SB

61

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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Labor and Commerce
Finance

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

DATE TURNED IN TO OFFICE: 3/16/09

Health and Social Services Committee considered SENATE BILL NO. 61

SB 61 MANDATORY UNIVERSAL HEALTH INSURANCE

"An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state, the Alaska Health Care Board to administer the Alaska health care program and the Alaska health care fund, the Alaska health care clearinghouse to administer the Alaska health care program under the direction of the Alaska Health Care Board, and eligibility standards and premium assistance for health care coverage of persons with low incomes; 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 61 (HSS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
CED	3/2	✓			1
DHS/PAFS	2/28	✓			2
DHS/BHMS	2/28	✓			3
DHS/MS	3/6	✓			4

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Joe Ellis	ELLIS	X			
Bill Thomas	THOMAS				✓
Fred Dyson	DYSON		✓		
Joe Paskvan	PASKVAN				X
CHAIR: Bettye Davis	DAVIS	X			

Senator Hollis French

Anchorage LIO
269-0234
269-0238 fax

MEMORANDUM

Date: March 10, 2009

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

From: Senator Hollis French
Senate Bill 61 Prime Sponsor

RE: Background information for SB 61 Senate HSS subcommittee

On March 2 the Senate Health and Social Services committee formed a subcommittee to consider several issues related to Senate Bill 61 that were brought up during the legislation's first hearing. In an effort to assist the subcommittee discussion on these questions, this memo provides background information from the bill sponsor for use during the March 10 subcommittee meeting.

The AARP letter of support for Senate Bill 61 noted a particular concern about health coverage for Alaskans between the ages of 50-64. The subcommittee has expressed an interest in determining how Senate Bill 61 will impact this group of Alaskans.

> AARP's Public Policy Institute[1] goes into detail about the difficulty Americans between the ages of 50-64 have when they attempt to access, and afford, health care. While Medicare kicks in at 65, many people retire before they become eligible for those benefits, and often standard individual market offerings are withheld, forcing older Alaskans into ACHIA plans which can cost up to 50% more than the price of standard risk premium rates[2].
>
> Senate Bill 61 will ensure that all Alaskans have access to affordable, quality health coverage by putting the price of a plan within reach. Like most Americans who lack health coverage, a majority of individuals who lack benefits between the ages of 50-64 are still members of the workforce[3]. The bill will assist these

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[1] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007
[2] AS 21.55.150 (c)
[3] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007

working, uninsured individuals in the same way that it will work for all other Alaskans.

In addition, there are some elements of the legislation that should be of particular interest to Alaskans between the ages of 50-64:

Guaranteed Issue, Credible Coverage and Preexisting Condition Exclusions:

Medical underwriting in Alaska's individual market can result in denial of standard coverage by private insurers, particularly when an applicant has less than perfect health. Since the need for medical attention often increases with age, this trend is particularly worrisome for older Alaskans, who are more likely to have identified medical needs than 20 year olds. And while the state's high risk pool cannot reject an individual, these plans are often too expensive for applicants. Senate Bill 61 requires that health insurance plans for sale through the health care clearinghouse offer coverage to any applicant, preventing a scenario where the only course of action is purchasing a plan through ACHIA.

The legislation also requires that plans sold through the clearinghouse give credit for prior coverage, and that preexisting condition exclusions be reduced by any length of "continuous credible coverage" that an individual had before they applied for coverage. For Alaskans that are leaving the workforce who aren't provided benefits through a retirement package, these protections will ensure a more seamless transition into retirement.

The final element that will assist individuals acquiring coverage for the first time through Senate Bill 61 is the provision that prohibits preexisting condition limitations from extending for over one year. By capping limitations at one year, Alaskans will still be discouraged from buying coverage only when it is medically necessary, but it will also ensure that health coverage sold through the clearinghouse is a quality product for those who haven't been able to buy coverage in the past, due to cost or other circumstances.

The three consumer protections listed above – guarantee issue, credit for continuous coverage, and preexisting condition limitation caps - are currently required elements of small group, employer based plans available in Alaska. Extending these protections to individual plans sold in the clearinghouse will level the playing field for all Alaskans, both young and old.

What is the structure of the clearinghouse, and how will it take into account Alaska's unique geographic and technological situation when attempting to reach all Alaskans?

The health care clearinghouse is the entity that is charged with administering the program, under the direction of the health care board. In particular, the bill specifies that the clearinghouse will disseminate information about health care insurance products, and provide assistance in the enrollment process for businesses or individuals[4].

[4] Senate Bill 61 – Sec. 21.54.230

During the Senate Health and Social Services committee hearing on March 2, 2009, the clearinghouse was characterized as an electronic web-based 'place' where health plans can be compared and purchased. This concept, taken from Massachusetts and the Federal Employee Health Benefits program, is an innovative model that has proven successful in both instances. That being said, nothing in the bill confines how the board can structure the clearinghouse, despite the recent successes of an electronic, web based solutions.

In Massachusetts, a variety of means have been used to implement health reform. The Commonwealth Connector website touts advertizing efforts, along with partnerships, mailings, employer education and grassroots initiatives as successful elements to educating the public[5]. As one example, 'Connect to Health' events were held throughout the state to educate and enroll residents in health insurance plans through the connector. A press release noted that these forums were made possible through the involvement of public officials, community health centers, hospitals, business groups, public school districts and health care advocates[6].

Customer service centers were also created to help implement the legislation, and toll free call centers are open daily to answer questions and provide enrollment assistance.

As currently drafted, the bill leaves all options open for the health care board to determine how to communicate with and enroll eligible Alaskans. Given the broad composition of the board - which includes consumer advocates, insurance representatives, business people, labor, medical professionals and hospitals - the perspectives necessary to craft an Alaska specific approach to enrolling people in health coverage should be achievable, particularly when we use other states as models.

The National Federation of Independent Business commented on Senate Bill 61 in a letter to Senator French dated January 25, 2009. In particular, the letter stated two specific concerns:

The first concern: "Unfortunately, SB 61 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll."

Senate Bill 61 has a unique section regarding employer contributions, as described during the March 2 bill hearing. The rules are simple. There is no levy for businesses whose payroll is less than $500,000 a year. For businesses with a payroll between $500,000 and $1 million annually, the levy is 1%. For businesses with a payroll greater than $1 million annually, the levy is 2% of payroll. The 'bar' of what it means to provide health coverage is set relatively low – either an employer must offer to pay 33% of a premium cost or they must successfully enroll 25% of employees in their program – regardless of their level of contribution – to avoid the employer levy. In addition, if an employer establishes a Section 125 account that allows employees to purchase health

[5] http://www.mahealthconnector.org - Overview -> Public Education and Outreach
[6] http://www.mahealthconnector.org - January 11, 2008 press release

insurance with pre-federal tax dollars, they too avoid the levy, since the establishment of such an account produces great tax savings for employees. The cost of section 125 accounts are relatively cheap – quotes last year were around several hundred dollars a year total for a small employer, covering all employees. This means that an employer can fulfill all provisions of the employer levy simply by giving employees access to a Section 125 account, at a total cost of several hundred dollars – for all employees – per year.

On the broad scale of health reform options, Senate Bill 61 includes very few obligations on non-providing employers. Massachusetts requires a payout of $295 per non-covered employee per year, and includes a provision which also encourages the creation of Section 125 accounts. California proposals on the table last year included payroll taxes that ranged from 1% to 6.5%. In San Francisco, a plan that requires businesses with over 100 employees in the city to pay at least $1.76 per hour towards health benefits was affirmed by the 9th circuit court of appeals just last year, it not being an excluded policy option for the city due to ERISA preemption.

The second concern: "It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers."

The legislation broadly defines 'essential health care services' as including preventative and primary care, emergency services, inpatient services and hospital treatment, ambulatory patient services, prescription drug coverage and mental health services[7]. It does not specify benefit levels that must be provided in each category, nor does it address permissible co-pays, co-insurance, deductibles, or other fiscal elements of a plan. For a private offering to fulfill the individual responsibility clause proposed in Sec 21.54.240, a private plan must 'meet or exceed' the definition of essential health care services provided in that section[8].

Currently most employer based group health plans are subject to regulation under ERISA, and health insurers that are licensed in the state are regulated by state insurance law, as well[9]. The concern about mandated benefits may be rooted in the specific medical procedures that current Alaska law requires as elements of state regulated health insurance plans. Examples of such mandates include cancer screening procedures, well baby examinations and limited alcoholism and drug abuse treatment. The more benefits a plan includes, the higher cost of the plan.

Language should be changed in Senate Bill 61 to say that a health care insurance plan sold in the group market fulfills the individual responsibility clause of the legislation. This change would help alleviate the concerns expressed by the National Federation of Independent Business, because the comprehensive group plans that currently provide benefits to employees around the state would fulfill the legislation, without requiring a modification of the benefits that they offer.

[7] Senate Bill 61 – Sec. 21.54.250
[8] Senate Bill 61 – Sec. 21.54.250 (a)(1) and (a)(4)
[9] http://www.dol.gov/ebsa/publications/selfcompliancetool.html

Senator Hollis French

Capitol Room 417
465-3892
465-6595 fax

MEMORANDUM

Date: 1/28/2009

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

From: Senator Hollis French

RE: Request for Hearing -- SB 61

This is a request that you schedule a hearing on SB 61 "Affordable Universal Health Insurance" at the earliest possible date.

