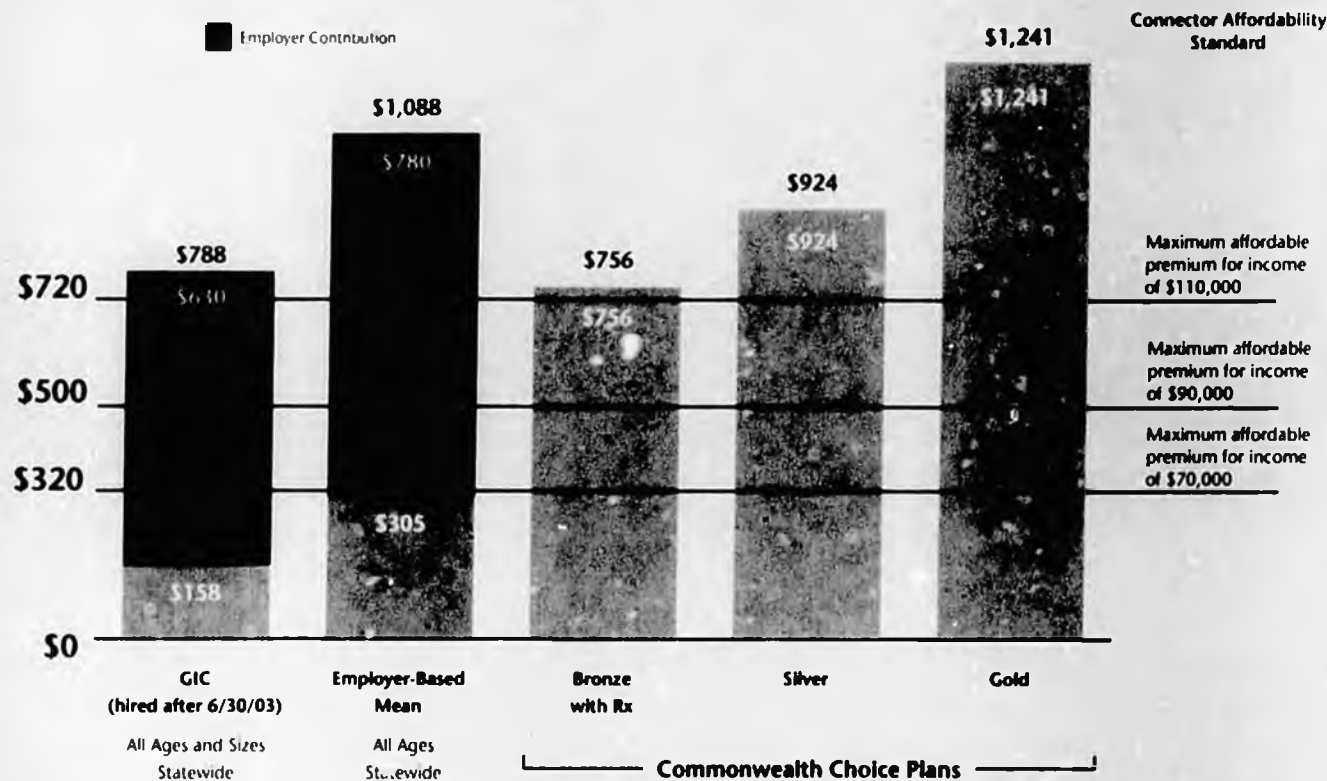


Commonwealth Care premiums for individuals compare favorably to the average employee contribution for employer-based coverage.

These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for the calendar year 2007. Please visit www.mahealthconnector.org for more details.

Note: The calculation of mean premiums for private employer-based insurance does not include those paid by government employees. Premium for Commonwealth Choice YAP with Rx plan calculated for a 22 year old unemployed individual living in Boston. Premiums for Commonwealth Choice Bronze with Rx, Silver, and Gold plans calculated for a 37 year old unemployed individual living in Boston. Data were rounded to the nearest whole dollar.
Source: 2007-2008 GIC Benefit Decision Guide; 2007 DHCFP Employer Survey; Connector Affordability Schedule, Commonwealth Connector website www.mahealthconnector.org. All data reported as of 10/2/07. These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for calendar year 2007. Please visit www.mahealthconnector.org for more details.

Lowest Monthly Cost of Health Insurance Employer and Connector Plans for Families

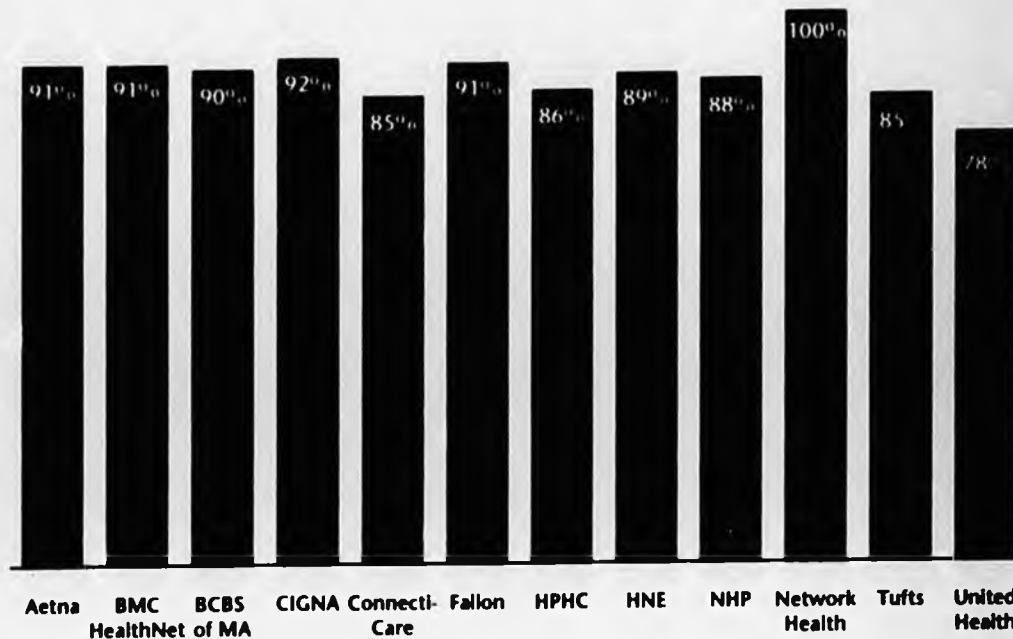


Commonwealth Choice premium contributions for families are higher than the average employee contribution for employer-based family coverage.

These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for the calendar year 2007. Please visit www.mahealthconnector.org for more details.

Note: Commonwealth Care plans provide coverage for adult individuals only, and therefore, do not have family plans. The calculation of mean premiums for private employer-based insurance does not include those paid by government employees. Premiums for Commonwealth Choice Bronze with Rx, Silver, and Gold plans calculated for a family of four, with two 37 year old unemployed parents and two children, living in Boston. Data were rounded to the nearest whole dollar.
Source: 2007-2008 GIC Benefit Decision Guide, 2007 DHCFP Employer Survey; Connector Affordability Schedule, Commonwealth Connector website www.mahealthconnector.org. All data reported as of 10/2/07. These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for calendar year 2007. Please visit www.mahealthconnector.org for more details.

Medical Expense Ratio by Health Plan for the First Six Months of 2007



Enrollment Data (total Massachusetts members in thousands):

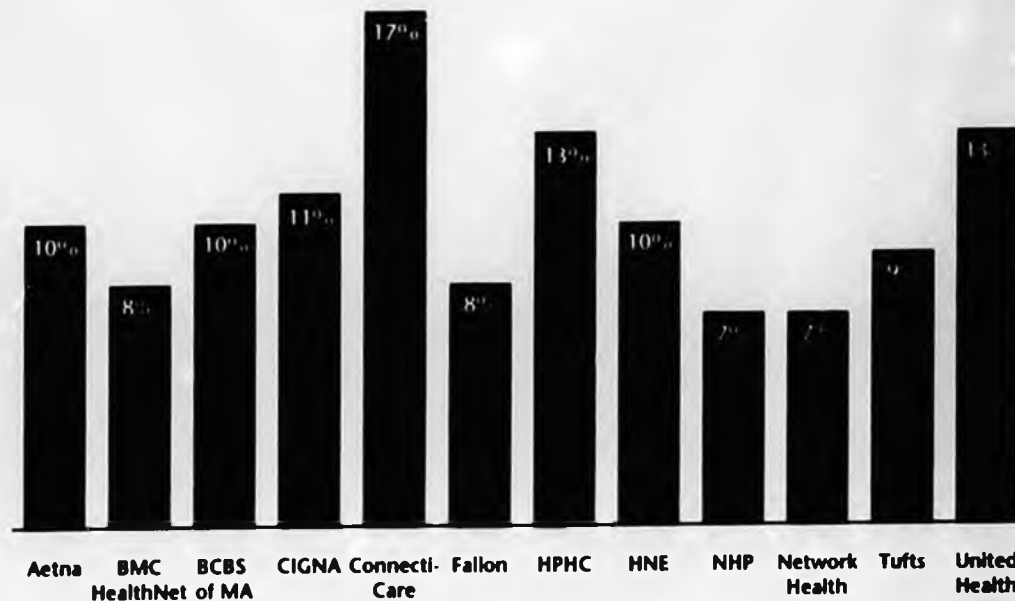
7	190	3,041	5	9	165	638	101	148	117	645	13
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The four largest Massachusetts health plans spent between 85% and 91% of their total revenue dollar on medical services provided to members in the first six months of 2007.

Note: Medical expense ratio is calculated by dividing total hospital and medical expenses by total revenue (including investment gain/loss). Blue Cross Blue Shield of Massachusetts (BCBSMA) includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.

Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 4B and insolvency reports from 6/30/07, with a "paid through" date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

Administrative Expense Ratio by Health Plan for the First Six Months of 2007



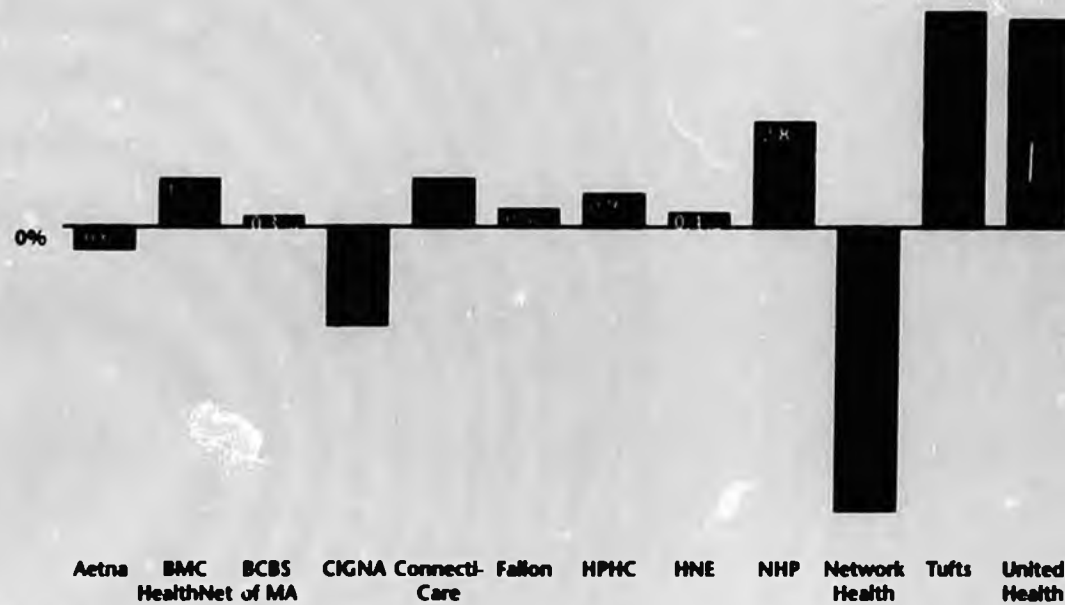
Enrollment Data (total Massachusetts members in thousands):

Aetna	BMC HealthNet of MA	BCBS of MA	CIGNA	Connecti-Care	Fallon	HPHC	HNE	NHP	Network Health	Tufts	United Health
7	181	3,041	5	9	165	638	101	148	108	645	13

Note: Administrative expense ratio is calculated by dividing total administrative expenses (including claims adjustment and general administrative expenses) by total revenue (including investment gain/loss). BCBSMA includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.
Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 1B and insolvency reports from 6/30/07, with a "paid through" date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

The four largest health plans spent between 8% and 13% of their total revenue on administrative expenses including staff, claims processing, rent and clinical oversight.

Profit Margin by Health Plan for the First Six Months of 2007



Enrollment Data (total members in Massachusetts in thousands):

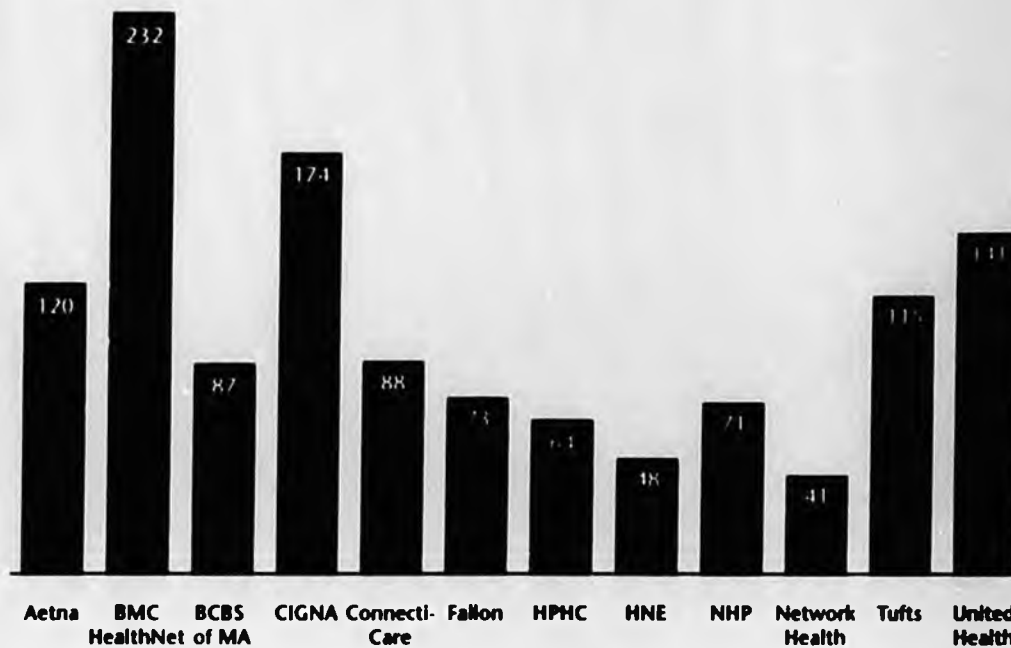
Aetna	BMC	BCBS	CIGNA	Connecti-Care	Fallon	HPHC	HNE	NHP	Network Health	Tufts	United Health
7	181	3,041	5	9	165	638	101	148	108	645	13

Profit margin represents the net margin available to the plan for other purposes after paying medical claims and administrative costs. Profit margins for the four largest health plans ranged from less than 1% to nearly 6% in the first six months of 2007.

Note: Profit margin is calculated by dividing net income by total revenue (including investment gain/loss). BCBSMA includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding. Source: Division of Insurance quarterly financial statements. BMC HealthNet and CMA Network Health data from MassHealth 48 and insolvency reports from 6/30/07, with a "paid through" date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

Days in Reserve

by Health Plan for the First Six Months of 2007



Enrollment Data (total Massachusetts members in thousands):

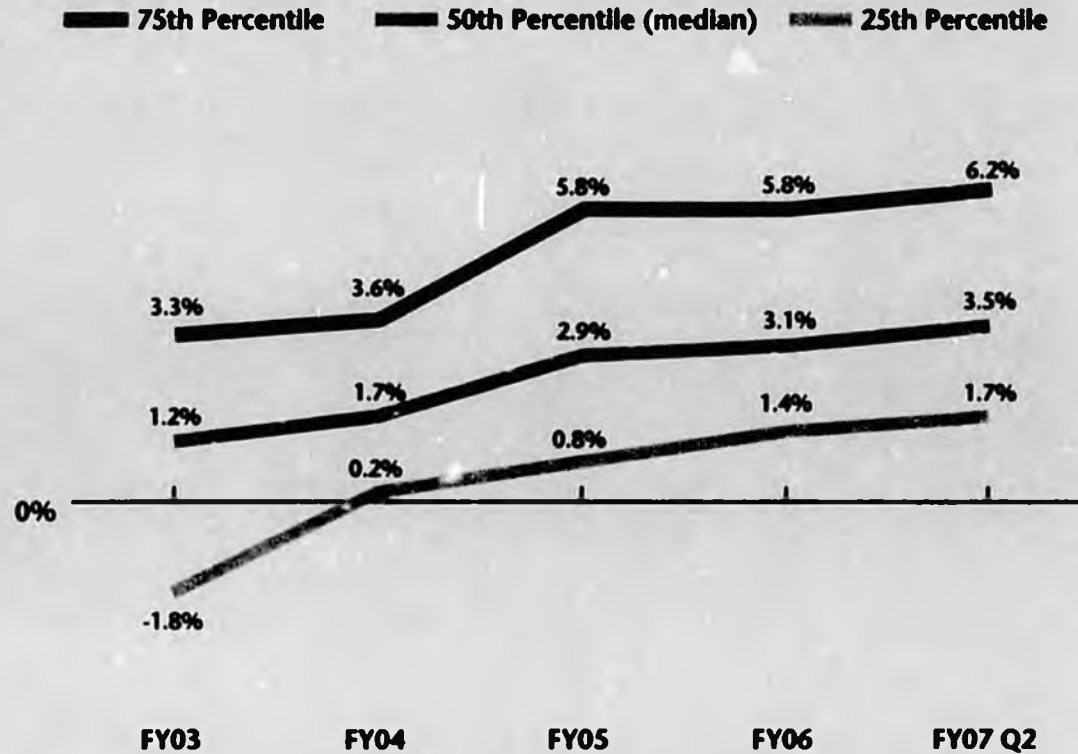
7	181	3,041	5	9	165	638	101	148	108	645	13
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Days in reserve is a measure of financial solvency. It reflects the number of days of medical expenses a plan could fund from its net worth. Performance on this measure varies widely, but nearly every plan has at least two months days in reserve and the majority have close to three months.

Note: Days in reserve is calculated by dividing net worth (including total capital and surplus) by the result of dividing total hospital and medical expenses by the number of days in the YTD period. BCBSMA includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.

Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 48 and insolvency reports from 6/30/07, with a paid through date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

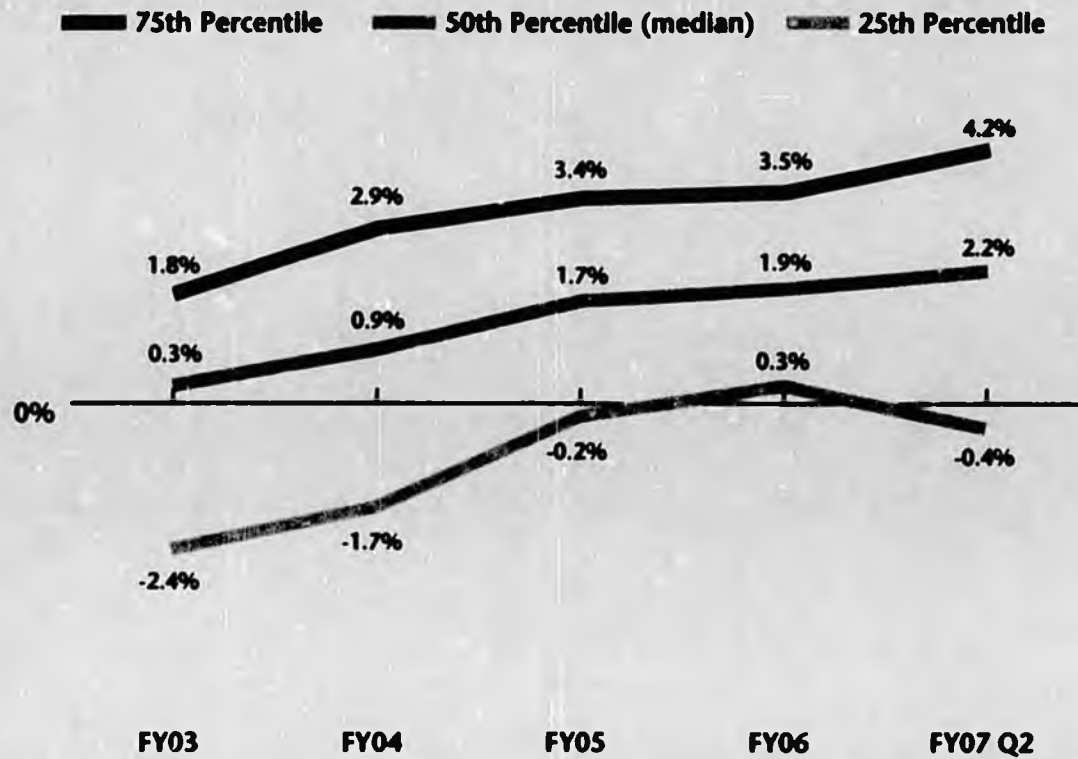
Total Margin Trend by Year



The overall financial performance of acute hospitals has improved steadily over the past four years.

Note: Total margin is calculated by dividing total income by total revenue. Fiscal Year Ends (FYE) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DMCFP Acute Hospital Financial Data, data reported as of 10/2/07.

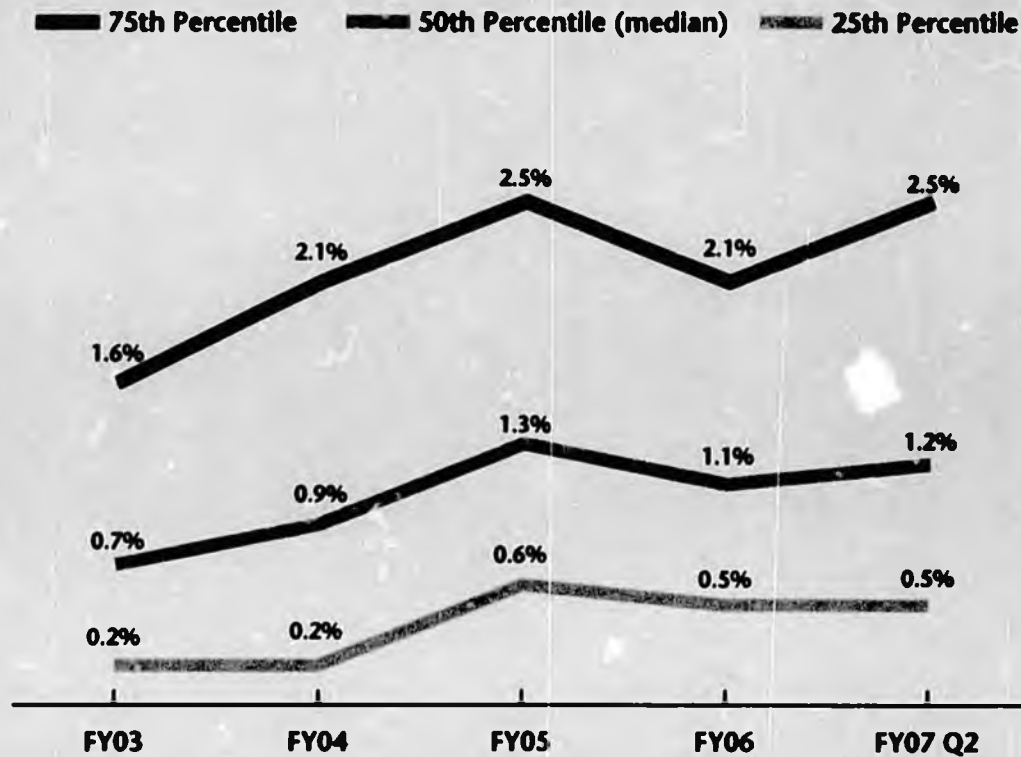
Operating Margin Trend by Year



Most acute hospitals experienced positive operating margins in the past year. However, a significant gap remains between the highest and lowest performing acute hospitals.

Note: Operating margin is calculated by dividing operating income by total revenue. Fiscal Year Ends (FYE) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DNCFP Acute Hospital Financial Data, data reported as of 10/2/07.

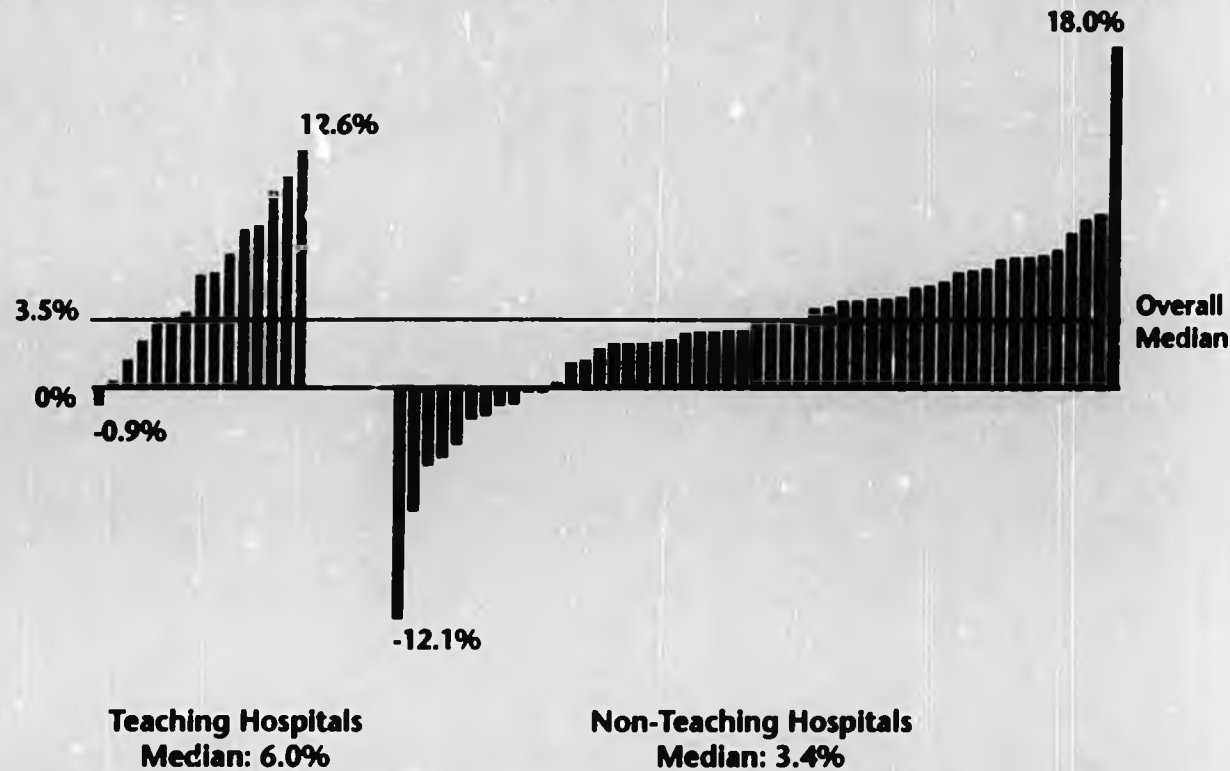
Non-Operating Margin Trend by Year



Non-operating margins for acute hospitals have improved over the past four years. However, the highest performing hospitals have experienced much greater gains than the lowest performing group of hospitals.

Note: Non-operating margin is calculated by dividing non-operating income by total revenue. Fiscal Year Ends (FYE) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 10/2/07.

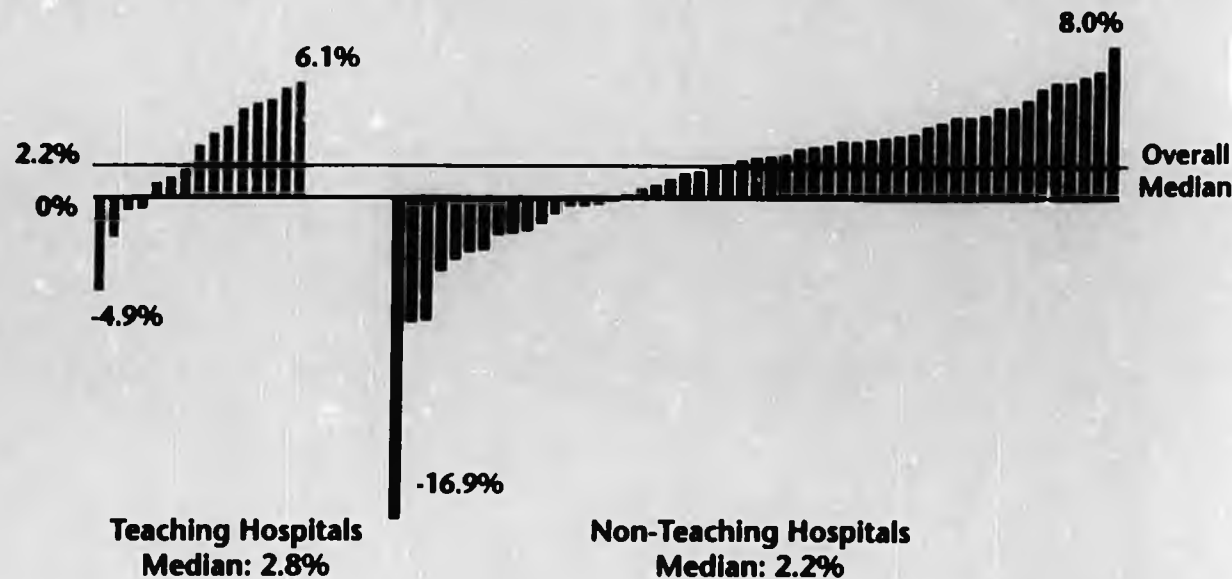
Total Margin by Teaching Status for FY07 Q2



The overall financial performance of acute hospitals varies widely by teaching status. The median total margin for teaching hospitals was 6% through the second quarter of fiscal year 2007 while the median total margin for non-teaching hospitals was 3.4%.

