ALASKA LEGISLATURE
HOUSE and SENATE FINANCE COMMITTEE FILES, 1993-1994

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APPENDIX B

COST SAVINGS ESTIMATE

Data Source

The data was taken from information reported to the Health Care Financing Administration (HCFA) by all States and the District of Columbia. The States report their data on the *Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services*, Form HCFA-2082. The data is based on claims paid for services provided in Fiscal Year 1991 (October 1, 1990 - September 30, 1991).

In the Annotations for the HCFA-2082 Data Tables, HCFA states that it does not guarantee the accuracy of the data provided by State Medicaid Agencies. However, HCFA does correct obvious errors and will estimate certain values when appropriate.

Savings Methodology

Of the service types available from the HCFA-2082 Data Tables, we selected services using two main criteria: (1) States frequently apply cost sharing to the service and (2) most of the services would not be exempted by Federal regulations. Utilizing this criteria, we selected three mandatory services and one optional service.

The three mandatory services include inpatient hospital, outpatient hospital, and physician visits. The optional service is prescription drugs. Although optional services vary by State, all States include prescription drugs as a covered service.

Whenever possible, we applied the most commonly used cost sharing amount when estimating our cost savings. For outpatient hospital, we selected $3 as the copayment amount since 8 of 16 States used it. For the remaining States, three other States used variable payments of $.50 to $3, 3 used $1, 1 used $2, and one had a coinsurance of 5 percent.

We selected $1.00 for physician visits. Out of 15 States using cost sharing on this service, 8 used $1, 3 varied between $.50 and $3, 2 used $2, 1 used $3, and 1 used $1 or $3 depending on the type of service. We chose $1 for prescription drugs also. For the 25 States applying cost sharing, 14 used $1, 8 used varying amounts from $.50 to $3, 2 used $.50, and 1 used $1.50.

For inpatient hospital services, we selected the most conservative cost sharing amount since States' methodology for applying cost sharing varies. Six of the States with cost sharing impose a one time copayment (or deductible for one State) per admission. Those payments range between $10 and $100 per hospital admission. Five State apply copayment charges on a per day basis. Three of the five States use a $3 cost share per day, one uses $5, and one varies between $2 and $3 depending on the cost of

service. After reviewing this information, we felt the most conservative choice would be a $3 copayment per total inpatient hospital days.

In order to estimate the cost savings to the Medicaid program if States without cost sharing implemented cost sharing on these four services, we extracted the number of paid service claims for the States without cost sharing. However, Rhode Island data was unavailable. Therefore, the cost savings estimates are based on 23 States without cost sharing.

We calculated the cost savings estimate in three steps. (1) The number of services for each State was multiplied by the cost sharing amount we selected. (2) Each State's service cost sharing amount was added to arrive at a total cost sharing amount. (3) The total service amounts for the four services were then added to project the total cost savings if States were to implement cost sharing on these four services. The numeric equations for this calculation follows:

STEP 1

$$S_i \times \$3.00 = ST_i$$
$$S_o \times \$3.00 = ST_o$$
$$S_p \times \$1.00 = ST_p$$
$$S_d \times \$1.00 = ST_d$$

STEP 2

$$ST_i^1 + ST_i^2 + ST_i^3 + \ldots ST_i^{23} = TAS_i$$
$$ST_o^1 + ST_o^2 + ST_o^3 + \ldots ST_o^{23} = TAS_o$$
$$ST_p^1 + ST_p^2 + ST_p^3 + \ldots ST_p^{23} = TAS_p$$
$$ST_d^1 + ST_d^2 + ST_d^3 + \ldots ST_d^{23} = TAS_d$$

STEP 3

$$TAS_i + TAS_o + TAS_p + TAS_d = \text{Total Cost Savings Estimate}$$

S = number of services
ST = each State's total cost sharing amount by service type
TAS = Total of all States' cost sharing amounts by service type
$^{1-23}$ = Each number 1 through 23 equals one State's total
$_i$ = inpatient hospital days
$_o$ = outpatient hospital
$_p$ = physician visits
$_d$ = prescription drugs

We presented two dollar amounts for cost savings -- total cost sharing estimates with and without exempted populations. To estimate the number of services that would be excluded under Federal regulation, we used State reported data on exclusions.

States were asked how many of their recipients would be exempted from cost sharing. Out of the 17 States able to answer the question, 9 estimated 40 to 50 percent and 8 estimated over 50 percent.

Using this information, we selected 50 percent as the number of services to exempt for the exempted populations calculation. However we realize that the number of beneficiaries exempted may not equal the number of services exempted, since exempted populations may use a greater or lesser percentage of certain services.

Cost Savings Tables

The following four tables illustrate the cost savings calculations for each service type. The fifth table provides the total cost savings estimate with and without exemptions and the last table divides total savings into Federal and States shares.

Savings Calculation for Inpatient Hospital Days

States	Total Services	Services x $3	Non-Exempt Services	Non-exempt x $3
Alaska	53,417	$160,251	26,708	$80,124
Connecticut	379,891	$1,139,673	189,945	$569,835
Delaware	61,255	$183,765	30,627	$91,881
Georgia	1,069,789	$3,209,367	534,894	$1,604,682
Hawaii	70,456	$211,368	35,228	$105,684
Idaho	71,993	$215,979	35,996	$107,988
Indiana	609,076	$1,827,228	304,538	$913,614
Kentucky	593,995	$1,781,985	296,997	$890,991
Louisiana	694,894	$2,084,682	347,447	$1,042,341
Minnesota	361,285	$1,083,855	180,642	$541,926
Nebraska	117,623	$352,869	58,811	$176,433
Nevada	115,865	$347,595	57,932	$173,796
New Jersey	933,760	$2,801,280	466,880	$1,400,640
New Mexico	131,393	$394,179	65,663	$197,088
New York	4,473,440	$13,420,320	2,236,720	$6,710,160
North Dakota	55,068	$165,204	27,534	$82,602
Ohio	1,202,638	$3,607,914	601,319	$1,803,957
Oklahoma	195,918	$587,754	97,959	$293,877
Oregon	155,606	$466,818	77,803	$233,409
Rhode Island	NA	NA	NA	NA
Tennessee	754,690	$2,264,070	377,345	$1,132,035
Texas	1,599,687	$4,799,061	799,843	$2,399,529
Utah	96,990	$290,970	48,495	$145,485
Washington	406,366	$1,219,098	203,183	$609,549
Total	14,205,095	$42,615,285	7,102,542	$21,307,626

Savings Calculation for Outpatient Hospital Services

States	Total Services	Services x $3	Non-Exempt Services	Non-exempt x $3
Alaska	73,064	$219,192	36,532	$109,596
Connecticut	1,111,299	$3,333,897	555,649	$1,666,947
Delaware	892,655	$2,677,965	446,327	$1,338,981
Georgia	5,148,675	$15,446,025	2,574,337	$7,723,011
Hawaii	2,647,094	$7,941,282	1,323,547	$3,970,641
Idaho	37,470	$112,410	18,735	$56,205
Indiana	2,204,139	$6,612,417	1,102,069	$3,306,207
Kentucky	1,384,708	$4,154,124	692,354	$2,077,062
Louisiana	133,228	$399,684	66,614	$199,842
Minnesota	1,048,055	$3,144,165	524,027	$1,572,081
Nebraska	85,311	$255,933	42,655	$127,965
Nevada	203,386	$610,158	101,693	$305,079
New Jersey	995,812	$2,987,436	497,906	$1,493,718
New Mexico	72,110	$216,330	36,055	$108,165
New York	8,078,562	$24,235,686	4,039,281	$12,117,843
North Dakota	67,354	$202,062	33,677	$101,031
Ohio	2,440,571	$7,321,713	1,220,285	$3,660,855
Oklahoma	115,459	$346,377	57,729	$173,187
Oregon	92,043	$276,129	46,021	$138,063
Rhode Island	NA	NA	NA	NA
Tennessee	1,717,441	$5,152,323	858,720	$2,576,160
Texas	826,138	$2,478,414	413,069	$1,239,207
Utah	1,021,588	$3,064,764	510,794	$1,532,382
Washington	4,191,245	$12,573,735	2,095,622	$6,286,866
Total	34,587,407	$103,762,221	17,293,698	$51,881,094

Savings Calculation for Physician Visits

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Alaska	198,529	$198,529	99,264	$99,264
Connecticut	1,831,991	$1,831,991	915,995	$915,995
Delaware	377,440	$377,440	188,720	$188,720
Georgia	5,976,371	$5,976,371	2,988,185	$2,988,185

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Hawaii	4,967,763	$4,967,763	2,483,881	$2,483,881
Idaho	232,423	$232,423	116,211	$116,211
Indiana	1,542,287	$1,542,287	771,143	$771,143
Kentucky	2,383,344	$2,383,344	1,191,672	$1,191,672
Louisiana	9,151,352	$9,151,352	4,575,676	$4,575,676
Minnesota	2,292,306	$2,292,306	1,146,153	$1,146,153
Nebraska	917,483	$917,483	458,741	$458,741
Nevada	364,945	$364,945	182,472	$182,472
New Jersey	3,352,290	$3,352,290	1,676,145	$1,676,145
New Mexico	394,014	$394,014	197,007	$197,007
New York	6,470,838	$6,470,838	3,235,419	$3,235,419
North Dakota	472,104	$472,104	236,052	$236,052
Ohio	5,143,620	$5,143,620	2,571,810	$2,571,810
Oklahoma	740,794	$740,794	370,397	$370,397
Oregon	393,261	$393,261	196,630	$196,630
Rhode Island	NA	NA	NA	NA
Tennessee	4,065,459	$4,065,459	2,032,729	$2,032,729
Texas	9,627,597	$9,627,597	4,813,798	$4,813,798
Utah	1,666,551	$1,666,551	833,275	$833,275
Washington	3,651,570	$3,651,570	1,825,785	$1,825,785
Total	66,212,332	$66,212,332	33,106,160	$33,106,160

Savings Calculation for Prescription Drugs

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Alaska	299,039	$299,039	149,519	$149,519
Connecticut	3,449,149	$3,449,149	1,724,574	$1,724,574
Delaware	479,796	$479,736	239,898	$239,898
Georgia	8,841,481	$8,841,481	4,420,740	$4,420,740
Hawaii[1]	600,000	$600,000	300,000	$300,000
Idaho	750,107	$750,107	375,053	$375,053
Indiana	3,261,632	$3,261,632	1,630,816	$1,630,816
Kentucky	7,254,476	$7,254,476	3,627,238	$3,627,238
Louisiana	8,187,936	$8,187,936	4,093,968	$4,093,968
Minnesota	4,573,505	$4,573,505	2,286,752	$2,286,752

States	Total Services	Services x $1	Non-Exempt Services	Non-exempt x $1
Nebraska	1,979,626	$1,979,626	989,813	$989,813
Nevada	493,239	$493,239	246,619	$246,619
New Jersey	8,427,969	$8,427,969	4,213,984	$4,213,984
New Mexico	1,454,448	$1,454,448	727,224	$727,224
New York	26,168,221	$26,168,221	13,084,110	$13,084,110
North Dakota	607,885	$607,885	303,942	$303,942
Ohio	15,319,466	$15,319,466	7,659,733	$7,659,733
Oklahoma	2,373,168	$2,373,168	1,186,584	$1,186,584
Oregon	2,100,122	$2,100,122	1,050,061	$1,050,061
Rhode Island	NA	NA	NA	NA
Tennessee	8,239,598	$8,239,598	4,119,799	$4,119,799
Texas	11,474,997	$11,474,997	5,737,498	$5,737,498
Utah	1,253,431	$1,253,431	626,715	$626,715
Washington	5,270,693	$5,270,693	2,635,346	$2,635,346
Total	122,859,984	$122,859,984	61,429,986	$61,429,986

[1] *Since Hawaii provided number of pills instead of prescriptions, the 1991 prescription number was obtained from the National Pharmaceutical Council's Pharmaceutical Benefits Under State Medical Assistance Programs, September 1992, p. 77.*

Total Cost Savings Calculation

Types of Service	Savings without Exemptions	Savings with Exemptions
Inpatient Hospital Days	$42,615,285	$21,307,626
Outpatient Hospital Services	$103,762,221	$51,881,094
Physician Visits	$66,212,332	$33,106,160
Prescription Drugs	$122,859,984	$61,429,986
Total	$335,449,822	$167,724,866

Calculation for Federal and State Share of Savings

States	FMAP 1991[1]	Savings without Exemptions[2]	Federal Share[3]	State Share[4]	Savings with Exemptions[5]	Federal Share	State Share
AK	50.00	$875,011	$437,506	$437,505	$437,503	$218,752	$218,751
CT	50.00	$9,754,710	$4,877,355	$4,877,355	$4,877,351	$2,438,676	$2,438,675
DE	50.00	$3,718,966	$1,859,483	$1,859,483	$1,859,480	$929,740	$929,740
GA	61.34	$33,473,244	$20,532,488	$12,940,756	$16,736,618	$10,266,241	$6,470,377
HI	54.14	$13,720,413	$7,428,232	$6,292,181	$6,860,206	$3,714,116	$3,146,090
ID	73.65	$1,310,919	$965,492	$345,427	$655,457	$482,744	$172,713
IN	63.24	$13,243,564	$8,375,230	$4,868,334	$6,621,780	$4,187,614	$2,434,166
KY	72.96	$15,573,929	$11,362,739	$4,211,190	$7,786,963	$5,681,368	$2,105,595
LA	74.48	$19,823,654	$14,764,658	$5,058,996	$9,911,827	$7,382,329	$2,529,498
MN	53.43	$11,093,831	$5,927,434	$5,166,397	$5,546,912	$2,963,715	$2,583,197
NE	62.71	$3,505,911	$2,198,557	$1,307,354	$1,752,952	$1,099,276	$653,676
NV	50.00	$1,815,937	$907,969	$907,968	$907,966	$453,983	$453,983
NJ	50.00	$17,568,975	$8,784,488	$8,784,487	$8,784,487	$4,392,244	$4,392,243
NM	73.38	$2,458,971	$1,804,393	$654,578	$1,229,484	$902,195	$327,289
NY	50.00	$70,295,065	$35,147,533	$35,147,532	$35,147,532	$17,573,766	$17,573,766
ND	70.00	$1,447,255	$1,013,079	$434,176	$723,627	$506,539	$217,088
OH	59.93	$31,392,713	$18,813,653	$12,579,060	$15,696,355	$9,406,826	$6,289,529
OK	69.65	$4,048,093	$2,819,497	$1,228,596	$2,024,045	$1,409,747	$614,298
OR	63.50	$3,236,330	$2,055,070	$1,181,260	$1,618,163	$1,027,534	$590,629
RI	53.74	NA	NA	NA	NA	NA	NA
TN	68.57	$19,721,450	$13,522,996	$6,198,452	$9,860,723	$6,761,496	$3,099,225
TX	63.53	$28,380,069	$18,029,858	$10,350,211	$14,190,032	$9,014,927	$5,175,105
UT	74.89	$6,275,716	$4,699,884	$1,575,832	$3,137,857	$2,349,941	$787,916
WA	54.21	$22,715,096	$12,313,854	$10,401,242	$11,357,546	$6,156,926	$5,200,620
Total	——	$335,449,322	$198,641,450	$136,808,372	$167,724,866	$99,320,697	$68,404,160

[1] Federal Medical Assistance Percentage (FMAP) - Rate of Federal Financial Participation in a State's Medicaid Program for FY 1991.

