BILLS 1981 - 1982
SSHB 41 cont.

Leg. Finance

1419

1419

	POSITION TITLE				RANGE/STEP	BARG. UNIT	LOCATION	EDV	APPROV	DISAPP
1	Clerk IV				9A	GGU	Fairbanks			
	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY		FORM 12 PAGE/LINE			
2	PFT	4			9			LEG		

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	6,648	
5	BENEFITS	1,050	
6	FICA	408	
7	HEALTH INS.	520	
8	TOTAL PERSONAL SERVICES	01	8,626
9	TRAVEL	02	0
10	CONTRACTUAL Lease Space Costs = $1,044		1,344
11	COMMODITIES	04	100
12	EQUIPMENT	05	1,000
13	OTHER		
14	TOTAL COST		11,070

	CODE	FUNDING SOURCE	
15		FED RCPTS. 1002	
16		GF MATCH. 1003	
17		GEN. FUND 1004	11,070
18		I-A RCPTS 1005	
19		PGM RCPTS 1028	
20		OTHER	
21	CONTINUATION		
22	ADDITION	11,070	

FOR B&M USE ONLY

AA KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Clerical Support-Fairbanks Field Office-State Comprehensive Health Plan.

AGENCY Administration PROGRAM Public Health

BRU Retirement & Benefit

COMPONENT Ne.

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

FY 82

1	POSITION TITLE: Clerk IV			RANGE/STEP: 9A	BARG. UNIT: GGU	LOCATION: Nome		
2	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY: 10	FORM 12 PAGE/LINE		

	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	7,568	
5	BENEFITS	1,195	
6	FICA	464	
7	HEALTH INS.	520	
8	TOTAL PERSONAL SERVICES 01		9,747
9	TRAVEL 02		0
10	CONTRACTUAL Lease Space Costs = $1,208		1,508
11	COMMODITIES 04		100
12	EQUIPMENT 05		1,000
13	OTHER		
14	TOTAL COST		12,355

	CODE	FUNDING SOURCE	
15		FED RCPTS. 1002	
16		GF MATCH. 1003	
17		GEN. FUND 1004	12,355
18		I-A RCPTS. 1007	
19		PGM RCPTS 1108	
20		OTHER	
21	CONTINUATION		
22	ADDITION	12,355	

FOR OMB USE ONLY

AMD KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Clerical Support-Nome Field Office-State Comprehensive Health Plan.

AGENCY Administration PROGRAM Public Health

BRU Retirement & Benefits

COMPONENT New

13 REQUEST FOR NEW POSITION

Page 10 of 12

REVISED DATE _____

FY 82

01-11358(8/80)

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION	GOV.	APPROV.	DISAPP.
1	Clerk IV			9A	GGU	Juneau			
	TYPE OF POSITION	STAFF MONTHS	RP No. / FCN No.	PRIORITY		FORM 12 PAGE/LINE	LEG.		
2	PFT	4		11					

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	5,900	
5	BENEFITS	931	
6	FICA	362	
7	HEALTH INS.	520	
8	TOTAL PERSONAL SERVICES 01		7,713
9	TRAVEL 02		0
10	CONTRACTUAL Lease Space Costs = $900		1,200
11	COMMODITIES 04		100
12	EQUIPMENT 05		1,000
13	OTHER		
14	TOTAL COST		10,013

	CODE	FUNDING SOURCE	
15		FED RCPTS. 1002	
16		GF MATCH. 1003	
17		GEN. FUND 1004	10,013
18		I-A RCPTS. 1007	
19		PGM RCPTS 1108	
20		OTHER	10,013
21	CONTINUATION		
22	ADDITION	10,013	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Clerical Support-State Comprehensive Health Plan.

AGENCY Administration PROGRAM Public Health

BRU Retirement & Benefits

COMPONENT New

13 REQUEST FOR NEW POSITION

REVISED DATE _____

FY 82

01-1130(8/80)

	POSITION TITLE				RANGE/STEP	BARG. UNIT	LOCATION		APPROV	DIRAPP
1	Correspondence Secretary II				10A	GGU	Juneau	GOV		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 4	RP No.	PCN No.	PRIORITY: 12		FORM 12 PAGE/LINE	LEG		

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	6,256	
5	BENEFITS	988	
6	FICA	384	
7	HEALTH INS.	520	
8	TOTAL PERSONAL SERVICES 01		8,148
9	TRAVEL 02		
10	CONTRACTUAL Lease Space Costs		900
11	COMMODITIES 04		100
12	EQUIPMENT 05		1,000
13	OTHER		
14	TOTAL COST		10,148

	CODE	FUNDING SOURCE	
15		FED RCPTS. 1002	
16		GF MATCH. 1003	
17		GEN. FUND 1004	10,148
18		I-A RCPTS. 1007	
19		PGM RCPTS 1108	
20		OTHER	
21	CONTINUATION		
22	ADDITION	10,148	

FOR OMB USE ONLY

ALASKA KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Clerical Support-Headquarters Office-State Comprehensive Health Plan.

AGENCY Administration PROGRAM Public Health

BRU Retirement & Benefits

COMPONENT New

13 REQUEST FOR NEW POSITION

REVISED DATE _____

FY 82

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
COMMITTEE, SUBSTITUTE FOR
SPONSOR SUBSTITUTE
HOUSE BILL NO. 41

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

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

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

a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan available to all residents of Alaska, and provides a cost-sharing program wherein the State will share in paying for either total or "supplementary" coverage for low income persons.

b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that CERTAIN Group insurance plans include coverage for alcoholism and drug dependence.

c. Section 9 directs the Commissioner of Health and Social Services to contract for medical services through insurance companies or health care services organizations for beneficiaries of the Department's medical programs once these methods are determined cost competitive. (Medicaid, General Relief Medical, Catastrophic Illness, Crippled Children's, and Maternal and Child Health Programs).

d. Sections 10 and 11 expand the Medicaid program by adding new beneficiaries and services respectively.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Financing Study" for the purpose of informing all Alaskans of various alternatives to coordinating existing health resources, identifying and filling gaps where health resources current-

ly do not exist and methods of financing services in a comprehensive and coordinated way.