Note: Total margin is calculated by dividing total income by total revenue. Fiscal Year Ends (FYE) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 9/18/07.

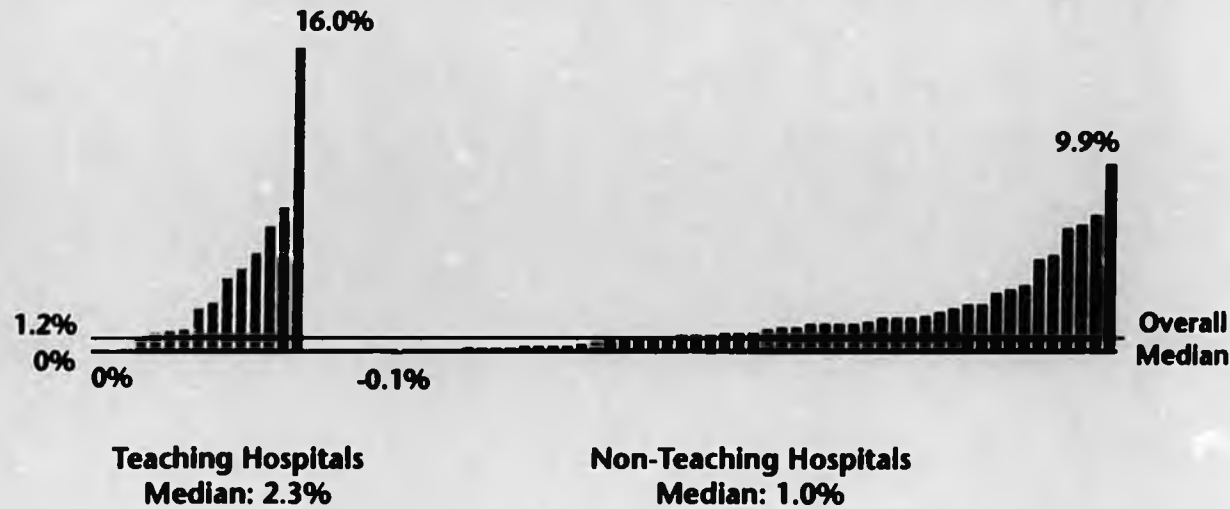
Operating Margin by Teaching Status for FY07 Q2



Teaching hospitals reported a higher operating margin than non-teaching hospitals in FY07 Q2.

Note: Operating margin is calculated by dividing operating income by total revenue. Fiscal Year Ends (FYE) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 9/18/07.

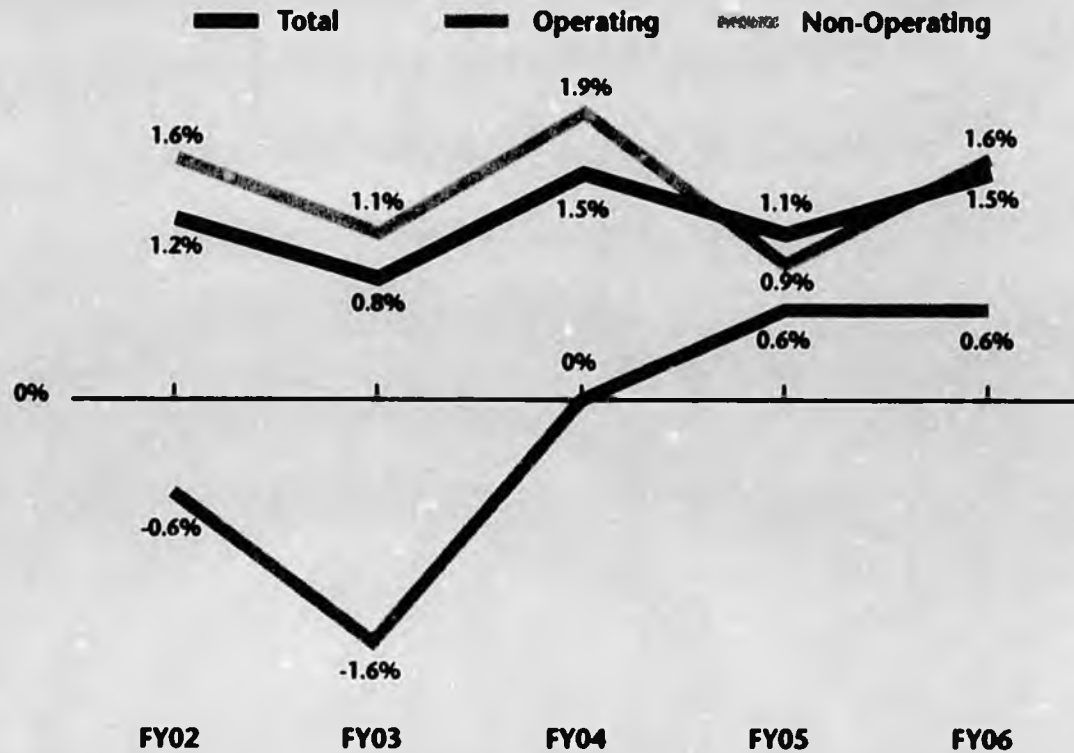
Non-Operating Margin by Teaching Status for FY07 Q2



Non-operating margin performance varies widely by hospital teaching status. The median non-operating margin for teaching hospitals was 2.3% through the second quarter of fiscal year 2007, while the median for non-teaching hospitals was less than half that at 1.0%.

Note: Non-operating margin is calculated by dividing non-operating income by total revenue. Fiscal Year Ends (FYE) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 9/18/07.

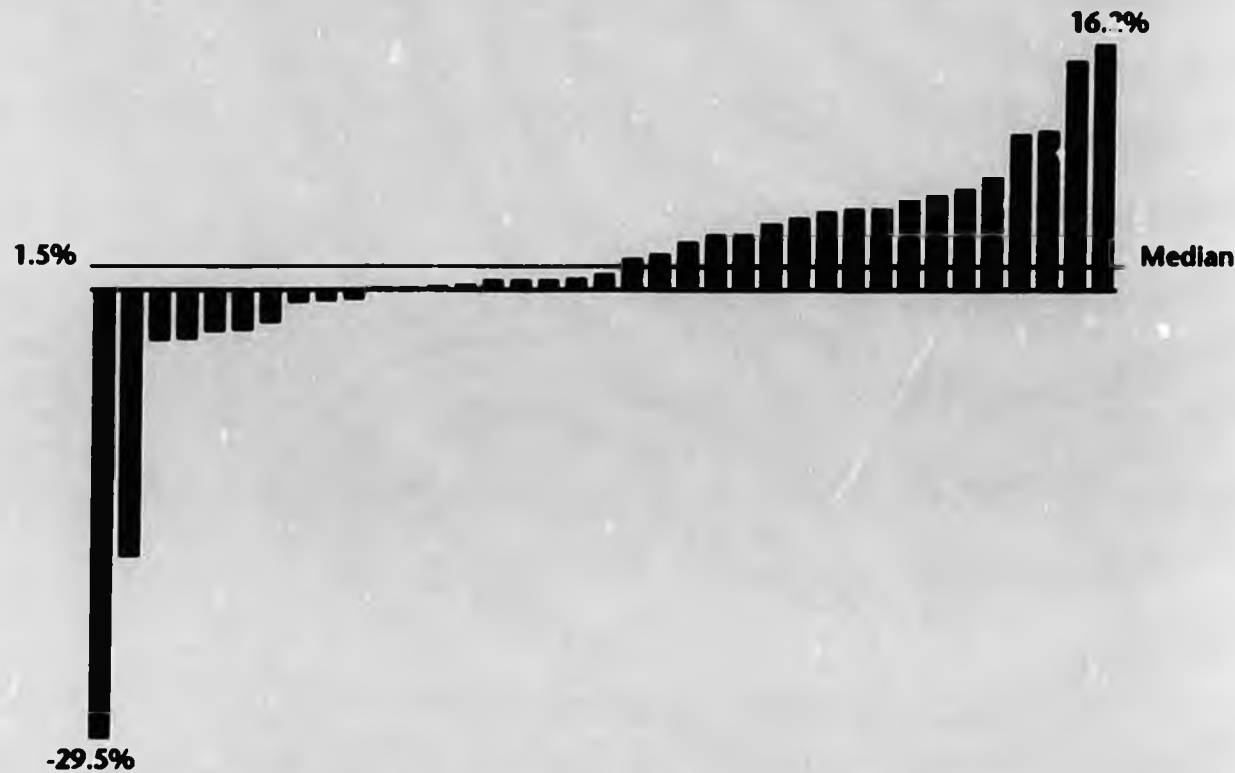
CHC Median Financial Margins by Fiscal Year



Community health centers (CHCs) have experienced improved financial performance over the past five years through reduction of operating losses.

Note: Fiscal Year Ends (FYE) vary across CHCs: of 37 CHCs, 30 have a 6/30 FYE, 4 have a 9/30 FYE, 2 have a 12/31 FYE, and 1 has a 7/31 FYE.
 Source: Data were obtained from CHC audited financial statements, for free-standing CHCs from FY02 through FY06. For FY02, FY03, FY04, FY05, and FY06, 34, 35, 35, 37, and 37 CHCs, respectively, were included in this analysis.