I have attached a sponsor statement, a sectional summary, a copy of the bill, and a bill packet for your use. I appreciate your consideration.

Attachments

26-LS0312\E
Bailey
3/11/09

CS FOR SENATE BILL NO. 61( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS FRENCH, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state, the Alaska Health Care Board to administer the Alaska health care program and the Alaska health care fund, the Alaska health care clearinghouse to administer the Alaska health care program under the direction of the Alaska Health Care Board, and eligibility standards and premium assistance for health care coverage of persons with low incomes; 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."

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

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

FINDINGS; PURPOSE. (a) The legislature finds that

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(1) the current health care system is unsustainable;

(2) improving and protecting the health of Alaskans must be a primary goal of the state;

(3) all Alaskans should have access to essential health care services that are affordable, that are based on publicly debated criteria, and that consider the well-being of individuals across their life spans;

(4) Alaska has an economic interest in ensuring equitable financing of essential health care for Alaskans who do not have access to basic health care;

(5) health care policies should emphasize public health and encourage the use of quality service and evidence-based treatment that are appropriate and safe and that discourage over-treatment;

(6) health care providers and informed patients must be the primary decision makers who are accountable for an individual's health;

(7) health care funding should be explicit, predictable, and economically sustainable;

(8) an economically sustainable health care system requires that providers receive fair and adequate compensation;

(9) health care must be balanced with other programs that also affect health; and

(10) health care must account for the allocation of resources and the human consequences of funding decisions.

(b) The purpose of this Act is to address the findings and concerns listed in (a) of this section by creating the Alaska health care program.

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

Article 2A. Alaska Health Care Program.

Sec. 21.54.200. Alaska health care program. The Alaska health care program is established to

(1) ensure that residents of the state have access to affordable health care insurance;

(2) require that residents of the state have, at a minimum, insurance covering essential health care services;

(3) reduce unsustainable health care cost increases;

(4) establish a system of health care insurance that integrates public involvement and oversight, consumer choice, and competition within the private health care insurance market;

(5) use models of health care insurance benefits, service delivery, and payments that control costs and overuse, emphasizing preventative care and chronic disease management within a primary care environment; and

(6) provide services for humane and dignified end-of-life care.

Sec. 21.54.210. Alaska Health Care Board. (a) The Alaska Health Care Board is established in the division to manage the Alaska health care program.

(b) The board shall consist of 13 members, including 12 members appointed by the governor, subject to confirmation by the legislature, and the commissioner of health and social services or the commissioner's designee, serving ex officio. The members of the board appointed by the governor must include

(1) one representative who is a licensed insurance producer;

(2) one representative from a health insurance company licensed to transact health care insurance in the state;

(3) two representatives of the business community other than health care insurers, one representing large businesses, and one representing small businesses;

(4) one representative each from two Alaska hospitals;

(5) one representative of a labor organization;

(6) two physicians licensed in Alaska;

(7) two health care consumer advocates; and

(8) one registered nurse.

(c) Except for the commissioner or the commissioner's designee, who serves ex officio, each board member serves for a term of three years beginning on January 1 and until a successor has been appointed. A member is eligible for reappointment.

(d) If there is a vacancy, the governor shall make an appointment, effective immediately, for the balance of the unexpired term.

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

1 under AS 39.20.180.
2 (f) The board shall select a member to serve as chair and a member to serve as
3 vice-chair for a term and with duties and powers necessary to perform their functions.
4 (g) A majority of the board constitutes a quorum for transacting business.
5 **Sec. 21.54.220. Powers and duties of the Alaska Health Care Board.** (a)
6 The Alaska Health Care Board shall
7 (1) administer, as a fiduciary, the Alaska health care fund established
8 under AS 21.54.280 in accordance with the Alaska health care program established by
9 AS 21.54.200 - 21.54.310;
10 (2) establish types or categories of health care insurance plans offered
11 through the Alaska health care clearinghouse;
12 (3) classify each plan offered through the clearinghouse as a
13 comprehensive or basic health care insurance plan, based on criteria including the
14 financial cost of the plan, including premium cost, deductible costs, and co-pay
15 provisions;
16 (4) establish criteria for participation by residents and insurers in the
17 Alaska health care program;
18 (5) establish an Alaska health care voucher system that provides health
19 care insurance to each individual who meets the needs-based participation criteria set
20 out in AS 21.54.240 or who is the beneficiary of contributions made to the fund that
21 specify the individual as the beneficiary under AS 21.54.280(b);
22 (6) ensure that eligible individuals are enrolled in a health care
23 insurance plan that provides essential health care services;
24 (7) prescribe the method for determining individual income for the
25 purpose of the Alaska health care program;
26 (8) establish procedures for enrolling a participant in the Alaska health
27 care program, including enrollment procedures describing when an individual may
28 enroll or select a different health insurance plan offered through the Alaska health care
29 clearinghouse; the procedures established under this paragraph must allow an
30 individual insured by a health care insurance plan offered through the Alaska health
31 care clearinghouse to select a different health care insurance plan from the plans

offered through the clearinghouse and to make that selection at least annually;

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

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

(11) ensure that every Alaskan who is required to participate in the Alaska health care program is offered health care insurance that protects the insured from severe financial hardship caused by the cost of receiving medical care.

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

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

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

(c) The clearinghouse shall

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

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

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

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

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

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

(3) is enrolled in Medicaid or Medicare;

(4) is covered under a health benefit plan offered in the group market;

(5) is an individual insured under an individual state plan of health

1 insurance under the Comprehensive Health Insurance Association under AS 21.55;
2 (6) is receiving health care benefits under a medical care program of
3 the Indian Health Service; however, a person receiving health care benefits under a
4 medical care plan of the Indian Health Service may elect to participate in the Alaska
5 health care program;
6 (7) has resided in the state for less than one year; however, a person
7 who has resided in the state for less than one year may receive services provided by
8 the Alaska health care clearinghouse under AS 21.54.230; or
9 (8) demonstrates satisfactorily to the board, under criteria established
10 by the board, that the person has deeply held religious beliefs contrary to the Alaska
11 health care program and the requirement to purchase health care insurance for
12 essential health care services.
13 (b) Except as provided in (g) of this section, the Alaska Health Care Board
14 shall provide a voucher to a resident with an income that is not more than 450 percent
15 of the most recent federal poverty guidelines, updated periodically in the Federal
16 Register by the United States Department of Health and Human Services under the
17 authority of 42 U.S.C. 9902(2), and who is only eligible for coverage through the
18 Comprehensive Health Insurance Association (AS 21.55). A voucher authorized by
19 this subsection must equalize the cost of insurance under the Comprehensive Health
20 Insurance Association with the cost of purchasing a health care insurance plan that
21 provides substantially equivalent benefits through the Alaska health care
22 clearinghouse. For purposes of cost comparison under this subsection, the board shall
23 determine whether a plan provided under the Comprehensive Health Insurance
24 Association provides substantially equivalent benefits to a health care insurance plan
25 offered through the clearinghouse.
26 (c) Except as provided in (g) of this section, a resident with an income that is
27 not more than the most recent federal poverty guidelines, updated periodically in the
28 Federal Register by the United States Department of Health and Human Services
29 under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska
30 health care program shall receive private health care insurance coverage for essential
31 health care services at no cost, paid from the fund.

(d) Except as provided in (g) of this section, a resident with an income between 100 percent and not more than 300 percent of the most recent federal poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), who is required to participate in the Alaska health care program shall pay premiums for health care insurance for essential health care services on a sliding scale established by the board.

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

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

(g) A person who is exempt from being required to participate in the Alaska health care program under

(1) (a)(1) - (5) of this section, but who is eligible to participate in a program identified in (a)(1) - (5) of this section, may not receive benefits under (b) - (d) of this section.

(2) (a)(7) of this section may not receive benefits under (b) - (d) of this section until the person has resided in the state for one year or more.

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,

(1) preventative and primary care;

(2) emergency services;

(3) inpatient services and hospital treatment;

(4) ambulatory patient services;

(5) prescription drug coverage; and

(6) mental health services.

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

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

(c) If an employer does not provide a health care insurance plan for all employees or provides a health care insurance plan that meets or exceeds coverage for essential health care services but does not enroll at least 25 percent of the employer's employees in the plan or does not offer to pay at least 33 percent of the premium for health care insurance under the plan, the employer shall pay the department as follows:

(1) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care plan under AS 21.54.240 is $500,000 or less, no payment is required;

(2) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care plan under AS 21.54.240 is greater than $500,000 but less than $1,000,000, the employer shall pay one percent of the gross payroll; or

(3) if an employer's annual gross payroll paid to employees who are required to participate in the Alaska health care program under AS 21.54.240 is $1,000,000 or greater, the employer shall pay two percent of the gross payroll.

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

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

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

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

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

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

(2) varied levels of copayment, coinsurance, deductable amounts, out-of-pocket maximums;

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

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

(d) A health care insurance plan offered through the Alaska health care clearinghouse that covers children must provide that the coverage will continue until the earlier of the child's reaching 25 years of age or two years after the child no longer resides with the family.

(e) Notwithstanding AS 21.54.110(a), a health care insurance plan offered through the Alaska health care clearinghouse may not exclude coverage for a preexisting condition that

(1) relates to a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received more than two years before the enrollment date;

(2) considers genetic information as a condition for which a preexisting exclusion may be imposed in the absence of a diagnosis of the condition related to the genetic information;

(3) extends more than 12 months after the enrollment date; or

(4) excludes a condition relating to pregnancy.