With this study in mind the Department is concerned that the report required in Section 2 of CS SSHB-41 have the benefit of the comprehensive data and recommendations that will be included in the Governor's study. At present the Governor's study is to be completed by December 15, 1981. This timing does not provide the opportunity to the Department of Administration to consider the information in the Governor's study and report by the 30th day of the 1982 legislative session. Therefore, the Department recommends that line 8, page 4 be amended to read as follows:

"The Commissioner of Administration shall report by the (30th) 60th day of the Second Session of the Twelfth State Legislature on:"

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

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

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

2. Section 9. We support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.

3. Section 10 as written would require DHSS to provide

Medicaid coverge to all optional groups, not just those that have been added piecemeal to the state statutes. We would recommend phasing additional eligible groups into the program rather than adding all remaining groups at a single time.

4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. Again, we would recommend phasing into additional services rather than adding all services at a single time.

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

Insurance Coverage for State Employees:

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

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

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structured Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to

insurance companies, instead of utilizing inappropriate euphmistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers.

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

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

Section 9 - Line 21 on Page 7 Through Line 13 on Page 9:

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

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

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

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

(2) no change

(3) the interest for a full month if the overdue claim is not paid by the 15th day of any penalty (calendar) month.

Section 10 - Line 14 on Page 9 Through Line 19 on Page 9:

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

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

(1) July 1982: Unborn Child Group
Caretaker Relatives
Individuals Under 21

(2) July 1983: Unemployed Father Group

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

(1) The Department will have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.

(2) The Department's permanent medical claims payment system will be implemented and the added bill processing burden will be eased.

(3) The Department would be prepared in advance with regulations and staff to handle the new coverage groups representing approximately 2,000 additional families.

Section 11 - Lines 20 Through 24 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under the Medicaid program. The Department recommends that each service be evaluated on its own merits, adding only those services that are important to maintaining the general health of Medicaid recipients. It is suggested the following services be specifically listed in CSSSHB41 rather than

the current blanket provision adding all services:

(1) Physical Therapy
(2) Occupational Therapy
(3) Prescribed Drugs
(4) Prosthetic Devices and Medical Supplies
(5) Other Practitioner Services

a. private psychologist
b. nurse practitioners
c. physician assistrants

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

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

Creation of a comprehensive health plan as contained in Section 1 would permit the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified to assure that GRM is not a disincentive to participation in the comprehensive health plan. One method of doing this would be to limit GRM coverage to one episode during any 12 month period. Finally, the relationship between the comprehensive health plan under CSSSHB41 and the present catastrophic illness program should be clarified. Most payments made under the catastrophic illness program are for major medical types of coverage that may also be covered under the comprehensive health plan.

POSITION PAPER/Department of Health & Social Services

Recommended by: Rod Betit

Rod Betit, Director
Division of Public
Assistance

Date: 4/3/81

Robert L. Cole by

Robert Cole, Coordinator
Office of Alcoholism and
Drug Abuse

Date: 4/3/81

Approved by: H. Beirne

for Helen D. Beirne
Commissioner

Date:

MEDICAID SERVICES

Currently Covered Services

Hospital - Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (SNF)

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

Laboratory and X-Ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

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

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

Community Mental Health Clinics

Family Planning Services

Outpatient Surgical Care Centers

Rural Health Clinics

Services Added By SSHB-41

Podiatrist Services

Chiropractic Services

Private Duty Nursing

Personal Care Services

* Physical Therapy

* Occupational Therapy

* Prescribed Drugs

Dentures and Routine Dental Services

* Prosthetic Devices and Medical Supplies

Other Diagnostic, Screening Preventative & Rehabilitative Services

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

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

Other Practitioner Services

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

Clinic Services - other than Community Mental Health Clinics

Services by Christian Science News

Services by Christian Science Sanatoria

* Currently accessible through General Relief Medical

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR HOUSE BILL 41

MEDICAID

Component/New Service Groups	FY 82 Request	New Categorically	Total with Categorically Needy
Hospital	11,826.7	2,614.9	14,441.6
Physician	6,415.2	1,418.4	7,833.6
Other Services	1,759.6	389.1	2,148.7
EPSDT	3,455.5	2,315.2	5,770.7
Nursing Homes	21,521.0		21,521.0
Subtotal	44,978.0	6,737.6	51,715.6
Indian Health	7,239.1	4,850.2	12,089.3
Subtotal	52,217.1	11,587.8	63,804.9
New Other Serv.		2,323.0	2,323.0
New Dental Serv.		1,843.6	1,843.6
New Drug Serv.		2,138.6	2.138.6
Total	52,217.1	17,893.0	70,110.1

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR HOUSE BILL 41
(CONTINUED)

GENERAL RELIEF MEDICAL

Component	FY 82 Request	Fiscal Note	Total Remaining
Hospital	7,102.7	(2,343.9)	4,758.8
Physician	2,954.6	(975.0)	1,979:6
Other Services	2,600.4	(1,300.2)	1,300.2
Nursing Homes	305.9		305.9
Catastrophic	980.2		980.2
Residential	189.7		189.7
Total	14,133.5	(4,619.1)	9,514.4

CASELOAD ESTIMATES FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR HOUSE BILL 41

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

SUMMARY OF BUDGET FOR SSHB41

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

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SSHB41
Title An ACT Relating to the Health of Residents of the State
Requested by HOUSE HESS Committee Date 2/26/81

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

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

GENERAL FUND		(4,619.1)				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

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

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

IV. DATE 2/26/81 PREPARED BY David M. Davidson
AGENCY Public Assistance
PHONE 465-3547

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) M&B Approval Tom Conduson Date 2/26/81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SSHB41
Title An ACT Relating to the Health and Residents of the State
Requested by HOUSE HESS Committee Date 2/26/81

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

EXPENDITURES (Thousands of Dollars)

		FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100	PERSONAL SERVICES		353.9				
200	TRAVEL		12.9				
300	CONTRACTUAL		133.8				
400	COMMODITIES		6.5				
500	EQUIPMENT		13.3				
600	LAND & STRUCTURES		0				
700	GRANTS, CLAIMS, ETC.		17893.0				
	TOTAL		18413.4				

FUNDING (Thousands of Dollars)

GENERAL FUND		6781.6				
FEDERAL FUNDS		11,631.8				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		12				
PART TIME						
TEMPORARY						

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

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

IV. DATE 2/26/81 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) M&B Approval Jason Gendusson Date 2/26/81

33-001 (Rev. 12/80)

PA
PHF / alcohol
Provide input to PA

Original sponsors: Buchholdt, Gardiner, Clocksin, et al

Offered: 3/31/81
Referred: Finance

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 41 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - FIRST SESSION

A BILL

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

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

* Section 1. AS 18 is amended by adding a new chapter to read:

CHAPTER 27. STATE HEALTH INSURANCE.