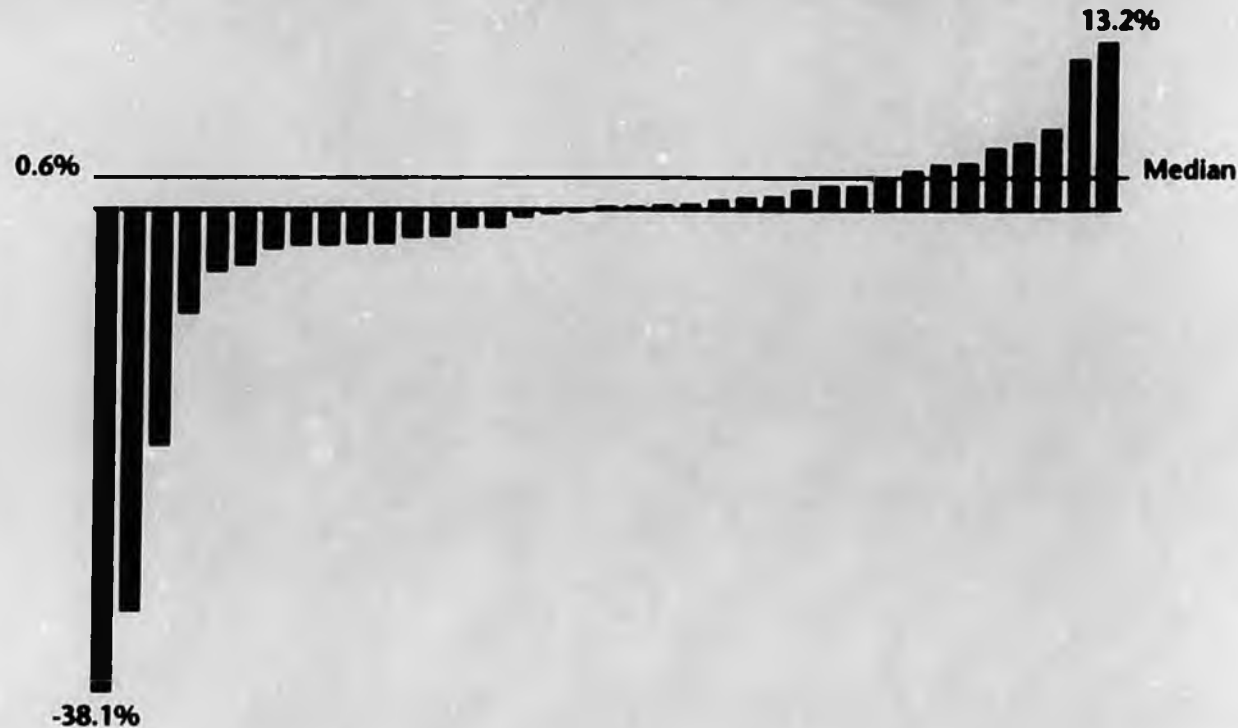
CHC Total Margin in FY06



The total margin for community health centers ranged from -30% to 16% in their 2006 fiscal year. Three-quarters of community health centers experienced positive total margins in their 2006 fiscal year, however one-quarter lost money overall.

Note: Total margin is calculated by dividing total income by total revenue. Fiscal Year Ends (FYE) vary across CHCs: of 37 CHCs, 30 have a 6/30 FYE, 4 have a 9/30 FYE, 2 have a 12/31 FYE, and 1 has a 7/31 FYE.
Source: Data were obtained from CHC audited financial statements for free-standing CHCs in FY06. For FY06, 37 CHCs were included in this analysis.

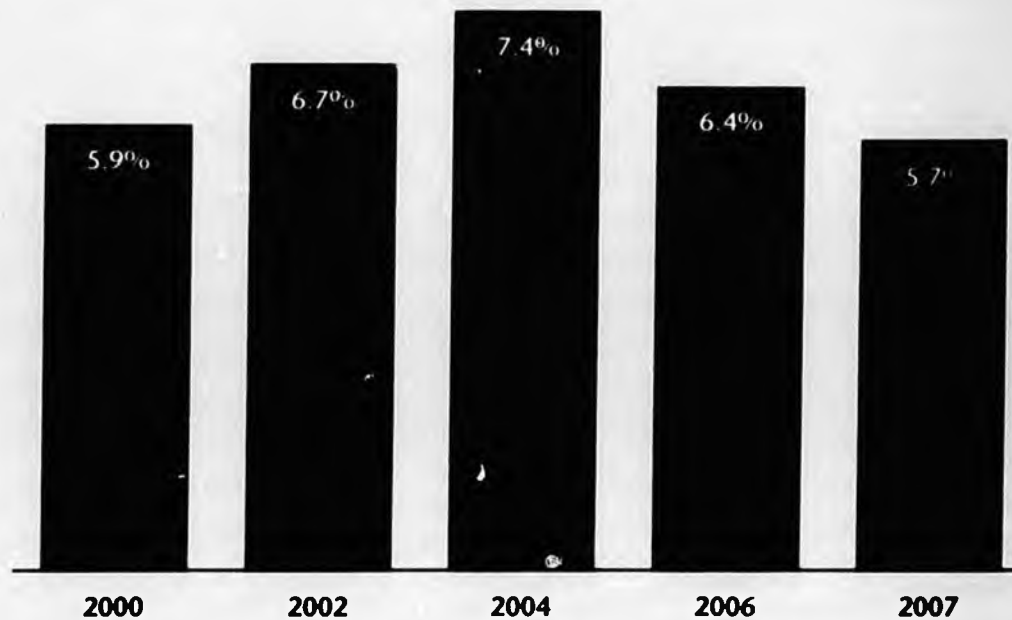
CHC Operating Margin in FY06



Operating margins for community health centers ranged from -38% to 13% in their 2006 fiscal year. Just over one-half of community health centers experienced positive operating margins, while just under one-half of community health centers lost money on operations.

Note: Operating margin is calculated by dividing operating income by total revenue. Fiscal Year Ends (FYE) vary across CHCs: of 37 CHCs, 30 have a 6/30 FYE, 4 have a 9/30 FYE, 2 have a 12/31, and 1 has a 7/31 FYE.
Source: Data were obtained from CHC Audited Financial Statements for free-standing CHCs in FY06. For FY06, there were 37 CHCs included in this analysis.

Don't Have Health Insurance Percent of All Massachusetts Residents

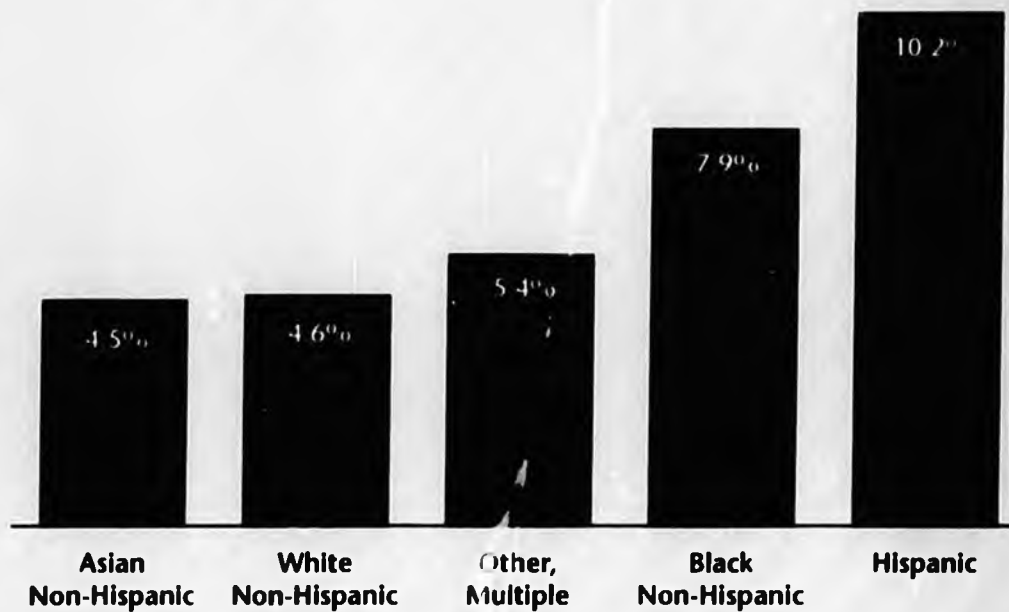


The overall uninsured rate for Massachusetts dropped from 6.4% to 5.7% from 2006 to 2007, and the number of people without coverage fell from 395,000 to 355,000, a 10% decrease reflecting the successful early implementation of health reform.

Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of 2007.