(f) A period of a preexisting condition exclusion permissible under (e) of this section must be reduced by the aggregate periods of creditable coverage, if any, as determined under AS 21.54.120, including creditable coverage resulting from participation in a plan offered through the Alaska health care clearinghouse, or a plan described in AS 21.54.240(a)(1) - (6). The aggregate of periods of creditable coverage is determined by adding all periods of creditable coverage before the enrollment date, excluding periods of creditable coverage before a continuous break in coverage of more than 90 days. This subsection does not apply if an individual's most recent period of creditable coverage ended on a date more than 90 days before the enrollment date. This subsection does not preclude application of a waiting period to all new enrollees under a health care insurance plan.

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

(1) state money appropriated to the fund;

(2) federal money appropriated to the fund;

(3) private employer and employee health care contributions or fees received by the department and appropriated to the fund;

(4) health care premiums received by the department and appropriated to the fund;

(5) other appropriations by the legislature;

(6) contributions appropriated to the fund from the United States government and its agencies or from any other source, public or private, provided for purposes that are consistent with the goals of the Alaska health care program; and

(7) interest earnings from investments of the fund appropriated to the fund.

(b) Contributions may be made to the fund by an employer, employers, or an individual that is specified for a particular beneficiary. If a contribution is made to the fund for the benefit of a particular beneficiary, the beneficiary shall receive a health care voucher in the amount of the contribution that may be used to purchase a health

1 care insurance plan. Money collected under AS 21.54.260(c) is not considered made
2 for the benefit of a particular beneficiary.
3 (c) The board may use the fund for the purpose of administering the Alaska
4 health care program consistent with AS 21.54.200 - 21.54.310.
5 **Sec. 21.54.290. Disputes and appeals.** A person is entitled to notice and an
6 opportunity for a hearing under regulations adopted by the Alaska Health Care Board
7 if
8 (1) the board or the Alaska health care clearinghouse denies enrollment
9 to the person;
10 (2) an accountable health care plan refuses to enroll an individual or
11 fails to provide essential health care services; or
12 (3) the person is adversely affected or aggrieved by a decision of the
13 board or the clearinghouse.
14 **Sec. 21.54.300. Reporting.** The Alaska Health Care Board shall submit a
15 written report on the operation of the Alaska health care program to the commissioner
16 and to the legislature by January 1 of each year. The report must include
17 (1) the number of individuals enrolled in the Alaska health care
18 program;
19 (2) the cost savings to the state, to employers, and to health care
20 providers;
21 (3) a measure of patient satisfaction;
22 (4) an assessment of patient access to essential health care services;
23 (5) a description of the changes or adjustments made to the program
24 during the period covered by the report;
25 (6) a discussion of the state agencies delivering redundant services, if
26 any, relating to health care benefits;
27 (7) an evaluation of state programs that regulate or deliver health care
28 benefits;
29 (8) recommendations for legislative changes necessary to meet the
30 goals of the program;
31 (9) an evaluation of and recommendations on the following topics:

(A) the use of electronic health records;

(B) children's health insurance programs;

(C) the effectiveness of Medicaid and the potential expansion of the Alaska Medicaid program, including a comparison between the costs of expanding the Alaska Medicaid program and the cost of providing benefits through the Alaska health care program;

(D) the effect of mandated benefits;

(E) prescription drug bargaining;

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

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

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

(I) maximizing federal funding to implement the program;

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

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

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

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

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

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

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

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

TRANSITIONAL PROVISIONS. Notwithstanding AS 21.54.210, enacted by sec. 2

of this Act, the initial terms for members of the Alaska Health Care Board, except for the commissioner of health of social services who serves ex officio, are as follows:

(1) four members shall be appointed to serve for a term ending December 31, 2010;

(2) four members shall be appointed to serve for a term ending December 31, 2011; and

(3) the remaining members shall be appointed to serve for a term ending December 31, 2012.

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

TRANSITIONAL PROVISIONS: REGULATIONS. The Alaska Health Care Board established under AS 21.54.210, enacted by sec. 2 of this Act, may proceed to adopt regulations necessary to implement this Act under AS 21.54.310, enacted by sec. 2 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

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

*** Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect January 1, 2010.

Alaska State Legislature

Senator Hollis French

Sponsor Statement

SB 61 - 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. The federal government might take action, but if it doesn't, Alaska needs to be ready to take the lead.

Many other states have joined the universal health care debate, but this bill is uniquely Alaskan. SB 61 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 61 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.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB 61**
() Publish Date:

Identifier (file name):SB61-CED-INS-03-02-09
Title: MANDATORY UNIVERSAL HEALTH INSURANCE
Sponsor: Senator French
Requester: Senate Health & Social Services

Dept. Affected: DCCED
RDU: Insurance
Component: Insurance Operations
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	878.1		1,756.1	1,756.1	1,756.1	1,756.1	1,756.1
Travel	48.2		96.4	96.4	96.4	96.4	96.4
Contractual	1,979.5		1,134.0	1,134.0	1,134.0	1,134.0	1,134.0
Supplies	24.0		12.0	12.0	12.0	12.0	12.0
Equipment	431.4		9.0	9.0	9.0	9.0	9.0
Land & Structures							
Grants & Claims							
Miscellaneous (Premium Costs)	1,146,000.0		1,146,000.0	1,146,000.0	1,146,000.0	1,146,000.0	1,146,000.0
TOTAL OPERATING	**1,149,361.2**		**1,149,007.5**	**1,149,007.5**	**1,149,007.5**	**1,149,007.5**	**1,149,007.5**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (1105)	**564,000.0**		**564,000.0**	**564,000.0**	**564,000.0**	**564,000.0**	**564,000.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	585,361.2		585,361.2	585,361.2	585,361.2	585,361.2	585,361.2
1005 GF/Program Receipts	564,000.0		564,000.0	564,000.0	564,000.0	564,000.0	564,000.0
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,149,361.2**		**1,149,361.2**	**1,149,361.2**	**1,149,361.2**	**1,149,361.2**	**1,149,361.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	24		24	24	24	24	24
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 an Alaska health insurance program. The bill establishes the Alaska Health Care Board to oversee the program and the Alaska Health Care Clearinghouse to administer the program, under the direction of the Board. The effective date of the Act is January 10, 2010.

(Continued on page 2)

Prepared by: Linda Hall, Director — Phone (907)269-7900
Division: Insurance — Date/Time 3/2/09 9:00 AM
Approved by: Emil R. Notti, Commissioner — Date 3/2/2009
Department of Commerce, Community and Economic Development

(Revised 9/10/2008 OMB)

3652

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB 61

ANALYSIS CONTINUATION

Caveat: The Division of Insurance has no existing expertise in establishing or administering State benefits programs. The Division of Insurance oversees the conduct of insurance companies, ensures solvency, and approves rates and forms. The Division of Insurance does not determine what are minimum essential health services or how they should be priced. Further, the Division of Insurance has no expertise in determining the eligibility of individuals for government subsidies. All of this expertise will have to be developed by the Division of Insurance from scratch, primarily by recruiting and hiring a substantial number of employees with this type of expertise.

Senate Bill 61 allows for a wide range of options that may be considered essential health care services. As a result, it is not possible to determine the cost of the bill with a high confidence in accuracy. The range of possible costs is wide, depending upon how the Board defines certain terms.

This fiscal note examines the potential cost of the program , as well as the estimated cost of administering the benefit. Costs for insurance premiums 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.

Assumptions:
*The Health Care 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 $12,000 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. 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.
*There are an estimated 115,000 uninsured persons in Alaska, 83% of whom are adults.

Cost Estimates for Alaska Health Care Program:
*There are 27,000 uninsured persons who are below 100% of the poverty level. Insurance is provided at no cost to the individual. Total cost to the state is $324,000,000.

*43,000 have incomes between 100% and 300% of poverty. They would pay premiums on a needs-based sliding scale. With an estimated average cost of $6,000 per person, the total cost to the state is $258,000,000.

Above 300% of poverty: $0 total. No cost to the State.
*There are about 25,500 uninsured individuals who are above 300% of the poverty level. They would bear the full cost of the mandatory insurance. These individuals would bear a total cost of about $306,000,000.

Fund Source
*A portion of the cost will be paid by a payroll tax of up to 2%, depending upon the size of the business. The Division of Insurance is aware of no statistics on which to estimate the amount of money that would be raised by the tax.

* A portion of the cost will also be funded by premiums paid in part by persons with income between 100% and 300% of the poverty line. These revenues are shown in the general fund program receipts fund source.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB061
() Publish Date:

Identifier (file name): SB061-DHSS-PAFS-02-28-09
Title: Mandatory Universal Health Insurance
Sponsor: French
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Public Assistance
Component: Public Assistance Field Services
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services	1,234.7		1,646.3	1,646.3	1,646.3	1,646.3	1,646.3
Travel	10.0		10.0	10.0	10.0	10.0	10.0
Contractual	255.3		340.4	340.4	340.4	340.4	340.4
Supplies	35.6		47.5	47.5	47.5	47.5	47.5
Equipment	250.0						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**1,785.6**	**0.0**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	892.8		1,022.1	1,022.1	1,022.1	1,022.1	1,022.1
1003 GF Match	892.8		1,022.1	1,022.1	1,022.1	1,022.1	1,022.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,785.6**		**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**	**2,044.2**

Estimate of any current year (FY2009) cost:

POSITIONS

Full-time	**23.0**		23.0	23.0	23.0	23.0	23.0
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, which is administered by the Division of Insurance.

The bill is expected to increase enrollment in Medicaid, since enrollment in Medicaid is one of the criteria that makes a person ineligible for health care coverage under the new program. The Division of Public Assistance accepts applications and determines whether a person meets program criteria and financially qualifies for the Medicaid program. This fiscal note reflects the additional administrative costs needed to support the increased workload as a result of more people applying for Medicaid.
(continued on page 2)

Prepared by: Ellie Fitzjarrald, Director
Division: Public Assistance
Phone (907) 465-5847
Date/Time 2/27/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 2/28/2009

(Revised 9/10/2008 OMB)

3654

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB061

ANALYSIS CONTINUATION

SB 61 has a January 1, 2010 effective date.

Assumptions:

In FY2010, the department anticipates receiving 14,000 Medicaid applications from persons who do not currently receive Medicaid, and that 10,000 will qualify and be enrolled. Additional staff will be needed to manage the increased application volume and workload. The Division of Public Assistance assumes that funding for additional staff in FY 2010 will include a three month start-up period beginning October 2009 to accommodate hiring and training of new staff.

Fourteen Eligibility Technicians are needed to make decisions on applications and act on changes in household income or other factors affecting a household's eligibility; two Lead Eligibility Technicians are needed to perform quality assurance, training on program rules, and other lead worker duties; one Eligibility Supervisor is needed to oversee and manage the work of the new staff; and four administrative support staff are needed to provide customer service, manage phone lines, and perform clerical support.

The increased volume of applications is anticipated to result in increased denials of eligibility and fair hearing requests. Hearing requests usually result when applicants do not receive an affirmative decision on their application. This increased demand will result in the need for one additional Public Assistance Analyst to serve as a hearing representative and support the fair hearing function.

Additionally, interaction with another department will also increase complexity of referrals and processing of applications. A Program Coordinator is necessary to establish and maintain service coordination and collaboration with the Alaska Health Care Program, and to facilitate consumer education, etc.

FY 2010 Administrative Costs (for 9 months): $1,785.6
Personal Services: $1,234.7 (salary and benefits for 23 new positions)
Travel: $10.0 (for training)
Contractual: $255.3 (for 9 month's cost for information technology, telecommunication, office space, phones)
Supplies: $35.6 (program materials and general office supplies
Equipment: $250.0 (One-time cost for desktop computers, printers, and workstations, and other office equipment

FY 2011 – FY 2015 Annual Administrative Costs: $2,044.2
Personal Services: $1,646.3 (salary and benefits for 23 new positions)
Travel: $10.0 (for training)
Contractual: $340.4 (annual cost for information technology, telecommunication, office space, phones)
Supplies: $47.5 (program materials and general office supplies)

3655

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB061**
() Publish Date:

Identifier (file name): **SB061-DHSS-BHMS-02-28-09**
Title: Mandatory Universal Health Insurance
Sponsor: French
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Behavioral Health
Component: Behavioral Health Medicaid Services
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	3,000.0		6,000.0	6,000.0	6,000.0	6,000.0	6,000.0
Miscellaneous							
TOTAL OPERATING	**3,000.0**	**0.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,830.0		3,660.0	3,660.0	3,660.0	3,660.0	3,660.0
1003 GF Match	1,170.0		2,340.0	2,340.0	2,340.0	2,340.0	2,340.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**3,000.0**	**0.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**	**6,000.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
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, which is administered by the Division of Insurance. The effective date for coverage is January 1, 2010.

This bill is expected to increase enrollment in Medicaid, which will increase costs. This fiscal note reflects the portion of additional costs to the Medicaid program for behavioral health services.

continued on page 2

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services
Phone: 907-269-7827
Date/Time: 1/27/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 2/28/2009

(Revised 9/10/2008 OMB)

3656

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

BILL NO. SB061

ANALYSIS CONTINUATION

ASSUMPTIONS

Enrollment

Participation is required for every resident who is not enrolled in a public medical assistance program (e.g. Medicaid, Medicare) or a private insurance program that provides essential health care services. About 20% of the uninsured are Native who have coverage under Indian Health Services. Most children who need long term care are expected to have already applied for Medicaid.

There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, and elderly = 800) who would be required to take up coverage. Of the 109,500 uninsured 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. This includes the eligible Native population who we assume would enroll in Medicaid as a result of outreach/advertising for the AK Health Care program.

Cost of Benefits

Once deemed eligible, a Medicaid enrollee is entitled to all Medicaid services, and is not limited to only those "essential health care services" listed in the bill. The average cost for all Medicaid benefits for children is **$3,000 per person per year** (based on analysis of Medicaid claim payments for non-disabled children). The total additional cost for benefits (all Medicaid components) is $30 million per year (10,000 persons x $3,000).

This component is allocated about 20% of the total Medicaid costs. Behavorial Health Medicaid Services include acute psychiatric hospital, residential psychiatric treatment centers and outpatient mental health services.

Fund Source

The federal government reimburses the state approximately 50% of the cost for most Medicaid claims. Some claims get an enhanced match rate (e.g. Indian Health Services is 100% federal). The fund source is based on the projected weighted average federal revenue for Behavioral Health Medicaid Services of **61% federal funds**. State matching funds for Medicaid are GF/M and do not come from the AK Heath Care Fund.

3657

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB061
() Publish Date:

Identifier (file name): SB061-DHSS-MS-03-06-09
Title: Mandatory Universal Health Insurance
Sponsor: French
Requester: Senate HSS

Dept. Affected: Health & Social Services
RDU: Health Care Services
Component: Medicaid Services
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2010**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	12,000.0		24,000.0	24,000.0	24,000.0	24,000.0	24,000.0
Miscellaneous							
TOTAL OPERATING	**12,000.0**	**0.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	8,112.0		16,224.0	16,224.0	16,224.0	16,224.0	16,224.0
1003 GF Match	3,888.0		7,776.0	7,776.0	7,776.0	7,776.0	7,776.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**12,000.0**	**0.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**	**24,000.0**

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time							
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, which is administered by the Division of Insurance. The effective date for coverage is January 1, 2010.

This bill is expected to increase enrollment in Medicaid, which will increase costs. This fiscal note reflects the portion of additional costs to the Medicaid program for health care services, other than behavioral health.

continued on page 2

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services
Phone: 907-269-7827
Date/Time: 3/6/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/6/2009

(Revised 9/10/2008 OMB)

3658

FISCAL NOTE

STATE OF ALASKA

2009 LEGISLATIVE SESSION

BILL NO. SB061

ANALYSIS CONTINUATION

ASSUMPTIONS

Enrollment

Participation is required for every resident who is not enrolled in a public medical assistance program (e.g. Medicaid, Medicare) or a private insurance program that provides essential health care services. About 20% of the uninsured are Native who have coverage under Indian Health Services. Most children who need long term care are expected to have already applied for Medicaid.

There are an estimated 109,500 uninsured persons in Alaska (children = 17,200, adults = 91,500, and elderly = 800) who would be required to take up coverage. Of the 109,500 uninsured 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. This includes the eligible Native population who we assume would enroll in Medicaid as a result of outreach/advertising for the AK Health Care program.

Cost of Benefits

Once deemed eligible, a Medicaid enrollee is entitled to all Medicaid services, and is not limited to only those "essential health care services" listed in the bill. The average cost for all Medicaid benefits for children is **$3,000 per person per year** (based on analysis of Medicaid claim payments for non-disabled children). The total additional cost for benefits (all Medicaid components) is $30 million per year (10,000 persons x $3,000).

This component is allocated about 80% of the total Medicaid costs. Health Care Services - Medicaid Services include inpatient/outpatient hospitals, physicians & clinics, prescription drugs, dental, transportation, lab/x-ray, durable medical equipment, physical/occupational/speech therapy, vision, and home health/hospice.

Fund Source

The federal government reimburses the state approximately 50% of the cost for most Medicaid claims. Some claims get an enhanced match rate (e.g. Indian Health Services is 100% federal). The fund source is based on the projected weighted average federal revenue for Health Care Services - Medicaid Services of **66.7% federal funds**. State matching funds for Medicaid are GF/M and do not come from the AK Heath Care Fund.

3659

SB 61 *Health Insurance For All Alaskans*

Detailed Bill Summary

SECTION 1 of the bill – Findings **Corresponds with version \R**

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 Division of Insurance. The board will have 13 voting members, and will include:

- one insurance producer licensed to do business in the state
- one representative from a health insurance company licensed in Alaska
- 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) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

Detailed Bill Summary

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
- Ensure that plans protect individuals from severe financial hardship in times of medical need

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) – (8) 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. In addition, individuals who have objections to the requirement to have health coverage on religious grounds can apply to be exempt from the individual responsibility clause.

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.

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Detailed Bill Summary

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.

Subsection (g) clarifies that an individual who is eligible for health coverage funded by a source other than the health care clearinghouse won't receive needs based vouchers to make insurance affordable.

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 the number of employees who lack health coverage and are required to attain it under this legislation. For businesses that pay below $500,000 gross annually to employees that are required to participate, no levy will be charged. For businesses with $500,000 to $1 million a year in gross payroll to employees required to participate in the plan, the levy will be 1% of gross payroll. For $1 million or greater, the levy will be 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

Detailed Bill Summary

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.

Subsection (e) borrows language from Alaska's small group health insurance law that limits the length of time a preexisting condition limitation can be imposed on new enrollees to a maximum of 12 months. It also only allows a two year look back for determining when preexisting conditions exist.

Subsection (f) requires insurers to give credit for prior coverage when determining preexisting condition exclusion periods on newly issued health insurance plans sold through the clearinghouse.

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/expansions 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.

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Health Insurance For All Alaskans

A Bipartisan Solution To Cover The Health Needs Of All Alaskans

SB 61 - AFFORDABLE HEALTH INSURANCE

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 [this bill] is a very promising solution to a significant problem faced by a large number of Alaskan businesses."

- Testimony during a September 10th, 2007 bill hearing in Anchorage, AK

SB 61 *Health Insurance For All Alaskans*

Legislation Summary

Senate Bill 61 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 61 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.

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SB 61 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?
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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SB 61 *Health Insurance For All Alaskans*

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 61 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 61 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 61 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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SB 61

Health Insurance For All Alaskans

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 61 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 61 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 61 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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SB 61

Health Insurance For All Alaskans

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 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 employers.

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

- ISER

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 61 mandates true access to health care through a unique voucher system that makes coverage affordable for all Alaskans.

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SB 61

Health Insurance For All Alaskans

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 61, 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 61 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 61 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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SB 61 *Health Insurance For All Alaskans*

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 61 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 then 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.

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SB 61 *Health Insurance For All Alaskans*

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 61. 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 61 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 61.

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" - Worchester Telegram and Gazette, published November 18th, 2007

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SB 61

Health Insurance For All Alaskans

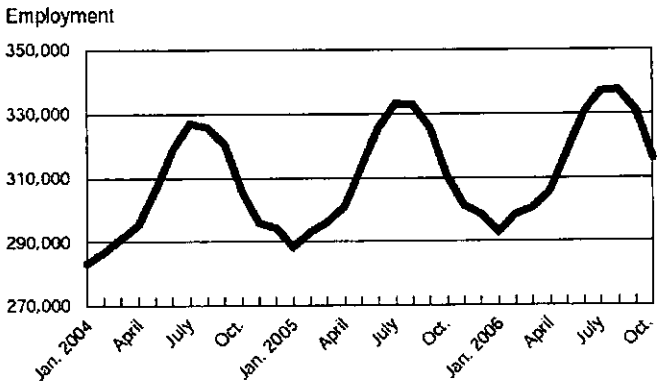
Continuity of Coverage

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 uninsured 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

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SB 61 Health Insurance For All Alaskans

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.

Not all businesses can afford the full price of health coverage. In addition, not all employees need insurance through their employer - many have coverage through spouses or public programs. Roughly 20% of Alaskans have limited health coverage through the Indian Health Service. Because of this, an employer will not be taxed under this legislation for not providing coverage to someone that already has health access, as defined in the legislation.

The employer levy is simple. It is calculated by adding up the gross payroll of all employees who participate in the framework of this bill. For businesses that pay less than $500,000 gross annually to employees who lack health coverage, no levy will be collected. For businesses that pay between $500,000 to $1,000,000 a year, the levy will be 1% of payroll. For over $1,000,000 annually, the payroll tax will be 2%. Companies that currently invest even a small amount of money into employee health coverage will be exempt from this levy, whether that investment consist of a modest contribution towards the price of a premium, or through the establishment of a Section 125 account, which facilitates pre-federal tax purchases of health coverage.

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:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us
www.healthyalaskans.com

SB 61

Health Insurance For All Alaskans

Massachusetts and SB 61 Compared

Issue Area	Alaska - SB 61	Massachusetts - Enacted
Sliding Scale Subsidies *Definitions:* 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 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.
Establishing A New Insurance Marketplace	The health care Clearinghouse will disseminate information, encourage competition, and help residents learn about different health coverage options.	The Connector provides information, encourages competition, and helps residents learn about different coverage options. It is a web-based marketplace.
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 process allows for some exceptions.	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.
Effect on Existing Public Programs	No changes to existing publicly funded programs.	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. Medicaid reimbursement rates were also increased under the legislation.
Financing	Employer payroll tax, varying from 0-2% of payroll depending on payroll size and the number of uncovered employees. Federal dollars will be pursued through 1115 waivers. State funds will also be used.	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. Federal dollars from 1115 waivers have been funneled to the project.
Insurance Market Reforms	**Yes:** Guarantee Issue for individual health plans, on the premise that the individual responsibility clause will prevent adverse selection. Preexisting condition limitations can extend no longer than 12 months for plans sold under the clearinghouse, and credit for prior coverage is required.	**Yes:** By merging the non-group and small group markets, insurance is portable and not tied to employment. Massachusetts already had guarantee issue laws and provisions that regulate preexisting condition limitations and credit for prior coverage within the individual market.

For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

SB 61

Health Insurance For All Alaskans

Other State Reform Efforts

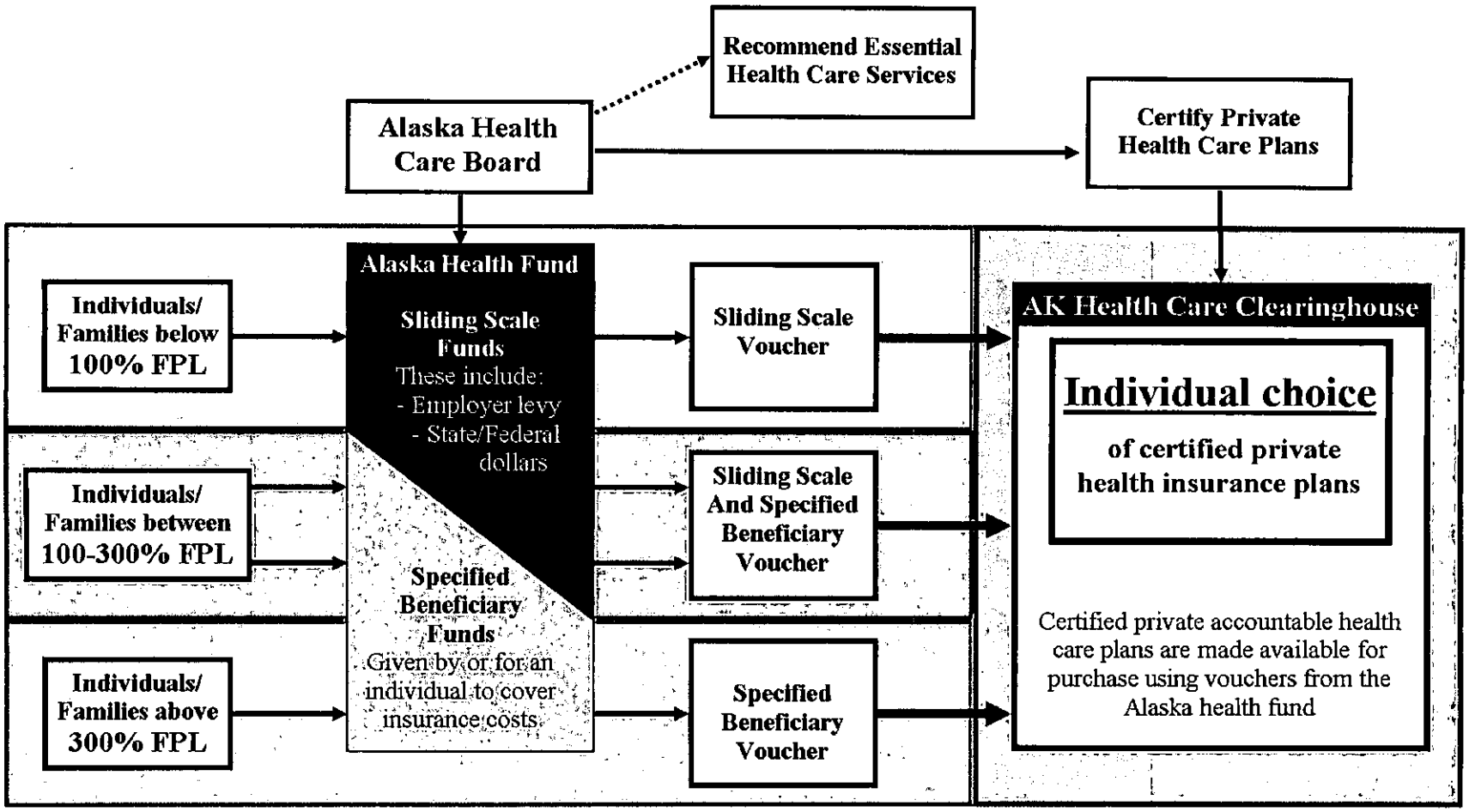
Issue Area	Alaska - Senate Bill 61	California - Governor Schwarzenegger's Plan 2008	Colorado—Legislature's Blue Ribbon Commission '08
Sliding Scale Subsidies *Definitions:* FPL = Federal Poverty Line	**Yes:** Households with incomes below 300% of the FPL will receive vouchers to make the price of coverage 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 payroll size and the number of uncovered 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. Preexisting condition limitations can extend no longer than 12 months for plans sold under the clearinghouse, and credit for prior coverage is required.	**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) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

SB 61

Health Insurance For All Alaskans

Alaska Health Care: The Framework For Change



For more information, contact Sen. French's office:
Phone: (907) 465-3892 E-Mail: Senator_Hollis_French@legis.state.ak.us **www.healthyalaskans.com**

Testimony 3/9/2009 SB 61

The Alaska Nurses Association is pleased to support Senator French's Senate Bill 61, Mandatory Universal Health Insurance. The legislative committee of the Association also represents the affiliate groups of the Alaska Chapter of Nurse Midwives, Alaska Home Health and Hospice Association, Alaska Nurse Anesthetists Association, Alaska Nurse Practitioner Association, Alaska School Nurses Association and the Alaska Chapter of the Forensic Nurses Association.

Our members are on record in support of innovative legislation that would make health insurance affordable for businesses and individuals. This bill meets that goal. According to a national survey by Consumer Reports [3/2008], 81% of respondents were concerned about being able to afford health care in retirement, 68% worry about being bankrupted by medical bills following a serious illness or accident and 65% feared losing their job-related coverage. The current economic picture with rising unemployment has exposed the weakness of relying on job-related health insurance. Senator French's bill addresses that problem.

The Alaska Nurses Association applauds Senator French's commitment to ensuring that health care become available for all Alaskans. We sincerely hope that SB61 will pass in the 26th legislative session.

Respectfully,

Lynn Hartz MSN
Family Nurse Practitioner
For the legislative committee of the Alaska Nurses Association
3701 E Tudor, ste. 208
Anchorage, AK 99507

Senator Hollis French

Anchorage LIO
269-0234
269-0238 fax

MEMORANDUM

Date: March 10, 2009

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

From: Senator Hollis French
Senate Bill 61 Prime Sponsor

RE: Background information for SB 61 Senate HSS subcommittee

On March 2 the Senate Health and Social Services committee formed a subcommittee to consider several issues related to Senate Bill 61 that were brought up during the legislation's first hearing. In an effort to assist the subcommittee discussion on these questions, this memo provides background information from the bill sponsor for use during the March 10 subcommittee meeting.

The AARP letter of support for Senate Bill 61 noted a particular concern about health coverage for Alaskans between the ages of 50-64. The subcommittee has expressed an interest in determining how Senate Bill 61 will impact this group of Alaskans.

AARP's Public Policy Institute[1] goes into detail about the difficulty Americans between the ages of 50-64 have when they attempt to access, and afford, health care. While Medicare kicks in at 65, many people retire before they become eligible for those benefits, and often standard individual market offerings are withheld, forcing older Alaskans into ACHIA plans which can cost up to 50% more than the price of standard risk premium rates[2].

Senate Bill 61 will ensure that all Alaskans have access to affordable, quality health coverage by putting the price of a plan within reach. Like most Americans who lack health coverage, a majority of individuals who lack benefits between the ages of 50-64 are still members of the workforce[3]. The bill will assist these

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[1] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007
[2] AS 21.55.150 (c)
[3] AARP Public Policy Institute, "Health Coverage among 50- to 64-Year-Olds," Data Digest #155, May 2007

working, uninsured individuals in the same way that it will work for all other Alaskans.

In addition, there are some elements of the legislation that should be of particular interest to Alaskans between the ages of 50-64:

Guaranteed Issue, Credible Coverage and Preexisting Condition Exclusions:

Medical underwriting in Alaska's individual market can result in denial of standard coverage by private insurers, particularly when an applicant has less than perfect health. Since the need for medical attention often increases with age, this trend is particularly worrisome for older Alaskans, who are more likely to have identified medical needs than 20 year olds. And while the state's high risk pool cannot reject an individual, these plans are often too expensive for applicants. Senate Bill 61 requires that health insurance plans for sale through the health care clearinghouse offer coverage to any applicant, preventing a scenario where the only course of action is purchasing a plan through ACHIA.

The legislation also requires that plans sold through the clearinghouse give credit for prior coverage, and that preexisting condition exclusions be reduced by any length of "continuous credible coverage" that an individual had before they applied for coverage. For Alaskans that are leaving the workforce who aren't provided benefits through a retirement package, these protections will ensure a more seamless transition into retirement.

The final element that will assist individuals acquiring coverage for the first time through Senate Bill 61 is the provision that prohibits preexisting condition limitations from extending for over one year. By capping limitations at one year, Alaskans will still be discouraged from buying coverage only when it is medically necessary, but it will also ensure that health coverage sold through the clearinghouse is a quality product for those who haven't been able to buy coverage in the past, due to cost or other circumstances.

The three consumer protections listed above – guarantee issue, credit for continuous coverage, and preexisting condition limitation caps - are currently required elements of small group, employer based plans available in Alaska. Extending these protections to individual plans sold in the clearinghouse will level the playing field for all Alaskans, both young and old.

What is the structure of the clearinghouse, and how will it take into account Alaska's unique geographic and technological situation when attempting to reach all Alaskans?

The health care clearinghouse is the entity that is charged with administering the program, under the direction of the health care board. In particular, the bill specifies that the clearinghouse will disseminate information about health care insurance products, and provide assistance in the enrollment process for businesses or individuals[4].

[4] Senate Bill 61 – Sec. 21.54.230

During the Senate Health and Social Services committee hearing on March 2, 2009, the clearinghouse was characterized as an electronic web-based 'place' where health plans can be compared and purchased. This concept, taken from Massachusetts and the Federal Employee Health Benefits program, is an innovative model that has proven successful in both instances. That being said, nothing in the bill confines how the board can structure the clearinghouse, despite the recent successes of an electronic, web based solutions.

In Massachusetts, a variety of means have been used to implement health reform. The Commonwealth Connector website touts advertizing efforts, along with partnerships, mailings, employer education and grassroots initiatives as successful elements to educating the public[5]. As one example, 'Connect to Health' events were held throughout the state to educate and enroll residents in health insurance plans through the connector. A press release noted that these forums were made possible through the involvement of public officials, community health centers, hospitals, business groups, public school districts and health care advocates[6].

Customer service centers were also created to help implement the legislation, and toll free call centers are open daily to answer questions and provide enrollment assistance.

As currently drafted, the bill leaves all options open for the health care board to determine how to communicate with and enroll eligible Alaskans. Given the broad composition of the board - which includes consumer advocates, insurance representatives, business people, labor, medical professionals and hospitals - the perspectives necessary to craft an Alaska specific approach to enrolling people in health coverage should be achievable, particularly when we use other states as models.

The National Federation of Independent Business commented on Senate Bill 61 in a letter to Senator French dated January 25, 2009. In particular, the letter stated two specific concerns:

The first concern: "Unfortunately, SB 61 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll."

Senate Bill 61 has a unique section regarding employer contributions, as described during the March 2 bill hearing. The rules are simple. There is no levy for businesses whose payroll is less than $500,000 a year. For businesses with a payroll between $500,000 and $1 million annually, the levy is 1%. For businesses with a payroll greater than $1 million annually, the levy is 2% of payroll. The 'bar' of what it means to provide health coverage is set relatively low – either an employer must offer to pay 33% of a premium cost or they must successfully enroll 25% of employees in their program – regardless of their level of contribution – to avoid the employer levy. In addition, if an employer establishes a Section 125 account that allows employees to purchase health

[5] http://www.mahealthconnector.org - Overview -> Public Education and Outreach
[6] http://www.mahealthconnector.org - January 11, 2008 press release

insurance with pre-federal tax dollars, they too avoid the levy, since the establishment of such an account produces great tax savings for employees. The cost of section 125 accounts are relatively cheap – quotes last year were around several hundred dollars a year total for a small employer, covering all employees. This means that an employer can fulfill all provisions of the employer levy simply by giving employees access to a Section 125 account, at a total cost of several hundred dollars – for all employees – per year.

On the broad scale of health reform options, Senate Bill 61 includes very few obligations on non-providing employers. Massachusetts requires a payout of $295 per non-covered employee per year, and includes a provision which also encourages the creation of Section 125 accounts. California proposals on the table last year included payroll taxes that ranged from 1% to 6.5%. In San Francisco, a plan that requires businesses with over 100 employees in the city to pay at least $1.76 per hour towards health benefits was affirmed by the 9th circuit court of appeals just last year, it not being an excluded policy option for the city due to ERISA preemption.

The second concern: "It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers."

The legislation broadly defines 'essential health care services' as including preventative and primary care, emergency services, inpatient services and hospital treatment, ambulatory patient services, prescription drug coverage and mental health services[7]. It does not specify benefit levels that must be provided in each category, nor does it address permissible co-pays, co-insurance, deductibles, or other fiscal elements of a plan. For a private offering to fulfill the individual responsibility clause proposed in Sec 21.54.240, a private plan must 'meet or exceed' the definition of essential health care services provided in that section[8].

Currently most employer based group health plans are subject to regulation under ERISA, and health insurers that are licensed in the state are regulated by state insurance law, as well[9]. The concern about mandated benefits may be rooted in the specific medical procedures that current Alaska law requires as elements of state regulated health insurance plans. Examples of such mandates include cancer screening procedures, well baby examinations and limited alcoholism and drug abuse treatment. The more benefits a plan includes, the higher cost of the plan.

Language should be changed in Senate Bill 61 to say that a health care insurance plan sold in the group market fulfills the individual responsibility clause of the legislation. This change would help alleviate the concerns expressed by the National Federation of Independent Business, because the comprehensive group plans that currently provide benefits to employees around the state would fulfill the legislation, without requiring a modification of the benefits that they offer.

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[7] Senate Bill 61 – Sec. 21.54.250
[8] Senate Bill 61 – Sec. 21.54.250 (a)(1) and (a)(4)
[9] http://www.dol.gov/ebsa/publications/selfcompliancetool.html

Lynda Zaugg

From: Andy Moderow
Sent: Monday, March 02, 2009 5:15 PM
To: Lynda Zaugg
Cc: Amory Lelake; Sen. Hollis French
Subject: SB 61 Subcommittee

Lynda,

Does this look accurate re: our conversation earlier? I'm sending this along to Amory in the Ellis office as well for her review.

2YO - A8

1. As noted in the AARP of support, Senator Davis is concerned about individuals in the 50-64 age group and how the bill would address their needs. She would also like to see those questions answered or at least discussed.

2. Christian Science proposal – she is curious if there is a way to deal with their concerns (without necessarily doing exactly what they proposed, depending on how the discussion goes.)

3. Discuss the NFIB letter, and see if there is a way to make the bill more palatable to small businesses who share their concerns.

4. Provide more guidance about the clearinghouse, in regards to the question from Senator Thomas who wanted to ensure that individuals without internet had the resources they needed to utilize clearinghouse services.

I spoke with Senator French about these questions/concerns, and he has mentioned his willingness for our office to produce, in writing, a 'report' addressing these question. After this is complete, maybe we could have one meeting of the subcommittee, where it is presented, questions can be asked, and further action is decided on? We could be ready for such a meeting by next week, and it probably wouldn't take too long.

Thoughts?

Andy Moderow
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www.healthyalaskans.com

Christian Science Committee on Publication for Alaska

P. O. Box 240976, Douglas, AK 99824
Phone: (907) 789-1544 Fax: (907) 364-2468
Email: Alaska@compub.org

Memo

TO: Senator Bettye Davis, Chair, Senate HSS Committee
FROM: Bev Smith, Christian Science Committee on Publication for Alaska BLS
DATE: March 9, 2009
RE: SB 61

Thank you for considering religious nonmedical healthcare as a covered benefit under SB 61.

I would like to bring to your attention California SB 840(sponsored by Sen. Kuehl) that passed both chambers of the legislature in August 2008 but was vetoed by the governor. In trying to provide a system of universal health care coverage for California residents the bill included in its list of covered benefits, Section 140501(z): "Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization." This same language was included in a recent refile of the bill last week (SB810) in the current 2009 California session by Sen. Leno, who has replaced Sen. Kuehl as the principal bill sponsor following Sen. Kuehl's exhaustion of her term limits last session.

Similar language was also provided in another California bill ABx1. In Section 12739.50(c) it says: " In establishing the standards for minimum creditable coverage, including the scope of services, enrollee and dependent deductible, copayment requirements, and coverage of services outside the deductible, the board shall consider all of the following:...(4) The extent to which and under what circumstances benefits offered or provided by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means may be included in or qualify as meeting the requirement to maintain minimum creditable coverage under Section 8899.50 of the Government Code."

The latter bill passed the Assembly but it never came before the Senate.

I offer these examples of California legislation to support including benefits for religious non-medical health care in SB 61. I hope you find them helpful. Please feel free to contact me with any questions you may have.

Thank you.

NFIB
The Voice of Small Business®

Alaska

January 25, 2009

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

RE: Senate Bill 61

Dear Senator French,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 61. 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.

National Federation of Independent Business — ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

Unfortunately, SB 61 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

NFIB

The Voice of Small Business®

Small Business Principles for Health Care Reform

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.

FOR IMMEDIATE RELEASE

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Employer Healthcare Mandate Would Wipe Out 1.6 Million Jobs

Business Simulations Show Negative Impact on Local Jobs, Revenue

WASHINGTON, D.C., January 28, 2009 – In a study released this week, the National Federation of Independent Business Research Foundation analyzed the potential impact of a national employer mandate on small businesses to provide healthcare.

The study conducted business simulations to measure the effects of a hypothetical national mandate requiring employers to offer private health insurance to all employees starting in 2009, and to finance a minimum of 50 percent of the cost. The simulation ran six classes of business to determine the impact on employers of different sizes. The results show that an employer mandate would have significant negative impacts on local jobs and on state revenues, particularly considering the rising costs of health insurance.

"In the current environment, an employer mandate could wipe out 1.6 million jobs in just five years and reduce the GDP by around $200 billion," said NFIB Senior Research Fellow William "Denny" Dennis. "This research should alarm everyone about the consequences of costly mandates to small businesses. It is essential that our leaders take into account the drastic impact a mandate like this would have on the livelihood of small businesses and families in local communities."

Simulation Results (Fact Sheet attached)

- Of the more than 1.6 million jobs lost between 2009 and 2013, small businesses would account for more than 1 million, 66 percent, of all jobs lost.
- U.S. real GDP would contract by approximately $200 billion between 2009 and 2013.
- Small businesses would lose roughly $113 billion in real output and account for 56 percent of all real output lost.
- Labor intensive industries (e.g. construction or restaurant) and businesses with 20 – 99 employees would experience the most job loss.

"In our current economic environment, it is so important that we stimulate and support our country's job creators – small businesses. Enacting healthcare reforms that fail to address rising costs, and place unmanageable burdens on business, is not a viable pathway for meaningful reform," said Todd Stottlemyer, president and CEO, NFIB. "It is important that reform fosters growth and doesn't place undue burdens or new financial pressures on these small employers."

Healthcare premiums continue to skyrocket, increasing by nearly 130 percent in just eight years, and are, on average, 18 percent higher than those of large businesses. These unsustainable costs significantly hinder small businesses' ability to invest in and grow their business. Healthcare reform legislation must take steps to curtail costs for small businesses, individuals and the self employed by pursuing creative approaches to pooling, tax code parity, and improved, competitive insurance markets.

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About the Simulation Model

NFIB used a proprietary Business Size Impact Module (BSIM) to simulate the impact of a national employer healthcare mandate on businesses by size of firm. The BSIM consists of a series of ten regional models designed to measure macroeconomic changes due to increased business costs. It receives inputs (new costs and spending) and generates outputs (macro variables) according to firm size. The unique capability of this model is important because often government policies have financial effects on businesses, and regulatory costs per unit are often higher on small firms than their larger counterparts.

The assumed mandate used in the study required that all employers must offer private health insurance to their employees, and that employers must finance at least 50 percent of their employees' health insurance premiums. The remaining share of employee premiums was assumed to be financed by employee contributions and federal subsidies. Implementation of the mandate is assumed to begin in 2009. Employment and output effects of the mandate were forecast for years 2009 to 2013, the first five years of program implementation.

For a copy of the full report, written by Michael Chow and Bruce Phillips, please contact Stephanie Cathcart, stephanie.cathcart@nfib.org, 202-314-2056.

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***Solutions Start Here** is a campaign developed and led by NFIB and its members as the small business platform for healthcare reform. By working to engage and educate policymakers about the unique healthcare issues faced by small business, Solutions Start Here will drive and integrate the concerns and needs of America's small business community into the national health reform debate. Because when healthcare is fixed for small business, it's fixed for America. For more information, visit www.FixedForAmerica.com.*

***NFIB** is the nation's leading small business association, representing small businesses in Washington, D.C. and all 50 state capitals. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB gives small and independent business owners a voice in shaping the public policy issues that affect their business. NFIB's powerful network of grassroots activists send their views directly to state and federal lawmakers through our unique member-only ballot, thus playing a critical role in supporting America's free enterprise system. NFIB's mission is to promote and protect the right of our members to own, operate and grow their businesses. More information is available online at www.NFIB.com/newsroom.*

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March 2, 2009

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

Re: SB 61 (French)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 61, authored by Senator Hollis French and co-sponsored by Senator Johnny Ellis.

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.

The current health system costs too much, makes too many mistakes, and often returns little value for our money. Access to affordable coverage is increasingly difficult—especially for AARP's 50- to 64-year old members who are among the fastest growing groups of uninsured. Even those with Medicare, if they can find a physician, are struggling to keep up with rapidly rising premiums costs that threaten their health and financial security.

why — Pole cap seems

One of the basic legislative principles AARP supports is that expansion of health coverage is desirable. Those who lack either private or public coverage are less likely to receive access to timely medical care and more likely to experience adverse health outcomes.

We understand that SB 61 is a work in progress and is probably the initial effort in what make take several sessions to work out. That's fine with us. The more participatory the debate, the more all Alaskans will understand how important it is to cover all of us. There are major issues that should be addressed in SB 61 and each of these issues should be thoroughly debated in the Legislature, in the media, and over the dinner table by Alaskan families.

Who is covered and how comprehensive is the coverage?

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

Is SB 61 efficient and economically practical?

Will the bill result in fairness and equity?

How much choice and autonomy does the bill permit?

Health care, as you know, is extremely complex. For example, if SB 61 passes, will there be a need for additional physician visits and nursing care? Do we have the health professionals to provide them? What new or expanded medical technology resources will be consumed as a result of coverage expansion? Conversely, what will we save in fewer visits to an emergency room through program expansion?

What will be the effect on quality of care, eg., medical outcomes and patient satisfaction?

What will be the effect on physician patterns of practice, eg., will we have greater adherence to practice guidelines?