Sec. 18.27.010. STATE COMPREHENSIVE HEALTH PLAN. (a) The commissioner shall establish minimum benefit standards for the state comprehensive health plan and shall provide for the underwriting and administration of the state comprehensive health plan.

(b) A resident of the state is entitled to enroll in the state comprehensive health plan.

(c) The state comprehensive health plan shall provide for copayments and deductibles, and shall provide an annual limit on the total amount of copayments and deductibles for each enrolled resident and the covered dependents of the resident for each year. The annual limit shall be the same regardless of family size.

(d) The commissioner shall contract for the administration and may contract for the underwriting of the state comprehensive health plan. A contract entered into under this subsection shall be based on competitive bids and shall be for a three-year period.

Sec. 18.27.020. STATE HEALTH INSURANCE COST SHARING PROGRAM. (a) Except as provided in (b) of this section, a resident of the state is entitled to cost sharing under the state health insurance cost sharing program if

(1) the resident is enrolled in the state comprehensive health plan or an individual health insurance plan which the insurance company has certified to the commissioner as equivalent to or exceeding the benefit standards of the state comprehensive health plan established by the commissioner under AS 18.27.010(a);

(2) the resident qualifies for cost sharing under (c) of this section.

(b) A person entitled to cost sharing under (a) and (c) of this section who is enrolled in a group health insurance plan or eligible for benefits under a state or federal health care program is entitled to cost sharing for supplemental care under the state comprehensive health insurance plan or under an individual health insurance plan certified under (a)(1) of this section. The benefits provided under a health insurance plan providing supplemental care are the same as those provided under the state comprehensive health care program established under AS 18.27.010 except that the benefits are supplemental to benefits provided under a group health insurance plan or under a state or federal health care program.

(c) The commissioner shall pay the state share of the costs of health insurance incurred by a resident of the state and his covered dependents under the following formula:

(1) if the total adjusted gross income of the resident and his dependents is at or below 75 percent of the base income, 100 percent of the premium cost of health insurance;

(2) if the total adjusted gross income of the resident and his dependents is between 75 percent of the base income and 125 percent of the base income, a graduated percentage of the premium cost of health insurance between 100 percent and zero percent;

(3) if the total adjusted gross income of the resident and

his dependents is at or below 45 percent of the base income, 100 percent of copayments and deductibles;

(4) if the total adjusted gross income of the resident and his dependents is between 45 percent of the base income and 95 percent of the base income, a graduated percentage of the copayments and deductibles from 100 percent and zero percent;

(5) if a resident is enrolled in an individual health insurance plan certified to the commissioner under (a) of this section, the state share of the cost of health insurance for the resident is limited to the amount that the state's share would have been if the resident had been enrolled in the state comprehensive health plan.

(d) The commissioner shall adopt minimum benefit standards and guidelines for determining benefit equivalence for the certification of plans under (a)(1) of this section.

(e) Notwithstanding the provisions of an individual health insurance plan, a plan certified by an insurance company to the commissioner under (a)(1) of this section provides the minimum benefits and the equivalent benefits required for certification.

Sec. 18.27.030. DEFINITIONS. In this chapter

(1) "adjusted gross income" means the adjusted gross income of the resident determined under the regulations of the commissioner;

(2) "base income" means

(A) family median income for Alaska determined by the federal Office of Human Development Service; and

(B) regional adjustments established by the commissioner to the family median income for Alaska determined by the federal Office of Human Development Service which are based on relative costs of living in the state;

(3) "benefit equivalence" means that the benefits provided

in an individual health insurance plan and certified to the commissioner under AS 18.27.020(d) are equivalent to benefits provided under the state comprehensive health plan;

(4) "commissioner" means the commissioner of administration;

(5) "copayment" means the portion of covered expenses payable by the resident after the deductible has been met;

(6) "insurance" means prepaid plans or indemnity plans.

* Sec. 2. The commissioner of administration shall report by the 30th day of the Second Session of the Twelfth State Legislature on:

(1) proposed minimum benefit standards and estimated actuarial costs of the state comprehensive health plan (AS 18.27);

(2) the anticipated number and characteristics of participants in the state health insurance cost sharing program (AS 18.27.020) and the projected cost to the state;

(3) a proposed plan for

(A) implementation of AS 18.27;

(B) eligibility determinations under AS 18.27;

(C) payment of the state share of premium costs and copayment and deductibles incurred under AS 18.27; and

(D) informing the public of benefits under AS 18.27;

(4) recommendations for amendments to AS 18.27.

* Sec. 3. Coverage under the state comprehensive health plan (AS 18.27.-010) and the state health insurance cost sharing program under AS 18.27.020 begins on July 1, 1982.

* Sec. 4. AS 21.54.060 is amended by adding a new paragraph to read:

(7) under a policy issued to the state to insure residents of the state under AS 18.27.

* Sec. 5. AS 39.30.090(1) is amended to read:

(1) A group insurance policy shall provide one or more of

the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance, alcoholism and drug dependency insurance, or other medical care insurance.

* Sec. 6. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) The group insurance policy under AS 39.30.090(1)

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 percent of the usual, customary and reasonable charge for a medical procedure, treatment or service in

the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to provide coverage for employees of the state and may apply to contracts for the benefit of employees of other participating governmental units only if the governing body of the governmental unit elects to have the provisions apply.

(c) In (a) of this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 7. AS 39.30.100 is amended to read:

Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-30.090]

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee, and

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a borough, municipal corporation, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts.

* Sec. 8. The provisions of secs. 5 - 7 of this Act apply to group policies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and which are delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for eligible employees in this state under AS 39.30.090 - 39.30.100 delivered, issued for delivery, or renewed after the effective date of this Act provides the minimum coverage required by this Act even if the language of the policy or contract does not specifically so provide.

* Sec. 9. AS 47.05 is amended by adding new sections to read:

Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall use medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health care service contracts that provide one or more of the services available under state medical assistance programs.

(b) The policy of insurance or the contract financed under this section must guarantee to

(1) provide services and supplies under policies of insur-

ance or contracts under AS 21;

(2) provide the statistical data, records, and reports relating to the provision, administration, and costs of providing services and supplies as required by the commissioner.

Sec. 47.05.080. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.05.070 when he determines that comparable benefits are available at equal or less cost than direct payments by the department to the providers of services and supplies.

Sec. 47.05.090. INTERIM PAYMENT. If the commissioner determines under regulations adopted by him that a provider of medical services is expected to serve a large volume of medical assistance clients, he may make an interim payment before receipt of billing for services to the provider.

Sec. 47.05.100. INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the commissioner shall pay

(1) interest at the rate of one percent per month when payment is delayed more than 45 days after presentation of the clean claim;

(2) interest at the rate of two percent per month when payment is delayed more than 90 days after presentation of the clean claim; and

(3) the interest for a full month if the overdue clean claim is not paid by the 15th day of a calendar month.

Sec. 47.05.110. DEFINITIONS. In AS 47.05.070 - 47.05.110

(1) "clean claim" means a claim for payment which can be processed without obtaining additional information from the provider of the service or from a third party; it includes a claim with errors originating in the department's claims processing system, but does not

include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;

(2) "commissioner" means the commissioner of health and social services;

(3) "health care service contract" means a contract with a nonprofit corporation which accepts prepayment for health care services and is sponsored by or associated with a group of physicians or a group of hospitals or both or by a health maintenance organization recognized under federal law;

(4) "medical assistance" means Medicaid (AS 47.07), general relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and crippled children's and maternal and child health programs (AS 18.05.-010).

* Sec. 10. AS 47.07.020(b) is repealed and reenacted to read:

(b) A resident of the state for whom the provisions of the Social Security Act in effect on March 1, 1981, allow optional medical coverage qualifying for federal financial participation is eligible for medical assistance. A resident of the state qualifying as medically needy is not eligible for medical assistance.

* Sec. 11. AS 47.07.030 is repealed and reenacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include those services eligible for federal financial participation under the provisions of Title XIX of the federal Social Security Act in effect on March 1, 1981.

* Sec. 12. AS 47.07.080 is amended by adding new paragraphs to read:

(5) "medically needy" means a person who meets the categorical requirements of eligibility for medical assistance but whose income

(A) exceeds the income standard for categorical assistance; and

(B) is less than the medically needy income standard after the deduction of allowable medical expenses;

(6) "categorical requirements of eligibility" means the standards established under 42 C.F.R., secs. 435.500 - 435.541;

(7) "medically needy income standard" means the standards established under 42 C.F.R., secs. 435.800 - 435.816.

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 14. Sections 1 and 4 of this Act take effect July 1, 1982.

* Sec. 15. Sections 5 - 8 of this Act take effect January 1, 1982.

* Sec. 16. Section 9 of this Act takes effect July 1, 1981.

* Sec. 17. Sections 2, 3, and 10 - 13 of this Act take effect immediately in accordance with AS 01.10.070(c).

ORIGINAL
BILL
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Alaska State Legislature

House of Representatives

Committee on Finance

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

M E M O R A N D U M

DATE: April 1, 1981

TO: House Finance Committee Members

FROM: Becky Fritz, Secretary
House Finance Committee

SUBJ: CS SSHB 41 (HESS) Back Up Information

The attached information has been provided by Representative Buchholdt as back up for CS SSHB 41 (HESS). This Bill has been tentatively scheduled to be brought up at the Finance Committee Meeting on Friday, April 3.

PLEASE BRING THIS WITH YOU TO THE NEXT MEETING.

CS SS HB 41 (HESS): Section-by-section analysis

SECTION 1: Sets up a state comprehensive health plan (hereafter referred to as "the Plan") and a state health insurance cost sharing program, by adding a new chapter to Title 18 (Health and Safety) of state law.

Sec. 18.27.010. State Comprehensive Health Plan. Provides for the establishment of the Plan in the Department of Administration. The Commissioner is directed to establish minimum benefit standards for the Plan, and provide for underwriting and administration of the Plan. The Department may self-insure the underwriting portion of the Plan. Any resident is eligible to enroll in the Plan. The Plan shall include an annual limit on the amount of copayments and deductibles that a resident will pay, and the limit must be the same for each family size. The contract for the Plan shall be for a period of three years.

Sec. 18.27.020. State Health Insurance Cost Sharing Program. A resident enrolled in the Plan, or another health insurance policy with benefits that meet or exceed the Plan's benefits. shall receive a subsidy to help defray the costs of health insurance. All residents with health insurance, except those enrolled in a group health insurance policy or those eligible for a state or federal health program, are eligible for a state subsidy, if they meet the income criteria of the subsidy schedule. Those who are ineligible for cost sharing because of their enrollment in a private group plan or a federal health care program are entitled to cost sharing for supplemental care provided to them under the Plan or an equivalent plan. Benefits provided as supplemental coverage are the same as those provided under the Plan and are only provided as a secondary source of health coverage to those who already have a primary source of coverage under a private group plan or a federal program.

The subsidy schedule for the cost sharing program is geared to family units, and a distinction is made between premium and out-of-pocket (copayment and deductible) subsidies. Regional cost adjustments to the income formula may be used when computing subsidy levels. In other words, a higher subsidy may be available for a Barrow family than for an Anchorage family. The subsidy schedule is summarized as follows:

monthly income	family pays	state pays
below 45% of median adj. gross income for Ak. (150% of poverty guideline)	0%	100%
45-75% of median	0% premium, portion of out-of-pocket	100% premium, portion of out-of-pocket
75-100% of median	portion of premium and out-of-pocket	portion of premium and out-of-pocket
100-125% of median income	portion of premium, 100% out-of-pocket	portion of premium and 0% out-of-pocket

The attached chart describes the subsidy available to each family income category on a statewide average. The state subsidy available for health insurance other than the Plan is limited to the amount the state would have paid had the resident been enrolled in the Plan.

SECTION 2: Report to the legislature.

The Commissioner shall report back to the legislature at the beginning of the next session on the following items: (1) proposed minimum benefits for the Plan and the actuarial costs anticipated; (2) the number and characteristics of people who are expected to enroll in the cost sharing program and how much it will cost the state; (3) a proposal to implement the Plan and the cost sharing program, to determine eligibility, to pay the state's share of the costs of the Plan and the cost sharing program, and to advertise the availability of the Plan and the cost sharing program; and (4) recommendations for amendments to AS 18.27.

SECTION 3: Effective date for AS 18.27.

Coverage under the Plan and subsidies under the cost sharing program must be available on July 1, 1982.

SECTION 4: Technical amendment to present law.

SECTION 5-8: Alcoholism and drug dependency coverage.

Requires state employee health insurance coverage to include coverage for treatment of alcoholism and drug dependency.

SECTION 9: Provides differing mechanisms for provider reimbursement under federal and state medical assistance programs.

Sec. 47.05.070. Medical Assistance By Insurance or Service Contracts. If the Commissioner (of Health and Social Services) determines that it would be more cost effective to pay for medical assistance services through means other than the current fee-for-service payment mechanism, she may do so. Payment of health insurance policy premiums or expenses of health maintenance organization, medical or hospital service contracts are authorized in this section.

Sec. 47.05.080. Implementation. Requires the Commissioner to implement 47.05.070 only if it would be cost effective to do so. In other words, these mechanisms would be used only if it would cost the same or less than the current fee-for-service arrangement.

Sec. 47.05.090. Interim Payment. The Department of Health and Social Services may make an interim payment to a provider of a large volume of services under state medical assistance programs.

Sec. 47.05.100. Interest on Late Payments. Requires the Department to pay 1% interest on provider claims for services rendered under medical assistance programs that are not paid within 45 days of receipt of a clean claim. The interest rate goes up to 2% for claims that are outstanding after three months.

SECTION 10: Requires the state to offer Medicaid to all categories of eligibles for whom services may be provided under federal law, as of March 1, 1981.

Alaska currently provides Medicaid services to all categories of people that federal law requires, and additional categories that are considered optional under federal law. This section would require the Department of Health and Social Services to provide Medicaid services to other categories of people that Medicaid considers optional. The state would then be offering services to all categories of people for which federal matching Medicaid funding is available, except for those considered "medically needy". There is no need for the state to pick up the medically needy option because these individuals would be covered under the Plan established in section 1, since anyone with an income less than 150% of the poverty guidelines will receive 100% state subsidy for the cost of the Plan.

SECTION 11: Requires the state to offer all Medicaid services allowable under federal law, as of March 1, 1981.

Alaska currently provides all of the services required under federal law, and some that are considered optional. This section would require the Department to pick up the rest of the services that are considered optional, It would then be offering all services available for Medicaid matching funds.

SECTION 12: Definitions.

SECTION 13: Deletes section of law that requires the Department to ask the legislature's permission to add any new Medicaid service or eligible categories.

This section of law would no longer be needed since all available categories would be offered.

SECTIONS 14-17: Effective dates.

Secs. 1-4: 7/1/82
Secs. 5-8, 10-12: 1/1/82
Sec. 9: 7/1/81
Secs. 2-3: immediately in accordance with AS 01.10.070(c), or the day after the bill is signed by the Governor.

(LC: 4/1/8/)

STATEWIDE AVERAGES OF HEALTH INSURANCE SUBSIDIES
AVAILABLE IN CS SS HB 41

Family of 1:

PERCENT OF MEDIAN*	PREMIUM SUBSIDY	% Payment / Subsidizable OUT-OF-POCKET SUBSIDY
125	0%	0%
120	10%	0%
115	20%	0%
110	30%	0%
105	40%	0%
100	50%	0%
95	60%	9%
90	70%	18%
85	80%	27%
80	90%	36%
75	100%	45%
70	100%	55%
65	100%	64%
60	100%	73%
55	100%	82%
50	100%	91%
45	100%	100%

Family of 2:

PERCENT OF MEDIAN*	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	0%	0%
120	10%	0%
115	20%	0%
110	30%	0%
105	40%	0%
100	50%	0%
95	60%	9%
90	70%	18%
85	80%	27%
80	90%	36%
75	100%	45%
70	100%	55%
65	100%	64%
60	100%	73%
55	100%	82%
50	100%	91%
45	100%	100%

* Median income figure for 1980

Family of 3

PERCENT OF MEDIAN*	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	0%	0%
120	10%	0%
115	20%	0%
110	30%	0%
105	40%	0%
100	50%	0%
95	60%	9%
90	70%	18%
85	80%	27%
80	90%	36%
75	100%	45%
70	100%	55%
65	100%	64%
60	100%	73%
55	100%	82%
50	100%	91%
45	100%	100%

Family of 4

PERCENT OF MEDIAN*	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	0%	0%
120	10%	0%
115	20%	0%
110	30%	0%
105	40%	0%
100	50%	0%
95	60%	9%
90	70%	18%
85	80%	27%
80	90%	36%
75	100%	45%
70	100%	55%
65	100%	64%
60	100%	73%
55	100%	82%
50	100%	91%
45	100%	100%

* Median income figure for 1980

(LC: 4/1/81)

FY 82 FISCAL SUMMARY FOR CSSB 41 (HESS)

	TOTAL	FEDERAL	STATE
Department of Health and Social Services			
Addition of Medicaid Services and New Optional Categorical Groups	18,413.4	11,631.8	6781.6
Decrease in GRM due to Transfer of Services and Eligibles to Medicaid	(4,619.1)	-	(4619.1)
Decrease of GRM due to Transfer of Eligibles to Comprehensive Plan	0	-	0
Department of Administration			
Alcoholism Benefits	180.0	-	180.0
Administrative Costs for Studying and Implementing the Comprehensive Plan	1,023.4	-	1023.4
Benefit Costs under Cost Sharing Program	0	-	0
TOTAL	14,997.7	11,631.8	3365.9

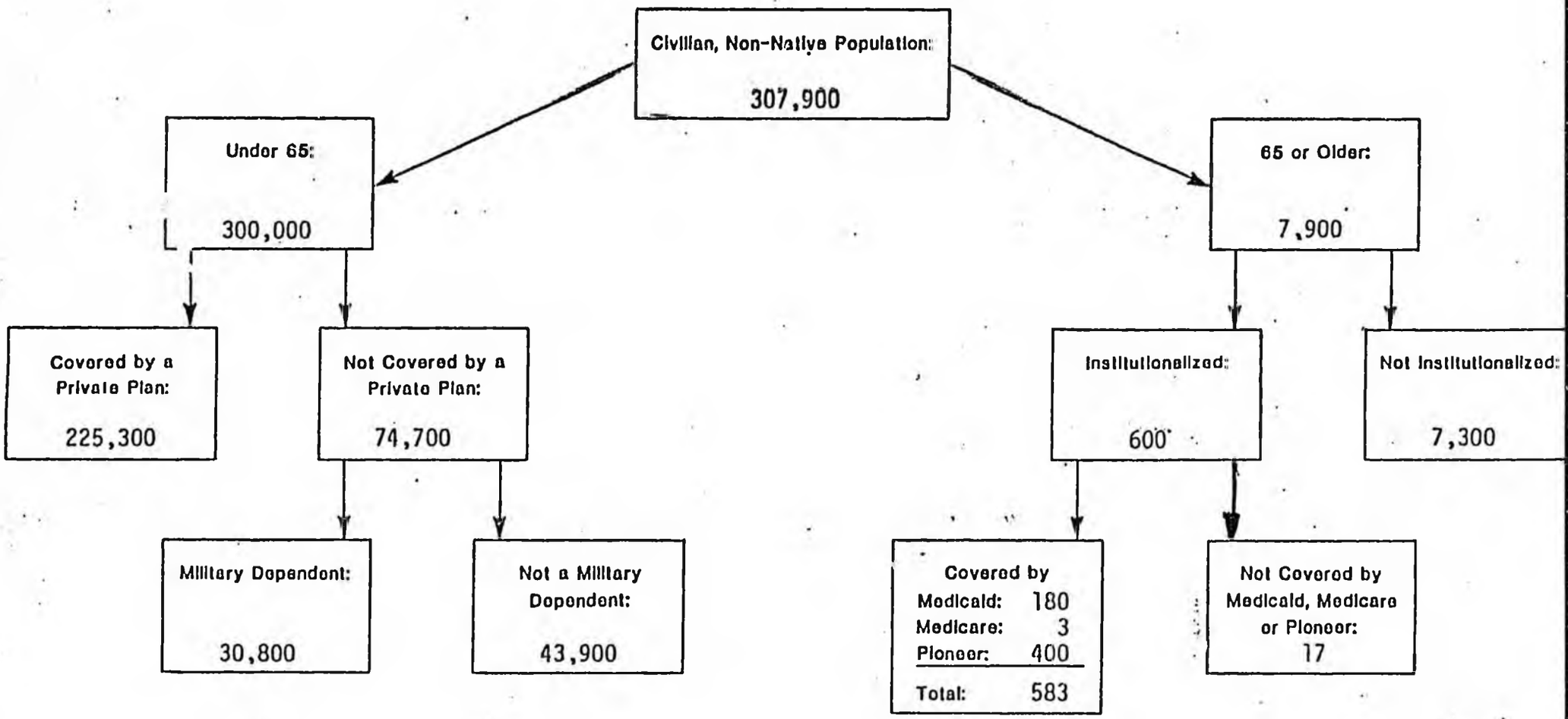
THE UNCOVERED POPULATION

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

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

(LC: 3/30/81)

CIVILIAN NON-NATIVE POPULATION: THIRD-PARTY COVERAGE



Source: Battelle Research Center

How the Health Plan and the cost sharing program would work

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

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

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

It is important to recognize the distinction between the Health Plan and the cost sharing program. Although cost sharing under the program is available to all enrolled in the Health Plan who meet the income and other requirements of the program, cost sharing is also available to residents meeting the requirements enrolled in other health plans or health insurance policies that provide benefits that are comparable to or more comprehensive than the benefits offered in the Health Plan. Thus, the Health Plan offers coverage to those who are currently without it, or who have coverage at an unreasonable price. The cost sharing program helps the Health Plan's participants and others defray the costs of health care financing.

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

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

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

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

(LC: 2/81)

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

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

Alaska currently offers all mandatory services to all mandatory groups of eligibles. In addition, it offers some optional services to some optional groups of eligibles. CSSSHB 41 (HESS) would require the state to offer all services, mandatory and optional, to all groups of eligibles, mandatory and optional, for which federal funding is available on March 1, 1981.

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

The question of how much will be cut from the federal budget for Medicaid in the future is not an easy one to answer. We will not know for sure until Congress acts. The most optimistic scenario would be one based largely on FY '82 funding levels because Alaska would spend more on Medicaid (in federal dollars) than it ever has before if this legislation is passed. David Stockman is apparently proposing a formula funding approach that would use FY '82 figures, as well as an average ratio from past years. However, it is important to reiterate that we do not know at this point in time exactly how Medicaid will be effected by budget cuts.[1]

(LC, using H&SS coverage information: 3/30/81)

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[1] Staff has written information on the several proposals for Medicaid budget cuts if members are interested.

MEDICAID SERVICES

Currently Covered Services

Hospital---inpatient and outpatient

Skilled nursing facility (SNF)

Intermediate Care Facility (ICF)

ICF for mentally retarded persons
and persons with related conditions (ICF/MR)

Laboratory and x-ray services

Physician services

Visual care services, dispensing and
opthalmic materials

Medical transportation

Speech, hearing, and language services

Psychiatric facility services

Home health care services

Early periodic screening, diagnosis,
and treatment of individuals under 21 (EPSDT)
a. dental services
b. prosthetic devices and medical supplies
c. physical therapy

Community mental health clinics

Family planning services

Patient surgical care centers

Rural health clinics

Services Added by SS HB 41

Podiatrist services

Chiropractic services

Private duty nursing

Personal care services

*Physical therapy

*Occupational therapy

*Prescribed drugs

Adult dentures and routine dental services

*Adult emergency dental services

*Prosthetic devices and medical supplies

Other diagnostic, screening, preventive & rehab. servic

Services to those over 65 in mental institutions

Services to those over 65 in tuberculosis institutions

Other practitioner services
a. private psychologist
b. nurse practitioner
c. physician assistant

Clinic services---other than comm. mental health clinic

Services by Christian Science nurses

Services by Christian Science sanatoria

* Currently avaiable through General Relief Medical

MEDICAID ELIGIBLES*

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent of AFDC child or other specified relative

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

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

All children in foster homes or private child-caring institutions

Eligibles added by SS HB 41

Child deprived of support of parent due to unemployment

Spouse of disabled parent

Spouse of unemployed parent

Pregnant woman and unborn child

All other financially eligible children

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

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

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

GLOSSARY

(1) premium--- monthly payment by insured person to insurance carrier for insurance policy

(2) deductible--- the amount of covered health expenses that the insured must pay in full, before carrier begins to assist with payment of expenses

(3) copayment--- the percentage of covered health expenses that the insured person is expected to pay in addition to the deductible payment

(4) out-of-pocket---deductible and copayments

(5) benefits--- two common meanings: (a) the types of medical services that a health insurance plan covers, i.e. hospital stay, doctor visit, x-rays, ambulance service, etc. (b) the portion of covered expenses that the insurance carrier pays

(6) maximum lifetime benefit--- the maximum dollar amount of health insurance benefits that a carrier will pay to a participant in a health insurance plan

Example using (1),(2),(3),(4b),(5),and (6): A plan costs $50/month (premium). A participant must pay the first $200 of covered expenses each year (deductible) in addition to the monthly premium payment. The participant must also pay 20% of covered expenses (copayment) up to $2000, in addition to deductible and premium payments. After the participant has incurred $2000 in copayments and deductible payments (out-of-pocket expenses), the insurance carrier will pay 100% of future expenses (benefits) up to $250,000 (maximum lifetime benefit).

(7) provider--- One who furnishes medical services, i.e. a doctor, dentist, chiropractor, hospital, etc.

(8) Medicaid--- A program that pays for medical care for public assistance recipients and certain other needy persons, jointly funded by the state and federal governments. It is important not to confuse Medicaid with Medicare which is a federal health insurance program primarily for the elderly.

(9) GRM--- General Relief Medical is a wholely state funded program that pays for medical care that is not provided under Medicaid to Medicaid recipients and to certain other needy persons.

(10) prepaid health plan--- This is a generic term that refers to an insurance plan, a hospital or medical service contract, or a health maintenance organization service contract.

(11) hospital or medical service contracts--- Prepaid health plans that provide subscribers with hospital or medical services under contract with the provider. Blue Cross and Blue Shield are the major examples.

(12) HMO--- A health maintenance organization is a prepaid health plan in which the carrier is also the direct provider of covered health services. Group Health in Seattle and the Kaiser Permanente Plans in Oregon, California, Hawaii and elsewhere are the major examples.

(13) insurance--- While insurance technically refers to indemnity coverage, for purposes of this bill it is defined to include prepaid plans as well.

(14) poverty guideline--- The income figure for each family size for Alaska that is intended to approximate the minimum income needed to provide the basic necessities of living. It is the income guideline used in certain federal programs.

(15) median income--- The middle adjusted gross income figure for each family size for Alaska used by certain federal programs. While the formula by which it is calculated does approximate the real median income, it is not a true statistical median.

(16) medical assistance programs--- Medicaid, GRM and other state programs that help needy people meet their medical expenses.

(17) high-risk uninsurable--- This term refers to a person who has difficulty obtaining insurance. He is considered a "high risk" because he has had a serious accident or medical condition in the past that requires continuous monitoring, in the form of expensive and on-going health services. Most carriers do not want to provide insurance for such individuals at the same rate as healthier people, and some do not wish to cover them at all.

(LC: 2/81)

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

Foreword

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

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

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
April 1978

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SUMMARY

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

I. INTRODUCTION

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

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

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

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

II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

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

Alaska Area Native Health Service

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

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

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

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

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

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

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

U. S. Public Health Service

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

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

Uniformed Services Health Benefits Program

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

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

Medicare

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

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

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

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

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

Medicaid

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

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

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

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

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

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

General Relief Medical

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

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

Catastrophic Illness Program

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

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

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

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

III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

Private Health Insurance

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

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

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

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

Blue Cross

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

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

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

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

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

Health Maintenance Organizations

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

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

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

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

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

Teamsters

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

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

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

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

The Covered Population

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

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

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

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

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

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

Services Covered

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

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

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

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

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

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

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

V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

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

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

Universal Coverage

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

Coverage for the Uncovered

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

Coverage for Non-Wage Earners and the Marginally Employed

State sponsored health insurance for defined groups of people who have no practical access to private health care coverage is the most limited approach to state sponsored health insurance. Under this ap-

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

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

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

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

Income Tax Credit

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

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

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

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

Medicaid Medically Needy Program

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

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

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

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

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

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

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

Mandatory Employer Coverage

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

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

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

High Risk Reinsurance Pools

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

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

Minimum Benefits Standards

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

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

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

VI. CONCLUSION

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

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

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

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

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

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

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

VII APPENDIX

TABLE I - SUMMARY OF STATE LEGISLATIVE OPTIONS TO EXPAND COMPREHENSIVE HEALTH CARE COVERAGE

	Program	Who It Would Cover	State Administrative Tasks	Estimated Annual Premium Costs To The State*	Other Payers
1.	Universal State sponsored coverage	All state residents without federal health coverage (267,500)	Verification of residency, enrollment, accounting, and financing	$87 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers
2.	State sponsored coverage for the uncovered	All state residents not covered under other public or private plans and their dependents (56,000-71,000 estimated)	Eligibility determination, enrollment, accounting, and financing	$27 - $41 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers
3.	State sponsored coverage for non-wage earners without coverage from public sources	The unemployed, self-employed, and the non-labor force and their dependents (60,000 estimated)	Eligibility, determination, enrollment, accounting, and financing	$25 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers
4.	Income tax credit	All residents filing tax returns (124,000 estimated) and their dependents	Negligible	$21 million (assuming a flat $250 credit)	Taxpayers and subscriber
5.	Medicaid medically needy program	Categorically needy with income above the public assistance level (1,580 estimated)	Eligibility determination, enrollment, accounting, and financing	$1.1 - $1.4 million (cost savings in GRM not included)	Federal government, federal taxpayers, and Alaska taxpayers
6.	Mandatory employer coverage	All non-agricultural wage and salary employed people, and their dependents (200,000 estimated)	Regulation of Employers	$0 (state cost sharing optional)	Employers and their client (optional cost sharing wit subscribers)
7.	High risk reinsurance pool	People who are unable to obtain health insurance at a reasonable premium due to health conditions	Investigation on a complaint basis	$0 (state cost sharing optional)	Subscribers, insurance companies and their client
8.	Health insurance regulation	Better coverage for current subscribers; possible decline in the number of low-income subscribers	Regulation of carriers	$0	Subscribers (including employers and other sponsors)

* These estimates are based on estimates of the current extent of coverage. Presumably alternatives 2, 3, & 4 would provide incentives for increasing health coverage, and therefore the state's premium costs would tend to rise over time.

Prepared by Legislative Affairs Agency Research Division 2/17/78

TABLE II ESTIMATED PREMIUM COSTS OF STATE-WIDE HEALTH COVERAGE WITH BENEFITS EQUIVALENT TO THE STATE EMPLOYEE HEALTH PLAN

Total FY '77 Civilian Population	398,000
U. S. Public Health Service Eligibles	(70,000)
CHAMPUS Eligibles	(55,000)
Medicaid Eligibles (excluding USPHS)	(5,500)
Eligible Population	267,500

	19 and Under (32.5%)	Over 19 (67.5%)
Number eligible	86,900	180,600
Premium Rate	$12.40	$34.10
Monthly Premium	$1,078,000	$6,158,000

ESTIMATED ANNUAL PREMIUM $86,800,000

TABLE III ESTIMATED RANGE OF INITIAL[1] PREMIUM COSTS OF HEALTH COVERAGE FOR THE UNCOVERED POPULATION

	High	Low
Uncovered Population	71,000	56,000
19 and Under (32%)	23,000	18,000
Premium Rate[2]	$22.00	$19.00
Monthly Premium	$506,000	$342,000
Over 19 (68%)	48,000	38,000
Premium Rate [2]	$60.00	$51.00
Monthly Premium	$2,880,000	$1,938,000
ESTIMATED ANNUAL PREMIUM	$41,000,000	$27,000,000

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1. These costs would approach the cost of universal coverage over time, as private subscribers opt for state subsidized coverage.

2 The estimated premium rate for state wide coverage, +50 to 75%. See Blue Cross memo which follows.

TABLE IV ESTIMATED RANGE OF PREMIUM COSTS OF HEALTH COVERAGE FOR NON-WAGE EARNERS AND DEPENDENTS WITHOUT HEALTH COVERAGE FROM PUBLIC SOURCES

Unemployed	18,300
Self-employed	15,000
Non-labor Force	244,000
Wage earner dependents	(105,000)
CHAMPUS eligibles	(46,000)
Medicaid eligibles	(14,800)
U. S. Public Health Service Eligibles	(51,500)
TOTAL	60,000

	High (+30%)	Low (+20%)
19 and Under (32.5%)		19,500
Premium Rate	$16.12	$14.88
Monthly Premium	$314,000	$290,000
Over 19 (67.5%)		40,500
Premium Rate	$44.33	$40.92
Monthly Premium	$1,795,000	$1,657,000
TOTAL ANNUAL PREMIUM	$25,300,000	$23,400,000

TABLE V ESTIMATED COST OF INCOME TAX CREDIT FOR PRIVATE HEALTH COVERAGE

Tax Returns Filed	124,000
Filers with Private Health Coverage (68.5%)	85,000
Annual Tax Credit	$250.00
TOTAL	$21,000,000

Blue Cross
of Washington and Alaska

John M. Hopkins
Vice President, Marketing

15700 Dayton Avenue North/P. O. Box 327
Seattle, Washington 98111
206/361-3586

November 30, 1977

Ms. Sharman Haley
Research Analyst
Legislative Affairs Agency
State of Alaska
Pouch Y, State Capitol
Juneau, Alaska 99811

Dear Sharman:

On September 29, you requested information concerning projected costs of a Blue Cross medical package for various classifications of State residents.

Three alternative approaches were requested in your letter. The attached proposal is applicable only for the first alternative, "coverage for all residents". The second alternative, to cover "all residents not currently covered under comprehensive group health plans", would present problems in defining and administering eligibility and in developing a controlled risk. Rates for the second alternative would probably be 50% to 75% higher than the rates for the first alternative.

The third alternative, to cover "the unemployed, the temporarily or seasonally employed, and the self-employed (mandating employer-sponsored coverage for all regular employees and their dependents)", would present fewer problems in controlling risk but would still require rates 20% to 30% higher than the first of the three alternatives and probably would have the least economic impact on the State's health care system.

We recognize that you may have many questions concerning the information contained in this letter. Please give me a call and we will try to help in any way we can.

Sincerely,

John M. Hopkins

JMH:bz

EXHIBIT 'A'

Blue Cross medical coverage extended from the Alaska State Employees to eligible residents of Alaska, given the following assumptions:

I. A resident is a person whose primary residence has been within the State of Alaska for a continuous period of at least six months.

II. An eligible resident is a resident not eligible for medical care benefits available through the following entities:

a. Federal Employee Health Programs
b. United States Armed Forces
c. CHAMPUS
d. Medicaid
e. United States Public Health Service

III. Healthcare benefits would be provided as primary coverage, with the sole exception that the Program be coordinated as secondary coverage to Medicare. Any persons eligible for Medicare and not enrolling in the Medicare Program will receive the same coordinated benefits had they been covered under Medicare.

IV. The State of Alaska would identify all eligible residents and submit necessary eligibility data to the Blue Cross Plan monthly on a computer tape in order that an updated eligibility file could be maintained for the Program. Administration and enforcement of eligibility rules would be the responsibility of the State of Alaska.

V. The State of Alaska would remit, monthly, funds due the Plan based on the eligibility file and contract rates.

VI. At the end of each contract year the Plan would provide a summary of Income, Incurred claims and administrative expenses under the Program. Any surpluses would be refunded to the State of Alaska. Any deficits would become due and payable to the Plan by the State of Alaska. The Plan would provide monthly reports to the State of Alaska during each contract year, itemizing year-to-date income and expense data.

VII. During the initial years of the Program it is likely that abnormally high rates of inflation and increases in utilization of healthcare services will occur. In an attempt to control these anticipated trends and their effects on the cost of the Program, it would be desirable for the State of Alaska to enact legislation to control the expansion of healthcare facilities and to set reasonable limits on the rate of return healthcare providers may be allowed.

continued . . .