Uninsured by Race and Ethnicity

Percent of All Massachusetts Residents, 2007

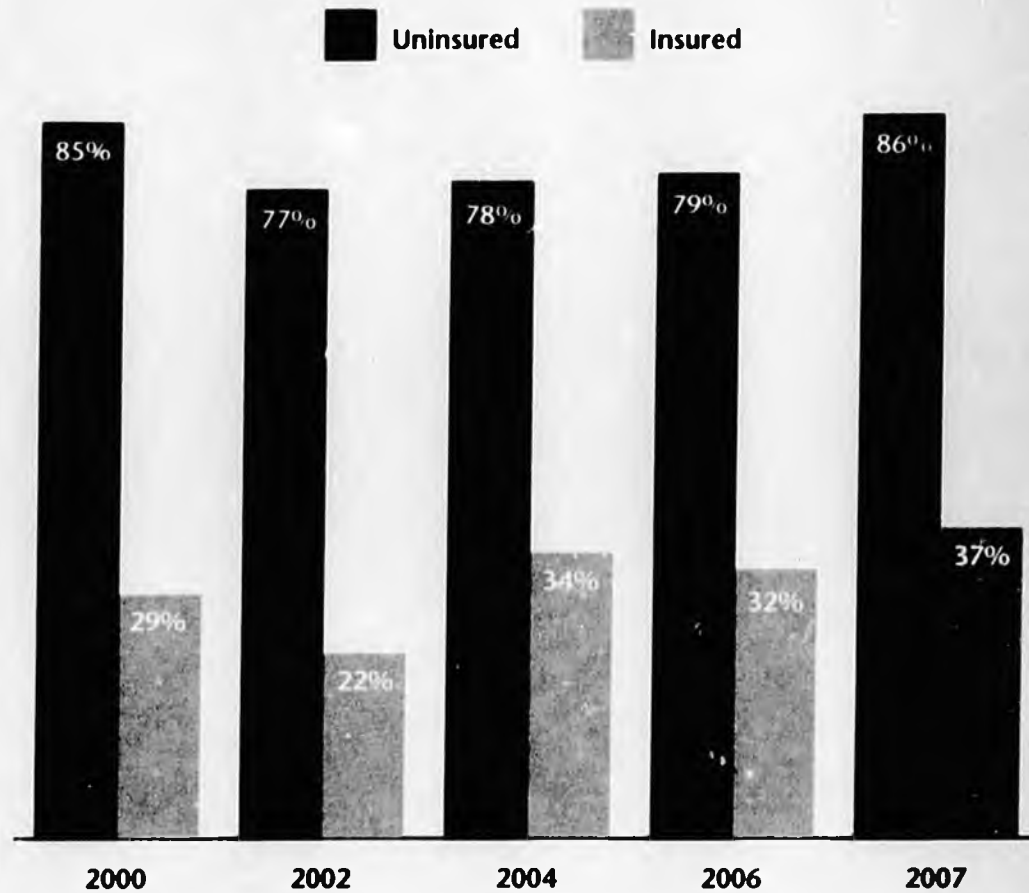


In 2007, 5.7% of all Massachusetts residents did not have health insurance. However, Hispanics and Black Non-Hispanic residents have higher rates of uninsurance when compared to other races and ethnicities.

Source: DHCFP Household Survey for 2007. The 2007 survey was conducted January through July of 2007.

Needed Care but Cost Was an Obstacle

Percent of Adults Ages 19 to 64

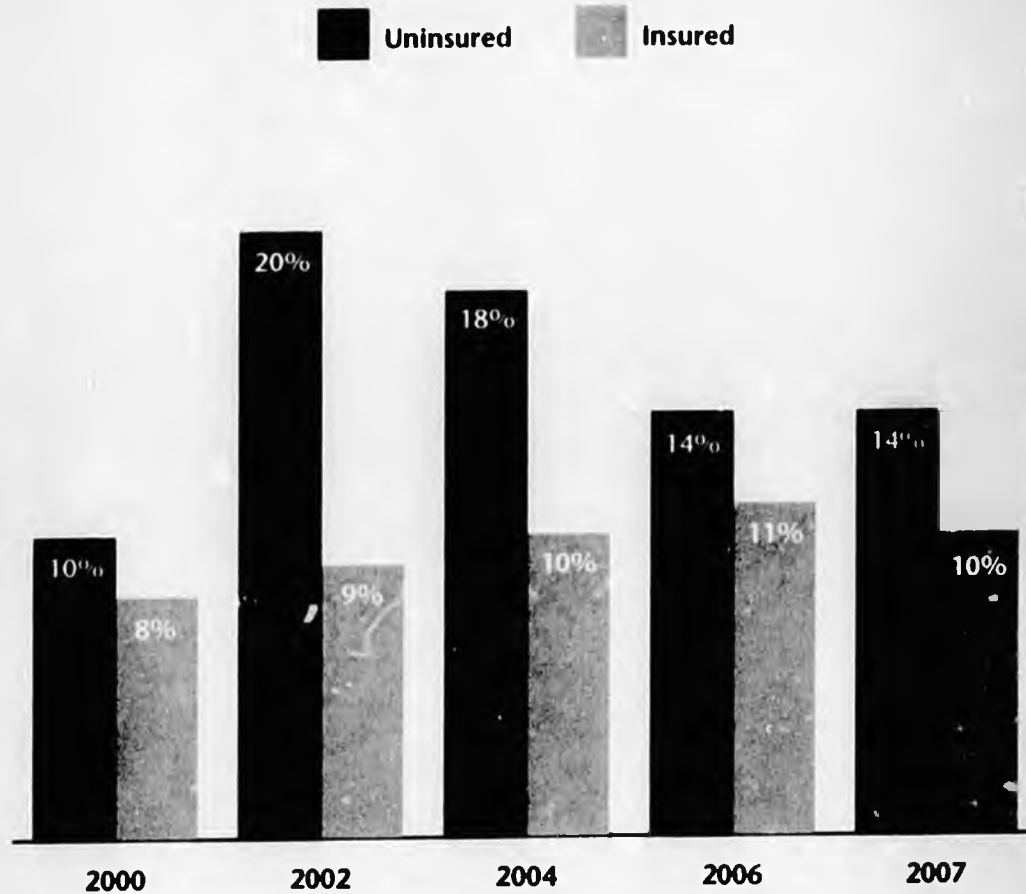


Cost appears to be a growing obstacle to accessing health care for Massachusetts residents and remains a significant barrier for most people without health coverage.

Note: In 2004 and 2006, the sample size doubled from survey years 2000 and 2002. In 2007, the sample size was about 16% smaller than in 2004 and 2006.
 Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of the survey year.

Reported Being in Fair or Poor Health

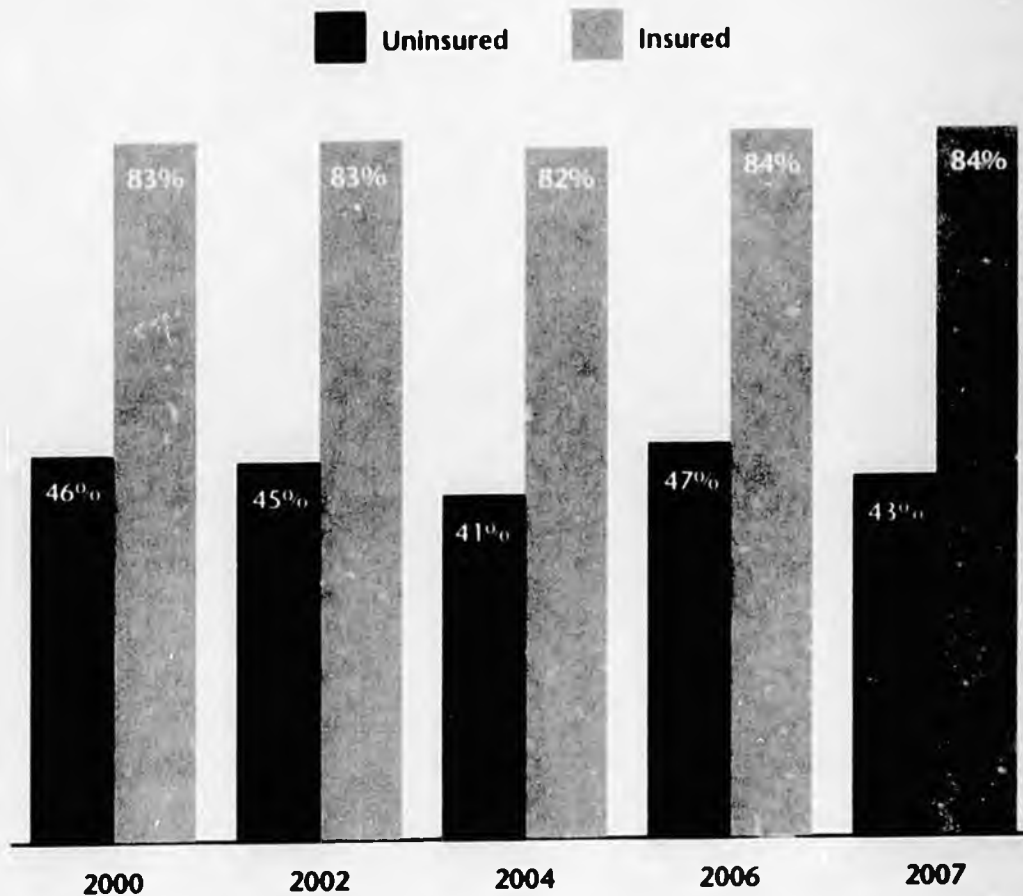
Percent of Adults Ages 19 to 64



Most Massachusetts residents surveyed, both insured and uninsured, reported being in good or excellent health.

Note: The differences between insured and uninsured residents are statistically significant for 2002, 2004, and 2007.
Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of the survey year.

Reported Having a Dental Visit in the Past Year, Percent of Adults Ages 19 to 64

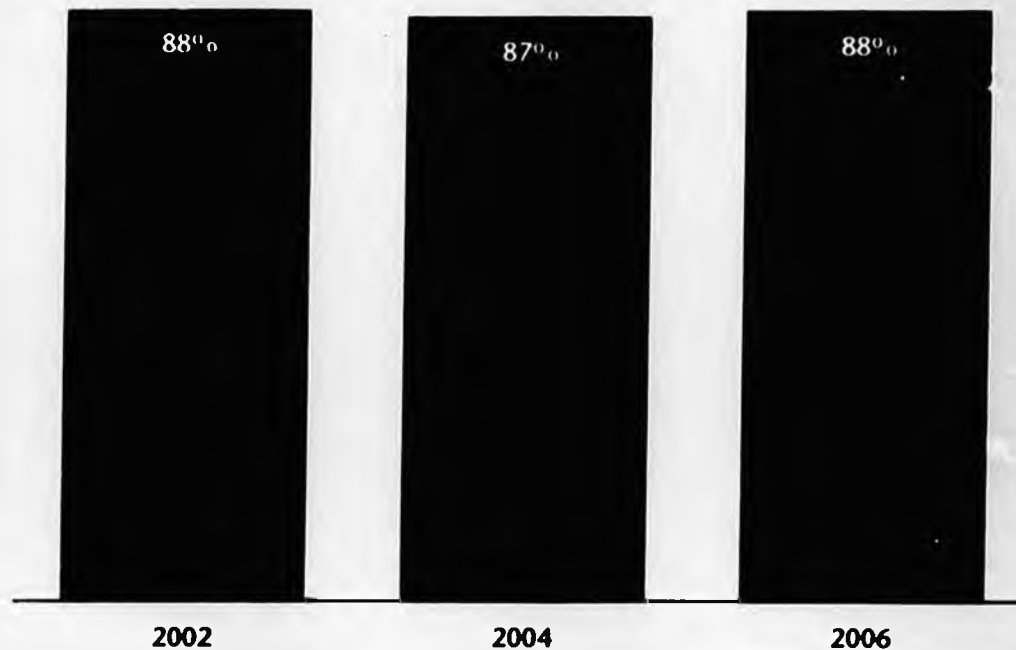


Only 43% of uninsured Massachusetts residents reported getting dental care in the past year compared to 84% of those with insurance coverage.

Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of the survey year.

Have a Personal Health Care Provider

Percent of Adults Ages 18+



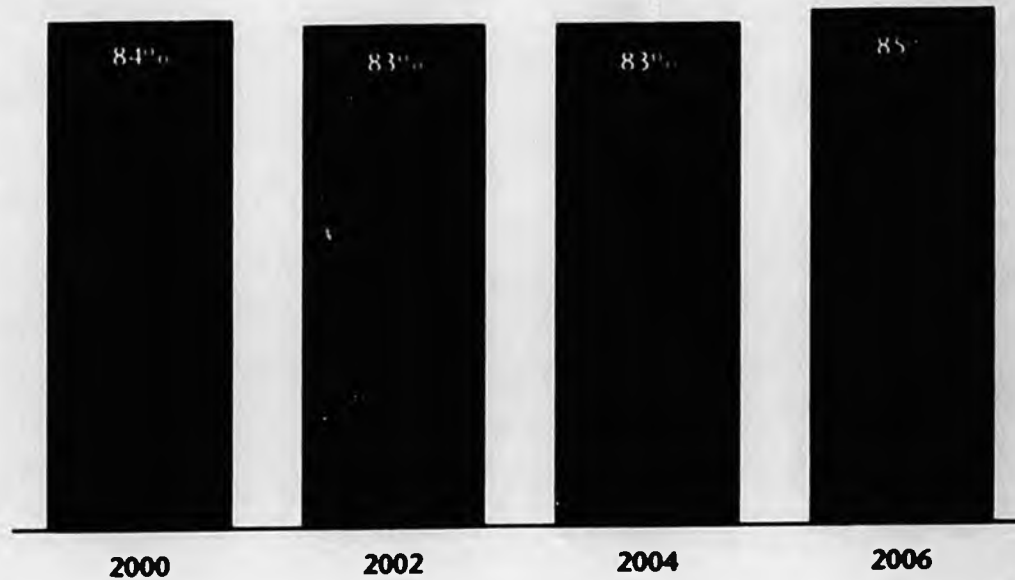
Percent of Adults Ages 18+ by Race/Ethnicity (Confidence Interval):

Race/Ethnicity	2002	2004	2006
White	90% (89% - 91%)	90% (88% - 91%)	90% (89% - 91%)
Black	82% (77% - 87%)	88% (83% - 93%)	87% (83% - 92%)
Hispanic	70% (65% - 75%)	66% (60% - 72%)	70% (65% - 76%)
Asian	78% (71% - 85%)	83% (77% - 90%)	80% (72% - 89%)

Source: Massachusetts Department of Public Health (DPH) results from the Behavioral Risk Factor Surveillance System (BRFSS) for 2002, 2004, and 2006. The BRFSS survey is conducted throughout the year.

The vast majority of Massachusetts residents surveyed reported having a personal physician, a percentage that has held steady over the past three survey periods. However, a significantly lower percentage of Hispanics and Asians reported having a personal physician compared to other racial and ethnic groups.

Had a Mammogram in the Past 2 Years, Percent of Women Ages 40+



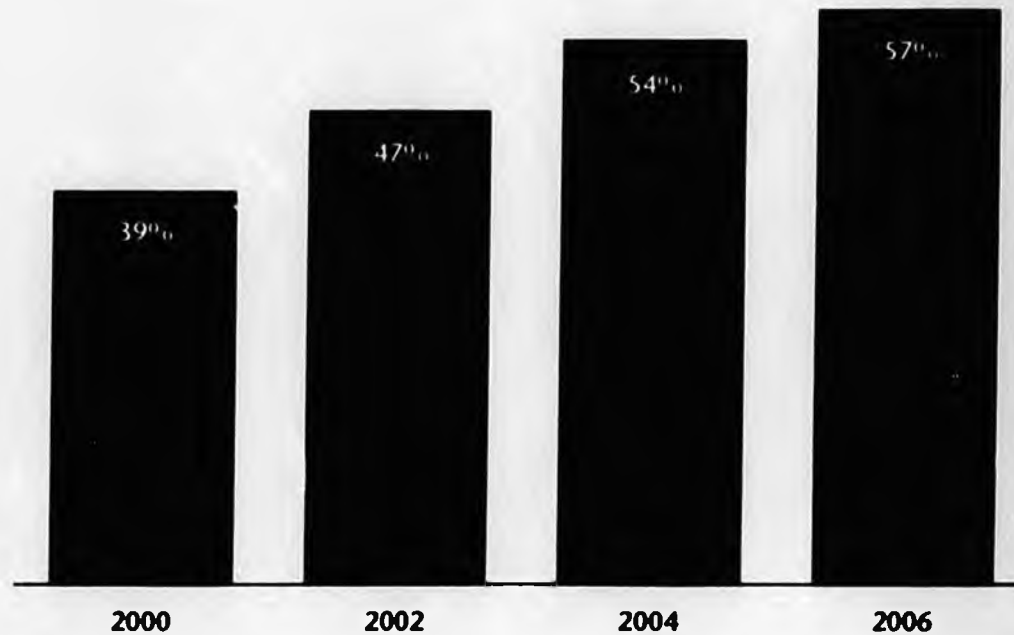
Most Massachusetts female residents ages 40 and over reported having a mammogram to screen for breast cancer.

Percent of Women Ages 40+ by Race/Ethnicity (Confidence Interval):

	2000	2002	2004	2006
White	84% (82% - 86%)	83% (81% - 85%)	82% (81% - 84%)	85% (84% - 87%)
Black	87% (80% - 95%)	82% (71% - 92%)	79% (64% - 95%)	80% (71% - 89%)
Hispanic	89% (84% - 94%)	86% (80% - 92%)	88% (82% - 93%)	87% (82% - 92%)
Asian	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data

Source: Massachusetts Department of Public Health (DPH) results from the Behavioral Risk Factor Surveillance System (BRFSS) for 2000, 2002, 2004, and 2006. The BRFSS survey is conducted throughout the year.

Had a Sigmoidoscopy or Colonoscopy in the Past 5 Years, Percent of Adults Ages 50+



Percent of Adults Ages 50+ by Race/Ethnicity (Confidence Interval):

Race/Ethnicity	2000	2002	2004	2006
White	39% (37% - 42%)	48% (45% - 50%)	55% (52% - 57%)	58% (56% - 60%)
Black	54% (41% - 67%)	49% (34% - 63%)	54% (41% - 66%)	60% (51% - 69%)
Hispanic	30% (20% - 40%)	35% (24% - 45%)	51% (41% - 61%)	49% (40% - 58%)
Asian	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data

The number of Massachusetts residents ages 50 and over that reported having a sigmoidoscopy or colonoscopy to screen for colorectal cancer has increased significantly since 2000.

Source: Massachusetts Department of Public Health (DPH) results from the Behavioral Risk Factor Surveillance System (BRFSS) for 2000, 2002, 2004, and 2006. The BRFSS survey is conducted throughout the year.

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Alaska State Legislature

Senator Hollis French
Senator Johnny Ellis
Senator Bill Wielechowski



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Jan. 2008 - Changes in the CS for Senate Bill 160

The following modifications have been made after substantial public comment on the legislation:

- The Health Care Board will provide recommendations on what plan types should be available through the clearinghouse, but they will not decide what benefits are or aren't included. The bill will require that all accountable health care plans include:
 - Preventative and primary care
 - Emergency Services
 - Hospitalization
 - Ambulatory patient services
 - Prescription Drugs
 - Mental health services
- The Health Care Board will review potential cost saving options and give recommendations to the legislature and department of Health and Social Services through an annual report. The board will also review options for maximizing federal funds for the program.
- The Health Care Board will set criteria and compare different health plans by the financial outline they set forth for participants, allowing individuals to compare options side by side.
- Employers who arrange for employees to purchase coverage using pre-tax dollars, through establishing Section 125 cafeteria plans, won't be subject to the employer levy.
- A right to a hearing will ensure that anyone who cannot afford coverage, under the plans framework, won't be required to acquire coverage under the mandate.
- Young adult plans will have different financial criteria, allowing for plans that have annual benefit caps but lower co-pays, deductibles and out of pocket expense limits. This element will make premiums more affordable for a percentage of the population that doesn't usually require much care.
- The bill will clarify that employers can send employees to the clearinghouse with vouchers they fund, covering all or a portion of health care costs.
- Illegal residents won't receive state subsidized health coverage under the bill.