[2] Each State's total savings for inpatient, outpatient, physician, and prescription drug services, assuming no recipients are exempted.

[3] The Federal share is arrived at by multiplying each State's total savings by the FMAP.

[4] The State share is arrived at by multiplying each State's total savings by (1 - FMAP), e.g. the calculation for Ohio would be savings multiplied by (1 - .5993) or .4007.

[5] Each State's total savings for inpatient, outpatient, physician, and prescription drug services, assuming 50 percent of the recipients are exempted.

APPENDIX C

COST SHARING ON MANDATORY SERVICES

State	Inpatient Hospital	Outpatient Hospital[1]	Physician Services[2]	Rural Health Clinic	Federally Qualified Health Center	Certified Nurse Practitioner
AL	50.00 a	3.00	1.00	1.00	1.00	1.00
AZ		5.00 n-e	1.00			
AR		.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
CA		1.00/5.00 n-e	1.00			
CO	15.00 a	3.00	2.00	2.00		
DC						
FL		1.00 n-e	1.00			
IL	2.00/3.00 d					
IA						
KS	25.00 a	1.00	1.00			
ME		.50-3.00				
MD						
MA		3.00 n-e				
MI						
MS	5.00 d	2.00	1.00	2.00	1.00	
MO	10.00 a	3.00[3]				
MT	3.00 d	1.00	1.00	1.00	1.00	
NH						
NC		3.00	3.00			
PA	3.00 d	.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC						
SD		5 percent	2.00			
VT	50.00 a	3.00				
VA	100.00 a[4]	3.00	1.00/3.00			
WV						
WI	3.00 d	3.00	.50-3.00	2.00-3.00		.50-3.00
WY		3.00/3.00 n-e	1.00			
Total States	11	16 / 5 n-e	15	7	5	4

1 For ease of charting, we compressed non-emergency use of emergency room (n-e) with outpatient services.
2 Some States include specialized services, e.g., ophthalmology or medical psychotherapy, under physician services.
3 Includes 2.00 for outpatient service and 1.00 for physician service
4 Inpatient hospital deductible
a = cost sharing per inpatient hospital admission
d = cost sharing per inpatient hospital day

COST SHARING ON OPTIONAL SERVICES

State	Prescription Drugs	Optometric/ Optician/ Vision Services[1]	Podiatric Services	Dental Services or Treatment/ Oral Surgery[2]	Chiropractic Services	Durable Medical Equipment
AL	.50-3.00	1.00				3.00
AZ						
AR	.50-3.00	.50-3.00	.50-3.00			
CA	1.00	1.00	1.00	1.00	1.00	
CO	.50 g/2.00 b	2.00	2.00			
DC	.50					
FL	1.00	1.00	1.00	1.00 s	1.00	
IL						
IA	1.00	2.00/2.00 o	1.00	3.00	1.00	2.00
KS	1.00	2.00	1.00			3.00
ME	1.00 g/2.00 b		.50-2.00			.50-3.00
MD	1.00					
MA	.50					
MI	1.00	2.00	2.00	3.00 s	1.00	
MS	1.00			2.00		
MO	.50-2.00	.50-3.00	.50-3.00	.50-3.00		
MT	1.00	1.00	1.00	1.00		.50
NH	.50 g/1.00 b					
NC	1.00	2.00/2.00 o	1.00	3.00	1.00	
PA	1.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC	1.50					
SD	1.00			1.00	.50	5 percent
VT	1.00-2.00					
VA	1.00	1.00				
WV	.50-1.00					
WI	1.00	1.00	1.00-3.00	.50-3.00	.50/1.00	.50-3.00
WY	1.00	1.00				
Total States	25	15 / 2 o	13	9 / 2 s	8	8

1 For ease of charting, we compressed optometric/vision and optician services.
2 For ease of charting, we compressed dental services/treatment with oral surgery.
b = brand name
g = generic
o = optician services
s = oral surgery

COST SHARING ON OPTIONAL SERVICES

State	Psychiatry/ Psychology/ Psycho-therapy[1]	Audiology Services	Ambulance/ Transport Services	Eyeglasses	Medical Supplies	Prosthetic Device
AL					1.00	
AZ						
AR			.50-3.00			.50-3.00
CA	1.00	1.00				
CO	.50/15 min					
DC				2.00		
FL						
IL						
IA	2.00	2.00	2.00		2.00	2.00
KS	2.00	3.00	1.00			3.00
ME		.50-2.00	.50-2.00		.50-3.00	
MD						
MA						
MI						
MS			2.00	2.00		
MO		.50-3.00		.50-3.00		.50-3.00 ae
MT	.50/1 hour	.50		1.00	.50	.50
NH						
NC				2.00		
PA	.50		.50-3.00	.50-3.00	.50-3.00	.50-3.00
SC						
SD					1.00	5 percent
VT						
VA						
WV						
WI	.50-2.00	1.00	.50-3.00	.50-3.00	.50	
WY	1.00					
Total States	8	7	7	7	7	7

1 For ease of charting, we compressed psychiatric, psychological, and psychotherapy services.
ae = artificial eye

COST SHARING ON OPTIONAL SERVICES

State	Hearing Aids/ Hearing Aid Services	Home Health Services	Physical Therapy	Clinic Services	Dentures/ Denture Services	Occupational Therapy
AL						
AZ						
AR		2 percent				
CA			1.00	1.00		1.00
CO						
DC						
FL	5 percent				5 percent	
IL						
IA	3.00		1.00			
KS		2.00				
ME		.50-2.00	.50-2.00			.50-2.00
MD						
MA						
MI	3.00					
MS		2.00		1.00 s		
MO	.50-3.00				5 percent	
MT	.50	1.00	.50	1.00 d		.50
NH						
NC						
PA				.50-3.00	.50-3.00	
SC						
SD					3.00	
VT						
VA		3.00	3.00	1.00		3.00
WV						
WI	.50/1.00/3.00		1.00/30 min.		3.00	1.00/30 min.
WY						
Total States	6	6	6	5	5	5

s = State clinic
d = diagnostic clinic

COST SHARING ON OPTIONAL SERVICES

State	Speech Therapy	Ambulatory Surgical Centers	Community/ Mental Health Centers	Private Duty Nurse/ Personal Care	Other
AL		3.00			
AZ					a
AR				2 percent	
CA	1.00	1.00			b
CO			2.00		
DC					
FL					
IL					
IA					c,d/2.00
KS		3.00	2.00		d/3.00,e/3.00
ME	.50-2.00			.50-3.00	
MD					
MA					
MI					
MS					
MO					
MT	.50		1.00	.50	e/1.00,f
NH					
NC					
PA		.50-3.00			g
SC					
SD			5 percent		h
VT					
VA	3.00				
WV					
WI	1.00/30 min.				i
WY					
Total States	5	4	4	3	11

a = non-emergency surgery/5.00, diagnostic/rehabilitative x-ray and lab services/1.00
b = acupuncture/1.00
c = rehabilitation agency services/2.00
d = orthopedic shoes or orthotics
e = outpatient surgery
f = home dialysis/.50, free standing dialysis center/1.00, social worker/.50 per hour, licensed counselor/.50 per hour
g = diagnostic radiology/nuclear medicine/radiation therapy/medical diagnostic services (when billed in total or only technical component is billed)/1.00, all other covered services/.50-3.00
h = EPSDT screening/dental procedures/optometric, or optical procedures for those over age 18/1.00
i = Medical day treatment and assessment/.50 per day

APPENDIX D

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date: JUN 1 1 1993

From: Bruce C. Vladeck
Administrator

Subject: Office of Inspector General (OIG) Draft Report: "Medicaid Cost Sharing" (OEI-03-91-01800)

To: Bryan B. Mitchell
Principal Deputy Inspector General

We have reviewed the above-mentioned draft report which presents findings on the impact of State cost sharing policies on the Medicaid program.

The Health Care Financing Administration nonconcurs with the recommendation contained in the report. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you agree with our position on the report's recommendation at your earliest convenience.

Attachment

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Comments of the Health Care Financing Administration (HCFA) on the Office of Inspector General (OIG) Draft Report: Medicaid Cost Sharing, OEI-03-91-01800

Recommendation

The HCFA should promote the development of effective cost sharing programs within States.

(1) The HCFA could encourage States to implement cost sharing. The HCFA could accomplish this by:

- o providing the States with technical assistance and information about State experiences with cost sharing;
- o allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or
- o recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing higher recipient cost sharing amounts.

(2) The HCFA could seek legislation to provide States with incentives to implement cost sharing programs, such as decreasing Federal matching to States who do not implement cost sharing.

(3) The HCFA could seek legislation to mandate cost sharing for all States.

Response

HCFA nonconcurs with this recommendation. We believe cost sharing should remain a voluntary State option.

The legislative history of section 1916 of the Social Security Act indicates that it was designed to allow States greater flexibility in the use of cost sharing without imposing unnecessary hardships on Medicaid recipients. Current regulations provide the States with a wide variety of options, and, thus, a considerable degree of program and administrative flexibility. Some of these options are as follows: (1) use of enrollment fees or premiums for the medically needy rather than copayments; (2) use of deductibles rather than copayments; (3) ability of States to relate recipient cost sharing to income (within maximum amount specified in regulations) and to charge different amounts to medically needy and categorically needy recipients; and (4) optional use of cumulative maximums for all deductibles, coinsurance, or

copayments charged to a family. While we agree that there is sufficient evidence to suggest that cost sharing saves money for the State Medicaid program and the Federal government, we believe that any changes in cost sharing policies should also be viewed in terms of its effect on Medicaid recipients.

There are significant variations of the Medicaid program among States. Consequently, advocating cost sharing may have differing effects on Medicaid recipients. Since States are looking at ways to decrease welfare payments, increased cost sharing may mean increased copayments for recipients who, in turn, will have even less money for other basic maintenance needs which have also risen in cost.

There are also potential difficulties with the implementation of cost sharing for outpatient prescription medications. One potential difficulty is that access to drugs may be limited, and the dollar savings on drugs may be outweighed by the use of high cost services, emergency rooms and potentially avoidable hospitalizations because of adverse complications experienced by persons who do not obtain their prescriptions. Any recommendation that includes prescription drugs should be reviewed to ensure that it does not conflict with other State options for limiting access to outpatient drugs for Medicaid, such as limits on the number of prescription transactions per month or on the supply (e.g., 30-day supply, 6-month supply), or a State's option to totally exclude certain drugs from reimbursement. These other limitations can also cause high-cost adverse health care needs. Furthermore, the added demand for a copayment, particularly if it is based on a percentage of total charge for the drug which is already high, can place an added burden on the Medicaid recipient.

Another consideration is the impact of cost sharing on providers of care for the Medicaid population. The burden for collection of "shared cost" is shifted to the provider. In some parts of the Medicaid program, provider reimbursement for care to Medicaid eligibles functions more as a disincentive than an incentive. The need for the provider to collect a copay from the Medicaid population may well function simply as another cap on provider fees rather than a true recipient share in the cost of medical care. Although OIG mentions that the burden is on the provider to collect the copay, this report would be enhanced by showing how copay is related to physician fees, especially the new HCFA physician fee schedule. For crossover patients covered by Medicare and Medicaid, the physician is subject to the Medicare physician fee schedule and the limits of State Medicaid program reimbursement rates. Cost sharing should not serve as a barrier to receiving necessary medical services. The question of whether providers deny medical care because of a failure to collect the patient's shared portion of cost is possibly important, but reportedly unknown to those in the State Medicaid offices.

Lastly, we believe that no further action should be taken pending the development and announcement of the Administration's health care proposal. However, if OIG decides to issue this report in final, we suggest that the report be shared with the States.

Technical Comments

The section of the report entitled, "Previous Cost Sharing Studies" could be improved by referencing the studies and adding caveats about the serious methodological flaws or shortcomings in them. We would not want them presented as useful testimony for current day practices or future program and policy recommendations.

In the Executive Summary Findings, the potential savings are shown as being between $167 to $335 million annually. We suggest adding a statement to explain that variance, *e.g.*, ". . . . savings of $167 million under current law, and $335 million if existing exemptions for covered populations and services were to be legislatively repealed."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Office of the Secretary

Washington, D.C. 20201

MAR 30 1993

MEMORANDUM TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM : Elizabeth M. James
Acting Assistant Secretary for
Management and Budget

SUBJECT : OIG Draft Report on Medicaid Cost Sharing
OEI-05-91-01080

Thank you for the opportunity to review this draft report. Focusing on the area of cost containment is important and the report obtained some good information through the executive interviews. We are, however, concerned with the conclusion that "the report demonstrates that States have developed cost sharing programs that reduce Medicaid expenditures."

We wish to raise two issues concerning your findings and the ensuing recommendations. First, the sample size and data are insufficient to support the findings. This conclusion is based on the following:

- Of the 27 states, only three provided program evaluation data (two of which were inconclusive).
- 22 states said that the cost sharing programs had reduced Medicaid expenditures. However, only 11 provided financial data depicting estimated savings.
- Only one of the state's estimates of savings included reductions in utilization. The remainder represented reductions in provider payments.
- The calculated savings estimates may be overly simplified. The maximum value was calculated simply by multiplying the number of 1991 claims by a "frequently used" copayment. A 50 percent exemption of services was assumed to arrive at the minimum value. A 50 percent recipient exemption is not necessarily equal to a 50 percent service exemption.

Second, the analyses of the sample data do not cover the interactions between cost sharing and other cost containment polices which could have influenced the observed Medicaid savings. For example,

- No analysis of changes in provider participation has been done. The only state with conclusive program evaluation data indicated that provider participation had remained stable not because recipients were paying the copayment but mainly because pursuit of the nominal amount was more expensive than the value of the copayment.

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- 17 states implemented other cost containment programs at the same time as their cost sharing and thus were unable to truly measure the effect of cost sharing.

- There is no attention to the burden incurred by recipients and providers from cost sharing programs. States are uncertain whether recipients are actually paying the copayments.

We believe additional sample data needs to be collected and analyzed before conclusions can be drawn as to the effectiveness of cost sharing programs. Perhaps a primary recommendation of this report should be that HCFA pursue further analysis in this area.

Table 3

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Alabama	Ambulatory surgical center services	$3.00	
	Durable medical equipment	$3.00	
	Federally qualified health centers	$1.00	
	Inpatient hospital	$50/admission	
	Outpatient hospital***	$3.00	
	Supplies/appliances	$1.00	
	Physician office visits (incl. optometric)	$1.00	
	Prescription drugs	Varies	Age 19+; pregnant women for non-pregnancy related prescriptions.
	Rural health clinic***	$1.00	
Alaska	None		
Arizona	Office visits	$1.00	
	Elective surgery	$5.00	
	Non-emergency use of ER	$5.00	
Arkansas	None		
California	Prescription drugs	$1.00	Age 19+.
	Emergency room (inappropriate use)	$5.00	
	Outpatient hospital	$1.00	
Colorado [1]	Physician services	$2.00	
	Community mental health centers	$2.00	
	Inpatient hospital	$15/stay	
	Outpatient hospital	$3.00	
	Prescription drugs	$1.00	
	Physician visit	$2.00	
	Rural health clinics	$2.00	
Connecticut	None		
Delaware	None		
DC	Prescription drugs	$0.50	Age 21+; pregnant women for non-pregnancy related prescriptions.
	Eyeglasses	$2.00	
Florida	Dentures	Varies [2]	Age 21+.
	Prosthetic devices - hearing aids	Varies [2]	Age 21+.
Georgia	None		
Hawaii	None		
Idaho	None		
Illinois	Inpatient hospital	Varies [3]	
Indiana	None		
Iowa	Chiropracty	$1.00	
	Dental	$3.00	Age 21+.
	Prescription drugs	$1.00	
	Eyeglasses - optician services	$2.00	
	Medical equipment & supplies	$2.00	
	Optometry	$2.00	
	Podiatry	$1.00	
	Prosthetic devices		
	—hearing aids	$3.00	
	—orthopedic shoes	$2.00	
	Psychology	$2.00	
	Psychotherapy (CMHC only)	$2.00	
	Rehabilitation agency	$2.00	
	Transportation - ambulance	$2.00	

Table 3 con't.

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Kansas	Ambulatory surgery center services	$3.00	
	Audiology	$3.00	
	Chiropracty	$0.50	
	Dental	$2.00	
	Prescription drugs	$1 00	
	Freestanding psychiatric hospital (private)	$25.00/stay	
	Home health agency (skilled nursing)	$2.00	
	Hospital - inpatient	$25.00	
	- non-emergency outpatient	$1.00	
	- outpatient surgery	$3.00	
	Medical equipment	$3.00	
	Mental health center	$2.00	
	Optometrist	$2.00	
	Physician office visit	$1.00	
	Podiatry	$1.00	
	Psychology	$2.00	
	Transportation - non-emer. ambulance	$1 00	
Kentucky	None		
Louisiana	None		
Maine	Prescription drugs	0.75 [4]	
Maryland	Prescription drugs	$0.50	
Massachusetts	None		
Michigan [6]	Chiropracty	$1 00	
	Dental	$3.00	Age 21+.
	Prescription drugs	$0.50	
	Optometry	$2.00	
	Podiatry	$2.00	
	Prosthetic devices - hearing aids	$3.00	
Minnesota	None		
Mississippi	Dental	$2.00	
	Prescription drugs	$1.00	
	Home health visit	$2.00	
	Hospital - emergency room	$2.00	
	- inpatient	$5.00	Age 18+; pregnant women for non-pregnancy related prescriptions.
	Optometry	$2.00	
	Rural health clinics - office visits	$1.00	
	Transportation - ambulance	$2.00	
Missouri	Audiology	Varies [5]	Age 18+.
	Dental	Varies [5]	
	Dentures	Varies [2]	
	Prescription drugs	Varies [6]	
	Hospital - inpatient	$10.00	
	- outpatient	$3.00	
	Optometry	Varies [5]	
	Podiatry	Varies [5]	
Montana	Audiology	$0.50	Age 21+.
	Clinic services	$1.00	
	Clinical social worker	$0.50	
	Dental	$1.00	
	Prescription drugs	$1.00	
	Eyeglasses	$1 00	
	Home dialysis for ESRD	$0 50	
	Home health (not including DME)	$1.00	
	Hospital - inpatient	$3.00/day [7]	
	- outpatient	$1 00	
	Nurse specialist services	$1 00	
	Occupational therapy	$0 50	
	Optometry	$1 00	
	Physical therapy (outpatient)	$0 50	
	Physician	$1 00	
	Podiatry	$1 00	

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1991 CRSCOPAY

Table 3 con't.

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Montana con't.	Private duty nursing	$0.50	
	Prosthetic devices	$0.50	
	- hearing aids	$0.50	
	- medical equip. & supplies	$0.50	
	Psychological	$0.50	
	Speech pathology	$0.50	
Nebraska	None		
Nevada	None		
New Hampshire	Prescription drugs:		
	- generics	$0.50	
	- brand names	$1.00	
New Jersey	None		
New Mexico	None		
New York	None		
North Carolina	Chiropracty	$0.50	
	Clinic	$0.50	
	Dental	$2.00	Age 18+
	Eyeglasses (each pair and repair of $4+)	$2.00	
	Hospital - outpatient	$1.00	
	Optometry	$1.00	
	Physician	$0.50	
	Podiatry	$1.00	
	Prescription drugs	$0.50	
North Dakota	Eyeglasses - replacement lenses & frames within 1 yr. of original prescription.	$3.00	
Ohio	None		
Oklahoma	None		
Oregon	None		
Pennsylvania	Prescription drugs	$0.50	
	Inpatient	$3.00/day [8]	
	Non-emergency service in a hospital	Varies [9]	
	Emergency room	Varies [9]	
	All other allowable services	Varies [10]	
Rhode Island	None		
South Carolina	Prescription drugs	$1.00	Age 21+; and pregnant women for non-pregnancy related prescriptions.
South Dakota	Ambulatory surgery center	Varies [2]	
	Chemical dependency treatment	Varies [2]	
	Chiropracty	$0.50	
	Dental	$1.00	
	Dentures	$3.00	
	Durable medical equipment	Varies [2]	
	EPSDT screening	$1.00	
	Hospital - outpatient (except lab)	Varies [2]	
	Mental health centers	Varies [2]	
	Optometry	$0.50	
	Physician	$3.00	
	Podiatry	$2.00	
	Prescription drugs	$1.00	Pregnant women for non-pregnancy related prescription drugs.
	Psychotherapy	$2.00	
	Rehab hospital outpatient (except lab)	Varies [2]	
Tennessee	None		
Texas	None		
Utah	None		
Vermont	Prescription drugs	$1.00	
Virginia [11]	Clinic	$1.00	
	Hospital - inpatient	$30.00	
	- outpatient, nonemergency	$2.00	
	Optometry - eye exams	$1.00	
	Physician	$1.00	
	Prescription drugs	$1.00	
Washington	None		
West Virginia	Prescription drugs	Varies [12]	
Wisconsin	Audiological testing	$1.00	
	Chiropracty	$1.00	
	Day treatment service	$0.50	

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1991. CRSCOPAY

Table 3 con't.

STATE COPAYMENT POLICIES IN EFFECT AS OF JANUARY 1, 1991

STATE	SERVICE	CO-PAY AMOUNT *	APPLICABLE TO **
Wisconsin (cont.)	Dental	Varies [13]	
	Prescription drugs	$0.50 [14]	
	Durable medical equipment	$1.00	
	Eyeglasses	Varies [15]	
	Hospital - inpatient, general	$3.00/day [16]	
	- inpatient, mental diseases	$3.00/day [16]	
	- outpatient	$3.00	
	- surgery	$3.00	
	Optometry	Varies [5]	
	Oral surgery	$1.00	
	Orthodonty	Varies [17]	
	Physician visits [18]		
	- consultations	$3.00	
	- diagnostic procedure in office	$1.00	
	- eye exams	$2.00	
	- home	$1.00	
	- lab procedure performed in office	$1.00	
	- radiology procedure in office	$2.00	
	- office	$1.00	
	- outpatient hospital	$1.00	
	Prosthetic devices - hearing aids	Varies [5]	
	Prosthodontic appliance	$3.00	
	Psychotherapy	Varies [15], [19]	
	Rural health clinics	$2.00	
	Speech/hearing/language	Varies [20]	
	Therapy, physical & occupational, per 15 minutes	$0.50 [21]	
	Transportation, ambulance/ non- emergency	$2.00/trip	
Wyoming	Prescription drugs	$1.00	

KEY:

CMHC = Community Mental Health Center

DME = Durable medical equipment.

ESRD = End stage rural disease.

* Unless otherwise specified, co-pay amounts are paid per service visit.

** This column refers to specific groups of people for whom states have opted to impose charges through provisions of law. Source: US Department of Health & Human Services: Health Care Financing Adminsitration Analysis of State Medicaid Program characteristics. 1986, Aug. 1937, p. 75-79.

*** For these services the state requires the copayment be paid per claim for all Medicaid beneficiaries who are also Medicare-eligible. All other Medicaid beneficiaries - the copayment is per visit.

1 Medicaid recipients are subject to a maximum of $120.00 in copayments per year.

2 Co-pay is 5% of reimbursement for these services.

3 $2.00 for per diem of $275 to $325; $3.00 for per diem over $325.

4 $4.50 per month limit on prescriptions.

5 $.50 to $3.00.

6 These co-pay policies are not applicable to individuals who enroll in the physician-sponsored plan.

7 Maximum copay charge of $66.00 per stay.

8 Maximum copay charge of $21.00 per stay

9 In Pennsylvania the copays for services range from $1.00 - $6.00 depending on the Medicaid fee for the services provided. If the Medicaid fee is:
$ 1.00 - $10.00 the copay is $1.00
$10.00 - $25.00 the copay is $2.00
$25.01 - $50.00 the copay is $4.00
$50.01 - more the copay is $6.00

10 For all other services Pennsylvania has established a copay based on the Medicaid fee for that service.
Medicaid fee of $ 1.00 - $10.00 copay is $0.50
Medicaid fee of $10.01 - $25.00 copay is $1.00
Medicaid fee of $25.01 - $50.00 copay is $2.00
Medicaid fee of $50.01 - or more copay is $3.00

11 Virginia's copayments are applicable to beneficiaries age 21+ and to pregnant women for non-pregnancy related service

12 $.50 on $10.00 or less; $1.00 on $10.01 and over.

13 $.50 to $1.00.

14 Copayment limited to $5.00 per month, per pharmacy.

15 $.50 to $2.00.

16 Maximum copay charge of $75 per stay.

17 $2.00 to $3.00.

18 A cap of $30 cumulative limit per calendar year per physician for all physician services (physician visits, surgery, lab & X-ray services, and diagnostic tests).

19 Copayment may be charged only on the first 15 visits or $500.00 per year.

20 $.50 per 15 minutes for some services; $1.00 per procedure for others

21 Copayment is limited to the first 30 hours or $1,500 of accumulated services, per beneficiary, per calendar year

Under Food and Drug Administration procedures, manufacturers may obtain changes in a drug's labeling after the drug is approved. These changes may include information about new uses of the drug or advantages that the drug has over other therapies. For this reason, the Committee expects that the formulary committee will periodically review its decisions to exclude drugs from its formulary to determine whether those drugs continue to have no significant therapeutic advantage over drugs listed on the formulary.

Sec. 5107. Elimination of the special exemption from prior authorization for new drugs

Under current law, States are prohibited from subjecting a covered outpatient drug to prior authorization during the first six months after a drug is approved by the Food and Drug Administration. The Committee bill eliminates this prohibition so that a State will be able to impose the prior authorization requirement at any time after a drug is approved.

Sec. 5108. Technical corrections relating to section 4401 of OBRA-1990

The Committee bill makes technical corrections to section 4401 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101–508, relating to reimbursement for prescribed drugs.

Part 3—Restrictions on divestiture of assets and estate recovery

Sec. 5111. Transfer of assets

Under current law, individuals residing in nursing facilities who dispose (or whose spouses dispose) of resources for less than fair market value during the 30-month period prior to application for Medicaid are subject to a delay in eligibility for nursing facility care (and home and community based services). If the individual is eligible for Medicaid at the time of institutionalization, the 30-month "look-back" period runs from the date of institutionalization. The period of ineligibility begins with the month in which the resources are transferred and lasts for the number of months equal to the lesser of (1) 30 or (2) the total uncompensated value of the resources transferred divided by the average cost to a private patient of nursing facility services in the State. This penalty does not apply in certain circumstances, including transfers to or from a spouse, to a disabled child, or to the extent that the State determines that denial of eligibility would work an undue hardship.

Under the Committee bill, individuals who, during the period 36 months prior to the first day of application for Medicaid benefits as an institutionalized individual, have transferred assets for less than fair market value will be subject to a denial of eligibility for Medicaid coverage for nursing facility (and home and community-based waiver services). The period during which benefits are denied will begin with the date on which the prohibited transfer occurred and will run for the number of months determined by dividing the total uncompensated value of the resources transferred by the average monthly cost, to a private patient, of nursing facility services in the State. The penalties for different transfers occurring within

the 36-month "look-back" period will run consecutively, not concurrently.

The Committee bill requires that individuals will not be ineligible for Medicaid coverage to the extent that the State agency determines, under procedures established by the State (in accordance with standards specified by the Secretary) that the denial of eligibility would work an undue hardship (in accordance with criteria established by the Secretary). Under the current law "undue hardship" provision, there is no Federal guidance on either the procedures a State should follow in making such determinations or the types of circumstances that should be regarded as working a hardship. States are simply required to include a definition of "undue hardship" in their State Medicaid plans. The Committee is concerned that some States may not be extending to all individuals facing hardship the protections of existing law. The Committee bill therefore amends current law to require the Secretary (1) to specify standards that State hardship determination procedures must meet, and (2) to establish criteria States must apply in determining whether a hardship exists.

The Committee expects the Secretary, in developing standards for the determination process, to address at least the following issues: notice to the institutionalized individuals that a hardship exception exists; adequate representation of the interests of such individuals; the timeliness of the determination process; protections for institutionalized individuals from transfer by a nursing facility while a determination is pending; and the ability to appeal an adverse determination.

The Committee expects the Secretary, in developing criteria for use by States in determining whether an "undue hardship" exists, will provide for special consideration of at least the following: cases in which the individual has no way to pay for the necessary care; cases in which the transfer was not knowingly authorized by the individual; and cases in which the individual assigns rights of recovery she or he may have in a cause of action against the transferee to the State or where the State has such rights pursuant to State law. In order to ensure that the standards and criteria are based on as much information as possible, the Committee expects the Secretary to develop them through a process that provides for notice and a period for public comment.

Under the Committee bill, an asset held by an individual in common with another person or persons in a joint tenancy or similar arrangement is considered to be transferred when any action is taken, by the individual or by any other person, that eliminates or reduces the individual's ownership or control of the asset.

Under the Committee bill, the following rules apply to assets placed in trust, without regard to the purposes of the trust, whether the trustees have (or exercise) any discretion, or any restrictions on distributions from the trust. With respect to revocable trusts, the corpus is considered a resource available to the individual; payments from the trust to or for the benefit of the individual are considered income to the individual; and any other payments from the trust are considered a transfer of assets by the individual.

With respect to irrevocable trusts which may benefit the grantor, the corpus of the trust is considered a resource available to the in-

dividual; payments from the trust to or for the benefit of the individual are considered income to the individual; and any other payments from the trust are considered a transfer of assets by the individual. Any portion of such an irrevocable trust from which no payment can under any circumstances be made to the individual shall be considered a transfer of assets by the individual as of the date of establishment of the trust.

With respect to irrevocable trusts which cannot benefit the grantor, the corpus shall be considered a transfer of assets by the individual as of the date of the establishment of the trust and payments from the trust after this date shall be disregarded.

Under the Committee bill, these rules do not apply to the following types of trusts: (1) trusts established for the benefit of a disabled individual by a parent, grandparent, or other representative payee (including a court or administrative body) of the individual; and (2) trusts composed only of pension, Social Security, and other income to the individual (plus accumulated income) under which the State receives any amounts remaining upon the death of the individual and which are established in States that limit nursing home eligibility to individuals with incomes below an amount set by the State no higher than 300 percent of the benefit rate under the Supplemental Security Income (SSI) program.

The Committee bill requires State Medicaid agencies to establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of these rules relating to "Medicaid qualifying trusts" with respect to an individual if the individual establishes (under criteria established by the Secretary) that the application of these rules would work an undue hardship on the individual.

Sec. 5112. Medicaid estate recoveries

Under current law, a State has the option of seeking recovery of amounts correctly paid on behalf of an individual under its Medicaid program from the individual's estate if the individual was 65 years or older at the time he or she received Medicaid benefits. The State may not seek recovery from the beneficiary's estate until the death of the surviving spouse, if any, and only if the individual has no surviving minor or disabled child.

Under the Committee bill, States are required to establish an estate recovery program that meets certain requirements. The program must identify and track resources (whether or not excluded for eligibility purposes) of individuals who receive nursing facility, home and community-based services, and other specified long-term care services. The program must promptly ascertain when the individual and the surviving spouse, if any, dies, and must provide for the collection of the amounts correctly paid by Medicaid on behalf of the individual for long-term care services from the estate of the individual or the surviving spouse. The term "estate" is defined as all real and personal property of a deceased individual and all other assets in which the individual had any legally cognizable title or interest at the time of his death, including assets conveyed to a survivor, heir, or assign through joint tenancy, survivorship, life estate, living trust, or other arrangement.

The Committee bill requires the State agency to establish procedures (in accordance with standards specified by the Secretary) under which the agency waives recovery if it would work an undue hardship (in accordance with criteria established by the Secretary). The Committee expects that, in developing standards for State recovery procedures, the Secretary will address adequacy of notice to, and representation of, affected parties; the timeliness of the process; and the availability of appeals and other issues. With respect to the establishment of criteria for use by States in determining whether to waive recovery, the Secretary should provide for special consideration of cases in which the estate subject to recovery is (1) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, or (2) a homestead of modest value or (3) other compelling circumstances. The Committee also expects the Secretary to provide guidance to States on how to address situations where recovery is not waived and beneficiaries of the estate from which recovery is sought wish to satisfy the State's recovery claim without selling a non-liquid asset subject to recovery.

Sec. 5113. Closing loophole permitting wealthy individuals to qualify for Medicaid

Under the Committee bill, Section 1902(r)(2) of the Social Security Act is amended to prohibit State plans from disregarding assets in cases where an individual has received or is eligible to receive payments under a long-term care policy. The provision does not apply to State plan provisions that are approved by the Secretary as of May 14, 1993. This provision prevents States from disregarding assets of individuals seeking Medicaid eligibility on the basis that individuals have purchased long-term care insurance policies. Certain states and the Secretary have interpreted section 1902(r)(2) as permitting such disregards.

Part 4—Improvement in identification and collection of third party payments

Sec. 5116. Liability of third parties to pay for care and services

Under current law, State Medicaid agencies are required to take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for covered services provided to Medicaid beneficiaries.

(a) Liability of ERISA plans.—The Committee bill includes group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plans, and health maintenance organizations among the third parties the legal liability of which States are required to ascertain with respect to services provided to Medicaid eligibles.

(b) Requiring States to prohibit insurers from taking Medicaid status into account.—The committee bill requires States to prohibit any health insurer, group health plan under ERISA, service benefit plan, or HMO from taking into account an individual's eligibility for Medicaid in enrolling the individual for coverage or making any payments for benefits to (or on behalf of) the individual.

(c) State right to subrogation.—The Committee bill provides that, in any case where a third party has a legal liability to make payment for services provided to a Medicaid beneficiary, a State is subrogated to the right of any other party to payment for such services to the extent that payment has been made by the Medicaid program.

Section 5117. Health coverage clearinghouse

The Committee bill directs the Secretary of Health and Human Services to establish and operate a Health Coverage Clearinghouse for the purpose of identifying indemnity insurers, service benefit plans, group health plans under ERISA, health maintenance organizations, and other third parties which may be liable for payment for services provided to Medicaid, Medicare, or Indian Health Service beneficiaries (or individuals receiving services funded under the Maternal and Child Health Block Grant). The bill directs State Medicaid agencies to request information from the Clearinghouse concerning the employment and group health coverage of a Medicaid beneficiary, the beneficiary's spouse, or, if the beneficiary is a dependent child, the beneficiary's parents. The bill sets forth procedures under which State Medicaid programs may obtain this information from the Clearinghouse as well as procedures for the maintenance of a data bank by the Clearinghouse. The bill also directs employers to provide information relating to coverage of individuals (and spouse and dependent children) under the employer's group health plan to the Clearinghouse and provides a civil monetary penalty for willful and repeated failure to comply.

Sec. 5118. Medical child support

Under current law, State Medicaid agencies must enter into cooperative arrangements with the State's Child Support Enforcement agency under Title IV–D of the Social Security Act with respect to the enforcement and collection of rights of payment for medical care by or through a parent. States must also require individuals, as a condition of Medicaid eligibility, to assign to the State any rights to support for the purpose of medical care by a court or administrative order.

The Committee bill requires States to have in effect the following laws relating to medical child support: (1) a law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, cannot be claimed as a dependent on the parent's Federal income tax return, or does not reside with the parent or in the insurer's service area; (2) a law that requires an insurer, in any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family coverage through the insurer, to permit the parent and/or child to enroll regardless of enrollment season restrictions; (3) a law that requires any employer doing business in the State that provides health coverage to a child pursuant to court or administrative order to withhold the employee's share of the premium (up to the maximum permitted by the Consumer Credit Protection Act); (4) a law that prohibits an insurer from imposing special requirements on a State agency acting as a subrogee or agent of a

Medicaid beneficiary; (5) a law that requires an insurer to facilitate payment for services to a child in cases where the child has health coverage through the noncustodial parent; and (6) a law that requires the State Medicaid agency to garnish wages, or withhold amounts from State tax refunds, to individuals who are subject to a medical child support order, have received payment from a third party of the costs of services to the child, and have not reimbursed the provider or the other parent or guardian.

For purposes of these laws, the term "insurer" includes an entity offering a service benefit plan, a health maintenance organization, and a group health plan under ERISA.

Part 5—Assuring proper payments to disproportionate share hospitals

Sec. 5121. Assuring proper payments to disproportionate share hospitals

Under current law, States are required to make adjustments to payments for inpatient services provided to Medicaid patients at hospitals serving disproportionate numbers of Medicaid and other low-income patients with special needs. States have broad authority to designate "disproportionate share" (DSH) hospitals. However, a hospital is deemed to be a DSH hospital, and is entitled to receive payment adjustments, if (1) its Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or (2) the hospital's low-income utilization rate exceeds 25 percent. There is no restriction on the amount of DSH payment adjustments any DSH facility can receive; however, the total amount of DSH payment adjustments in any State may not exceed the higher of (1) 12 percent of the total Medicaid expenditures in the State during the fiscal year or (2) the total amount of DSH payment adjustments made by the State during FY 1992.

The Committee is concerned by reports that some States are making DSH payment adjustments to hospitals that do not provide inpatient services to Medicaid beneficiaries. The purpose of the Medicaid DSH payment adjustment is to assist those facilities with high volumes of Medicaid patients in meeting the costs of providing care to the uninsured patients that they serve, since these facilities are unlikely to have large numbers of privately insured patients through which to offset their operating losses on the uninsured. It is difficult for the Committee to understand how the payment of a Medicaid DSH payment adjustment to a facility that has no Medicaid inpatients can be justified on statutory or policy grounds. The Committee bill therefore prohibits States from designating a hospital as a Medicaid disproportionate share hospital unless at least 1 percent of the facility's inpatient days are attributable to Medicaid patients.

The Committee is also concerned by reports that some States have made DSH payment adjustments to State psychiatric or university hospitals in amounts that exceed the net costs, and in some instances the total costs, of operating the facilities. According to such reports, once received by the State hospital, these excess Medicaid DSH payments are transferred to the State general fund,

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3100
State Capitol
Juneau, Alaska 99801-1182

MEMORANDUM

TO: Senator Steve Frank, Co-Chair
Senator Drue Pearce, Co-Chair
Senate Finance Committee

FROM: David Skidmore, Staff Aide

RE: Sectional Analysis of SB 366

DATE: 25 March, 1994

This document was prepared in response to your request for a sectional analysis of Senate Bill 366. In large part, the statutory changes proposed in this bill are required by the federal Omnibus Budget Reconciliation Act of 1993, and the Department of Health and Social Services would face a penalty if the necessary legislation is not adopted. Beyond this, SB 366 directs the Division of Medical Assistance to implement a copayment policy with regard to Alaska's Medicaid plan.

Section 1 of the Bill establishes the purposes of the Act. The purposes of the Act are to (1) bring the state into compliance with federal law with respect to the recovery of Medicaid payments from the estates and trusts of individuals under certain circumstances and with respect to the establishment of medical support orders for children; and (2) allow diversion of certain employee pension payments into Medicaid-qualifying trusts if the trusts provide that Medicaid payments made on behalf of the individual may be recovered from the trust after the individual's death. There is actually a third purpose of the bill in Section 19: to provide that the State Medicaid plan shall impose copayment requirements on eligible persons to the maximum extent allowed under federal law.

Section 2 of the Bill amends AS 14.25.200(a). This amendment provides that a teacher's or member's right to receive benefits from the Teachers' Retirement System of Alaska may be assigned to a trust or similar legal device that meets the requirements for a Medicaid-qualifying trust under AS 47.07.020(f) and 42 U.S.C. 1396p(d)(4).

Section 3 of the Bill amends AS 21.36 (TRADE PRACTICES AND FRAUDS) by adding a new section 095 (COVERAGE OF CHILDREN). This new section imposes certain requirements on providers of insurance, relating to

coverage of children of the insured who are not in the custody of the insured.

Section 4 of the Bill amends AS 25.27.020(a). This amendment establishes a duty on the Child Support Enforcement Agency to ensure that a medical support order meet the requirements of AS 25.27.063 (see Section 7) and to act on behalf of DH&SS in the enforcement of AS 47.07.025(b) (see Section 18).

Section 5 of the Bill amends AS 25.27.060(c). This amendment establishes a duty on the court to ensure that a medical support order meet the requirements of AS 25.27.063 (see Section 7).

Section 6 of the Bill amends AS 25.27.062(i). This amendment extends the duty of an employer to withhold current child support obligation from an obligor's wages, adding to this amount the obligor's share of any premium for health coverage required to be withheld under AS 25.27.063(c)(4) (see Section 7).

Section 7 of the Bill amends AS 25.27 (CHILD SUPPORT ENFORCEMENT AGENCY) by adding a new section 063 (MEDICAL SUPPORT ORDER). This section sets forth the requirements of a medical support order which requires that the obligor provide health care coverage for the child to whom the duty of support is owed.

Section 8 of the Bill amends AS 25.27.065(b). This amendment is necessary for the sake of conformity. Under current statute, an agreement between an obligor and a person who is entitled to receive support on behalf of an obligee to waive past or future child support is not effective when the obligee is receiving public assistance and the right to receive child support has been assigned to a governmental agency (unless such an agreement has been adopted as an administrative order of the agency). This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 9 of the Bill amends AS 25.27.120(a). This amendment is necessary for the sake of conformity. Under current statute, an obligor is liable to the state in the amount of public assistance granted to a child to whom the obligor owes a duty of support with the exception that if a support order has been entered, the liability of the obligor may not exceed the amount of support provided for in the support order. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 10 of the Bill amends AS 25.27.120(d). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency fails to notify the obligor of the liability accruing due to the obligee's receipt of public assistance, interest does not accrue on the liability to the state unless a support order has been entered. This

amendment extends this provision to include an obligee who is receiving medical assistance.

Section 11 of the Bill amends AS 25.27.130(b). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency is establishing or enforcing an order of support, the agency is not limited to the amount of public assistance being granted to the minor child. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 12 of the Bill amends AS 25.27.130(c). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency recovers any amount for which the obligor is liable that exceeds the total public assistance granted, the excess amount shall be granted to the obligee. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 13 of the Bill amends AS 25.27.130(d). This amendment is necessary for the sake of conformity. Under current statute, if the obligee is not receiving public assistance at the time the Child Support Enforcement Agency recovers money from the obligor for which the obligor is liable, the amount recovered shall be distributed to the obligee for support payments that have become due and unpaid since the termination of public assistance. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 14 of the Bill amends AS 25.27.130(e). This amendment is necessary for the sake of conformity. Under current statute, if the Child Support Enforcement Agency has recovered an amount for which the obligor is liable and the obligee is no longer receiving public assistance, the agency may not retain an amount in excess of the total unreimbursed public assistance. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 15 of the Bill amends AS 25.27.130(f). This amendment is necessary for the sake of conformity. Under current statute, if required by federal law, the state shall have first claim on any amount recovered through offset of the obligor's federal tax refund for unreimbursed public assistance received by the obligee. This amendment extends this provision to include an obligee who is receiving medical assistance.

Section 16 of the Bill amends AS 39.35 500. This amendment provides that a public employee's right to receive benefits from the Public Employee's Retirement System of Alaska may be assigned to a trust or similar legal device that meets the requirements for a Medicaid-qualifying trust under AS 47.07.020(f) and 42 U.S.C. 1396p(d)(4).

Section 17 of the Bill amends AS 47.07.020 (MEDICAID ELIGIBLE PERSONS) by adding new subsections (f) and (g). Subsection (f) provides

that a person may not be denied eligibility for Medicaid on the basis of a diversion of income into a Medicaid-qualifying trust. Subsection (g) provides that a person's eligibility for Medicaid may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person.

Section 18 of the Bill amends AS 47.07 (MEDICAL ASSISTANCE FOR NEEDY PERSONS) by adding a new section 025 (ASSIGNMENT OF MEDICAL SUPPORT RIGHTS). This new section provides that an applicant for or recipient of Medicaid is considered to have assigned to the state all rights to medical support that the applicant or recipient may have from all sources. In addition, this new section establishes the authority of DH&SS--through the CSEA or on its own behalf--to garnish the wages, salary, or other employment income of persons to whom this section applies. OBRA '93 requires that the Title XIX agency have the authority to pursue collection of medical support debt.

Section 19 of the Bill amends AS 47.07 by adding a new section 042 (RECIPIENT COST-SHARING). This new section provides: that the State Medicaid plan shall impose copayment requirements on eligible persons to the maximum extent allowed under federal law; that health care providers shall collect the allowable charge; that the department shall reduce payments to each provider by the amount of the allowable charge; that a provider may not deny services because a recipient is unable to share costs; and that an inability to share costs does not relieve the recipient of liability for the costs.

Section 20 of the Bill amends AS 47.07 by adding a new section 055 (RECOVERY OF MEDICAL ASSISTANCE FROM ESTATES). This new section provides that the estate of an individual who received Medicaid assistance is subject to a claim for recovery of the medical assistance after the individual's death, given the fulfillment of certain circumstances.

Section 21 of the Bill provides that the copayment charges imposed under Section 19 apply only to services performed on or after July 1, 1994.

Section 22 of the Bill provides that the effective date is July 1, 1994.

SB

367

SFIN
FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 4/25/94

FURTHER:

DATE TURNED INTO OFFICE: 4-28-94

The Finance Committee considered SENATE BILL NO. 367

Relating to health care and insurance; efd

and recommends:

[ ] replace with ____ CS SB 367 (FINANCE)

or [ ] adopt previous ____ CS ________ ( )

[ ] attaches amendment(s)

[ ] same title
[ ] new title
[ ] technical title change (HB only)

[ ] adopts ________ Letter of Intent

[ ] further referral to the ________

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

~~forthcoming FN~~
~~$ Rev (may be 0)~~
0 Corrections
$ Governor

NEW FISCAL NOTES

Department	Date	Zero	Fiscal
C&ED	4/29/94		$322.6
Gov	4/29/94		$622.7

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal

[ ] Appropriation No Fiscal Note

DO PASS:

Steve Rieger

Tim Kelly

OTHER RECOMMENDATIONS:

Bert Sharp NR

1. [signature] do pass
Co-Chair: Signature/Recommendation

2. [signature] NO REC
Co-Chair: Signature/Recommendation

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 367 (FIN)

Revision Date: 4/28/94
Title: Health Care Reform Committees
Sponsor: Senate HESS Committee
Requestor:

Department Affected: Commerce and Economic Development
BRU: Insurance
Component: Operations

COMPONENT SERIAL NO. 0354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	227.8	995.2	995.2	995.2		
TRAVEL	--	--	--	--		
CONTRACTUAL	42.4	212.0	212.0	212.0		
SUPPLIES	4.0	20.0	20.0	20.0		
EQUIPMENT	48.4	197.6	20.0	20.0		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	322.6	1,424.8	1,247.2	1,247.2		

CAPITAL EXPENDITURES	500.0	500.0	500.0	500.0		

CHANGE IN REVENUES ( )						

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	822.6	1,924.8	1,747.2	1,747.2		
1006 GF/MHTIA						
Other						
TOTAL	822.6	1,924.8	1,747.2	1,747.2		

Estimate of current year (FY 94) cost: $

POSITIONS

FULL-TIME	4.0	20.0	20.0	20.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

PLEASE SEE ATTACHED.

Prepared by: David J. Walsh, Director
Division: Insurance
Phone: 465-2515
Date: 4/29/94

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development
Date: 4/28/94

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Rev 11/93

		FY 95	FY 96	FY 97	FY 98
SB 367 Fiscal Note for the Dept of Commerce and Economic Development					
Division of Insurance					
Data Collection/Analysis and Claims:					
1	Chief R-22 @ $74.5	74.5	74.5	74.5	74.5
1	Analyst/Programmer IV R-19 @$61.9	61.9	61.9	61.9	61.9
1	Analyst/Programmer III R-17 @$54.5	54.5	54.5	54.5	54.5
1	Secretary R-10 @$36.9	36.9	36.9	36.9	36.9
1	Economist II R-20 @ $65.8		65.8	65.8	65.8
4	Statistical Tech I R-12 @ $41.0		164.0	164.0	164.0
3	Statistical Tech II R-14 @ $45.2		135.6	135.6	135.6
2	Statistical Clerk R-10 @ $36.9		73.8	73.8	73.8
3	Research Analyst II R-16 @ $51.2		153.6	153.6	153.6
3	Research Analyst III R-18 @ $58.2		174.6	174.6	174.6
20	Total:	227.8	995.2	995.2	995.2
	Contractual- $10.6 per position	42.4	212.0	212.0	212.0
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.3				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	4.0	20.0	20.0	20.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	48.4	197.6	20.0	20.0
	Capital Expenditure:				
	Contractual Claims Handling/Data Collection costs:	500.0	500.0	500.0	500.0
Subtotal of Costs for Data Collection:		822.6	1,924.8	1,747.2	1,747.2
Total Costs:		822.6	1924.8	1747.2	1747.2

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CS SB 367 (Fin)

Revision Date:
Title: An Act relating to review and approval of health insurance rates and rating factors; ...
Sponsor: Senate HESS
Requestor: Senate Finance

Dept. Affected: Office of the Governor
BRU: Commissions and Special Offices
Component: Health Care Plan/Public Health Advisory Committees
COMPONENT SERIAL NO.

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	300.0	417.0				
TRAVEL	82.0	84.3				
CONTRACTUAL	200.8	230.7				
SUPPLIES	5.2	7.0				
EQUIPMENT	84.7	1.0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	672.7	740.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

	FY95	FY96	FY97	FY98	FY99	FY00
1002 Federal Receipts						
1003 GF Match						
1004 GF	672.7	740.0				
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	672.7	740.0	0.0	0.0	0.0	0.0

POSITIONS:

	FY95	FY96	FY97	FY98	FY99	FY00
FULL-TIME	7	7				
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)
This version of the bill establishes two advisory committees, the HEALTH CARE PLAN ADVISORY COMMITTEE (Sec 14) and the PUBLIC HEALTH ADVISORY COMMITTEE (Sec 15). See attached pages for analysis.

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services
Phone: 465-3616
Date: 04/29/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor
Date: 04/29/94

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(Rev 10/93)94flsno.xls/CBR

Analysis: CSSB 367 (FIN) April 29, 1994

Fiscal note reflects costs related to the Health Care Plan Advisory and Public Health Advisory Committee to June 30, 1996, repeal date of the enabling legislation per Sec. XX of the bill. Fiscal note further assumes staff will serve both committees.

	FY95	FY96
Personal Services:	300.0	417.0

Personal Services costs reflect 9 months in FY95 and 12 months in FY96 with merit increases in FY96.

1 Executive Director (Rg 23)
2 Health Planners (Rg 19)
2 Research Analysts (Rg 18)
1 Administrative Assistant (Rg 12)
1 Clerk (Rg 10)

	FY95	FY96
Travel:	82.0	84.3

Health Care Plan Advisory Committee:
(7 members) assumes 4 meetings in FY95 and 5 meetings in FY96

	FY95	FY96
airfare/per diem	11,200	14,000

Public Health Advisory Committee:
(9 members) assumes 4 meetings in FY95 and 3 meetings in FY96

	FY95	FY96
airfare/per diem	18,9[illegible]0	14,200

Public Health Advisory subcommittee:
assumes 8 subcommittee meetings each fiscal year

	FY95	FY96
airfare/per diem	25,200	25,200

Staff travel:

meetings related travel and 3 out-of-state trips

	FY95	FY96
airfare/per diem	8,700	9,400

Travel - continued

Honorarium:

Health Care Plan Advisory Committee members receive $250/day honorarium

	FY95	FY96
assumes 2 day meetings	14,000	17,500
8 teleconferences	4,000	4,000

Contractual: 200.8 230.7

Professional Services:

	FY95	FY96
consulting actuary	10,000	10,000
legal services	70,000	70,000

Contractual costs per position:

	FY95	FY96
toll costs, postage fax, utilities, etc.	54,500	70,400

Communications:

	FY95	FY96
teleconferences	28,000	28,000

Advertising:

	FY95	FY96
public notice for meetings and public hearings	17,000	17,000

Lease Space:

	FY95	FY96
175 sf per position x $1.80 per sf cost	19,800	30,500
facility rental for meetings	1,500	4,800

Supplies:	5.2	7.0
Assumes $1.0 per position		
Equipment:	84.7	1.0
work stations, phones, computer equipment @ 12.1 per position		

Amendment to Senate Bill 367 (Finance)

4-28-94

SENATE FINANCE COMMITTEE
Amendment Number: 7
Bill Number: SB 367
Sponsor: ________ Date: 4/27/94
Logged In By: ________

Delete Sections 2, 5, and 7.

Add new sections as follows:

Kelly MOVED
Rieger opposed
ADOPTED
5-1
(Kerttula ABSENT)

Section 2: AS 21.51 is amended by adding a new section to read:

Sec. 21.52.350. PREMIUM RATES AND RATING FACTORS. A disability insurer

(1) shall file with the director rates or rating factors for disability insurance before the intended effective date of the rate or rating factor;

(2) may not use a rate or rating factor that has not been filed with the director: and

(3) may file a new rate or rating factor at any time.

Section 5: AS 21.86 is amended by adding a new section to read:

Sec.21.86.075. PREMIUM RATES AND CHARGES. A health maintenance organization

(1) shall file with the director rates, rating factors, premiums. fees for services, and enrollee fees, including a change to a rate, rating factor premium, or fee, used in providing health care services to enrollees of the health maintenance organization;

(2) may not use a rate, rating factor, premium, or fee that has not been filed with the director; and

(3) may file a new rate, rating factor, premium, or fee at any time.

Section 7: AS 21.87.190 is repealed and reenacted to read:

Sec. 21.87.190. RATES and CHARGES. A service corporation

(1) shall file with the director subscription rates, rating factors, fees, and payment charges, including a change to a rate, rating factor, fee, or payment charge, to be charged to or on account of the service cooperation's subscribers;

(2) may not use a rate, rating factor, fee or payment charge, that has not been filed with the director; and

(3) may file a new rate , rating factor, fee, or payment charge at any time.

AMENDMENT

OFFERED IN THE SENATE BY SENATOR RIEGER
TO: CSSB 367( )(Draft 8-LS1498\X)

4/28/94 MOVED Rieger
ADOPTED

Page 1, line 2, after "factors;"

delete "relating to certain civil actions against health care providers"

insert "prohibiting a civil action based on professional negligence against a health care provider by a person who on the date of the negligent act or omission is less than two years of age, unless the action is brought before the person's eighth birthday"

SENATE FINANCE COMMITTEE
Amendment Number: 3
Bill Number: SB 367
Sponsor: Rieger Date: 4/28/94
Logged In By: BM

AMENDMENT

OFFERED IN THE SENATE
TO: CSSB 367( )(Draft 8-LS1498\X)

ADOPTED

Page 3, lines 8 - 31
Delete

Page 3, line 8
Add:
Sec. 21.58.020. HEALTH CARE DATA SYSTEM. (a) The Department of Commerce and Economic Development shall develop and may, subject to appropriation, periodically update a health care data system. To the extent practicable, the date system base year shall be calendar year 1995 and the system may include

(1) health care expenditures, including capital expenditures associated with receiving health care;
(2) demographic data;
(3) clinical information in a format which does not identify individual patients, including diagnosis, type of provider, type of service, location and length of care, referral patterns, quality of care, and result of care;
(4) billing and payment data in a format which does not identify individual patients; and
(5) public health data, including vital statistics and health status.

(b) The commissioner may request health care data necessary to develop or update the data system required under (a) of this section from a health care provider or insurer. A health care provider or insurer who receives a request under this subsection may but is not required to comply with the request.

(c) Information and data obtained or produced by the director under this section, except as provided under (e) of this section, shall be kept confidential as a matter

Page 4, line 6
After "recipient"
Add "or provider"

SENATE FINANCE COMMITTEE
Amendment Number: 4
Bill Number: SB 367
Date: 4/28/94
Sponsor:
Logged In By:

8-LS1498\X
Ford
4/26/94

CS FOR SENATE BILL NO. 367( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): **SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to review and approval of health insurance rates and rating**
2 **factors; relating to certain civil actions against health care providers; relating to**
3 **coordination of insurance benefits and to determination and disclosure of fees paid**
4 **to an insured or health care provider; establishing an advisory committee on a**
5 **health care plan and an advisory committee on public health; and providing for**
6 **an effective date."**

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

8 * **Section 1.** AS 09.10 is amended by adding a new section to read:
9 Sec. 09.10.065. LIMITATION ON ACTIONS BY CERTAIN MINORS
10 AGAINST HEALTH CARE PROVIDERS. (a) Notwithstanding AS 09.10.140, an
11 action based on professional negligence may not be brought against a health care
12 provider by a person who is, on the date of the alleged negligent act or omission less
13 than two years of age, unless the action is brought before the person's eighth birthday.

1 (b) The limitation imposed under (a) of this section is tolled during any period
2 in which there exists
3 (1) fraud, including fraud or collusion by a parent, guardian, insurer,
4 or health care provider, resulting in the failure to bring an action on behalf of an
5 injured minor;
6 (2) intentional concealment; or
7 (3) the undiscovered presence of a foreign body, that has no therapeutic
8 or diagnostic purpose or effect, in the body of the injured person and the action is
9 based on the presence of the foreign body.
10 (c) In this section,
11 (1) "health care provider" has the meaning given in AS 21.58.400;
12 (2) "professional negligence" means a negligent act or omission by a
13 physician in rendering professional services;
14 (3) "professional services" means services provided by a health care
15 provider that are within the scope of services for which the health care provider is
16 licensed, and that are not prohibited under the health care provider's license or by a
17 hospital in which the health care provider practices.
18 * **Sec. 2.** AS 21.51 is amended by adding a new section to read:
19 Sec. 21.51.350. PREMIUM RATES AND RATING FACTORS. (a) A
20 disability insurer
21 (1) shall file with the director rates or rating factors for disability
22 insurance at least 90 days before the intended effective date of the rate or rating factor;
23 and
24 (2) may not use a rate or rating factor that has not been filed with the
25 director as required under this subsection.
26 (b) A rate or rating factor not disapproved by the director before the intended
27 effective date of the rate or rating factor is considered approved by the director.
28 * **Sec. 3.** AS 21 is amended by adding a new chapter to read:
29 CHAPTER 58. HEALTH CARE.
30 Sec. 21.58.010. REQUIRED AVAILABILITY OF PRICE LIST. A health care
31 provider shall prepare a list of the provider's prices that includes the dates during

which the prices will be applicable. The price list shall be made available either by posting the price list in a conspicuous location in the health care provider's office or by similarly posting a notice that the price list is available for review upon request. The contents of the price list required under this section must include the provider's 40 most commonly provided health care services or those health care services provided more than five times in a calendar year, whichever would result in a shorter price list of health care services.

Sec. 21.58.020. HEALTH CARE DATA SYSTEM. (a) The Department of Commerce and Economic Development shall develop and periodically update a health care data system. To the extent practicable, the data system base year shall be calendar year 1995 and the system may include

(1) health care expenditures, including capital expenditures associated with receiving health care;

(2) demographic data;

(3) clinical information, including patient [illegible] type of provider, type of service, location and length of care, referral patterns, quality of care, and [illegible] [illegible]

(4) billing and payment data; and

(5) public health data, including vital statistics and health status.

(b) The commissioner may, by regulation, require health care providers to submit claims data and additional information necessary to develop or update the data system required under (a) of this section.

(c) The commissioner may pursue waivers from applicable federal law or from federal agencies to the extent necessary to maximize the collection and analysis of health care data.

(d) Information and data obtained or produced by the director under this section are subject to the disclosure requirements and exceptions of AS 09.25.110 and 09.25.120 and the regulations adopted under those statutes. Information or data identifying a recipient of health care services is considered to be a medical and related public health record subject to the exception to public inspection under AS 09.25.120 and, except as provided under (e) of this section, shall be kept confidential as a matter

1 of law. A person who wrongfully discloses or who uses or permits the use of
2 confidential information or data in violation of this subsection is guilty of a class B
3 misdemeanor.
4 (e) Information or data regarding health care services
5 (1) may be disclosed in an aggregate form that does not identify an
6 individual recipient; and
7 (2) that identify an individual recipient may be disclosed to a health
8 care provider, if the individual recipient has agreed to release the information or data.
9 Sec. 21.58.030. UNIFORM DATA AND PROCEDURES FOR HEALTH
10 CLAIMS. (a) The director shall adopt by regulation uniform claims forms, uniform
11 standards, and uniform procedures for the processing of data relating to billing for and
12 payment of health care services provided to residents of the state. A health insurance
13 company shall comply with the uniform claims forms, standards, and procedures
14 established under this section.
15 (b) The director shall ensure that other regulations adopted by the director
16 under this title that apply to a health insurer are not in conflict or inconsistent with
17 regulations adopted under (a) of this section.
18 Sec. 21.58.040. APPROPRIATIONS. The legislature may appropriate a
19 portion of the proceeds of the tax on insurance premiums collected under
20 AS 21.09.210 to pay the administrative costs of this chapter.
21 Sec. 21.58.400. DEFINITIONS. In this chapter,
22 (1) "commissioner" means the commissioner of commerce and
23 economic development;
24 (2) "health care provider" means an acupuncturist licensed under
25 AS 08.06; an audiologist licensed under AS 08.11; a chiropractor licensed under
26 AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under
27 AS 08.36; a marital or family therapist licensed under AS 08.63; a direct-entry
28 midwife certified under AS 08.65; a nurse licensed under AS 08.68; a dispensing
29 optician licensed under AS 08.71; a naturopath licensed under AS 08.45; an
30 optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical
31 therapist or occupational therapist licensed under AS 08.84; or a physician's assistant

1 certified under AS 08.64; a physician licensed under AS 08.64; a podiatrist; a
2 psychologist and a psychological associate licensed under AS 08.86; a clinical social
3 worker licensed under AS 08.95; an emergency medical technician certified under
4 AS 18.08.082; a mobile intensive care paramedic trained as required under
5 AS 18.08.082; a health maintenance organization as defined in AS 21.86.900; a
6 hospital or medical service corporation as defined in AS 21.87.330; a hospital as
7 defined in AS 18.20.130, including a governmentally owned or operated hospital; and
8 an employee of a health care provider acting within the course and scope of
9 employment;
10 (3) "health care services" means preventive, diagnostic, medical,
11 surgical, reproductive, psychiatric, psychologic, rehabilitative, health maintenance,
12 dental, podiatric, optometric, optical, audiologic, nutritive, and chiropractic care;
13 prescription drugs, laboratory and radiologic services, medical supplies, durable
14 medical equipment and devices; personal assistance services; inpatient and outpatient
15 care; home health care; hospice care; and long-term or institutional care;
16 (4) "health insurance" means an individual or group contract or other
17 plan providing coverage of health care services that is issued by the corporation or by
18 a health insurance company, a hospital service corporation, a medical service
19 corporation, or a health maintenance organization; "health insurance" includes disability
20 insurance under AS 21.12.050;
21 (5) "health insurance company" means an insurer that is authorized to
22 transact health insurance.
23 * **Sec. 4.** AS 21.86.070(g) is amended to read:
24 (g) The director may require that additional relevant material considered
25 necessary by the director be submitted in order to determine the acceptability of a
26 filing made under [EITHER] (b) [OR (e)] of this section.
27 * **Sec. 5.** AS 21.86 is amended by adding a new section to read:
28 Sec. 21.86.075. PREMIUM RATES AND CHARGES. (a) A health
29 maintenance organization
30 (1) shall file with the director rates, rating factors, premiums, fees for
31 services, and enrollee fees, including a change to a rate, rating factor, premium, or fee,

1 used in providing health care services to enrollees of the health maintenance
2 organization; a filing required under this paragraph must be made at least 90 days
3 before the intended effective date of the filing; and
4 (2) may not use a rate, rating factor, premium, or fee that has not been
5 filed with the director as required under this subsection.
6 (b) A filing under this section not disapproved by the director before its
7 intended effective date is considered approved by the director.
8 * **Sec. 6.** AS 21.86.260(a) is amended to read:
9 (a) Except as provided in AS 21.56**, AS 21.89.100 - 21.89.120,** and in this
10 chapter, this title does not apply to a health maintenance organization that obtains a
11 certificate of authority under this chapter. This subsection does not apply to an insurer
12 licensed under AS 21.09 or a hospital or medical service corporation licensed under
13 AS 21.87 except with respect to its health maintenance organization activities
14 authorized by and regulated under this chapter.
15 * **Sec. 7.** AS 21.87.190 is repealed and reenacted to read:
16 Sec. 21.87.190. RATES AND CHARGES. (a) A service corporation
17 (1) shall file with the director subscription rates, rating factors, fees,
18 and payment charges, including a change to a rate, rating factor, fee, or payment
19 charge, to be charged to or on account of the service corporation's subscribers; a filing
20 required under this paragraph must be made at least 90 days before the intended
21 effective date of the filing; and
22 (2) may not use a rate, rating factor, fee, or payment charge that has
23 not been filed with the director as required under this subsection.
24 (b) A filing under this section not disapproved by the director before its
25 intended effective date is considered approved by the director.
26 * **Sec. 8.** AS 21.87.340 is amended to read:
27 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
28 provisions contained or referred to previously in this chapter, the following chapters
29 and provisions of this title also apply with respect to service corporations to the extent
30 applicable and not in conflict with the express provisions of this chapter and the
31 reasonable implications of the express provisions, and for the purposes of the

1 application the corporations shall be considered to be mutual "insurers":

2 (1) AS 21.03;

3 (2) AS 21.06;

4 (3) AS 21.09, except AS 21.09.090;

5 (4) AS 21.18.010;

6 (5) AS 21.18.030;

7 (6) AS 21.18.040;

8 (7) AS 21.18.120;

9 (8) AS 21.21.321;

10 (9) AS 21.36;

11 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385;

12 (11) AS 21.51.120;

13 (12) AS 21.53;

14 (13) AS 21.54.020;

15 (14) AS 21.56;

16 (15) AS 21.69.400;

17 (16) AS 21.69.520;

18 (17) AS 21.69.600, 21.69.620, and 21.69.630;

19 (18) AS 21.78;

20 (19) AS 21.89.040;

21 (20) AS 21.89.060 **and 21.89.100 - 21.89.120**;

22 (21) AS 21.90.

23 * **Sec. 9.** AS 21.89 is amended by adding new sections to read:

24 Sec. 21.89.100. REQUIRED PROVISIONS REGARDING COORDINATION

25 OF BENEFITS. (a) When an insured has coverage under two or more plans that

26 provide for coordination of benefits, the coverage from those plans must be

27 coordinated so that the insured receives the maximum allowable benefit from each

28 plan. The aggregate benefit should be more than that offered by any of the plans

29 individually, but the insured may not receive more than the total of the charges for the

30 health care services received.

31 (b) A plan that provides for coordination of benefits must contain a provision

1 that

2 (1) discloses that coordination of benefits applies when the insured has
3 health care coverage under more than one plan;

4 (2) states what benefits from the plan and other sources are recognized
5 under the coordinating provision and that indicates if one or more plan benefits are
6 exempt from the coordinating provision;

7 (3) states what health care expenses are allowable and what health care
8 expenses are excluded under the coordinating provision;

9 (4) states the claim period to be used in applying the coordinating
10 benefits provision; a claim period may not be less than 12 months, but may exclude
11 a period before coverage starts or after coverage ends;

12 (5) indicates the manner in which benefits are reduced by coordination;
13 a reduction in benefits is subject to the following order of benefit provisions:

14 (A) plan benefits applicable to an insured as an employee,
15 member, or subscriber, and also as a dependent, are first determined as benefits
16 applicable to the insured as employee, member, or subscriber;

17 (B) if a minor is eligible for benefits as a dependent of more
18 than one insured, the plan of the insured whose date of birth falls earlier in the
19 year is applied first, unless a different order of application is required by a
20 court;

21 (C) benefits not determined under this paragraph that are
22 applicable under more than one plan are determined under that plan applicable
23 to the insured for the longer period of time;

24 (D) when one of the plans is a medical plan and the other is a
25 dental plan, and a determination cannot be made under the provisions of (A) -
26 (C) of this paragraph, the medical plan shall be considered as the primary
27 coverage;

28 (E) if under the provisions of (A) - (D) of this paragraph the
29 plan is secondary to another source of benefits, the benefits of the plan may not
30 be reduced unless the sum of benefits payable for allowable expenses and the
31 benefits payable for allowable expenses under the other source exceed the

1 allowable expenses in a claim determination period;

2 (6) provides that the insurer has the right to receive and to release
3 information necessary to expedite a claim payment when coordinating benefits;

4 (7) allows the insurer to make a payment necessary to repay another
5 insurer for a payment that should have been made under the policy applicable to the
6 insured; and

7 (8) gives the insurer the right to recover excess payments from the
8 insured paid to another insurer providing benefits to the insured.

9 (c) In coordinating benefits from a plan that contractually reduces the fees for
10 services that participating health care providers accept as payment in full, the following
11 rules apply:

12 (1) when the reduced fee plan is the primary coverage and treatment
13 is provided by a participating health care provider, the reduced fee is that health care
14 provider's full fee; a secondary plan shall pay the lesser of its allowed benefit or the
15 difference between the primary plan's benefit and the reduced fee;

16 (2) when the reduced fee plan is the primary coverage and treatment
17 is provided by a nonparticipating health care provider, the reduced fee plan shall
18 provide its allowed amount for nonparticipating health care providers and the
19 secondary plan shall pay the lesser of

20 (A) its allowed benefit for the service;

21 (B) the difference between the primary plan's benefits for the
22 service and the health care provider's full fee;

23 (3) when a full fee plan is the primary coverage and a reduced fee plan
24 is secondary coverage, the full fee plan shall provide its allowed amount for the
25 service and the secondary plan shall pay the lesser of its allowed benefit for the service
26 or the difference between the primary plan's benefits and the health care provider's full
27 fee.

28 (d) In coordinating benefits between an indemnity and a capitation plan, the
29 following rules apply:

30 (1) when the capitation plan is the primary coverage, the capitation
31 payments to the treating health care provider remain the capitation plan's usual

1 benefits; the indemnity plan shall pay benefits for the patient's surcharges or
2 copayments up to the indemnity plan's allowable benefit;
3 (2) when the indemnity plan is the primary coverage and treatment is
4 received from a health care provider who is participating in a capitation plan, the
5 indemnity plan shall pay its allowable benefits; the capitation payments to the health
6 care provider are secondary coverage;
7 (3) when the indemnity plan or policy is the primary coverage, and
8 treatment is received from a health care provider who is not participating in a
9 capitation plan , the indemnity plan shall pay its allowable benefits; the capitation plan
10 shall pay benefits, in keeping with the capitation plan's allowed amount for treatment
11 by nonparticipating health care providers;
12 (4) a plan may not contractually direct a health care provider to charge
13 a secondary insurer for more than the amount that would be charged to the insured
14 absent secondary coverage.
15 (e) A certificate indicating insurance coverage must contain a summary of the
16 provisions in this section regarding coordination of benefits.
17 Sec. 21.89.110. DETERMINATION AND DISCLOSURE OF USUAL,
18 CUSTOMARY, AND REASONABLE FEES. An insurer who pays a claim under a
19 disability policy or an indemnity under a group or blanket disability insurance policy,
20 a health maintenance organization that adopts a schedule of charges, or a hospital or
21 medical service corporation that pays a subscriber or compensates a health care
22 provider on the basis of a usual, customary, or reasonable fee or charge shall
23 (1) maintain and use a statistically credible profile of fees of health care
24 providers in this state on which to base payment of the claim; the profile must (A) be
25 updated at least once every six months and may not contain fees for services
26 performed more than one year before the date of the most recent profile; (B) contain
27 fees for the geographic area in which a claimant might receive treatment; and (C) may
28 not include fees clearly marked "DO NOT PROFILE"; if statistically credible data for
29 a particular health care service in a certain geographic area does not exist, the insurer
30 may include in the profile a sufficient number of fees for that service from another
31 geographic area in order to establish a reliable data base; however, the final basis for

1 payment must be adjusted to reflect the general cost difference between the geographic
2 area where the service was performed and the other geographic area used in
3 establishing the statistically credible profile; the adjustment may be based upon the
4 Consumer Price Index, the medical care component of the Consumer Price Index, or
5 a reasonable basis stated in writing and determined acceptable by the director;
6 (2) respond within 15 working days after receiving a written request
7 from an insured, a health care provider with a valid assignment of payments, or a
8 health care provider engaged to provide services under a professional services contract,
9 with a full written disclosure of the methods employed under (1) of this section that
10 resulted in the difference between the amount paid on a claim for benefits and the
11 actual charges submitted; and
12 (3) disclose in a proposal for insurance, a policy of insurance, a
13 certificate of insurance, an employee benefit description or supplemental document, or
14 a professional service contract between an insurer and a health care provider
15 (A) the frequency with which the insurer determines the usual,
16 customary, and reasonable fee;
17 (B) a general description of the methodology used to determine
18 the usual, customary, and reasonable fee;
19 (C) the percentile of usual, customary, and reasonable fees at
20 which the insurer will reimburse the insured, or the contract health care
21 provider.
22 Sec. 21.89.120. DEFINITIONS FOR AS 21.89.100 - 21.89.120. In
23 AS 21.89.100 - 21.89.120,
24 (1) "health care provider" has the meaning given in AS 21.58.400;
25 (2) "health care service" has the meaning given in AS 21.87.330;
26 (3) "plan" means a group or blanket disability policy issued under
27 AS 21.54, small employer coverage issued under AS 21.56, evidence of coverage
28 issued under AS 21.86, or a subscriber contract issued under AS 21.87;
29 (4) "professional services contract" includes a contract for professional
30 services between a health care provider and insurer or health maintenance corporation,
31 and a service contract between a health care provider and a hospital or medical service

1 corporation;

2 (5) "service corporation" has the meaning given in AS 21.87.330.

3 * **Sec. 10.** Section 7, ch. 39, SLA 1993, is amended to read:

4 Sec. 7. AS 21.86.260(a) is repealed and reenacted to read:

5 (a) Except as provided in **<u>AS 21.89.100 - 21.89.120 and</u>** this chapter, this title
6 does not apply to a health maintenance organization that obtains a certificate of
7 authority under this chapter. This subsection does not apply to an insurer licensed
8 under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87
9 except with respect to its health maintenance organization activities authorized by and
10 regulated under this chapter.

11 * **Sec. 11.** Section 9, ch. 39, SLA 1993, is amended to read:

12 Sec. 9. AS 21.87.340 is repealed and reenacted to read:

13 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the
14 provisions contained or referred to previously in this chapter, the following chapters
15 and provisions of this title also apply with respect to service corporations to the extent
16 applicable and not in conflict with the express provisions of this chapter and the
17 reasonable implications of the express provisions, and for the purposes of the
18 application the corporations shall be considered to be mutual "insurers":

19 (1) AS 21.03

20 (2) AS 21.06

21 (3) AS 21.09, except AS 21.09.090

22 (4) AS 21.18.010

23 (5) AS 21.18.030

24 (6) AS 21.18.040

25 (7) AS 21.18.120

26 (8) AS 21.21.321

27 (9) AS 21.36

28 (10) AS 21.42.345 - 21.42.365, 21.42.375, 21.42.380, and 21.42.385

29 (11) AS 21.51.120

30 (12) AS 21.53

31 (13) AS 21.54.020

1 (14) AS 21.69.400
2 (15) AS 21.69.520
3 (16) AS 21.69.600, 21.69.620, and 21.69.630
4 (17) AS 21.78
5 (18) AS 21.89.040
6 (19) AS 21.89.060 **and 21.89.100 - 21.89.120**
7 (20) AS 21.90.

8 * **Sec. 12.** AS 21.86.070(e) and 21.86.070(f) are repealed.

9 * **Sec. 13.** APPLICABILITY. Sections 6, 8, and 9 of this Act apply to a policy of
10 insurance, evidence of coverage under AS 21.86, or a service agreement or subscriber's
11 contract under AS 21.87, issued or renewed on or after the effective date of this Act.

12 * **Sec. 14.** HEALTH CARE PLAN ADVISORY COMMITTEE. (a) The legislature finds
13 that it is necessary to have reliable information on the specific content and cost of any
14 proposed mandatory health care plan, before it can be taken to the public for review. The
15 legislature further finds that questions of a single payer system versus a muiti payer system
16 for any mandatory coverage, and questions regarding inclusion or exclusion of certain groups
17 of Alaskans who are covered by other federal health insurance, are not prejudiced by the
18 direction given to the advisory committee created in this section.

19 (b) The Health Care Plan Advisory Committee is established in the Office of the
20 Governor. The committee consists of seven members who are appointed by the governor as
21 follows:

22 (1) one person with experience in providing health care services on an inpatient
23 basis;

24 (2) one person with experience in providing health care services on an
25 outpatient basis;

26 (3) one person with experience as a health care provider;

27 (4) one person who has experience in health care insurance; and

28 (5) three persons who represent the public.

29 (c) Notwithstanding any other provision of law, a committee member is subject to the
30 provisions of AS 39.50 as if the committee member were a member of a state commission or
31 board described under AS 39.50.200(b).

1 (d) A committee member is entitled to receive compensation at the rate of $250 a day
2 for each day spent in performing duties as a committee member and to travel and per diem
3 expenses authorized by law for boards and commissions under AS 39.20.180.
4 (e) The committee may
5 (1) establish subcommittees;
6 (2) conduct hearings;
7 (3) employ personnel necessary to complete assigned duties;
8 (4) enter into contracts;
9 (5) subject to appropriation, expend money.
10 (f) By December 15, 1994, the committee shall report to the legislature on the scope
11 of the health care insurance coverage and the cost of providing health care insurance if health
12 care insurance were to be offered under the following conditions:
13 (1) participation is mandatory by all state residents; coverage shall include a
14 spouse and dependent children;
15 (2) health care services that are covered must include preventive care and
16 immunizations, prenatal care, children's health care, and catastrophic medical expense
17 coverage;
18 (3) coverage shall be designed to impose a family deductible of $3,000 for all
19 covered health care services other than prenatal care, preventive care, and immunizations, and
20 to allow reimbursement in a calendar year at not more than 80 percent for all covered health
21 care services, other than prenatal care, preventive care, and immunizations, after the first
22 $3,000 in covered expenses; prenatal care, preventive care, and immunizations may be
23 reimbursed at more than 80 percent for a covered expense; coverage for health care services
24 that are offered on an outpatient basis shall provide reimbursement for outpatient health care
25 services at a rate equal to or higher than the rate for inpatient services;
26 (4) premiums shall be set at a single rate for all covered individuals, except
27 (A) a surcharge for coverage of each dependent child or spouse may
28 be imposed; a surcharge may not exceed 50 percent of the individual premium; it is
29 the intent of the legislature that the premium be set at a rate that does not exceed $100
30 per month or 14 percent of the individual's monthly gross income, whichever is lower;
31 (B) premium rates are allowed to vary depending on whether the

1 individual smokes or any other factors within the control of an individual, and
2 depending on whether the individual is less than 30 years of age; a premium may not
3 vary under a community rating system, other than as specified in this section;
4 (5) a one-year exclusion for preexisting conditions for new enrollees is
5 imposed; this paragraph does not apply to a person who has resided in the state for at least
6 one year, or who is less than one year old and was born in this state.
7 (g) By December 15, 1995, the committee shall report to the legislature on
8 (1) the cost of providing health insurance coverage under the following
9 conditions:
10 (A) coverage shall meet the conditions set out under (f)(1) - (5) of this
11 section;
12 (B) additional medical benefits are included as recommended by the
13 committee;
14 (C) it is the intent of the legislature that the premium be set at a rate
15 that does not exceed $150 per month or 14 percent of the individual's monthly gross
16 income, whichever is lower;
17 (2) the effect of the following conditions assuming that insurance coverage as
18 specified under (f) of this section is provided:
19 (A) premium payment is by payroll deduction, employer contribution,
20 or a combination of employer contribution and payroll deduction;
21 (B) premium payment by an unemployed or self-employed person is
22 by direct payment;
23 (3) assuming that the state requires all residents to participate in a state health
24 insurance plan, changes necessary in existing provisions of law to
25 (A) allow integration of optional health insurance plans with the
26 mandatory insurance plan; the integration should allow an individual or group to
27 purchase supplemental insurance coverage without duplication of coverage; and
28 (B) discourage health insurance that reimburses covered benefits at a
29 rate greater than 80 percent of the cost of the benefits;
30 (4) recommended legislation regarding public health issues;
31 (5) recommended legislation to simplify health care administration;

1 (6) recommended legislation regarding antitrust changes necessary to allow the
2 use of pooled purchasing to reduce the cost of health care if required under federal law;
3 (7) recommended legislation to enact tort reform measures intended to reduce
4 the cost of health care, including changes to statutes of limitation, contingent fee agreements,
5 and to the Alaska Rules of Civil Procedure;
6 (8) recommended legislation regarding long-term health care, including
7 methods to encourage individual savings for the cost of long-term health care;
8 (9) recommended legislation regarding how the state should educate residents
9 on health care, including how to be a prudent consumer, increasing awareness of provider
10 charges, and a curriculum that should be used in public schools in the state.
11 (h) By December 15, 1995, the committee shall recommend to the legislature
12 legislation necessary to improve data collection used to control health care expenditures or to
13 improve the efficiency of the health care system in the state.
14 (i) In this section, "health care provider" has the meaning given in AS 21.58.400.
15 * **Sec. 15.** PUBLIC HEALTH ADVISORY COMMITTEE. (a) The Public Health
16 Advisory Committee is established in the Office of the Governor. The committee consists of
17 nine members with significant public health expertise who are appointed by the governor. The
18 governor shall consider public and private health care professionals, labor organizations,
19 businesses, the education system, the Alaska Public Health Association, the Alaska Mental
20 Health Board, and the Alaska Native Health Board for service on the Public Health Advisory
21 Committee, as well as recognizing the need for geographic, ethnic, and cultural diversity.
22 (b) A committee member is entitled to travel and per diem expenses authorized by law
23 for boards and commissions under AS 39.20.180.
24 (c) The committee may
25 (1) establish subcommittees;
26 (2) conduct hearings;
27 (3) employ personnel necessary to complete assigned duties;
28 (4) enter into contracts;
29 (5) subject to appropriation, expend money.
30 (d) The committee shall
31 (1) advise the commissioner of health and social services, the commissioner

1 of administration, and the commissioner of commerce and economic development on public
2 health matters;
3 (2) develop a public health improvement plan as described under (e) of this
4 section.
5 (e) The plan developed by the committee may
6 (1) recognize the need for
7 (A) community involvement in health care planning and delivery;
8 (B) attention to local needs that may vary from place to place;
9 (C) accountability for the use of public funds;
10 (D) equity and stability in the distribution of public funds;
11 (E) shared responsibility of all levels of government for administering
12 and financing public health care delivery; and
13 (F) coordination of basic public health services; and
14 (2) include
15 (A) an analysis of the health status of the residents of the state;
16 (B) an assessment of the most appropriate role for various levels of
17 government to play in addressing the health care needs of the residents of the state;
18 (C) a delineation of the standards that should be used in assessment,
19 policy development, and quality assurance in the delivery of public health services;
20 (D) documentation of the extent to which the current public health
21 system implements or achieves the standards identified under (C) of this paragraph;
22 (E) identification of interjurisdictional issues involved in health care
23 access and delivery;
24 (F) recommendations, including recommendations for specific
25 legislative action when necessary, pertaining to the following:
26 (i) strategies, time lines, financial needs, and specific sources
27 of stable revenue for bringing the state public health care system up to
28 standards identified by the committee;
29 (ii) appropriate sharing of the responsibility of local, regional,
30 state, and federal government entities to deliver public health care services
31 efficiently and effectively, including recommendations for organization within

1 state government;

2 (iii) integration of the public health care system with state and

3 national health care reform efforts;

4 (iv) the committee's estimate of the optimal share that public

5 health should represent in the total health care delivery system of the state,

6 expressed in terms of a percentage of health care dollars spent or in terms of

7 public dollars per state resident;

8 (v) a program designed to give incentives to a primary health

9 care provider to practice in the state, especially in rural and underserved areas

10 of the state.

11 (f) In this section, "health care provider" has the meaning given in AS 21.58.400.

12 *** Sec. 16.** Sections 14 and 15 of this Act are repealed June 30, 1996.

13 *** Sec. 17.** This Act takes effect July 1, 1994.

Kelly MOVED

4/28/94 w/d

#1

Amendment to SB 367 (Finance)

Conceptual adopt House version 'use file & use system'

Delete Sections 2, 5, and 7.

Add new Sub-Section G(10), Page 16, Line 11:

(10) recommended legislation regarding health insurance rate regulation and regulation of medical and dental service costs.

SENATE FINANCE COMMITTEE
Amendment Number: 1
Bill Number: SB 367 Date: 4/27/94
Sponsor:
Logged In By: BR

HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

State:	Citation:	Filing Requirement:	Applies to:
Alabama	No provision		
Alaska	No provision		
Arizona	Reg.4-14-607	File and use	Individual health
Arkansas	§23-79-109	Prior approval (30 day deemer provision	Individual health
California	§10290 tit.10 Reg.2213	File and use (30 days)	Individual health
Colorado	§10-16-107	File and use (30 days)	All health
Connecticut	§38a-481	File and use (30 days)	All health
Delaware	tit.18§§3333, 2504	File and use (90 days)	All health including Med Supp and BC/BS
District of Columbia	§35-517	File and use (30 days)	All health
Florida	Reg.4-58	File and use	All health
Georgia	§33-20-20	Prior approval	All health
Hawaii	No provision		
Idaho	§41-2136	File and use	Individual health
Illinois	I.C. §355	File and use	All health
Indiana	§27-8-5-1	File and use	All health
Iowa	Reg.191-36.9	File and use	All health including Med Supp
Kansas	§40-2215	File and use (30 days)	Individual health
Kentucky	§§304.17-380 to 304.17-383	Prior approval	Individual policies unless contain loss ratio guarantee
Louisiana	R.S.22:211	File and use	All health
Maine	24-A§2736	File and use (60 days)	Individual health Med Supp, LTC

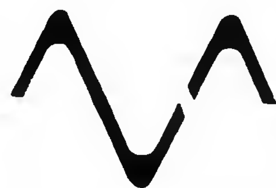
Maryland	Reg.9:30:44.02	File and use (90 days)	All health
Massachusetts	Ch.175§108	File and use (30 days)	All health
Michigan	§500.3474	File and use	Individual health
Minnesota	§62A.02	File and use (60 days)	All policies
Mississippi	Reg.LA&H 73-4	File and use	All health
Missouri	No provision		
Montana	No provision		
Nebraska	§44-710	File and use	All health
Nevada	§689A.360	File and use	Individual health
New Hampshire	§415:1	File and use (30 days)	All health
New Jersey	Reg.11:4-18.1	File and use	Individual health
New Mexico	§59A-18-13	Prior approval	All health
New York	§3216	File and use	Individual health
North Carolina	§58-51-95 §50-51-85	File and use (90 days) File and use	All health Group health
North Dakota	§26.1-30-19	Prior approval (60 day deemer)	All health
Ohio	§3923.021	File and use (30 days)	All health
Oklahoma	tit.36§4402	File and use	Individual health
Oregon	No provision		
Pennsylvania	§40-39-101	Prior approval	All health
Rhode Island	Reg.XXIII,Part XI	prior approval	All health
South Carolina	§38-71-310	Prior approval (90 day deemer)	Individual health
South Dakota	No provision		
Tennessee	§56-26-102	Prior approval (30 day deemer)	All health except experience rated groups
Texas	Art.3.42	File and use	Individual health

Utah	Reg.R540-85	File and use	Individual health
Vermont	Title 8 §4062	File and use (30 days)	All health
Virginia	§38.2-316	File and use	All health
Washington	No provision		
West Virginia	§33-16B-1	Prior approval (60 day deemer)	All health
Wisconsin	§625.13	Use and file (30 days)	Individual health
Wyoming	§26-18-136	File and use	Individual health

Information supplied by NAIC Chart 7/92

Public Policy Survey
Individual Medical Insurance Market

AN INDUSTRY STUDY



Milliman & Robertson, Inc.
Actuaries and Consultants

- For the period of 1987 through 1989, the individual medical insurance market experienced a net loss in that 1.5 times as many companies left the market as entered it.

Within the segments of the market, departures from the individual marketplace were most severe, with 2.1 times as many companies leaving as entering. While some of the individual marketplace departures represented a move to another product form, such as one-life group, the market has suffered a net loss in the number of companies.

The most frequent reasons given for a company ceasing to issue individual major medical policies were lack of profitability and mandated benefit regulation.

- Rate regulation and the difficulty experienced by companies in getting rate approval appears to affect the market situation state by state. Observations include:

  - Rate regulation and timeliness of rate increase approvals were the most frequent comments by Survey respondents about difficulties with state regulation. States with the authority to regulate rates had more company comments in total and per company than those that lacked such authority;

  - States with the authority to regulate rates had relatively low growth in insureds and high growth in uninsureds;

  - Of the six most competitive states, none have authority to regulate rates; of the six least competitive states, four have such authority. Of the 25 most competitive states, 17 do not have the authority to regulate premium rate levels, while of the 26 least competitive states, 13 do have such authority and two additional states review rate filings as though they have such authority.

  - Two-thirds of the states with the authority to regulate rates have fewer than 10 companies issuing 500 or more policies per year, compared to two-thirds of the

Differences between CSSB 367(HES) and proposed CSSB 367(FIN)

Deletions in CSSB 367(HES)

All sections that violated the single subject rule which were identified by Legal Services were deleted. These include the crime of driving while intoxicated (secs. 15, 16, 17, and 18), increasing taxes on cigarettes (sec. 19), and the rate of interest on judgments or decrees (sec. 4).

All sections referring to arbitration (secs. 1, 2, 5, 27).

Changes to the expert advisory panel (sec. 6, 25, 28, 29, 30).

Deletion of the medical practice advisory committee (sec. 24).

Additions in proposed CSSB 367(FIN)

Sets up the Public Health Advisory Committee in the Office of the Governor (sec. 15).

Changes in proposed CSSB 367(FIN)

Composition of the Health Care Plan Advisory Committee. It still consists of seven members but has three persons who represent the public instead of two. (sec. 14)

Compensation of the members of the Health Care Plan Advisory Committee was dropped from $400 to $250 a day. (sec. 14)

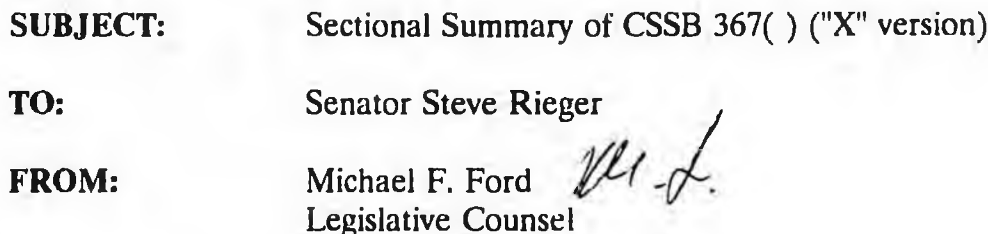
DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM April 28, 1994



SUBJECT: Sectional Summary of CSSB 367( ) ("X" version)

TO: Senator Steve Rieger

FROM: Michael F. Ford
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Requires that civil action brought against a health care provider by a person who is on the date of the injury less than two years of age, must be brought by the person's eight birthday. Provides certain exceptions for this rule.

Section 2. Requires that a disability insurer must file rates and rating factors with the division of insurance at least 90 days before the intended effective date. Rates or rating factors not disapproved by the director of the division of insurance before the intended effective date are considered approved by the director.

Section 3.
Sec. 21.58.010. Requires that a health care provider prepare and make available to the public a price list of the 40 most commonly provided health care services.

Sec. 21.58.020. Requires development of a health care data system. Provides that the base year shall be calendar year 1995 and specifies that certain information may be included. Authorizes the commissioner of Commerce and Economic Development to adopt regulations to require health care providers to submit certain data and to pursue waivers from applicable federal law. Provides that information that identifies a recipient of health care services is confidential and an exception to the public inspection requirements of AS 09.25.120, except as provided under (e) of this section.

Sec. 21.58.030. Requires the director of the division of insurance to adopt by regulation uniform claims forms, uniform standards, and uniform procedures for processing health care billing data.

Sec. 21.58.040. Allows the legislature to appropriate the proceeds of the tax on insurance premiums to pay administrative costs of AS 21.58.

Sec. 21.58.400. Definitions.

Section 4. Technical amendment.

Section 5. Requires that a health maintenance organization file rates and rating factors with the division of insurance at least 90 days before the intended effective date. Rates or rating factors not disapproved by the director of the division of insurance before the intended effective date are considered approved by the director.

Section 6. Technical amendment.

Section 7. Requires that a hospital or medical service corporation file subscription rates and rating factors with the division of insurance at least 90 days before the intended effective date. Rates or rating factors not disapproved by the director of the division of insurance before the intended effective date are considered approved by the director.

Section 8. Technical amendment.

Section 9.
Sec. 21.89.100. Imposes requirements on coordination of benefits when an insured has coverage under two or more insurance plans.

Sec. 21.89.110. Requires certain insurers to maintain certain information on fees charged by health care providers and to disclose certain information related to the determination of the usual, customary and reasonable fees charged for health care services.

Section 10. Technical amendment.

Section 11. Technical amendment.

Section 12. Technical amendment.

Section 13. Applicability clause.

<u>**Section 14.**</u> Establishes a health care advisory committee in the office of the governor. Provides for membership, duties and powers of the committee.

<u>**Section 15.**</u> Establishes a public health advisory committee in the officer of the governor. Provides for membership, duties and powers of the committee.

<u>**Section 16.**</u> Repealer.

<u>**Section 17.**</u> Effective date.

MFF:lmb
94-131.lmb

SB 36

To all Physicians — PLEASE READ THIS!!! If you live on the Hillside, PLEASE fax a short letter to Sen. Rieger at (fax) 465-2069 that you do NOT support the Alaska Health Care Data System. Thanks! 4/22/94
It needs to go out Monday!!

Alaska Health Care Data System

Background

Health care bills have been flying all over Juneau this session, but there is an extremely dangerous one that has surfaced that should be of importance to all Alaska physicians. Embedded in Sen. Rieger's bill no. 367 (4/8/94) is a provision to create a monster State Computer Data System to track ALL patient information by health care providers.

This computer system would require physicians to fill out paper work to track not only "health care expenditures and demographic information", but clinical information including "patient diagnosis, type of provider, type of services, location and length of care, reference patterns, and result of care." (21.58.020)

This raises serious questions of invasion of privacy and misuse. Do Alaskans really want all their medical information and diagnoses in some huge state computer bank where it would be rife for misuse?

Furthermore, "information ... is considered to be ... a public health record subject to public inspection under AS 09.25.120." While the politicians claim this will be used only for health care financing decisions, it is but a short step to complete inspection of medical practice and private issues by bureaucrats.

More worrisome is the language that "The Commissioner may pursue waivers from applicable federal (privacy) law to the extent necessary to maximize this collection and analysis of health care data." (21.58.020(c))

The Department of Commerce has charge of this enormous system, and has placed an estimated fiscal price tag of $72. million, so far unfunded.

Importance

Senator Rieger's bill went to the Senate Judiciary committee this week, where Senator Robin Taylor promptly removed the Health Care Data System. Unfortunately, it is being returned to the Senate Finance Committee on ~~4/[illegible]/94~~ 4/28/94, where at the request of Sen. Rieger and Sen. Jim Duncan it is likely to be re-inserted.

It is interesting that in these days of short budgets, the politics are to begin the path to complete regulation of private health care with an exteremely expensive computer system that we neither want nor need.

Please FAX your senator that you oppose the creation of the Alaska State Health Care Data System.

The senators who will be making the decision in the Senate Finance Committee are:

Sen. Bert Sharp	FAX 465-2070
Sen. Steve Frank	FAX 465-4714
Sen. George Jacko	FAX 465-2997
Sen. Drue Pearce	FAX 465-3872
Sen. Tim Kelly	FAX 465-3756

18 Sec. 21.58.020. HEALTH CARE DATA SYSTEM. (a) The Department of
19 Commerce and Economic Development shall develop and periodically update a health
20 care data system. To the extent practicable, the data system base year shall be
21 calendar year 1995 and the system may include
22 (1) health care expenditures, including capital expenditures associated
23 with receiving health care;
24 (2) demographic data;
25 (3) clinical information, including patient diagnosis, type of provider,
26 type of service, location and length of care, referral patterns, quality of care, and result
27 of care;
28 (4) billing and payment data; and
29 (5) public health data, including vital statistics and health status.
30 (b) The commissioner may, by regulation, require health care providers to
31 submit claims data and additional information necessary to develop or update the data

1 system required under (a) of this section.
2 (c) The commissioner may pursue waivers from applicable federal law or from
3 federal agencies to the extent necessary to maximize the collection and analysis of
4 health care data.
5 (d) Information and data obtained or produced by the director under this
6 section are subject to the disclosure requirements and exceptions of AS 09.25.110 and
7 09.25.120 and the regulations adopted under those statutes. Information or data
8 identifying a recipient of health care services is considered to be a medical and related
9 public health record subject to the exception to public inspection under AS 09.25.120
10 and, except as provided under (c) of this section, shall be kept confidential as a matter
11 of law. A person who wrongfully discloses or who uses or permits the use of
12 confidential information or data in violation of this subsection is guilty of a class B
13 misdemeanor.

NORTHWEST MEDICAL
PROFESSIONAL CORPORATION
2841 DeBarr Road, Suite 22 • Anchorage, Alaska 99508
Phone: (907) 276-6301

Vernon A. Cates, M.D.
General Practice
John W. Gerster, M.D.
Internal Medicine
Robert D. Hanek, M.D.
Family Practice

fax: (907) 2(4-1541

Alexander T. Baskous, M.D.
Family Practice
J.C. Cates, D.O.
Family Practice

27-Apr-94

Dr. Donald Lehmann
700 Katlian Dr. Suite E
Sitka, AK 99835

Dear Dr. Lehmann:

Don Rogers asked that I communicate this information to you on the proposed vast "Alaska Health Care Data System".

I had thought when I was in Juneau all last week that I had finally taken care of this, but unfortunately it has arisen from the dead and is likely to be re-inserted into SB 367 when it comes out of Senate Finance. As of noon today, the bill had not yet been considered, but is likely first on the Senate Finance agenda at 8:30 tomorrow morning (Thurs.).

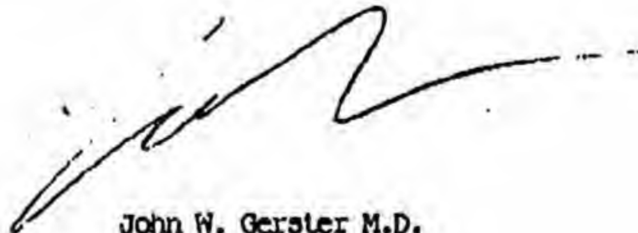
I am amazed how little play this enormous data system has received in the press. Commissioner Fuhs assured me personally that the fiscal estimate of $72 million is accurate, yet Sens. Frank and Rieger have literally laughed at the cost, and are determined to re-insert the Data System in the health care bill. (I think they owe a favor to Jim Duncan.)

Not only would the paper work be a huge hassle for physicians, but do Alaskans really want some monster computer in Juneau containing their diagnoses, referral patterns, and result of care?

I am writing to you in the hope that the Medical Society may be able to at least communicate to the Senators involved by first thing tomorrow; I fear that this will get rammed through with little or no debate.

Please read the information, and feel free to call me today to discuss it.
Office: 276-6301 Home: 346-3370

Thanks.



John W. Gerster M.D.

JWG/hs

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 367 (JUD)

Revision Date:

Title: Health Care Reform Committees

Sponsor: (S) HES

Requestor: (S) JUD

Dept. Affected: Revenue

BRU: R[illegible]anue Operations

Component: Income and Excise Audit

COMPONENT SERIAL NO. 113

new FN

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY			FY97	FY98	FY99	FY00
PERSONAL SERVICES							
TRAVEL							
CONTRACTUAL							
SUPPLIES							
EQUIPMENT							
LAND & STRUCTURES							
GRANTS, CLAIMS							
MISCELLANEOUS							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE: General	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) impact: $ 0.0

ANALYSIS: (Attach a separate page if necessary.)

This bill does not impact Department of Revenue.

Prepared by: Larry E. Meyers — Phone: 465-2320

Division: Director — Date: April 25, 1994

Approved by Commissioner: Darrel J. Rexwinkel — Date: April 25, 1994

Agency: Department of Revenue

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!pb:sb367

STATE OF ALASKA
1994 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO.: CSSB 367(JUD)

Revision Date: 4/25/94
Title: Health Care Reform
Sponsor: S. HESS
Requestor: S. JUD

Dept. Affected: Corrections
BRU: All
Component: All
Component Serial #: 694-1884

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXP.	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS,CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXP	0.0	0.0	0.0	0.0	0.0	0.0

CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY94) cost $ 0.0

POSITIONS

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

ANALYSIS: The Senate Judiciary version of the bill deletes the provisions for lowering DWI blood alcohol limit to .08%, upon which the expenses in the department's prior fiscal note were based.

Prepared by: Diane Schenker, Special Assistant
Division: Office of the Commissioner
Approved by: J. Frank Prewitt, Jr., Commissioner
Agency: Department of Corrections

Phone: 465-4643/786-2147
Date: 4/25/94
Date: 4/25/94

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 367 (JUD)

Revision Date:
Title: "An Act relating to Health Care..."
Sponsor: Senate HESS
Requestor:

Department Affected: Office of the Governor
BRU: Commissions and Special Offices
Component: Health Care Plan/Medical Practice Advisory Committees
COMPONENT SERIAL NO.

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	246.6	344.4				
TRAVEL	53.5	55.9				
CONTRACTUAL	209.0	245.9				
SUPPLIES	4.5	6.0				
EQUIPMENT	72.6	1.0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	586.2	653.2				
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						
FUND SOURCE						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	586.2	653.2				
1006 GF/MHTIA						
OTHER						
TOTAL	586.2	653.2				
POSITIONS						
FULL-TIME	6	6				
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

ANALYSIS: (Attach a separate page if necessary.)
See attached

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services
Phone: 465-3616
Date: 4/25/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor
Date: 4/25/94

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Rev 11/93

Travel - continued

Honorarium:

committee members receive $100/day honorarium

Health Care Plan Advisory Committee:

	FY95	FY96
assumes 2 day meetings	5,600	7,000
8 teleconferences	1,600	1,600

Medical Practices Advisory Committee:

	FY95	FY96
assumes 2 day meetings	3,200	2,400
3 teleconferences	400	800

Medical Practices Advisory subcommittees:

	FY95	FY96
assumes 2 day meetings	3,200	3,200

Contractual: 209.0 245.9

Professional Services:

	FY95	FY96
consulting actuary	10,000	10,000
legal services	70,000	70,000

Contractual costs per position:

	FY95	FY96
toll costs, postage, fax, utilities, etc.	54,500	70,400

Communications:

Health Care Plan Advisory Committee:
statewide teleconferences for public hearings

	FY95	FY96
teleconferences	28,000	28,000

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CSSB 367 (JUD)

Revision Date:
Title: "An Act relating to Health Care..."

Sponsor: Senate HESS
Requestor:

Department Affected: Office of the Governor
BRU: Commissions and Special Offices
Component: Health Care Plan/Medical Practice Advisory Committees
COMPONENT SERIAL NO.

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	246.6	344.4				
TRAVEL	53.5	55.9				
CONTRACTUAL	209.0	245.9				
SUPPLIES	4.5	6.0				
EQUIPMENT	72.6	1.0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	586.2	653.2				
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						
FUND SOURCE						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	586.2	653.2				
1006 GF/MHTIA						
OTHER						
TOTAL	586.2	653.2				
POSITIONS						
FULL-TIME	6	6				
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

ANALYSIS: (Attach a separate page if necessary.)
See attached

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services
Phone: 465-3616
Date: 4/25/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor
Date: 4/25/94

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Fiscal note reflects costs related to the Health Care Plan Advisory and Medical Practices Advisory Committees to June 30, 1996, repeal date of the enabling legislation per Sec. 31 of the bill. Fiscal note further assumes staff will serve both committees.

	FY95	FY96
Personal Services:	246.6	344.4

Personal services costs reflect 9 months in FY95, 12 months with merit increases in FY96.

1 Executive Director, Rg 23
3 Research Analysts, Rg 18
1 Administrative Assistant, Rg 12
1 Clerk, Rg 10

	FY95	FY96
Travel:	53.5	55.9

Health Care Plan Advisory Committee:
(7 members)
assumes 4 meetings FY95, 5 meetings FY96

	FY95	FY96
airfare/per diem	11,200	14,000

Medical Practices Advisory Committee:
(4 members)
assumes 4 meetings FY95, 3 meetings FY96

	FY95	FY96
airfare/per diem	8,400	6,300

Medical Practices Advisory subcommittees:
assumes 8 subcommittee meetings each fiscal year

	FY95	FY96
airfare/per diem	11,200	11,200

Staff travel:

meetings related travel and 3 out-of-state trips

	FY95	FY96
airfare/per diem	8,700	9,400

Travel - continued

Honorarium:

committee members receive $100/day honorarium

Health Care Plan Advisory Committee:

	FY95	FY96
assumes 2 day meetings	5,600	7,000
8 teleconferences	1,600	1,600

Medical Practices Advisory Committee:

	FY95	FY96
assumes 2 day meetings	3,200	2,400
3 teleconferences	400	800

Medical Practices Advisory subcommittees:

	FY95	FY96
assumes 2 day meetings	3,200	3,200

Contractual: 209.0 245.9

Professional Services:

	FY95	FY96
consulting actuary	10,000	10,000
legal services	70,000	70,000

Contractual costs per position:

	FY95	FY96
toll costs, postage, fax, utilities, etc.	54,500	70,400

Communications:

Health Care Plan Advisory Committee:
statewide teleconferences for public hearings

	FY95	FY96
teleconferences	28,000	28,000

Contractual - continued

Medical Practices Advisory Committee:
statewide teleconferences for public hearings

	FY95	FY96
teleconferences	7,000	14,000

Advertising:

	FY95	FY96
Public notice for meetings and public hearings:	21,000	22,000

Lease Space:

	FY95	FY96
175 sq.ft. per position x $1.80 sq. foot	17,000	26,700
facility rental for meetings	1,500	4,800

Supplies:	4.5	6.0

1.0 per position

Equipment:	72.6	1.0

work stations, phones, computer
equipment @ 12.1 per position