The questions can go on for pages...and they should. SB 61 is a bill that deserves serious debate in every Committee of referral. AARP believes that we will eventually come out with a bill that all of us can live with and one that will improve the health status of all Alaskans of all ages. Let's keep that discussion going in the Senate Health and Social Services Committee.

We urge an "AYE" vote on SB 61.

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,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
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CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Hollis French

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, March 02, 2009 9:18 AM
To: Andy Moderow; Lynda Zaugg
Cc: Fick, Tyson C (CED); Fitzjarrald, Elinor A (HSS); Sherwood, Jon (HSS)
Subject: SB 61 hearing today

Just wanted to give you a heads up that I will be available to testify for the department on SB 61 this afternoon if needed. DPA director Ellie Fitzjarrald and HCS medical assistance administrator Jon Sherwood will be available to answer questions on the fiscal notes.
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Christian Science Committee on Publication for Alaska

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To: Senator Bettye Davis, Chair
Members of the Senate Health and Social Services Committee

From: Beverly Smith, Christian Science Committee on Publication for Alaska

Date: March 2, 2009

RE: Senate Bill No. 61
An Act establishing an Alaska health care program to ensure insurance coverage for essential health services for residents of the state;...

Thank you for giving me the opportunity to testify regarding SB 61.

In my capacity as Christian Science Committee on Publication for Alaska, one of my roles is to ensure that you have accurate information concerning spiritual healing as practiced in Christian Science, so that this cost effective, reliable and effective form of care is not overlooked or restricted in the State's health care reform efforts. In this regard, it is important to preserve the choice of Alaskans to pursue spiritual means for the prevention and cure of disease, including Christian Science treatment and care, and this legislation can be an important avenue for doing so.

I would like to thank the sponsors for including in the bill under Sec. 21.54.240(a) (8) an opportunity for some Alaskans to "opt-out" of participation in the Alaska health care program if "that...person has deeply held religious beliefs contrary to the Alaska health care program and the requirement to purchase health care insurance for essential health care services." However to meet the health care needs of ALL Alaska residents we feel that health care reform legislation should include coverage for spiritual care similar to state and federal government plans that currently do so.

To accomplish this, we request that the following amendment be incorporated into such legislation to provide for consideration of spiritual care benefits as follows:

Amend Section 2 of the bill, by adding the following

"21.54.251. Definitions. The term "essential health care services" as used in Section 21.54.250 shall be interpreted to include nonmedical health care services provided by a religious nonmedical provider as defined in AS 21.07.250 (15)." *

I have provided an attachment which sets forth the explanation for including religious nonmedical care in legislation such as SB 61.

This document provides some examples of religious nonmedical care addressed in various government and private insurance plans. Note that the final bullet under Recommendation #1 shows Premera, Blue Cross Blue Shield of Alaska, covers treatment by Christian Science practitioners.

I am happy to work with lawmakers to make sure language is included so that insurance coverage is provided for those Alaskans choosing spiritual care to meet their healthcare needs.

This care is both reliable and effective. If people are achieving complete healing through spiritual care without incurring large medical bills, society is benefited.

We applaud you for your efforts in bringing solutions to the health care challenges in Alaska and we appreciate the desire to make humanity safer and healthier. We respectfully request that the inclusion of religious nonmedical health care as a covered benefit be expressed clearly within SB 61.

* Chapter 21.07. REGULATION OF MANAGED CARE INSURANCE PLANS

Sec. 21.07.250. Definitions.

In this chapter, ...

(15)"religious nonmedical provider" means a person who does not provide medical care, but who provides only religious nonmedical treatment or nursing care for an illness or injury;

Christian Science Committee on Publication for Alaska

ACCESS TO SPIRITUAL CARE

Recommendations for
Health Care Reform Legislation

As the Alaska legislature considers health care reform, it is important that any new framework include spiritual care. Prayer-based healing has been a mainstay in American life for years. Despite the progress in medical science, many Americans continue to rely on prayer as their primary means of health care for one simple reason: they trust its effectiveness, its completeness and its reliability. For millions of other Americans, the issue at hand is, in some ways, more fundamental: having the option to choose the method of health care that is most effective for them.

Everyone deserves access to reliable and cost-effective health care. This should be one of the primary goals of health care reform. Because spiritual care is reliable and cost-effective, it should be part of the solution in addressing the health care challenges facing our nation.

Christian Science is a method of spiritual care that is available to everyone. For over a century, individuals from many different faith traditions have found Christian Science to be reliable and effective in addressing the challenges posed by injury, illness, and disease. For this reason, they will often choose religious nonmedical health care in lieu of medical care. The practice of Christian Science includes assistance from Christian Science practitioners (individuals who have been recognized as having demonstrated the ability to help others achieve healing through prayer), as well as from Christian Science nurses (individuals who provide physical assistance for the patient's daily needs while the patient prays for healing).

We have identified two areas where statutory provisions may be needed to achieve public access to spiritual care within the context of health care reform legislation, and make the following two recommendations:

Recommendation # 1: Provide Public Access to Spiritual Care.

Health care reform legislation should provide the public with access to spiritual care. Existing law contains numerous examples of programs that offer benefits for spiritual care, including:

- Four plans under the Federal Employees Health Benefits Program (FEHBP) cover religious nonmedical nursing care and/or Christian Science practitioner services:
  - Government Employees' Health Association (GEHA)
  - Mail Handlers Benefit Plan
  - Special Agents Mutual Benefit Association
  - Association Benefit Plan

- Religious nonmedical nursing services are covered under the Medicare and Medicaid programs (see 42 U.S.C. §§ 1395x(ss) and 1395i-5).

- TRICARE (for military dependents) – Covers care in Christian Science nursing facilities, Christian Science nursing services, and Christian Science practitioner services.

- Under Section 223 of the Internal Revenue Code ("IRC"), funds contained in a Health Savings Account may be used to pay for spiritual care. Section 223 references the definition of "medical expenses" in Section 213(d) of the IRC, which has been interpreted to include Christian Science practitioner services and Christian Science nursing care.

- Alaska and a number of other states (e.g., California, Illinois, Kansas, Missouri, Oklahoma, Oregon, Texas) allow coverage of spiritual treatment through prayer in their governmental employees' health insurance plans. Premera, Blue Cross Blue Shield of Alaska, under the Alaska Care plan for state employees and retired state workers, covers treatment by "Christian Science Practitioners authorized by the Mother Church, First Church of Christ, Scientist, Boston, Massachusetts." (See Select Benefits Booklet, pg. 27-8.)

Recommendation # 2: Application of Nonmedical Requirements for Quality Assurance

Statutory provisions that require insurers to make determinations of "medical necessity" and to provide medical oversight for services rendered serve as important patient protections in the context of medical care. However, patients choosing spiritual care in lieu of medical care do not want medical requirements applied to the services they receive. In addition, spiritual care providers do not diagnose disease or provide any form of medical intervention or treatment. For these reasons, the application of medical requirements to spiritual care providers can limit patient access to care. While accommodation from medical criteria may be necessary, we support the application of nonmedical safeguards to ensure that funds are spent appropriately. Some examples of existing laws that contain this type of accommodation are:

- The federal Medicare law accommodates patients in religious nonmedical health care institutions from being required to have a medical diagnosis and from the activities of peer review organizations, but requires religious nonmedical health care institutions (RNHCIs) to meet detailed requirements designed to protect patient health and safety. 42 U.S.C. §§ 1395x(ss)(3); 42 U.S.C. § 1320c-11; 42 C.F.R. § 403.700, et seq.

- Some states' insurance laws, including Alaska's, specifically accommodate health plans that include religious nonmedical providers by allowing the plans not to apply medical requirements that would limit patient access to religious nonmedical care. (see, e.g., Alaska Stat. Ann. § 21.07.080 and Me. Rev. Stat. tit. 24-A, § 4307(4); Mass. Gen. Laws Ann. 176O, § 11; Wash. Rev. Code Ann. § 48.43.520).

Thank you for considering these important issues. We offer to act as a resource regarding spiritual care, and would appreciate being included in future health care reform discussions and stakeholder meetings.

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Memo

TO: Senator Bettye Davis, Chair, Senate HSS Committee
FROM: Bev Smith, Christian Science Committee on Publication for Alaska BLS
DATE: March 9, 2009
RE: SB 61

Thank you for considering religious nonmedical healthcare as a covered benefit under SB 61.

I would like to bring to your attention California SB 840(sponsored by Sen. Kuehl) that passed both chambers of the legislature in August 2008 but was vetoed by the governor. In trying to provide a system of universal health care coverage for California residents the bill included in its list of covered benefits, Section 140501(z): "Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization." This same language was included in a recent refile of the bill last week (SB810) in the current 2009 California session by Sen. Leno, who has replaced Sen. Kuehl as the principal bill sponsor following Sen. Kuehl's exhaustion of her term limits last session.

Similar language was also provided in another California bill ABx1. In Section 12739.50(c) it says: " In establishing the standards for minimum creditable coverage, including the scope of services, enrollee and dependent deductible, copayment requirements, and coverage of services outside the deductible, the board shall consider all of the following:...(4) The extent to which and under what circumstances benefits offered or provided by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means may be included in or qualify as meeting the requirement to maintain minimum creditable coverage under Section 8899.50 of the Government Code."

The latter bill passed the Assembly but it never came before the Senate.

I offer these examples of California legislation to support including benefits for religious non-medical health care in SB 61. I hope you find them helpful. Please feel free to contact me with any questions you may have.

Thank you.