- An open season will occur at least once a year, where individuals can switch plan types and providers. New entrants to the market can purchase coverage at any time.
- Individuals who can no longer afford the plan they are enrolled in due to unforeseeable circumstances can apply to transfer to a different plan at any time, independent of the open season.
- Individuals who are only qualified for coverage through ACHIA will be granted larger needs based vouchers that will make the fiscal impact of purchasing a plan equivalent to purchasing traditional coverage through the clearinghouse.
- One registered nurse and the Commissioner of Health and Social Services were added to the Health Care Board.
- New Alaska residents will have to wait for one year before receiving needs based vouchers, much like the Permanent Fund currently requires. These new residents will not have an obligation to have health coverage during that time.
- IHS recipients have the option of utilizing the clearinghouse for health care benefits, but won't need additional coverage to fulfill the individual responsibility clause.

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Detailed Bill Summary

SECTION 1 of the bill – Findings

SECTION 2 of the bill - Provides the framework for the bill

Sec. 21.54.200: Establishes the health care program

This section lays out what the legislation will accomplish.

- it ensures that all state residents can afford quality health coverage that suits their particular needs
- it requires that health coverage is meaningful, as discussed later in AS 21.54.250
- it reduces unsustainable health care cost increases, through encouraging primary care and prevention
- it centers on consumer choice by providing a framework for competition, where insurance plans must compete to acquire and retain customers

Sec. 21.54.210: Establishes the Alaska Health Care Board

This section establishes the Alaska Health Care Board under the Department of Health and Social Services.

The board will have 13 voting members, and will include:

- two representatives from the insurance industry
- one representative that works for a large business
- one representative that works for a small business
- two representatives from Alaska hospitals
- one representative of a labor organization
- two licensed Alaska physicians
- two consumer advocates
- one registered nurse
- the commissioner of Health and Social Services, or their designee

Each member, except the commissioner, serves a 3 year term and are subject to appointment and reappointment by the Governor. Members will be entitled to standard per diem and transportation costs under AS 39.20.180. The board will select a chair and a vice chair, and a majority of the board will be considered a quorum for transacting business.

Sec. 21.54.220: Defines the powers and duties of the Alaska Health Care Board

The board oversees two of the main elements in this bill: the health care Clearinghouse and the health care fund, the function of which are described in later sections of the bill.

In particular, the board will:

- ensure that a variety of plans are available in the clearinghouse, where individuals make plan selections based on their personal needs
- help educate the public about different plan options, and ensure that residents are enrolled in a health benefit plan
- establish enrollment criteria and procedures for individuals, and provide for an annual open season when customers can change their plan selections.

For more information, contact Sen. French's office:

Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us

www.healthyalaskans.com

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

In particular, the board will *(continued)*:

- The board will hear complaints or objections to decisions made by the program or clearinghouse. Individuals who feel aggrieved by a decision of the board are entitled to a hearing
- Establish criteria and implement the voucher system, which will be discussed in a later section

Sec. 21.54.230: Alaska Health Care Clearinghouse

The health care clearinghouse will be the 'place' where Alaskans are connected up with private health plans that suit their needs. The clearinghouse will disseminate information about health insurance and the plans that are 'certified' to fulfill the essential health care services criteria, as defined later in the bill.

The Clearinghouse will be the place where individuals with health care vouchers make plan selections and are connected up with quality insurance products.

Sec. 21.54.240: Establishes the Voucher system, and includes the individual responsibility clause

This section ensures that all Alaskans can afford quality health coverage. It begins in (a) with the individual responsibility clause, which requires that all Alaskans have health coverage that provides essential health care services. This requirement will only affect those who don't currently have coverage: (1) – (7) outline specific examples of individuals who will be exempt from the individual responsibility clause. Excepted from the requirement are individuals who receive benefits under employer plans or publicly funded programs, including IHS recipients.

Subsections (b) through (e) describe the sliding scale voucher system which makes health coverage affordable for all legal residents. Sliding scale vouchers are issued to individuals in households based on the federal government's federal poverty level criteria (FPL), which sets a poverty line annually based on household size. This year the FPL has been set at \$13,000 of gross income a year for an individual, or \$26,500 per year for a family of four.

Subsection (c) provides a guarantee that anyone who falls below the federal poverty line won't have to pay for health coverage.

Subsection (d) provides vouchers, on a sliding scale, to individuals in households that earn between 100% and 300% of the FPL. Using the numbers from above, this means that an individual who earns between \$13,000 and \$39,000 a year or a family of four that has a household income between \$26,500 and \$79,500 will be eligible for a sliding scale voucher that makes health insurance affordable. The amount of these vouchers will be set by the board, and will vary, with more assistance going to those who earn less.

Subsection (e) requires that all individuals over 300% of the FPL acquire health coverage. While these individuals will not receive needs based vouchers, they will be eligible to receive specified beneficiary vouchers, which are discussed in a later section of the bill.

For more information, contact Sen. French's office:

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www.healthyalaskans.com

SB 160

Health Insurance For All Alaskans

Senators French, Ellis and Wielechowski

Subsection (b) provides larger vouchers to individuals who only qualify for ACHIA coverage, making the cost of coverage equal to that available in the normal market. These vouchers will be issued to people who earn up to 450% of the FPL.

Subsection (f) ensures that only legal residents of Alaska receive needs based vouchers.

Sec. 21.54.250: Defines essential health care services

This section defines the benefits that all health insurance plans sold through the clearinghouse must include. Insurance plans will include coverage for:

- preventative and primary care
- emergency services
- inpatient services and hospital treatment
- ambulatory patient services
- prescription drug coverage
- mental health services

Sec. 21.54.260: Relates to employer provided health coverage

(a) and (b) are included to make it clear that nothing in this legislation changes employer based health coverage for companies that elect to provide it.

(c) and (d) relate to the employer levy, which ensures that all employers contribute to the health of employees around the state. This tax is only levied against employers who don't offer health coverage, and the amount depends on employer size. For businesses with 0-10 full time employees, no levy is taken regardless of whether the employer offers coverage. For employers with 10-20 employees, the tax is 1% of gross payroll. For employers with 20 or more employees, the tax is 2%. If an employer either a) offers to pay 33% of premium costs or b) successfully enrolls 25% of employees in an employer sponsored plan they will be exempt from this tax. In addition, if an employer establishes a so-called 'Section 125' cafeteria plan that allows employees to purchase health coverage with pre-federal tax dollars, the employer will be exempt from this levy.

Sec. 21.54.270: Relates to the structure of insurance plans available in the clearinghouse

This section requires that plans provide coverage for essential health care services, as described in 21.54.250. (b) in this section mandates that an insurance company not turn down an individual looking for coverage.

Subsection (c) makes clear that health insurance plans can have varied levels of deductibles, co-pays, co-insurance and out of pocket maximums. They can include high deductible health care plans, and benefit levels can be different for in network and out of network providers. In addition, this subsection encourages lower cost plans that are especially designed for young adults, ages 18-30, which have different terms than are found in normal plans.

Subsection (d) increases the length of time that a child must be covered under a clearinghouse plan to 25 years of age, or until 2 years after the dependent no longer resides with the family.

For more information, contact Sen. French's office:

Phone: (907) 269-0153 E-Mail: Senator_Hollis_French@legis.state.ak.us

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Sec. 21.54.280: Establishes the Alaska Health Fund and Specified Beneficiary vouchers

The health fund is established as a separate trust fund of the state, and will include:

- state money and appropriations
- federal money, pursued through a variety of routes including 1115a waivers
- employer levy established in 21.54.260
- health care premiums received and appropriated to the fund
- money from any source that is given with purposes consistent with the purpose of the program

(b) establishes specified beneficiary vouchers, which gives an employer, employers or individuals the ability to contribute to the health premium of a given individual, through a voucher.

Sec. 21.54.290: Disputes and appeals

This section gives an individual the opportunity for a hearing if they are denied health coverage by a certified plan, or if a plan fails to deliver essential health care services. In addition, if a person feels adversely affected or aggrieved by a decision of the board or clearinghouse, they have the right to a hearing.

Sec. 21.54.300: Reporting

This section provides for an annual report by the health care board that includes statistics relating to how the health reform program is performing. In addition, the board will also give an evaluation and recommendations on a variety of important health reform topics, including the use of electronic health records, S-CHIP, the effect of mandated benefits, prescription drug bargaining, ways to maximize federal health care dollars, recruitment and retention of medical professionals, evidenced based treatment procedures, Medicaid effectiveness and more.

Sec. 21.54.310: Regulations

This section requires that the board establish regulations under the Administrative Procedure Act.

The remainder of the bill deals with definitions, transitional provisions and effective dates.

For more information, contact Sen. French's office:

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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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February 21, 2008

The Honorable Bettye Davis, Chair
Senate Health, Education, and
Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

I testified on February 18 before the Senate HES committee regarding Senate Bill 160, providing for Universal Health Care. The subsequent press release from the Senate majority press office indicated that the department had changed its position on this legislation. I need to clarify the Department of Health and Social Services' position on Senate Bill 160.

As I testified, "I am here on behalf of the department in support of this bill in the attempt to make health care a reality for Alaskans." Thus, we are in support of the *effort* to ensure Alaskans have access to health care.

However, the department has not changed its position on the legislation, which remains the same as Commissioner Karleen Jackson testified last summer.

The Department of Health and Social Services supports the **concept** in SB160 of health care for all Alaska citizens, but we recognize that health insurance and access to health care are two different things. As I later testified, "We must work concurrently to ensure there are providers available and willing to accept those seeking services. As Senator French has brought up, health insurance alone does not guarantee that those seeking services will receive it if there are no providers."

The Department believes that the State needs to have the health care infrastructure in place first to support increased utilization of health care, before we mandate coverage. And we are not sure if requiring everyone to have insurance, and having the state subsidize the effort, is the answer.

Senator Davis
February 21, 2008
Page 2

I apologize for the miscommunication in relaying the Department's position.

Sincerely,



William J. Streur
Deputy Commissioner for Medicaid and
Health Care Policy

cc: **Senator Hollis French, Capitol Building, Room 417**
Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506
Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Sherry Hill, Assistant Commissioner for Public Affairs
Wilda Laughlin, Special Assistant
Mike Tibbles, Governor's Chief of Staff
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant